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The Significance of Relationships in Clinical Ethics: Lessons from the RESET Project via Symbiotic Empirical Ethics

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Abstract

During the early stages of the COVID-19 pandemic, many healthcare services unrelated to the virus were temporarily halted. In April 2020, the Department of Health in England directed that these services should be reinstated alongside ongoing pandemic management. This process of "resetting" healthcare created a novel context in which it became crucial to examine how ethical principles informed—and should guide—the incorporation of infection control into everyday clinical practice. This paper draws on findings from the 'NHS Reset Ethics' project, which investigated the routine ethical dilemmas faced in restarting maternity and paediatric services across the NHS during the pandemic. Healthcare practitioners and members of the public contributed through interviews and focus groups, with the detailed qualitative methods described in other publications. This article, however, centers on our application of Frith's symbiotic empirical ethics framework, which allows us to move from empirical observations to the normative proposition that clinical ethics should explicitly recognize the centrality of relationships in healthcare practice. The approach follows a five-step process designed to iteratively develop and refine ethical theory, grounded in a naturalistic understanding of ethics that views theoretical reflection and practical experience as mutually shaping one another. Findings from the Reset project indicated that modifications to working practices introduced ethical tensions for healthcare staff, while infection prevention and control measures often acted as obstacles to both providing and receiving care. For healthcare professionals, delivering care within the context of meaningful, relational interactions emerged as a morally significant aspect of clinical practice. Our study indicates that prioritizing the role of relationships throughout a hospital setting can better support the ethically significant, reciprocal expressions of care among healthcare professionals, patients, and families. We propose two strategies to advance this relational approach. First, clinical ethics practice should shift to explicitly recognize the importance of the networks of relationships—including those with the patient's care team—that shape patient experience. Second, organizational decision-making should consider the moral value that healthcare professionals place on caring relationships and acknowledge how these relationships can help navigate and resolve ethical challenges.

Keywords: Clinical Ethics, RESET Project, Symbiotic Empirical Ethics, COVID-19

Introduction

The COVID-19 pandemic has profoundly affected the UK's National Health Service (NHS), challenging core assumptions and guiding principles within clinical ethics frameworks that inform how healthcare professionals (HCPs) provide care to patients and their families. When planning to restart non-COVID-19 services while continuing pandemic management, decision-makers faced the ethical task of integrating infection prevention and control (IPC) measures into routine care. This dual focus introduced new dilemmas, as choices had to weigh patients' and families' access to care against the responsibility to protect hospital communities and the wider public from infection. Early pandemic guidelines, rapidly developed to address worst-case scenarios, [1] largely overlooked the complexities involved in maintaining non-COVID care alongside emergency pandemic responses.

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The Reset Ethics project (Reset) focused specifically on ethical challenges in reorganizing maternity and paediatric services during COVID-19. Maternity care was prioritized due to its essential, non-deferrable nature, while paediatric services were included because children generally faced lower risks of severe COVID-19 outcomes [2]. Concerns were also raised by professional and patient groups regarding the unintended harms of balancing these services with pandemic-related restrictions [3]. A rapid review of ethical guidance on restarting these services highlighted that IPC decisions, such as limiting visitors or relying on virtual consultations, could disrupt care models built around family-centered, relational approaches [1]. Our study aimed to examine how decision-makers navigated these ethical tensions while resetting non-COVID services after the UK Government's announcement on 29th April 2020.1 Although the plan was for a time-limited "reset period" with defined IPC measures, ongoing pandemic developments required continuous adaptation, including lockdowns, social distancing, visitor limitations, and mandatory use of personal protective equipment (PPE).

Data collected between November 2020 and July 2021 revealed that HCPs struggled to reconcile evolving IPC protocols with the professional and ethical standards they sought to uphold. Measures such as PPE requirements, social distancing, and restrictions on family presence—like limiting birth partners or allowing only one parent with a hospitalized child—were experienced as obstacles to forming meaningful patient and family relationships. For HCPs, the ability to provide care as part of relational interactions was perceived as a morally significant element of practice [4].

This article builds on these insights to examine the role of relationships within clinical ethics, using empirical evidence to suggest ways of addressing the ethical challenges faced by participants. We outline our application of an empirical ethics methodology to move from observed practices toward the normative claim that, particularly in maternity and paediatric settings, clinical ethics should explicitly recognize relationality as central to care. By doing so, our work contributes to ongoing discussions on how clinical ethics can be more effectively conceptualized, with implications that extend beyond pandemic contexts.

The article proceeds in several stages. First, we provide an overview of the Reset project, including its background, aims, and objectives. We then contextualize our findings within clinical ethics, noting that while relational aspects are increasingly recognized, they remain under-emphasized. This is followed by a theoretical discussion of relationality in healthcare. We next situate our study within empirical bioethics, a methodology that integrates empirical findings with normative analysis, and introduce Frith's symbiotic empirical ethics approach, which guided our thematic analysis.

