

In critique of moral resilience: UK healthcare professionals' experiences working with asylum applicants housed in contingency accommodation during the COVID-19 pandemic

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ABSTRACT

This research explores the experiences of UK NHS healthcare professionals working with asylum applicants housed in contingency accommodation during the COVID-19 pandemic. Using a critical understanding of the concept of moral resilience as a theoretical framework, we explore how the difficult circumstances in which they worked were navigated, and the extent to which moral suffering led to moral transformation. Ten staff from a general practice participated in semistructured interviews. Encountering the harms endured by people seeking asylum prior to arrival in the UK and through the UK's 'Hostile Environment' caused healthcare staff moral suffering. They responded to this in several ways, including: (1) feeling grateful for their own fortunes; (2) defining the limitations of their professional obligations; (3) focusing on the rewards of work and (4) going above and beyond usual care. Although moral resilience is reflected in much of the data, some participants described how the work caused ideological transformations and motivated challenges to systems of oppression. We show how current moral resilience theory fails to capture these transformative political and social responses, warning of how, instead, it might encourage healthcare staff to maintain the status quo. We caution against the widespread endorsement of current formulations of moral resilience in contemporary social and political climates, where the hostile and austere systems causing suffering are the result of ideological political decisions. Future work should instead focus on enabling working conditions to support, and developing theory to capture, collective resistance.

INTRODUCTION

The UK has long operated a complex and chaotic asylum system, making it challenging for those claiming asylum to be granted protection. The Immigration Acts of 2014 and 2016 introduced further restrictions to welfare so that migrants face a network of immigration controls embedded into public services.¹ This 'Hostile Environment' aims to drive down net migration to the UK.² People seeking asylum can wait for years for a decision and may have to make repeated claims before refugee status is granted. Those awaiting a decision are forbidden from working and instead receive around £6.00 per day.^{3,4} People seeking asylum have no control over where they are provided accommodation, and the Home Office outsource the management of asylum accommodation to private providers in a way that creates 'a market-oriented transfer of

responsibilities'.⁵ 'Contingency accommodation' (CA) refers to temporary lodgings used when the usual housing stock is full. Typically, when a person's asylum claim is closed (granted or refused), they are evicted from their accommodation; however, this was suspended during the COVID-19 pandemic. As a result, the use of CA increased.⁶ Hotels provided the majority, but military barracks were also used.⁷ Concerns have been repeatedly raised regarding standard and unsafe conditions in CA, with poor food, a lack of access to sanitary products and an inability to access healthcare and store medication.⁸ Conditions at Napier army barracks received national attention and were described as 'not fit for habitation' by the Independent Chief Inspector of Borders and Immigration condemnation.⁹

The barriers faced by people seeking asylum when accessing healthcare before the pandemic are well documented.^{10,11} Though those with active asylum claims—asylum seekers—and those granted leave to remain—refugees—are eligible for free NHS care, those with asylum claims refused are considered irregular migrants and are chargeable for some services. In 2017, charging was extended, with costs to be paid before treatment.¹⁰ General practice (GP)—also called primary care—is the first point of contact for NHS healthcare for most. GP services remain free for all, but charges now apply to community services allied to primary care. The pandemic compounded this, as many services operated remotely. Multiple parties raised additional concerns about healthcare for those housed in CA.^{8,12} This considered, some GPs developed specialist services for CA residents.¹³

Recent attention has focused on how, globally, healthcare professionals (HCPs) work in increasingly resource-scarce complex and challenging social and political environments, and how this can cause moral suffering, distress and injury.^{14,15} Working with people seeking asylum is known to be challenging for HCPs and multiple studies have documented the moral dilemmas faced by NHS staff during the pandemic.^{16–18} However, we found no papers exploring the experiences of HCPs working with people seeking asylum during the pandemic, nor any work exploring the moral dimensions of care in this context. This research begins to address this gap. We explore the experiences of staff working in an NHS General Practice providing care to people seeking asylum housed in CA during the COVID-19 pandemic. The staff provided on-site



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face-to-face medical and social care at a new CA site housing over 200 people seeking asylum. The service was developed rapidly in response to the healthcare needs of the residents—a new local population—in early 2020. The team included general practitioners, nurses, mental health practitioners and students, several of whom had been redeployed from other NHS and social care roles as part of the pandemic response. Using a theoretical framework that critically considers the concept of moral resilience, we examine how staff navigated the difficult circumstances in which they operated, and the extent to which their moral dilemmas engendered personal or professional transformation.¹⁹ In doing so, we contribute to the literature that critiques the concept of moral resilience. We argue that the concept fails to capture moral transformation, nor does it facilitate challenges to hostile and austere social and political orders.

