

Public Ethics in Emergencies: Learning from the COVID-19 Pandemic

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Introduction

This chapter explores the lessons that can be drawn from the ways in which bioethical governance operated during the COVID-19 pandemic. First, it examines the way in which our thinking is framed because this may substantially determine the policy choices that we make. We need to align the ways in which we think in order to respond collectively to challenges. Second, it explores the contemporary context of public reasoning. Assumptions about public information and communications from previous pandemic planning frameworks proved unreliable during COVID-19. The ways in which we talk about issues are crucial to successful public engagement as we coordinate responses. Third, this chapter examines the governance of ethical concerns. During COVID-19 the institutions that public health experts anticipated would protect against the risks of pandemics dissolved at the very moment when they were expected to come into their own. Lessons can be drawn to help us to prepare better for the governance of bioethical deliberations in future emergencies. If we can think more consistently, talk more effectively, and act more coherently, then we can hope to respond better.

Thinking in Emergencies: The Importance of Ethical Frameworks

Ethical frameworks can be used to increase ethical awareness, provide guidance for action, and improve deliberation [1]. They can also provide a benchmark against which to assess plans, including when holding individual people, organisations, and governments to account for their actions [2]. COVID-19 has proved particularly challenging because there has been no consensus on the best way to frame the ethical and political problems that we have faced. This section outlines four dimensions in which frameworks need to operate when societies face all-consuming emergencies.

Clinical Ethics

Typically, discussions about resource scarcity assume that responsibility sits with frontline clinicians to determine what care should be offered to which patients, perhaps with institutional or clinical ethics support [3,4]. Their actions are judged against ethical principles such as those proposed by Ezekiel Emanuel and colleagues of maximising benefits, treating people equally, promoting and rewarding instrumental value (although avoiding the risk that people's wealth should determine whether they live or die), and giving priority to those people who are worst off [5]. From a similar starting point, and building on significant previous conceptual and public engagement work, Douglas White and colleagues express concern about categorical exclusions and point out the need to avoid 'morally irrelevant considerations, such as sex, race, religion, intellectual disability, insurance status, wealth, citizenship, social status, or social connections' [3]. Their solution is a points system based on capacity to benefit. They propose adapting it to prioritise those people who are vital to the public health response, although the definition of this category and the rationale are unclear. Where scores are equal, life cycle considerations would justify the prioritisation of young patients so that they get an opportunity to pass through life stages.

However, the key ethical questions that COVID-19 makes us confront go beyond individual clinician-patient transactions.

Public Health Ethics

Public health ethics does not sit in opposition to the focus on specific patients, but it supplements it with additional consideration of the social and system contexts in which it rapidly becomes apparent that trade-offs may be necessary [6]. It emphasises rights to

health and security, recognises interdependencies, and is concerned with exacerbation of vulnerabilities that are associated with public health emergencies [7–9].

These emergencies may include matters within the scope of health systems. Thus guidance from the Intensive Care Society in the UK sets out a capacity management matrix that identifies the responsibilities of leaders within the health system to provide mutual aid in order to avoid the need to consider the prospects of a patient surviving and receiving ‘sustained benefit’ if admitted to critical care [10]. More broadly, it is necessary to consider whether to limit some services in order to increase the resources of another (e.g., intensive care for patients who have COVID-19), or whether to prioritise one aspect of wellbeing over another (e.g., survival over mental health for people who are advised to self-isolate). There may be pressures to adapt regulatory systems, such as emergency authorisations for medicines with reduced efficacy and safety data [11].

Processes are important. Vaccination ethics recognises that the need for collective action requires oversight by a politically legitimate authority [12]. Usually authorisation is additional to consent. However, if the urgency of the situation is thought to justify mandatory immunisation, the decision of the legitimate authority may be alternative to patient’s consent [13,14]. Similar principles apply to other interventions, including non-pharmaceutical ones such as quarantine and contact tracing. Good governance requires evaluation to see whether interventions can reasonably be expected to achieve their objectives [15], and that options are submitted for decision to an appropriate authority [16]. This body should be accountable for the reasonableness of its decisions by reference to criteria that are acceptable to the public who are affected, and ideally tested through some form of deliberative democratic process [17–19].