Using this methodology, we examine the ethical issues reported by participants, highlighting tensions between traditional patient-centered clinical ethics and public health-driven pandemic ethics. The "resetting" of healthcare services brought these tensions into sharp relief, creating significant challenges for HCPs.

We conclude with a normative recommendation: clinical ethics should explicitly account for the relational networks surrounding patients, including their relationships with healthcare teams. Recognizing these relationships better reflects the ethical significance of relationality in healthcare and aligns with relational theories asserting that individuals are constituted through their networks of relationships, rather than as isolated, autonomous entities (emphasis added) [5].

Background

The reset ethics research

Although a considerable literature exists on ethical theories and national or international ethical frameworks relevant to pandemics [6], there is comparatively little empirical work examining how these frameworks are actually interpreted and used in day-to-day clinical settings. The COVID-19 crisis intensified the urgency of these questions and highlighted the need to understand how hospital leaders and HCPs could be supported when making rapid ethical decisions in unfamiliar conditions. Yet the policies and guidelines introduced to manage emerging ethical problems—particularly those linked to swiftly implemented, nationally mandated IPC measures and the resulting alterations to clinical work—received limited ethical scrutiny [7]. In particular, the policies intended to reorganise clinical services during the pandemic were rarely subjected to ethical evaluation [8]. The Reset project emerged in response to this gap, targeting the immediate need for ethical analysis and support within maternity and paediatric services. Rather than addressing a narrow research question, the project pursued a broad goal: to explore the everyday ethical difficulties created by the reorganisation of these services

during COVID-19; to investigate how HCPs understood and applied new policies and decision-making structures; and to identify which ethical concerns were most prominent in their clinical practice. Our intention was to propose ways of supporting ethical decision-making for HCPs operating under pandemic-related constraints, by developing empirically grounded, practical, and implementable recommendations for embedded ethics support in policy and clinical care [9]. Ultimately, the project aimed to contribute to normative ethical theory using empirical evidence.

To achieve this, we adopted the symbiotic empirical ethics approach [10], which employs philosophical analysis to interpret empirical data, generate normative insights, and formulate recommendations for policy and practice. The empirical findings have been presented elsewhere [4]. In this article, our focus is on applying Frith's empirical bioethics methodology—symbiotic empirical ethics (explained in detail below)—to develop normative responses to the challenges described by participating HCPs. A central question we address is whether clinical ethics should return to its traditional focus on the isolated individual patient, or whether a recalibration is required so that everyday clinical ethics explicitly incorporates attention to "the patient-in-relationships," recognising that individuals are, in fundamental ways, shaped by the relational networks in which they are situated [5].

Clinical ethics and public health ethics

For the purposes of this discussion, we take clinical ethics to encompass the ethical commitments that shape how all healthcare professionals (HCPs) engage with patients. A defining feature of clinical ethics is its focus on the direct encounter between clinician and patient [11]. This interaction is traditionally conceived as an individualised, one-to-one relationship grounded in a clinician's professional duty to place the welfare of their patient above all else [12]. This emphasis on the individual has deep historical roots in classical Greek medical traditions, most notably the Hippocratic Oath, which continues to inform contemporary documents such as the World Medical Association's Declaration of Geneva [13]. Within this framing, patients are often understood as autonomous, rational agents capable of articulating their own wishes and making decisions in accordance with their personal values [14]. Clinical ethics therefore largely centres on the clinician–patient dyad, with ethical decision-making oriented around respecting and enabling the autonomy of the individual patient [15].

Public health ethics, in contrast, begins from the responsibilities of the state to safeguard the wellbeing of the population as a whole, including protection from communicable diseases [16]. It prioritises fairness, collective welfare, and the distribution of risks and benefits at a societal level. In a pandemic, government interventions—such as national lockdowns—may justifiably restrict individual liberties in order to protect the community. For HCPs, moving between the individual-facing commitments of clinical ethics and the collective considerations of public health ethics can create tensions. These tensions are not unique to pandemics: even in ordinary circumstances, clinicians are rarely able to focus exclusively on a single patient, as doing so may disadvantage others under their care. As Daniel Sokol notes, clinicians are constantly required to rank and prioritise competing needs [17]. The COVID-19 pandemic intensified these longstanding pressures within the NHS, exposing the friction between individual-centred clinical ethics and broader public health imperatives.

Professional guidance similarly reflects the dual obligations HCPs must navigate. UK doctors must follow the General Medical Council's (GMC) guidance on good medical practice [12], which historically required that a clinician make the care of their patient their primary concern. Alongside this, the guidance also obliges clinicians to protect and promote the health of both patients and the wider public [18]. The Declaration of Geneva likewise requires healthcare professionals to share knowledge for the benefit of both individual patients and the advancement of healthcare more widely, and to maintain their own wellbeing so that they can practise safely [13]. These additions, as Laurie, Harmon and Dove observe, signal a shift towards a more communitarian ethos within the document [19].