Research context

Theoretical framework: a critical perspective on moral resilience

Focus on individuals' resilience has grown in recent years; it is now positioned as a desirable trait for coping with stressors, and a key determinant in differentiating how individuals respond to adversity.²⁰ The concept of moral resilience has been proposed as a way of understanding how individuals respond to moral suffering in ways that allow growth and reorientation towards core values.¹⁹ Rushton defines moral resilience as 'the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion or setbacks'.¹⁹ Although there are recent calls to focus on relational aspects of moral resilience, most healthcare literature tends to adopt an individualistic lens, rooted in psychology.^{21 22} Moral resilience is frequently positioned as a healthcare workforce issue, due to the high rates of moral distress and 'burnout' in healthcare workers and the need for hardy workers who are able to withstand such a challenging environment.^{23 24} This has come to the fore during the COVID-19 pandemic, a time of increasing strain on NHS resources. As a result, some have called for the development of moral resilience-based prevention and intervention strategies, which focus on the individual, rather than the workplace.^{25 26}

However, a critique of the now omnipresent and popular concept of resilience is building. In 1981, Hooks highlighted how lauding Black women facing racism and sexism as resilient permitted such oppression to continue: 'endurance should not be confused with transformation'.²⁷ More recently, scholars and practitioners highlight how moral resilience places the onus on individuals to absorb stressors.^{28 29} Witnessing individual suffering may be inevitable in caring roles. However, the now-ubiquitous focus on 'resilience' in the context of cuts to healthcare resources and resultant strain on services responsabilises individuals, in this case HCPs, when in fact the hostile and austere systems underpinning this suffering are derived from ideological political decisions.³⁰

This considered, we adopt a critical perspective on the concept of moral resilience, taking Hooks and Traynor's cautions as our point of departure.^{27 30} We also draw on a hypothesis from Wiess and Gren who explored the moral discomfort of public sector employees working with refugees in Norway.³¹ They posit that although working in moral discomfort can be demanding, rather than evoking feelings of guilt or stress as in moral suffering, individuals adopted a reflective position to enable them to do 'a good enough job'. Thus, rather than moral discomfort being transformative it merely upheld the status quo through continuing 'mundane work practices'. Our theoretical framework thus urges a critical understanding of how and why actors operate in situations which challenge their morality; how making compromises

may inadvertently actuate complicity in hostile systems; and the extent to which they undergo individual and social transformation. In doing so, we examine the utility and limitations of the concept of moral resilience in contemporary healthcare.

METHODS

Study design

All HCPs (n=27) who had previously worked, or were currently working, within the GP service providing primary care to people seeking asylum living in CA were invited to take part in an online interview about their experiences by email. Semistructured interviews allowed exploration of the HCP experiences and provided space for participants to foreground issues important to them.³² Ten, including doctors, nurses, mental health practitioners, healthcare assistants and students volunteered to take part, some of whom had been redeployed to primary care due to the pandemic. All 10 were interviewed by GP, a predoctoral Clinical Academic who has formal training in undertaking research interviews and qualitative analysis. GP had no established relationship with the participants; at the outset of the interview, she introduced herself and her research interests in migrant health. Two site visits to the CA were undertaken by the LT and GP to familiarise themselves with the environment.

Verbal consent was obtained, and one-off one-to-one interviews were conducted between May and August 2021 using secure videoconferencing software. Interviews lasted 45 min to 1.5 hours and were undertaken at a time convenient to the participant, some dialled in from home, some from the workplace. No payment was offered.

