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Longitudinal Shifts in Illness and Moral Perception Among Hospital Staff During the COVID-19 Pandemic: A Study at Fundación Santa Fe de Bogotá, Colombia

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Abstract

Background: The COVID-19 pandemic triggered an unparalleled public health crisis, reshaping not only clinical environments but also the moral and psychological frameworks through which hospital staff understood vulnerability, responsibility, and care. This study explores how perceptions of "illness" and "morality" changed among healthcare and administrative personnel at a major Colombian university hospital, with the aim of identifying adaptive mechanisms and vulnerabilities relevant to future crisis preparedness and moral endurance.

Methods: Using a descriptive design with three repeated measurements and a small repeated-response subsample, the study covered three pivotal phases of the pandemic: June 2020 (M1), June-July 2021 (M2), and April 2023 (M3). Across these stages, 209 response records were collected through the Associative Network technique, which elicited spontaneous associations and brief narratives about "illness" and "morality." Qualitative interpretation was combined with descriptive quantitative analysis through polarity indices. Because most participants differed across moments, the study is best interpreted as repeated cross-sectional measurements with a small exploratory longitudinal component. Results: Perceptions of "illness" changed markedly, with polarity indices moving from -0.4 in M1 to -0.7 in M2 and -0.8 in M3. The strongest interpretation is not that illness was neutral at the beginning and only later became negative, but that an already affectively charged concept became more negative, personal, familial, and biographical as the pandemic unfolded. Healthcare professionals showed pronounced negativity, but the composition of the sample changed across moments; in M3, healthcare professionals represented approximately 40.6% of participants rather than the majority. Morality retained a normative core related to values, duty, conduct, respect, and responsibility, while also acquiring a practical and affective function as a resource for endurance, hope, self-strengthening, and relational awareness.

Conclusions: The prolonged crisis reconfigured the associative frameworks through which hospital staff understood illness and morality. Illness became less distant and more personally threatening; morality did not cease to be normative, but gained an additional role as a practical resource for sustaining action under shared vulnerability. Phronesis is therefore used here as an interpretive lens for situated practical wisdom, not as a directly measured empirical variable.

Keywords: COVID-19 pandemic, Illness Perception, Moral Perception, Vulnerability, Phronesis, Colombia.

Background

The COVID-19 pandemic constituted an unparalleled global health crisis, with no precedent since the 1918 Spanish flu, and left profound and lasting impacts on societies and individuals worldwide [1]. Although the immediate epidemiological and clinical aspects of the pandemic have been extensively documented, its deeper effects on human perception, particularly concerning fundamental concepts such as illness and morality, require sustained examination. This is especially relevant in hospital settings, where disease was not only an object of professional attention but also a personal, familial, and institutional threat. Colombia faced the pandemic amid social inequality, resource constraints, high hospital pressure, and a lower physician density than many high-income settings, making this case relevant to an international conversation about preparedness and moral life under crisis. As Spinney (2018) suggests in the context of the Spanish flu, historical distance often provides greater clarity [1]. Furthermore, moral reflection unfolds over time, justifying continued analysis years after the pandemic's peak intensity. Humanity will inevitably face future pandemics, making it necessary to learn from past experiences (Spinney, 2018) [1]. Analyzing the past is crucial for developing more effective future preparedness strategies [2]. This study focuses on how perceptions of the health-illness continuum and morality evolved among hospital staff, individuals at the epicenter of the pandemic. Its contribution is descriptive and interpretive: it reconstructs how staff associations changed across three pandemic moments and how those changes may be understood in light of vulnerability, adaptation, relational responsibility, and phronesis understood as situated practical wisdom.

Methods

Study Design and Setting

This study employed a descriptive design with three repeated measurement points. It was conducted at Fundación Santa Fe de Bogotá (FSFB), a major university hospital in Colombia, and received approval from the institutional Research Ethics Committee. Because most respondents differed across moments, the full dataset should not be read as a stable longitudinal cohort. The design is better described as repeated cross-sectional measurements with a small exploratory repeated-response subsample. Its objective was to characterize perceptions of illness and morality among hospital personnel, including both healthcare and administrative staff, during the COVID-19 pandemic.