Updated GMC guidance, in effect from January 2024, introduces subtle but notable changes to the framing of professional responsibilities. One such revision is the expectation to prioritise the care of patients—a shift from the previous focus on "your patient"—which signals a broader, more population-oriented understanding of professional duty [20]. Comparable language appears in the Nursing and Midwifery Council's Code, which directs practitioners to put the interests of people who use or require their services first [21]. These developments suggest that HCPs are increasingly expected to consider

more than the immediate needs of the individual before them, and that community-level considerations are becoming part of the ethical landscape of clinical practice.

Despite this, each HCP must still determine an appropriate balance between their obligations to the individual patient and their responsibilities toward the wider public. During the pandemic, mandatory IPC measures often removed the possibility of exercising such professional judgement. In the early phases—when SARS-CoV-2 was new and poorly understood—strict adherence to IPC protocols was widely accepted as necessary. As understanding of the virus evolved, however, many HCPs working in maternity and paediatric services felt that rigid infection-control requirements did not always acknowledge the importance of human contact and relational connection for patients and families. These concerns formed the basis of many of the ethical challenges described by our participants.

We argue below that the pandemic experience has underscored the need for clinical ethics to explicitly recognise the ethical significance of patients' wider relationships. Rather than maintaining a narrow focus on the individual patient while acknowledging, in parallel, concerns about public welfare, clinical ethics should also attend to the network of relationships in which patients are embedded. Family members, close friends, and other significant relationships shape the patient's experience of illness and care; yet current ethical frameworks do not consistently make space for these relational dimensions. While one might attempt to fold such relationships into the obligation to prioritise a patient's care, our data indicate that a more explicit recognition of relationality is essential.

We therefore propose a shift in how ethical priorities are conceptualised: moving away from a predominantly patient-centred orientation toward an approach in which relationships serve as a central organising principle. Such an approach would more effectively integrate clinical and public health ethics, acknowledging that patients are constituted through the relationships that sustain them. To develop this argument, we next turn to key theories of relationality and outline why a relational perspective is vital for re-envisioning clinical ethics and everyday healthcare practice. This theoretical foundation informs the analysis that follows.

Relationships and theories of relationality

Patients do not make healthcare decisions in isolation but within social, cultural and interpersonal contexts that shape and constrain what is possible for them [14]. This became especially clear during the COVID-19 pandemic, when many families were distressed by being unable to visit hospitalised relatives or accompany them at the end of life. Reflecting on these experiences, Carlos Gómez Vírseda and Rafael Usanos argue that relationality ought to be placed "at the centre of bioethical theory" [14]. Drawing on developments in the social sciences—such as cultural anthropology, nature-focused philosophy, and discourse ethics—alongside key movements in phenomenology, including philosophical anthropology, existentialism, and hermeneutics, they extract several foundational insights for a relational account of autonomy [14].

The first is that human beings are inherently biocultural and live through networks of social relations; these relationships are not peripheral but constitutive of human life [22]. The second is a cosmological insight that views all elements of the world as interconnected, positioning humans and their societies within a web of relationships that extends beyond individual persons [23]. The third insight concerns ethics: if moral life is relational, then ethical validity depends on shared reasoning among all who are affected, replacing the older idea of solitary moral judgement with one rooted in dialogue and collective agreement [24].

Gómez Vírseda and Usanos describe how each philosophical development carries implications for bioethics. Although their primary aim is to justify a relational model of autonomy, their broader analysis strengthens our argument that clinical ethics should adopt a more explicitly relational orientation—one that better serves patients, their families and friends, and the healthcare professionals who care for them. As Sokol notes, and as our findings reinforce, a relational perspective aligns more accurately with how clinical work is actually done [17]. Patients' experiences of illness and decision-making are inevitably shaped by their familial, social and community ties, as well as by the relationships they have with the healthcare team. Moreover, recognising relationality supports dialogue with moral traditions that depart from the assumptions of mainstream Western bioethics. The African framework of Igwebuike illustrates this: grounded in a metaphysics of interdependence, it treats human beings as fundamentally interconnected ("number is strength") and promotes virtues such as solidarity, mutual support and

identification with others [25, 26]. Behaviours that undermine human dignity or diminish relational "humanness" are rejected.