Public health ethics recognises that this involves deploying state power [20]. Health is not the only legitimate goal, and citizens retain rights against interference [21]. Governments should seek to use the least restrictive or coercive means to achieve public health gains [22–24]. Therefore public health ethics is underpinned by political theory [25].

Justice Approaches

The UK Pandemic Influenza Planning Ethical Framework, on which the response to COVID-19

has drawn, sets out the fundamental principle that ‘everyone matters equally’. This egalitarian commitment does not require each person to be treated identically, but it does mean that their interests are the concern of us all, and of society, and that they must be treated fairly and with respect [26].

Generic social distancing requirements (including lockdown, stay-at-home, and shelter-in-place) may seem to treat everyone in the same way, but the practical and psychosocial impacts can be widely different. Some jobs enabled people to work effectively at home with reduced outgoings but stable income. Those people will have experienced net economic benefits. Other people have seen dramatic reductions in income, or lost their jobs, but they must continue to eat and pay rent.

Health and social impacts are also not uniform. Staying at home may not be particularly isolating for people with strong social networks that are maintained remotely through social media and video links. For lonely people and for some who have mental health conditions, the cost of social distancing may be much greater [27]. Equal treatment may not be fair or equitable if it has harsher impacts on some than on others.

Fairness may require that people who are adversely affected are compensated so that impacts are equalised. Some have argued that those most vulnerable to the adverse effects of the virus should get greater protection in order to equalise their chances of surviving [7,8]. Governments in rich nations have responded with expensive support packages, sometimes subsidising employers to keep people in work, and sometimes providing direct payments.

Justice considerations are particularly important when trade-offs are required, choosing who will gain and who will lose as well as assessing net impacts. An aggregate benefit may obscure very different impacts on individual people. COVID-19-related deaths occur mainly in older age groups, but it is younger people who suffer most directly from economic recession, and this raises questions of inter-generational justice.

The impact of the virus has been more severe in communities that have suffered historical injustices and to whom we may have an obligation to put right those structural disadvantages and restore an equality of respect and dignity. In the UK, people in Black communities have been more likely to become ill, and less likely to survive [28]. Death rates in the most

deprived areas of England are more than double those in the least deprived areas [29]. The principles at stake can be articulated in terms of the proper response to vulnerability [30], health justice in realising capabilities [31], or the ‘right to health’ [32,33].

The Good Society

Finally, we should frame our thinking about public ethics in an emergency by considering our vision of the sort of society in which we aspire to live. The European Group on Ethics in Science and New Technologies argued that ‘Good leadership in times of crisis is dependent upon protecting and promoting democracy, and human rights and the rule of law’ [34]. It stressed the value of social solidarity, which it described as a ‘social vaccine’, and it noted how the pandemic had elicited acts of kindness that must be encouraged. The emphasis on solidarity and state responsibility can be contrasted with the focus on liberty and the limits of governmental power in the debates across the USA. In the UK, tensions have been apparent between libertarian approaches that shy away from state diktat, and support for collective and mutual responsibility.

We need to align these domains of thinking if we are to frame our collective response effectively. Clinical and public health ethical frameworks and decision-support tools should be consistent with a common understanding of the justice issues that is in turn compatible with our shared sense of the idea of a well-functioning society. This is very difficult to achieve in the current context of democratic deliberation.

Challenges of Public Reason

Effective public reason was particularly challenging during the COVID-19 pandemic. It operated in a political context in which trust in experts had been undermined, and a social context in which there had been an explosion of channels for public debate. Lack of transparency undermined confidence further, and the need to address societal taboos over discussing death and dying exacerbated the challenges.

Dwindling Faith in Expertise and Lack of Transparency?

The established practice of the UK when presented with a major threat is to convene the Scientific Advisory Group for Emergencies (SAGE). This brings

together relevant expertise, tailored to the circumstances, under the leadership of the Government Chief Scientific Adviser. SAGE had been activated eight times since 2009, including in relation to threats from the Zika, Ebola, and swine flu viruses. COVID-19 required a much more extensive and intensive coordination of expertise. SAGE met 74 times during 2020 alone, whereas for Zika it met only five times in total, and for Ebola there were three meetings. Even during the H1N1 swine flu pandemic there were only 22 meetings between May 2009 and January 2010.