An advisory group of HCP with relevant clinical and research experience developed a topic guide containing interview questions. Although this was subtly iteratively adjusted by GP, it formed the framework for all interviews. Notes were taken during the interview and audio recordings were transcribed verbatim by GP. All data were anonymised at source. Individuals' professional roles and other demographic data have been omitted from this paper to preserve anonymity, given the small sample size and particular research setting.

Data analysis

Thematic analysis was used, both LT and GP coded data using NVivo V.12 to increase analytical robustness. Dominant themes were derived from the transcripts, themes coded and data extracted. First phase analysis focused on barriers and mitigations of providing care in CA, and is explored elsewhere (in press). The personal and professional impacts of the work for the participants emerged as a dominant theme warranting additional examination. Secondary thematic analysis was therefore undertaken using Weiss and Gren's moral discomfort as a theoretical framework by GP, LT, KW and RF. This was applied to the data after collection, moral resilience was not a feature of the interview topic guide.

Research team and reflexivity

The research team are clinical academics with an interest in migrant health. LT (PI) and RF conceptualised and planned the research. LT led on developing study materials and ethics application. LT supervised GP in recruitment and interviews. All authors (LT, GP, RF and KW) contributed to the analysis and met regularly to discuss and triangulate findings. The risks of bias introduced by research undertaken by informed outsiders include the imposition of one's own beliefs and resultant social desirability bias. To mitigate this, the interview topic guide was

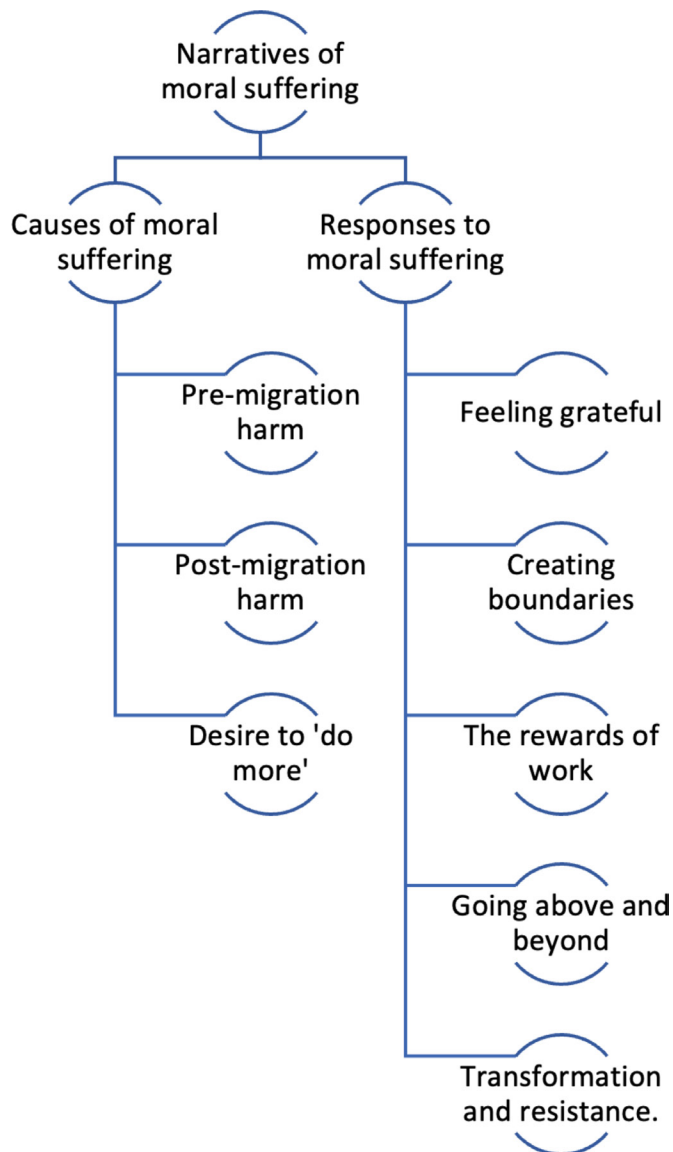


Figure 1 Coding tree.

developed with several clinicians, one of which who worked within the CA service. Some of the authors have undertaken migrant health advocacy work and have been critical of the UK government's treatment of people seeking asylum. This has the potential to shape both the data interpretation and concepts in this paper.