This notion of "humanness" is vividly reflected in the Reset project data. Participants—patients, family members and healthcare professionals—often described infection prevention and control (IPC) rules as obstructing a sense of compassionate, human-to-human care during the pandemic [4]. Here, humanness aligns with a relational ethic of care: an orientation grounded in emotional connection, empathy and presence with others [27]. Elements that interfered with such connection, like face masks or physical barriers, were experienced as disrupting the possibility of meaningful relational interaction [28]. Our findings therefore reiterate the real-world relevance of these theoretical ideas for healthcare delivery. In what follows, we argue that clinical ethics should explicitly acknowledge the relational dimensions of healthcare, both to protect patient and family well-being and to support healthcare professionals in their moral work. Although the existing Nursing & Midwifery Council Code and the recent revision of the GMC's Good Medical Practice already gesture toward a broader ethical horizon that extends beyond the single patient, we contend that clinical ethics requires a more explicit commitment to understanding each patient as embedded within a network of supportive relationships. Our research illustrates how central these networks are to people's experiences of illness and care. To situate our qualitative findings within a methodological framework, we now turn to outline the principles and practice of empirical bioethics.

Empirical bioethics: a summary

Empirical bioethics is recognised as a methodologically and theoretically demanding area of scholarship [29]. Researchers working in this field must navigate the conceptual, empirical, and metaethical difficulties that arise when attempting to bring empirical investigation and normative analysis together. This work is frequently undertaken by interdisciplinary teams. The defining purpose of empirical bioethics is to fuse the empirical and the normative, rather than to run them as parallel strands or to treat empirical findings merely as illustrative material for ethical argument. Achieving such integration requires transparency about the mechanisms by which empirical observations contribute to normative claims, and about why the resulting ethical conclusions can be defended. The central methodological challenge, therefore, lies in moving coherently from descriptive accounts of what is happening to justified claims about what ought to happen [30]. As Jonathan Ives and Heather Draper note, this involves acknowledging that facts and values are often intertwined in real-world contexts, while at the same time avoiding the classic philosophical pitfall of deriving an "ought" directly from an "is" [31].

A broad range of methodological strategies has been developed to help address this descriptive–normative tension [32]. In a systematic review of 33 papers, each outlining a distinct approach, Rachel Davies and colleagues found that most could be grouped into two broad categories: dialogical and consultative methodologies, with some blending elements of both [32]. Dialogical approaches aim to generate shared understandings—often regarding a specific ethical problem—via direct dialogue between participants and researchers. Consultative approaches, in contrast, gather empirical data from participants and then analyse it independently; researchers subsequently derive normative insights that either address particular applied issues or contribute to theoretical development.

In the next section, we explain how we employed the symbiotic empirical ethics approach to integrate our qualitative findings with the normative arguments presented in this article.

Materials and Methods

A full account of the study's qualitative design and procedures can be found in Chiumento *et al*. [4]. The brief outline offered here is included only to provide context for the later discussion of the symbiotic empirical ethics approach, which forms the core of this article.

The Reset project was carried out across five NHS trusts, recruited during late 2020—a period when the COVID-19 crisis continued to place extreme pressure on healthcare services [33]. As part of the project, we conducted interviews with senior operational leaders and with a range of healthcare professionals (HCPs). We also facilitated focus groups involving HCPs, clinical psychologists working in hospital settings, and members of the public. A detailed description of these processes, including how the data were generated and analysed, is reported elsewhere [4]. **Table 1** summarises the research timeline and provides relevant demographic details for orientation.

During interviews, participants were invited to discuss how decisions about reorganising and "resetting''

services were approached within their organisations, and to consider the ethical consequences of the substantial shifts in everyday clinical work. The focus groups were designed to probe these emerging issues further, drawing on perspectives from both professionals and the wider community.

The Reset project provides valuable perspectives on how senior NHS leaders, healthcare professionals in maternity and paediatric services, and the families who used those services navigated the 'reset' periods of the COVID-19 pandemic. As services were reorganised, everyday clinical routines and pandemic-driven public health requirements frequently pulled in different directions, creating points of friction that shaped participants' experiences. Our findings broaden the existing COVID-19 scholarship by offering insights that complement studies focused mainly on ethical dilemmas encountered during the earliest, most acute stages of the crisis.

There are, however, several limitations that should be acknowledged. Participation from Black and minoritised ethnic groups—which make up a substantial proportion of the NHS workforce—was limited, and it proved difficult to include more junior healthcare staff. Individuals who were shielding may also be under-represented. In addition, recruitment for the public focus groups relied on existing patient or involvement panels, meaning that many participants already had some familiarity with NHS governance or patient-engagement structures. This may have shaped which aspects of their experiences they foregrounded. Finally, although we argue that relationality is fundamental to all healthcare, the particular relational dynamics of maternity and paediatric care may mean that some of our conclusions have less direct applicability in other clinical fields.