The complexity of COVID-19 can be seen in the additional expert groups that fed into SAGE, namely the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B), the Scientific Pandemic Infections Group on Modelling (SPI-M), the PHE Serology Working Group, the COVID-19 Clinical Information Network (CO-CIN), the Environmental Modelling Group, COVID-19 Genomics UK (COG-UK), Health Data Research UK (HDR UK), the Children’s Task and Finish Working Group, the Hospital Onset COVID-19 Working Group, the Ethnicity Subgroup, and the Social Care Working Group (SCWG).

Despite this mobilisation of expertise, and high public trust in science [35], the UK has struggled to maintain public trust in expert-driven decision making [36]. It was undermined by lack of transparency. Although SAGE first convened for COVID-19 in late January 2020, the membership, minutes, and papers remained obscure until May. Among the consequences of this early lack of transparency was establishment of a rival ‘Independent SAGE’ (Indie SAGE) in early May 2020. This group aims ‘to provide independent scientific advice to the UK government and public on how to minimise deaths and support Britain’s recovery from the COVID-19 crisis’, and ‘was founded with the intention of putting scientific facts and debate into the public domain’. The implications of this way of explaining the mission of ‘Independent Sage’ are, of course, that government advisers lack independence and therefore should not be trusted, and that there is a conspiracy against the public to keep them in the dark about the science.

Anti-Societal Media?

As COVID-19 hit, contemporary politics had become aggressively divisive, and public health measures such

as mask wearing became treated as indicative of ideological allegiances. This trend might decrease as we reflect on the experience, but other factors are likely to present enduring challenges.

First, social media has dissolved, or at least diluted, trusted sources of truth in public discourse. During COVID-19, governments, scientists, and clinicians have struggled to be heard above the clamour of competing claims to be the voice of truth. Conspiracy theories abound, ranging from denial of the existence of the virus through its deliberate introduction (including from China into the USA or vice versa, by Bill Gates or by Big Pharma) to dissemination via 5G [37]. False news travels further and faster than scientific truth [38]. People who rely on social media for information are more likely to hold conspiracy beliefs about COVID-19, and those who hold such beliefs are less likely to exhibit health-protective behaviours [39], or to comply with government guidelines [40].

Second, demand for soundbites and slogans makes measured, timely responses hard to communicate. Simplicity is valued at the expense of accuracy on complex and uncertain issues. In the UK, public health messages were distilled into slogans such as ‘Stay Home, Protect the NHS, Save Lives’. These are unhelpful to those people whose circumstances depart from the assumed norm, such as essential workers who must leave home to support the NHS, or those for whom economic or social circumstances make compliance unrealistic. However, debate about these issues is suppressed in the public sphere for fear of undermining the impact of the ‘nudges’ that are being applied. They are behavioural interventions rather than vehicles for conveying information, and their use gives credence to people who are concerned that they are coercive impositions rather than health advice.

Third, the desire of media outlets constantly to report success and failure and to hold people to account led to perverse incentives and premature certainty. From the early stages of the pandemic, governments felt compelled to promote numbers of tests without regard either to the reliability of the tests (some of which had to be withdrawn from the market) or to whether the results would prompt any action [41–43]. Testing became an end in itself. In the UK, high numbers of tests were not matched with efficient contact tracing or with effective encouragement of people to self-isolate. This departed even further from the scientific rationales for testing when it played into the need of the media to find people to

blame for not achieving the promised number. The context of scrutiny therefore served to incentivise poor public health practice.

‘Tragic Choices’

The third contextual element that hampered public reason during COVID-19 concerned the difficulties that officials face when exploring ‘tragic choices’, in which all of the available options present uncomfortable ethical problems. In private ethics, it is acceptable to privilege your own values or the needs of people close to you. In academic ethics, it is permissible to explore the taboo and unpalatable. However, in public ethics, the first is regarded as selfish and the second rapidly exposes officials to attack rather than debate. Academics and clinicians can readily debate matters such as prioritising scarce critical care resources without attracting criticism – it is the essence of their role [5,44,45]. Things are trickier for official bodies.