RESULTS

Results were coded, analysed, and are presented around the main themes which emerged from the analysis of (1) the causes and (2) responses to the moral suffering associated with the personal and professional impacts of work at the CA. Figure 1 provides an overview of the coding tree, around which results are presented.

Causes of moral suffering

The causes of moral suffering included the harm residents endured prior to arrival in the UK and harm sustained by the UK's 'Hostile Environment':

A lot of people have gone through all of these horrific experiences, but the thing that was getting to them was that they're sort of just

there in the (CA). And they have got nothing to do and they can't work because they have not been granted asylum ... this is the thing with getting to them. ... people have been waiting years for asylum and are just stuck there. (Participant 6)
it can affect people quite badly working here ... you can get emotionally entangled ... you hear a lot of horrific stories. You realize the world is a cruel place (Participant 7)
It's quite heart-breaking listening to people's stories. You feel quite powerless ... you do wish there was more that you could offer. (Participant 8)

Many also described significant workloads and persistent feelings that they wanted to 'do more'.

Responses to moral suffering

Participants' responses to this moral suffering evoked many of Rushton's core features of moral resilience.¹⁷ Five key domains emerged and are examined in turn: (1) feeling grateful, (2) creating boundaries, (3) the rewards of work, (4) going above and beyond and (v) transformation and resistance.

Feeling grateful: 'We get to leave, and everyone else has to stay'
Many participants described how their work made them feel lucky:

That was always that underlying feeling, we get to leave, and everyone else has to stay ... it just makes you think, and you realise how lucky you are to be in your situation. And you don't actually realise that until you've seen how other people live. (Participant 3)
It makes you think about the situation you're in; it's not too bad at all ... I come from my cushy home and my nice car, my clean clothes and have a nice hot shower and go home and have hot food. They don't have that at all. Working here has really made me appreciate it ... The other day I ordered a takeaway for £40 ... £5 is what they get for a week ... I'm more grateful ... I work through this situation because I know what situation they're in. (Participant 7)

Staff depreciate their problems using reflections on privilege to motivate their work. In this way, they respond to the injustices they witness by seeking meaning in their work and locating with aspects of life that engage gratitude—a core tenet of moral resilience.¹⁹

Creating boundaries: 'I'm going to do as much as I can, but I can't keep pushing it.'

Participants described creating boundaries and retreating from attempting system change to protect their own mental well-being:

Policies around the provision of housing and food are impenetrable. Impenetrable, to a point where for my own mental health, I had to step back because it was causing me some stress ... I feel like I'm going insane. So, I was just like, for me, I'm going to do as much as I can, but I can't keep pushing it. (Participant 6)
I'm not responsible for everything ... I think I would crack up myself if it was that. (Participant 1)

Others limited their exposure to patients' traumatic stories:

I think it has (affected me outside work) but I've got a bit of a guard up ... You know, there's so much trauma ... I feel like I could become attached. Sometimes I don't want to hear it. (Participant 7)

Here compromises and trade-offs are recognised: there is always 'more' that could be done, but this might cause harm—articulated as 'burn out', 'cracking up' and 'going insane'. Self-regulation and recognition of limitations—central features of

Rushton's moral resilience—are clearly demonstrated. By setting limitations, staff self-preserve and can continue their work; however, this limits their ability to make meaningful changes.

The rewards of work: 'It was one of the most useful and rewarding jobs'

Many participants described the importance of finding meaning in work. Often this was augmented by the social discourse around the plight of displaced people and the consequent deservingness of patients:

Being able to provide some sort of care and reassurance was, really, really rewarding ... you hear stuff in the news about asylum seekers and refugees, and think this is awful. (Participant 3)

It felt quite a positive thing to be doing. And you actually get a lot of affirmation from other people when you tell people you're doing it. So that's bolstering, isn't it? (Participant 9)

Perception of this work being 'useful' 'rewarding' and 'positive' seemed to be particularly important given the needs of the patients and the uncertainty surrounding the pandemic.