To derive normative insights from the empirical material, we adopted Frith's symbiotic empirical ethics—a practical approach within empirical bioethics designed to support ethical reflection grounded in real-world contexts [10]. Davies *et al*. classify this method as consultative but leaning toward the dialogical end of the methodological spectrum [32]. The approach involves five interconnected components: (1) offering a detailed account of the situation under examination; (2) identifying the ethical theories and concepts that are relevant; (3) drawing on these theories to analyse the empirical findings; (4) developing ethical understanding or theory in light of that analysis; and (5) formulating justified normative recommendations [10].

Results and Discussion

We report our findings through the sequential stages of the symbiotic empirical ethics framework. Using the contextual accounts provided by healthcare professionals and members of the public who contributed to the Reset project, we argue that clinical ethics would be strengthened by adopting a more explicitly relational orientation. Such an approach, we suggest, would offer better ethical support not only for practitioners and patients, but also for families and the wider networks involved in a patient's care, thereby advancing the overarching goal of clinical ethics to promote high-quality care. For clarity and ease of reading, the participant quotations included in this article have been lightly edited and, where necessary, abbreviated.

Setting out the circumstances

Our interviews with senior leaders in participating trusts were designed to uncover the ethical commitments—both stated and unstated—that shaped their decision-making during service reset. Conversations with HCPs and focus group discussions provided a contrasting perspective, enabling us to explore how frontline staff experienced the consequences of those decisions. These discussions centred on the practical adjustments staff were required to make as paediatric and maternity services were reorganised, how HCPs felt about these changes, and the ethical difficulties that emerged from them.

Across our dataset, the ethical issues most commonly raised were linked to shifts in day-to-day practice imposed by pandemic IPC requirements, which disrupted nearly every form of relationship within the hospital environment:

Once services resumed, everyone had to remain in their own bed spaces—you couldn't, for example, go and comfort another parent whose child was heading to theatre. The whole atmosphere changed. We monitored this closely and stopped families from mixing. Before the pandemic, our ward was sociable: children often played together, physios would get them interacting across bed spaces, and parents built strong bonds. Staff usually cared for the same children for long periods, so relationships really formed. I'd often sit with a distressed parent for half an hour. All that communal, relational activity had to end.

– Ward manager, trauma/orthopaedic/ENT/spinal unit

Participants repeatedly emphasised that relationships are central to how maternity and paediatric care is organised—relationships between clinicians and patients, between clinicians and families, within families themselves, and within clinical teams. Restrictive visiting rules, although intended to protect everyone, challenged these relational foundations:

The visiting restrictions—sometimes allowing only one parent, sometimes none—put enormous pressure on families. Staff witnessed parents having to make major decisions alone. I remember accompanying a mother to theatre as a kind of stand-in partner, because she wasn't allowed anyone with her. She'd been preparing for her child's surgery for five years and needed support.

– *Clinical psychologist, focus group*

HCPs described these interpersonal, often physical, interactions as essential to providing meaningful care. Participants stressed that paediatric and maternity services rely heavily on shared emotional labour, family involvement, and collaborative decision-making. IPC rules, while protective, were felt to obstruct these practices and sometimes undermine patient care:

In rehab, children stay for long periods, and we usually work extensively with whole families—teaching them how to support the child and involving a wide network of caregivers. Normally the child is gradually reintroduced to extended family and familiar social environments. Under the one-parent rule, families became fragmented. Parents alternated at the bedside without ever being together to process what had happened. Children couldn't use communal spaces or go home for short visits. This had substantial negative effects on rehabilitation and on families' ability to understand and cope with trauma.

– *Paediatric physiotherapist, focus group*

Another participant described how relational restrictions affected clinical outcomes:

Only one parent was allowed, which was extremely hard—especially while their child was in intensive care and at risk of dying. Later, both parents developed symptoms and had to isolate, meaning they couldn't visit at all. This child had major, life-changing injuries. Normally we would involve siblings and extended family in rehabilitation, but none of that was possible. We couldn't even take him outdoors. It affected every aspect of his care, and he eventually went home with significant disabilities we would usually have helped the family prepare for.

– *Paediatric physiotherapist, burns specialist*

These experiences contributed to a broader sense of frustration and disappointment: many HCPs felt that long-standing efforts to embed family-centred care had been rapidly overridden.

In neonatal care, we've spent years moving away from a paternalistic model and toward genuine partnership with parents. Overnight, that progress disappeared. Fathers and partners were suddenly excluded. It completely contradicted our ethos, where families are seen as integral to the team. Watching years of work unravel was disheartening.

– *Consultant Neonatologist*

Members of our public focus groups expressed similar concerns. They described how IPC rules interfered with the supportive relationships they felt were fundamental—such as partner involvement during antenatal appointments, labour, and the care of hospitalised children:

I had severe perinatal anxiety and PTSD. My partner wasn't allowed to attend any appointments. I had a very distressing interaction with a consultant, and I had to cope with it alone. I gave birth wearing a mask—so my son's first sight of me was behind it.