Participants

A total of 209 response records were collected across the three time points: 79 in Moment 1 (M1), 61 in Moment 2 (M2), and 69 in Moment 3 (M3). The age distribution remained relatively consistent across moments; participants ranged from 20 to 70 years of age, with the predominant group, 70% of the total cohort, aged 30-49 years. However, the distribution by role, healthcare professional versus non-healthcare staff, varied significantly. In M1, healthcare professionals constituted the majority, approximately 70%, whereas in M2 their participation decreased markedly to approximately 28%-30%. In M3, healthcare professionals accounted for approximately 40.6% of participants, while non-healthcare staff comprised approximately 59.4%. This correction is important because M3 should not be described as having a healthcare-professional majority. The shift may be attributable to the extreme workload experienced by healthcare professionals during the pandemic's peak. Approximately 10 participants provided repeated responses in two or three moments, but only two clearly provided responses in all three moments; therefore, the individual longitudinal component should be treated as exploratory.

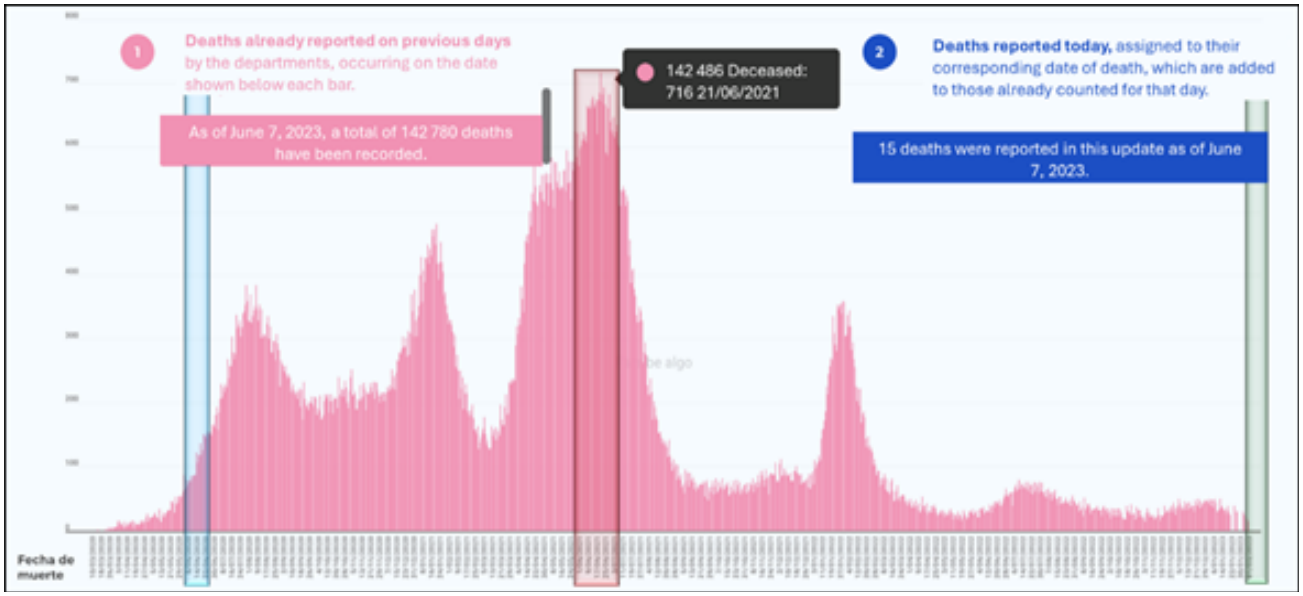
Data Collection

Data were collected using the Associative Network technique, which served as the primary data collection tool [3-5]. This technique allowed exploration of perceptions associated with the inductive term's "illness" and "morality." The study was implemented virtually, consistent with institutional efforts to reduce participant burden and minimize contagion risk during the pandemic. Participants were asked to provide four words associated with each central term and then explain why they had associated those words with the term. Data collection occurred at three distinct moments reflecting different stages of the pandemic in Colombia (Figure 1):

- **Moment 1 (M1):** June 2020. This period corresponded to the early phase of national lockdowns and closures of social spaces, with intensive care unit (ICU) occupancy at approximately 50% and daily national deaths below 75 (Figure 1, first column).

- **Moment 2 (M2):** June-July 2021. This period coincided with the highest peak of contagion and mortality, which overwhelmed ICUs. National ICU capacity increased from fewer than 5 000 to more than 13 000 beds, and daily national deaths ranged from 500 to 700. This period was characterized by intense media attention to the pandemic and by the arrival of vaccines in Colombia in February 2021 (Figure 1, second column).
- **Moment 3 (M3):** April 2023. This period occurred after the pandemic had ceased to dominate public attention, additional ICU capacity had been closed, and COVID-19 had begun to be framed as a past event. Data collection took place shortly before the World Health Organization declared the end of the public health emergency of international concern on May 5, 2023 (Figure 1, third column).