Going above and beyond: 'I will do what I can, money, food, whatever clothes, I will try my best'

A spectrum of going above and beyond usual care was described. For some, this involved working to the limits of their capacity:

I think all of us have probably worked far more hours than we ought to be working ... going above and beyond what might otherwise be expected within 'normal' primary care ... we know what's at stake with the people that we are caring for ... (they) are amongst the most vulnerable people on the planet. (Participant 1)

We just made sure that we do as much as possible in those hours that we work there, and then you sort of don't feel guilty anymore because you've done your best. (Participant 3)

Rushton suggests being able to discern when one has exerted sufficient effort to fulfil one's ethical obligations is a central feature of moral resilience. Participant 3 is explicit that doing their best mitigates their guilt.

Some made donations to patients. These accounts often included language about deservingness, vulnerability and gratitude.

I found out [a 6-month-old baby] had been in a lorry the week before ... that really got to me, thinking that this poor little baby ... I got some stuff for the baby and got her a pram ... from being in a lorry a week before to having a pram and some clothes make a massive difference. And then that helped her to be comfortable with us and disclose some more things she needed support with, so it was quite rewarding, definitely. (Participant 10)

I remember one guy came up to me, said 'I'm going to be made destitute, homeless.' I thought, geez. I said, 'here's my number. If I can do anything to help you, I'll get you a tent'. What can you say to that person? What can you do for that person to make them, no amount of tablets is going make that person happy? So, I thought, all I could do is say I will do what I can, money, food, whatever clothes, I will try my best. (Participant 7)

Participant 7 acknowledges the limitations of biomedical approaches to social suffering and a desire to improve the life of this person. This illuminates their frustration with the Hostile Environment and injustices faced by their vulnerable patients, who are denied adequate welfare support.

Transformation and resistance: 'It's changed my opinion'

Some participants described how their beliefs changed because of their work:

It's changed my opinion ... I think it made me a lot more aware of those situations ... it's changed my opinion on legislation surrounding asylum seekers and refugees. (Participant 3)

Many recounted attempts by the medical team to resist patients' deportation or detention, with some success:

A few times when patients were suddenly removed in the middle of the night ... they were sent to holding centres. I feel like the doctors went above and beyond and sometimes got them released and back, they really just spent so much time really just providing evidence and writing letters to support people with their applications (Participant 2)

Others used their newfound insights to challenge anti-asylum seeker and refugee sentiment beyond the workplace, both in direct conversation and through political action:

It was quite new to me to be honest, I didn't know that much about it (but) I wrote a couple of letters to MPs and stuff about the barracks that people were staying in and I signed some petitions ... I had quite a few discussions with people who were not necessarily racist but we're quite anti-refugee and I felt that they had no idea really what people had been through (Participant 8)

I've got my opinion now around refugees and asylum seekers, and it's evidence-based ... I have challenging conversations with people that I potentially wouldn't have been able to have beforehand. So, I challenge opinions, but with personal stories, now. (Participant 1)

Being resolute and courageous in moral action despite obstacles is essential to moral resilience. However, these narratives go beyond the maintenance of one's existing core values, the transformation which is not captured by the concept of moral resilience. Exposure to difficult stories of trauma and exploitation provided staff with an armoury for advocacy beyond the clinic. This challenges Wiess and Gren's theory of moral discomfort as being a morally inert state, instead suggesting that working within environments that challenge morality can be transformative.

DISCUSSION

This paper, which describes experiences of NHS staff working within a specialist service in a unique setting during the pandemic, makes empirical and theoretical contributions to existing literature. We provide an empirical insight into how contemporary hostile bordering practices in the UK play out in healthcare. We add to a literature problematising bordering in healthcare, shedding new light on the practitioners' perspective.^{33–35} Some redeployed staff, having never previously worked with people seeking asylum, expressed disbelief at the state-sponsored neglect they were subject to. For some, the injustice and suffering they witnessed resulted in reflections on their own lives with guilt, gratitude, or both. Illuminating these responses provides a social commentary on the current punitive governmental approach to immigration, and its human cost.