In late March 2020, the UK’s Moral and Ethical Advisory Group (MEAG) discussed a draft document on critical care prioritisation that built on an evidence review of the significance of age in predicting prognosis. In the event this was not progressed, as it became apparent that there was sufficient critical care unit (CCU) capacity to avoid the need for rationing. At much the same time, the National Institute for Health and Care Excellence (NICE) was preparing a rapid guideline but did not include any data on the extent to which age was an independent predictor of outcomes. These events are linked by the understandable fear among public bodies of being accused of discrimination, as indeed they were [46,47].

We should be worried about discrimination, but the effect of these pressures was to prevent a public discussion, and to drive the work into an obscure section of a professional society website [10]. Given the evidence of poor survival of older people with COVID-19 admitted to intensive care, it is plausible to argue that, where resources are scarce, it is unethical to discriminate against young people by ignoring evidence of their better chances of successful treatment. However, such nuances are obliterated by the weaponisation of media slogans such as those typifying attempts to apply ethical guidelines as being ‘death panels’ [48]. There are important ethical issues to be explored, and survey work by academics suggests that there would have been broad support for maximising survival [49]. However, the media and

political climate mitigated against public reasoning on this issue.

The dynamics of power and accountability link only very loosely and unstably with the concerns of public ethics as we have presented them. This presents formidable challenges in ensuring that politics and the wellbeing of the people come together. Therefore we turn to consider how governance has worked during the pandemic.

Governance and Coordination Problems

During COVID-19, anticipatory governance was exposed as inadequate [50]. The structures in place for bioethics governance [51] have largely given way to broader politics. Failures of government responses have led to ethical matters becoming subsumed into partisan politics and market forces, and subjected to the threat of judicial determinations. The weaknesses of our processes for coordination of society for the common good were exposed.

How It Was Supposed to Work

Viral pandemics have been on national risk registers for decades. The International Health Regulations of 2005 specifically provide for ‘public health emergencies of international concern’ (PHEIC). Although under protracted discussion since 1995, it was the challenges of severe acute respiratory syndrome (SARS) in 2003 that prompted the agreement of the new Regulations [52]. Further learning from the H1N1 flu pandemic and from Ebola prompted the World Health Organization (WHO) to assert the idea of a shared global sovereignty to better protect the world from threats of pandemic diseases [53]. Scholars identified the opportunities for ‘adaptive governance’ in which reflexive learning could enhance the ability of health policy to deliver outcomes that respond to the values, interests, and concerns of stakeholders [54]. Problems were modelled in late 2019 during a simulation exercise convened by the Johns Hopkins Bloomberg School of Public Health, the World Economic Forum, and the Gates Foundation.

The international experience shows that the bioethics governance could operate as anticipated. The WHO declared that COVID-19 met the criteria for a PHEIC on 30 January 2020, when 98 cases had been identified outside China across 18 countries, of which four had seen local human-to-human transmission (Germany, Japan, Viet Nam, and the USA). Since that

period, it has issued regular briefings and developed materials to support states in responding. By February 2020 the WHO had established a Working Group on Ethics and COVID-19, which published on resource allocation, various aspects of research ethics, and digital contact tracing [55–57]. In April 2020 an ethical statement from the UNESCO Bioethics Committee, a body charged with advancing a shared understanding of global bioethics that transcends cultural differences, stressed the vulnerabilities that COVID-19 was exposing [58]. In a number of countries the mechanisms for bioethics governance worked as anticipated. The French standing advisory *Comite Consultatif National d’Ethique* produced an opinion on ethical issues by 13 March 2020 [59]. An opinion on solidarity and responsibility in COVID-19 was published by the German ethics committee towards the end of March, and another on immunity certification was published in September 2020 [60,61]. In Italy the national bioethics committee published opinions on triage criteria in early April [62], and on matters of public health, freedom, and solidarity in June 2020 [63].