– Public focus group participant

When pandemic and routine ethics intersect: identifying engaged principles and theories

Symbiotic empirical ethics is grounded in an Aristotelian perspective, which holds that ethical principles must be adapted to fit—and be made meaningful within—the specific circumstances in which they are applied [10]. While principles can exist in the abstract, they gain practical significance when translated into actionable guidance for real-world situations [34]. In this way, empirical data can help evaluate whether ethical frameworks align with particular contexts and indicate how principles might be specified to better suit those contexts. In this study, our focus is on the ethical principles underpinning clinical ethics, which broadly require healthcare professionals (HCPs) to act for the patient's benefit, minimise harm, and respect the patient's values and preferences [35].

Findings from the Reset project highlighted a tension in non-COVID clinical practice between the principles of routine, patient-centred care and the demands of pandemic-oriented, public health ethics. During the pandemic, protecting hospital staff, patients, and the

wider community from viral spread often conflicted with the priorities and preferences of patients and families.

This conflict between 'everyday' clinical ethics and pandemic-driven public health imperatives framed the experiences of our participants. When the first wave of COVID-19 struck the UK, national decision-making structures, necessarily designed for rapid deployment, adopted a one-size-fits-all approach. Under these rules, HCPs encountered significant practical obstacles in providing the level of patient-centred care that their professional ethics would normally demand:

"There's just no perfect PPE. The disposable masks run out, leave pressure marks, and don't fit everyone. The hoods with air packs are impossible—you can't hear anything and can't use a stethoscope properly. When I'm taking blood through a pump, I normally listen for bubbles all the time, but with the hood on, I can't hear anything."

– Nurse, paediatric intensive care

In the early stages of the pandemic, strict adherence to IPC measures often left no room for professional discretion or adaptation to the needs of individual patients and families. For many HCPs, this meant care that fell short of both professional ethical standards and personal moral expectations, creating profound ethical strain:

"If someone tests positive, they can't stay on the unit. I spent over an hour trying to manage a sick child, but mostly dealing with a father threatening to harm himself while Facetiming his crying partner. I asked middle management for guidance, and they said just ensure he doesn't act on it. I'm not a psychologist—how am I supposed to judge that? And if something happened, would it be my responsibility? It was emotionally draining. I could understand his perspective—he'd cared for his child for five years and didn't want to entrust them to strangers."

– Advanced nurse practitioner, paediatric intensive care

Even when some flexibility existed, staff sometimes felt unable to exercise discretion, constrained by long-standing strictures and concerns about infection risks to themselves, colleagues, and patients—especially in teams where colleagues had died from COVID-19 or where staff had witnessed severe illness:

"We introduced 'compassionate visiting' policies for individual cases—young women, anxious or previously traumatised patients who needed support. But staff were hesitant. They preferred clear rules: one partner only, and nothing else. Even after co-producing the policy, staff would check with me before making exceptions. I would tell them it's their call, and I would support it, but it took time. I think the anxiety and fear of doing something wrong really limited their initiative."

– Head of Midwifery

These accounts illustrate the ethical collision experienced by HCPs between the principles of routine, patient-centred care and the demands of pandemic-focused public health ethics. They underscore how the unprecedented context of COVID-19 created both practical and moral challenges, highlighting the importance of examining how ethical principles operate in real-world crises.

Using ethical theory as a tool of analysis

In this phase of symbiotic empirical ethics, moral concepts are treated as a knowledge resource that can be applied to understand the interactions between clinical practice, organisational and social roles, and normative principles [10]. Ethical theories and principles serve as analytic tools, helping to interpret data much like sociological theories are used to examine social phenomena. We applied these ethical frameworks to clarify disagreements, define key terms, and highlight ambiguities within the experiences reported by participants.

During the pandemic, clinical psychologists in the CP focus group reported an increased demand for psychological support from HCPs, reflecting the heightened strain on staff caused by changes in working practices. Pre-pandemic, psychologists were typically consulted when HCPs faced difficult clinical decisions or complex interactions with patients and families. Under pandemic conditions, staff were frequently placed in situations where they felt unable to act in ways they considered morally necessary for families. To compensate, they often went beyond the usual scope of their roles, taking on additional emotional responsibilities:

"It was incredibly hard, especially for mothers going through very difficult circumstances. They sought psychological support, but couldn't rely on the usual presence of partners or family. This placed a heavy emotional burden on us as well. The situations themselves were emotionally challenging, and having to

provide that extra layer of support made it even more difficult."

– Paediatric physiotherapist, burns specialist, clinician focus group participant

Our initial thematic analysis indicated that the ethical challenges described by interviewees were closely tied to the relational dimensions of care. Many of the reported difficulties stemmed from nationally mandated IPC measures—such as social distancing, visitor restrictions, and PPE—which had varying, sometimes cumulative, impacts as the pandemic unfolded:

"Safety must come first, but then there's the human side. We know we caused harm—not necessarily visible harm, since many of the women were otherwise healthy—but excluding partners at scans or during birth is something they can't recover. Women who were already isolated due to shielding suddenly found themselves entirely alone. It's a constant tension: balancing safety against the human need for connection."