Figure 1: Reported COVID-19 Deaths in Colombia by Month



Source: National Institute of Health of Colombia. The shading indicates the timing of data collection: blue, Moment 1; red, Moment 2; green, Moment 3 (https://www.ins.gov.co/Noticias/Paginas/Coronavirus.aspx).

Contextual Pandemic Factors

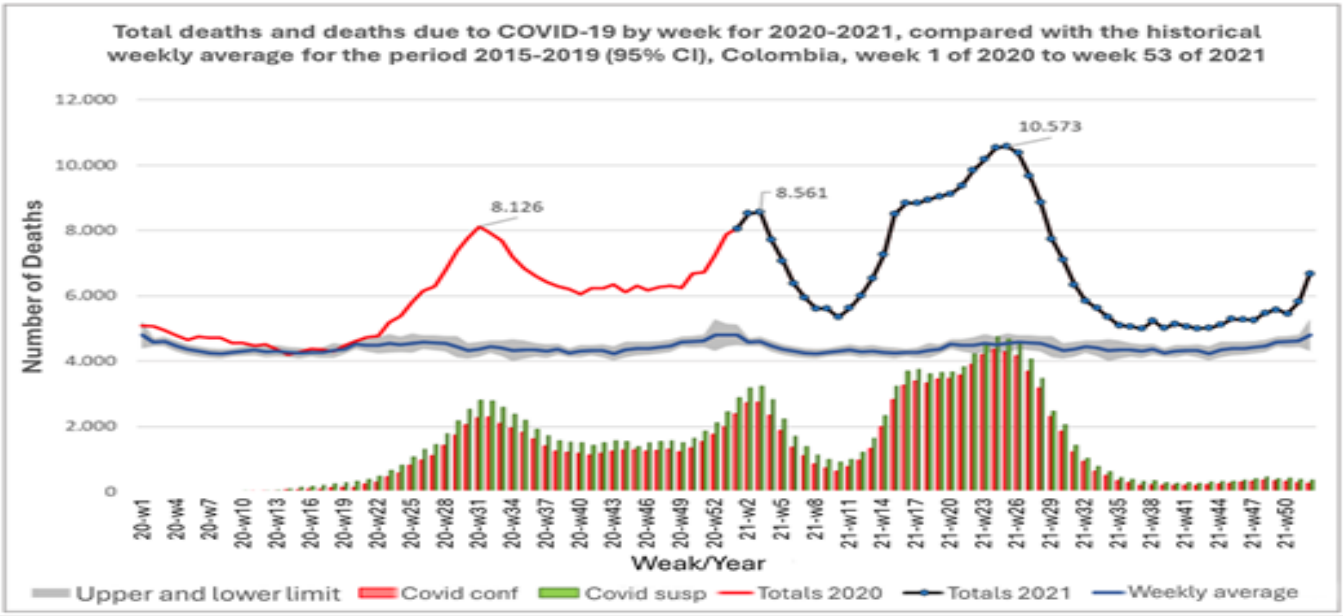
The study period spanned from the initial Colombian lockdown in March 2020, through the vaccine rollout beginning in February 2021, discussions of herd immunity in August 2021, and societal fatigue and polarization, including anti-vaccine versus pro-vaccine debates, long-COVID concerns, and new variants in 2022, to the official end of the global health emergency in May 2023. At FSFB, numerous pandemic-related strategies were implemented, including daily virtual briefings, remote work arrangements, daily health reporting for staff, mental health support programs such as "Self-Care to Share Care," and extensive research activities, including this study. Vaccination of staff began in March 2021. These national and institutional elements are not outcomes of the present study, but they are relevant contextual variables for interpreting the differences between M1, M2, and M3. By M3, most participants reported having contracted the virus, and approximately 20% reported the death of a family member due to COVID-19 across the study period (Table 1). National data indicated substantial excess mortality during the pandemic peaks, highlighting the immense pressure on the healthcare system and its professionals (Figure 2) [6]. Colombia's baseline physician density of 2.5 per 1000 inhabitants is below the global average, a factor that exacerbated workforce scarcity during the crisis (World Bank, n.d.).

Table 1. Self-Reported COVID-19 Exposure and Familial Mortality (%)

Question	Moment	No	Yes
Have you been diagnosed with SARS-CoV-2?	M2	75%	25%
	M3	25%	75%
Has a family member been diagnosed with SARS-CoV-2?	M2	39%	61%
	M3	13%	87%
Has a family member died from SARS-CoV-2?	M2	79%	21%
	M3	80%	20%

Source: Study data.