We also contribute to the literature on moral resilience. Understood as a way of (re)connecting to values and (re)orientating to drivers, Rushton's conceptualisation of moral resilience is evident through much of the data.¹⁹ Participants described self-regulation through setting limits on their professional obligations and counting their blessings, motivating themselves and

focusing on the rewarding nature of the work. These strategies for self-preservation allowed them to continue work despite insurmountable workloads, resource insecurity and frequent moral suffering. Thus, through Rushton's lens, moral resilience emerges as a positive phenomenon, and one with implications for workforce planning.^{23 24}

However, our analysis shows that HCP underwent and propagated ideological transformation, with some describing concrete political and social action. This was epitomised by participants 1 and 8 who use their new experiences to challenge anti-refugee sentiment beyond the workplace for the first time. In this way, we identify limitations for the current formulations of the concept of moral resilience. We also contest Wiess and Gren's hypothesis that working in morally challenging environments merely produces workers who adopt a negative affective state of discomfort.³⁰ Instead, we show how working in exceptional conditions—on-site in CA during the COVID-19 pandemic—might engender forms of solidarity and activism.

The origin of the term resilience comes from physics, where it is used to describe a material that bounces back into shape following a stressor. Moral resilience mirrors this; transformations in participants' moral ideology are, therefore, not reflected in current articulations of moral resilience. This omission limits its utility in the context of increasing social and political hostility. We echo Traynor's assertion that tolerance of the intolerable is not the right answer and caution the widespread application in contemporary social and political climates.^{30 31} Instead, our analysis suggests that Rushton's construction of the concept should be extended, particularly in the domains of being 'resolute and courageous in one's moral action, despite obstacles' and 'enacting moral outrage'.¹⁹ The compromises used by HCP to get the job done make clear the limits of current conceptualisations of moral resilience as a vehicle for anything other than maintaining the status quo. Although working to maximum capacity might absolve individual HCPs of feelings of guilt about patients' suffering, it changes nothing about the system that created hardship in the first place.

The analysis also raises ethical questions about what constitutes transformation, and adds to literature critically examining what counts as disrupting the status quo in medical activism.^{36 37} Those going 'above and beyond' worked extra hours or made charitable gestures to their vulnerable patients and described how they made a material difference to individuals' lives. However, a radical social justice lens questions this approach: the homeless and destitute asylum seeker, now with a tent, is still homeless and destitute.

Despite attempts to mitigate, the issue of social desirability bias remains a potential limitation in this data. The research also has a small sample size and unique clinical context. However, hostile border practices are increasing and questions about the role of healthcare provision in these contested spaces are increasingly important.³⁸ The interview data collected were rich and the analysis makes important empirical and theoretical contributions to current critical thinking on moral resilience. At a time of increasing inequalities in health and wealth, and continued cuts to healthcare resources, future research should explore how these findings translate to other clinical settings.

CONCLUSION

In conclusion, this paper has used a critical understanding of moral resilience to analyse NHS HCP accounts of working with asylum applicants housed in CA during the pandemic. Though Rushton's moral resilience is reflected in much of the data, the

concept is limited in two important ways. First, by failing to capture HCPs moral transformations and acts of political and social resistance. Second, and most importantly, is how an undiscerning focus on individuals' moral resilience maintains and sustains power differentials in healthcare by failing to support staff to properly consider the structural conditions that lead to moral injury and the role of HCP in tackling them at the root cause. We therefore add to the critical literature cautioning the widespread endorsement of the current formulations of moral resilience in contemporary social and political climates, where the hostile and austere systems causing suffering are the result of ideological political decisions. Rather than continued fixation on the concept of individuals' resilience, which can negate the potential for transformation, future work should focus on collective resistance, especially how to develop theory to capture this and enable working conditions to support it.

Contributors LT and RF planned the research project. LT led on the development of research methods, study protocol and ethics application. GP undertook the research interviews and transcription. LT and GP undertook coding of transcripts. All authors (LT, GP, RF and KW) contributed to the analysis and write up. LT acts as guarantor.

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