– Head of midwifery

"I looked after a few parents who never saw their child together. The only time they were both present was to receive bad news. Then treatment was withdrawn. They won't have shared memories or common stories, which will affect their grieving. That's a really hard consequence of the pandemic—it's emotionally devastating."

– Nurse, paediatric intensive care

These accounts suggest that harms arose primarily from prioritising community protection over the family-centred relationships that are central to paediatric and maternity care. The problem was not the IPC measures themselves, which were necessary, but the way physical health was often prioritised over relational and emotional considerations. Removing professional discretion from HCPs—preventing them from engaging patients and their families in decisions or tailoring care to relational needs—was a key contributor. Being required to act contrary to these relational and ethical commitments created a disconnect for many participants between their daily practice and both their professional obligations and personal moral values.

Relationships recalibrated: developing theory from our data

The symbiotic empirical ethics approach is based on the idea that the relationship between theory and practice is reciprocal rather than linear. As Frith explains, theory can both guide the interpretation of data and be reshaped by what the data reveal. In this framework, theory helps explain findings and generate normative insights, while empirical evidence informs refinements or extensions of ethical theory. This approach allows ethical concepts to be responsive to practical challenges, with data helping to shape theories that are sensitive to real-world experiences. Using this interplay between theory and data, and drawing on our identification of the ethical importance of relationships in clinical care, we propose that explicitly attending to relationships could enhance both clinician and patient well-being and support ethical decision-making in healthcare contexts.

Our findings highlighted that the resetting of healthcare services during the pandemic had profound effects on the relational context in which care is delivered. Public health IPC measures shifted the NHS focus from the individual patient to a population-level perspective [36]. While individual patient care remained ethically important, this "frame shift" altered how HCPs interpreted their professional obligations, particularly the expectation in current GMC guidance that doctors make the care of each patient their foremost concern. Participants described being unable to deliver care in the way they felt was right. PPE, social distancing, and other IPC measures meant that "good enough" care—often mediated at a distance and behind barriers—was all that could be offered, even in situations of intense emotional or ethical complexity. This tension between pandemic-oriented ethics and everyday clinical norms was felt acutely across the networks connecting patients, families, and NHS staff.

Relational theorists argue that individuals are constituted through their networks of relationships [5]. The notion of humans as isolated, bounded individuals is therefore re-examined, with particular attention given to face-to-face interactions, which hold special significance in relational thinking [28]. Raul Lejano proposes that a logic of relationality—understanding the patterns and dynamics of relationships—better captures how people function together in practice [37]. He contrasts this with a rationalist, rule-driven approach, which focuses on compliance and output, often neglecting how policies are enacted in relational contexts. In practice, this rational logic can create gaps between formal rules and how they are interpreted or applied by those directly affected.

Applying Lejano's relational logic to healthcare practice encourages viewing HCPs, patients, and families not merely as rule-followers but as relational agents. In routine care, the interactions between colleagues, patients, and families help determine how rules are adapted to meet specific clinical needs. In emergencies, such as a pandemic, relational priorities may sometimes be overridden, but acknowledging the consequences of neglecting relational factors could encourage more nuanced applications of policies as knowledge about a disease grows. Relational logic emphasizes sequences of actions and responses that sustain relationships—within healthcare teams, between staff and patients, between teams and families, and among family members themselves. The objective is to foster understanding and consensus within the spirit, if not always the letter, of policy. In practice, such negotiations may involve HCPs, patients, or managers, and can even inform organizational change from the ground up.

A relational logic frames individuals as outward-facing, responsible for the effects of their actions on others, and constituted through relationships rather than existing as autonomous Cartesian subjects [38, 39]. Gómez-Vírseda and Usanos, in the context of the pandemic, provide a layered account of relationality in bioethics [14], which our findings empirically support. For both the public and HCPs, relational needs—emotional engagement, sharing major life events, supporting others, and making joint decisions—were central. Caring relationships between HCPs, patients, and families co-constitute identities as people-in-relationships, shaping both professional and personal selves. Our data illustrate the harms caused when these relationships were disrupted:

"We begged the trust to allow this woman in; she had two negative COVID tests, but the trust insisted she quarantine for two weeks. The baby deteriorated on day five and eventually died on day seven. That was the only time she saw her child. It's frustrating and angering, knowing you're just following government guidelines."