Figure 2. Excess Mortality in Colombia, 2020-2021



Source: MINSALUD (2022) [6].

Data Analysis

The analysis focused on describing the characteristics and evolution of perceptions elicited by the Associative Network technique, examining evaluative components and implicit attitudes toward "illness" and "morality" across the three time points and between staff groups (healthcare vs. non-healthcare). The polarity index was used descriptively to characterize the valence of associations, calculated as positive associations minus negative associations divided by the total number of classified associations. Qualitative analysis of the associative narratives was performed to contextualize and deepen understanding of the associative network findings. The narrative corpus was organized in NVivo, and the final interpretation integrated the polarity indices with thematic reading of participants' explanations. Comparisons were made across time points to identify temporal shifts. A separate analysis was conducted of the small repeated-response subset in order to distinguish aggregate temporal change from individual continuity.

Results

Perception of Illness

A notable shift occurred in the perception of "illness" between M1 and the subsequent moments, M2 and M3. The overall valence of

the term became increasingly negative over time (Table 2). However, M1 should not be interpreted as emotionally neutral in a broad sense. The change is better understood as intensification and displacement: illness became less distant and less exclusively clinical, and increasingly personal, familial, and biographical.

Table 2: Polarity Index of the Term "Illness"

Group		Value	Polarity
Total health		-0.6	Negative
Total non-health		-0.6	Negative
Total M1		-0.4	Less negative than M2 and M3
Total M2		-0.7	Negative
Total M3		-0.8	Strongest negative predominance
Health	**M1**	-0.4	Less negative than later health-care staff measurements
	M2	-0.7	Negative
	M3	-0.8	Negative
Non-health	**M1**	-0.2	Weak negative predominance
	M2	-0.7	Negative
	M3	-0.7	Negative

Source: Study data. Polarity values are interpreted descriptively; no a priori categorical threshold is assumed.

- **Moment 1:** Healthcare professionals perceived illness partly as an inherent aspect of their work. However, their negative valence toward the term "illness" was already more pronounced than that of non-healthcare staff, suggesting that professional familiarity did not eliminate negative valence. This supports a cautious interpretation: the pandemic intensified and personalized an already affectively charged concept rather than transforming a purely neutral concept into a negative one.
- **Moments 2 and 3:** The perception of illness shifted significantly toward a personal and family threat for both groups. This negative perception intensified, particularly among healthcare professionals, by M3. The increased negativity in M2 was linked narratively to fears of personal and familial contagion, fatigue, loss, and proximity to death. In M3, this perception persisted despite the decline of the public emergency, suggesting that the symbolic and moral effects of the pandemic extended beyond its acute epidemiological phase.
- **Narrative Volume:** The volume of written narratives associated with "illness" decreased in M2, potentially reflecting staff overload, especially among healthcare professionals, whose participation rate also declined. Conversely, narrative volume was highest in M1, possibly indicating a need for catharsis amid the initial uncertainty. Direct COVID-19 terms did not dominate the associations as strongly as might be expected; this suggests that the pandemic reshaped the broader semantic field of illness through pain, death, uncertainty, family vulnerability, incapacity, anguish, and loss.

Perception of Morality

Narratives associated with "**morality**" were generally more descriptive and often attempted to define the concept, particularly in M1.

- **Moment 1:** Morality was frequently associated with appropriate professional conduct, or deontology, and was also described with an individualistic focus, presenting it primarily as a personal attribute detached from its social dimension. This indicates that morality retained a strong normative core related to values, duty, conduct, respect, and responsibility.
- **Moment 2:** A shift occurred in which "morality" also emerged as a personal resource for coping and resilience, captured

by the notion of "**bolstering one's morale**" to face adversity. This suggests a link between moral concepts and affective states used to manage pandemic-related challenges. The pandemic did not replace deontological or normative morality with affective morality; rather, it added a second function: morality as a way of sustaining action amid fear, uncertainty, fatigue, and vulnerability. The analysis also revealed greater visibility of interdependence, including family, support, society, community, teamwork, coexistence, and shared responsibility, but this should be understood as increased relational salience rather than conclusive evidence of collective moral transformation.