– Neonatologist, interview participant

Stringent public health measures, though intended to protect hospital communities and ensure healthcare delivery, limited or removed HCPs' ability to adapt policies to individual patient and family circumstances. Even when some discretion existed, staff were anxious about the implications of mistakes—such as a patient contracting COVID-19 or perceived unfairness in decisions. Our analysis suggests that many of the ethical challenges participants faced were linked to the non-negotiable nature of pandemic IPC measures.

Viewed through the lens of Gómez-Vírseda and Usanos' relationality and Lejano's relational logic, these findings highlight a tension between the rational, rule-focused logic of policy design and the relational interpretation HCPs enact in practice. Clinical ethics traditionally frames patients as rational, autonomous agents whose personal wishes guide care [14, 40]. Hospital policies are created with rational, outcome-driven objectives in mind, but in practice, HCPs interpret and apply them relationally. The extent of this relational prioritization varies by setting and specialty. While policy aims to meet regulatory or organizational targets, relational care is implicit, forming part of the "humanness" of everyday practice.

GMC guidance requires doctors to prioritize individual patients [12], yet does not explicitly account for the "patient-in-relationships," despite pre-pandemic maternity and paediatric practice recognizing families as part of the care team. During the acute COVID-19 phase, non-negotiable IPC measures often displaced these caring relationships:

"It's stressful when experienced, highly involved parents are excluded because they are integral to our team. They aren't just supportive; they are part of the treatment process. It's extremely difficult for staff to turn them away, knowing the crucial role they play."

– Paediatric intensive care consultant, interview participant

Discussion and conclusions – rethinking clinical ethics

We have argued that prioritizing the role of relationships in the wellbeing of hospital communities can better foster ethically important, multi-directional care between healthcare professionals (HCPs), patients, and their families. We are not suggesting that relationships are entirely ignored in healthcare decision-making—they clearly are recognized. Rather, we propose that policies and procedures should explicitly consider their potential impact on relationships, alongside rational outcomes such as infection prevention and control (IPC) measures. Importantly, this relational focus should apply broadly across healthcare decision-making, not only during crises or pandemics. We offer two recommendations to advance a relational approach. First, clinical ethics should explicitly acknowledge the significance of the networks of relationships—including those among healthcare team members—within which patients are situated [14].

Second, organizational decision-making should integrate the ethical value of caring relationships and recognize the role these connections play in negotiating complex ethical challenges.

Regarding the first recommendation, the pandemic heightened the difficulty for HCPs in balancing obligations to individual patients with duties to the wider community [41]. By explicitly recognizing relational considerations, the benefits of family support could be incorporated into HCPs' professional responsibilities. In practice, HCPs already consider broader concerns beyond a single patient's interests [17], reinforcing the case for explicitly foregrounding relationality. For example, guidance for neonatologists emphasizes that family-integrated care is central to the specialty, and that practitioners must understand the holistic approach required to build meaningful rapport with families [42]. Similarly, the Royal College of Midwives highlights the midwife's role in supporting women and their families throughout the childbearing process, assisting them in adapting to parental responsibilities [43]. The NHS as a whole is underpinned by relational values and priorities [44]. These professional guidelines demonstrate the importance of attending to the "patient-in-relationships," rather than solely as an individual, and this focus should be embedded in clinical ethics, as Gómez-Vírseda and Usanos have argued [14].

The second recommendation builds on the first. Recognizing relational networks in clinical ethics requires equivalent attention in organizational decision-making. Our findings indicate that positive relationships with colleagues and patients are critical to HCP wellbeing, particularly when ethically difficult decisions arise. Therefore, hospitals and other healthcare organizations should consider policies and decision-making approaches informed by, or at least attentive to, relational logic. This entails valuing a wider spectrum of human experiences in defining the patient and broadening the range of relevant outcomes considered in decisions. Lessons may be drawn from hospice care, where attention to a patient's "total pain"—encompassing physical, emotional, social, and spiritual dimensions—has reshaped interactions between healthcare professionals and dying patients [45]. Both current and previous GMC guidance require HCPs to assess patients by considering psychological, spiritual, social, economic, and cultural factors, alongside their values and needs [46]. Extending this attention to include patients' supportive relationships in organizational decision-making would be a logical and relatively modest expansion.

The Reset project demonstrates that interpersonal relationships are central to patient care. Without relational engagement, healthcare risks becoming purely functional treatment, distinct from holistic care [47]. Lejano similarly underscores that interpersonal relationships and everyday interactions are the mechanisms through which policies are operationalized, so that policy effectively becomes "the workings of relationships" [37]. This principle also applies to clinical ethics in practice, where emphasizing the "humanness" central to Igwebuike could serve as a way to evaluate policies and practices, improving both staff and patient wellbeing. We argue, therefore, that shifting clinical ethics to explicitly focus on the "patient-in-relationships" represents a well-justified normative recommendation.

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All experiments were performed in accordance with relevant guidelines and regulations (such as the Declaration of Helsinki).

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