Longitudinal Subgroup Analysis (Participants at M1, M2, and M3)

Analysis of the approximately 10% of participants present across all three moments revealed significant transformations:

- **Illness Perception:** The change in attitudes toward illness was more pronounced between M1 and M3 than between M1 and M2. Alongside persistent negative attitudes, some positive or adaptive associations emerged by M3, suggesting possible learning, acceptance, renewed attention to care, or resilience after prolonged exposure. Because the repeated-response subsample was small, these findings should be understood as interpretive indications rather than robust evidence of individual longitudinal change.
- **Moral Perception:** The evolution toward greater emphasis on moral development and human interconnection observed between M1 and M2 likely continued between M2 and M3. The evidence is consistent with the broader interpretation that morality retained normative meaning while gaining a more practical and relational function; it should not be overstated as proof of universal moral development.

Discussion

This study shows dynamic shifts in how hospital staff perceived illness and morality throughout the COVID-19 pandemic. Illness became progressively more negative, less distant, and more personally and familially charged. Morality retained a normative core, but also emerged as a resource for endurance, hope, practical orientation, and relational awareness. The evolution in illness perception among healthcare professionals, from viewing illness partly as an integral component of professional identity to perceiving it as a profound personal threat, underscores the psychological and moral toll of prolonged exposure to risk, uncertainty, and loss. This internalization aligns with documented findings of increased stress and burnout [7-9]. Although shared vulnerability could theoretically enhance empathy, the negativity observed here underscores the critical need for institutional support and self-care strategies, such as the "Self-Care to Share Care" program implemented at FSFB [10,11].

The evolution of moral perception requires careful formulation. A tempting but overly strong claim would be that morality shifted from a deontological concept to an affective or relational one. The data support a more precise interpretation: normative morality remained present, while crisis conditions made visible an additional function of morality as support, endurance, and practical orientation. The emergence of "bolstering one's morale" suggests that morality was used not only as a cognitive framework for judgment but also as an affective resource for psychological endurance, a finding that resonates with theories linking morality and emotion [12]. This counter relativistic views in which morality is solely a matter of individual preference, while also highlighting the social nature of ethics during public health emergencies that require balancing individual liberties with collective well-being [13,14].

The findings from the repeated-response subgroup, which showed the emergence of positive attitudes toward illness by M3, may reflect psychological adaptation or resilience. However, the subgroup is too small to support strong individual-level longitudinal claims. Phronesis offers a useful interpretive frame, provided that its status is kept clear: the study did not measure practical wisdom directly and does not prove the existence of collective phronesis. What it can reasonably claim is that the observed changes are compatible with a phronetic interpretation. Under uncertain and morally demanding conditions, staff adjusted their frameworks of

meaning in order to sustain action, recognize dependence, and navigate tensions between self-care, care for others, professional duty, and collective responsibility. The pandemic also reshaped temporal perception, establishing itself as a major biographical and historical marker. Narratives frequently referenced a clear temporal demarcation, "before" and "after" the pandemic, consistent with literature on pandemic-induced disruptions to the sense of time's passage [15].

These findings echo historical observations that moral frameworks adapt to context; the values emphasized during crises, such as the competitive virtues in Homeric warfare described by Crisp (2013), may differ from those prioritized in peacetime [16]. The pandemic context foregrounded tensions between individual liberty and collective protection, professional obligation and personal limits, and technical response and moral endurance. Maliandi's convergent ethics (2010a, 2010b, 2013) helps clarify this point: the associative changes observed here may be read as attempts to reorganize tensions rather than as evidence of a completed moral transformation [16-19].

Limitations

This study's findings should be interpreted in light of its limitations. Although data were collected at three time points, most of the analysis is based on repeated measurements with changing participants rather than a full longitudinal cohort. Only a small core group participated across more than one moment, and only two participants clearly responded in all three moments. The sample composition also changed across moments; the reduction in healthcare staff participation in M2 likely reflects workload during the pandemic peak and may have influenced aggregate comparisons. The study was conducted within a single hospital context, Fundación Santa Fe de Bogotá, so its value lies in situated depth rather than statistical generalizability. The Associative Network technique captures spontaneous associations and brief narratives, but it does not directly measure psychological distress, moral development, resilience, or phronesis as psychometric variables. The polarity indices are descriptive and must be interpreted together with the qualitative material. Finally, reliance on self-report and a single analytic strategy may introduce common method and confirmability limitations.

Conclusion

The Reconfiguration of the Moral Self in Crisis

This study does more than chronicle perceptual shifts among hospital staff during the COVID-19 pandemic; it maps a reconfiguration of moral meaning when people are confronted with sustained vulnerability. The findings present a narrative of moral transformation, moving from the abstract toward the embodied and from the individual toward the relational. This evolution should be read proportionally: it does not prove universal moral development, but it does show that morality may function not only as a static code of conduct but also as a practical resource for navigating vulnerability.

The initial perception of "**illness**" as a professional, manageable object and "**morality**" as a deontological or individualistic framework represents a state of relative professional equilibrium. In this state, a psychological and ethical distance separates the caregiver from the patient and the self from the other. The pandemic disrupted this distance. As illness moved from a clinical problem into an imminent personal and family threat, it weakened the protective separation created by professional roles. This was not merely a psychological burden; it was also a moral and interpretive crisis that forced a re-evaluation of the relationship between vulnerability, duty, and care.

The subsequent emergence of morality as a resource for "**bolstering morale**" is one of the most significant findings of this study. It signals a functional expansion: morality was not only a cognitive tool for judging actions but also an affective and existential resource for endurance. When external structures of certainty and safety are weakened, moral agents may turn to internal and relational resources that allow them to keep acting, caring, and deciding under pressure. This is not ethics abandoned for survival; it is ethics made practical under conditions of crisis.

This inward turn, however, did not result in isolation. On the contrary, it made interdependence more visible. The shared experience of vulnerability challenged the image of the autonomous, self-sufficient moral agent. The shift from an individualistic to a more social and developmental understanding of morality suggests that, in a crisis, ethical life is realized not only in duties to others but also with and through others in a bond of shared precarity. This is the basis of a relational ethics forged in the context of a common threat.

Therefore, the discourse on memory, forgetting, and Aristotelian phronesis finds a more precise grounding here. Practical wisdom was not measured directly, and it should not be presented as a demonstrated outcome. Rather, phronesis helps interpret the capacity to deliberate and act under contingent, unpredictable, and morally demanding circumstances. Hospital staff, in adapting their moral frameworks from abstract principles to relational resilience, may be understood as engaging in situated practical wisdom. They were not merely applying ethics; they were trying to sustain ethical agency in real time [20].

Ultimately, the lesson of this pandemic for bioethics and moral philosophy extends beyond institutional preparedness understood as logistics alone. It challenges institutions to move beyond ethics conceived only as risk management or rule application. The task is to cultivate moral capacities, both individual and institutional, capable of supporting adaptive, relational, and resilient action. Future crises will require institutions not only to operate effectively, but also to sustain shared moral capacities under uncertainty.

Epilogue in a Figure: Comparison of Scenes from the Spanish Influenza and the COVID-19 Pandemic

As we stand at the intersection of history and lived experience, the visual epilogue presented here invites reflection on the enduring human response to pandemic crisis, a response that transcends generations, cultures, and medical paradigms. These juxtaposed scenes from the Spanish influenza and COVID-19 pandemics are not merely historical artifacts; they are vivid reminders of collective vulnerability and resilience.

Figure 3: Comparison of Scenes from the Spanish Influenza and the COVID-19 Pandemic

A: Japanese schoolchildren wearing protective masks during the 1918-1920 influenza pandemic.

B: Japanese schoolchildren wearing protective masks during the COVID-19 pandemic in 2021.

C: Emergency hospital established for influenza patients at Camp Funston, Kansas, 1918.

D: IFEMA field hospital in Madrid established for COVID-19 patients, 2020.

E: Mass grave in Philadelphia during the 1918 pandemic.

F: Mass grave in New York City during the COVID-19 pandemic, 2020.

Declarations

Ethics approval and consent to participate

This study was approved by the institutional Research Ethics Committee of Fundación Santa Fe de Bogotá under document CCEI-12141-2020. The Research Ethics Committee approved the study for digital implementation, allowing participation without a signed consent form. Participants indicated their agreement by responding "yes" and completing the digital questionnaire, which was considered confirmation of voluntary participation. This procedure was permitted because Colombian Regulation 8430 of 1993 classifies this type of research as posing no risk. The study also adhered to the principles outlined in the Declaration of Helsinki. Participation was voluntary, and no economic compensation was offered.

Consent for Publication

Not applicable.

Availability of Data and Materials

Due to institutional confidentiality policies and in accordance with the ethical guidelines of Fundación Santa Fe de Bogotá, access to the databases generated and analyzed in this study is restricted. However, data may be formally requested from the institution, subject to review and approval in compliance with current institutional and ethical standards.

Competing Interests

The author declares that she has no competing interests.

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Authors' Contributions

The author contributed to the conception, design, data collection, analysis, and writing of the manuscript. The author read and approved the final version of the manuscript.

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