How It Happened

However, this pattern was not seen in the UK. According to the Global Health Security Index, the two best prepared countries in the world were the USA and the UK. Both have long traditions of public health and bioethical leadership, and both have extensive resources. The UK had undertaken a careful review of learning from the H1N1 flu pandemic [64]. It had publicly reaffirmed its commitment to the Ethical Framework that had been drawn up in 2007. It convened the MEAG, although its existence was not announced for many months after its first meeting, as a successor to the Committee on the Ethical Aspects of Pandemic Influenza. The Nuffield Council on Bioethics, the nearest the UK has to a national bioethics committee, published a very timely report, *Research in Global Health Emergencies* [65]. However, despite the resources of the UK, the expected mechanisms for bioethics governance failed to inform the government response effectively [66,67].

MEAG met frequently to discuss issues and provide informal advice to officials, but its minutes reveal little of the substance of that advice, raising concerns about transparency. Although COVID-specific statements of principle were issued for Scotland and Wales

[68,69], MEAG published no specific opinion. In part this reflects a divergence of views and approaches within the group that made it hard to reach a consensus in the time available. However, it may be connected with a concern about expert advice being used to criticise the government.

There was also a tendency of the governments in the UK and the USA to resist using existing expert bodies. Rather than building on the experience of PHE, a new Joint Biosecurity Centre was established and, in the midst of the pandemic, it was announced that PHE would be dissolved and a new National Institute for Health Protection established (subsequently set up with the title UK Health Security Agency). Despite the UK's long-established public health services, the government was quick to seek private sector involvement in personal protective equipment (PPE) procurement, data analysis, testing, and contact tracing.

This interplay between science and politics was manifested in the context of vaccine delivery, illustrated by the prioritisation of first doses for many people over the twin doses recommended by the manufacturers. In the UK a detailed scientific review led to an independent recommendation by the Joint Committee on Vaccination and Immunisation to take this step, in order to increase the short-term impact of vaccination in the face of a rapidly escalating wave of infections. However, this decision was quickly politicised. It was raised in an intervention by former Prime Minister Tony Blair prior to the data being clear, and attacked by French President Emmanuel Macron, who in turn was attacked in an outbreak of vaccine nationalism [70]. An apocalyptic post on Twitter suggested that the UK was doing exactly what the virus needed to create resistance to vaccines [71]. Vaccine diplomacy has become as much a political tool as a public health measure [72].

Conclusion

COVID-19 has shown us that we lack an accepted conceptual approach to balance and mediate the competing demands that the pandemic has made on states. The UK government has been unable to articulate the rationales for its responses, and has lurched, consequentially, between health and economic perspectives. The problems that we have discussed about suspicion of expertise and the degradation of public discourse are global. COVID-19 may have rekindled our faith in science, but it is also possible that rising mortality is blamed on failure of science. Some social media

platforms are beginning to recognise the damage that they have done to the common good by failing to address misinformation and allowing the algorithms that drive targeted dissemination to stoke conspiracy theories. The pandemic has exposed the weaknesses of our collective thinking, our readiness to discuss the issues rationally and effectively, and our ability to act effectively in the public good. Rebuilding effective public ethics in its wake will present a monumental challenge. We must attempt it, but it is imperative that we do not underestimate the task if we are to respond better to future pandemics than we have to COVID-19.

In the wake of the COVID-19 pandemic, there is an increasing awareness that health security will depend on improved recognition of the interdependence of human and animal health, universal access to health-care, and reduction in inequality. Global health governance needs to develop accordingly [73]. In public ethics, trust in the integrity and ethical orientation of decision-makers is of fundamental importance. Unless people believe that decisions are driven by values that they recognise as appropriate, they will not take the advice given to them. Two principles follow from this. The first is that there must be openness and transparency about the ethical issues and approaches that are being applied. Without this, people cannot trust that decisions are ethically informed. The second principle concerns the democratic legitimacy of those values in pluralist societies. People do not necessarily need to agree with government decisions, but they do need to accept that they are reasonable and responsible. This requires deliberative processes that generate commonly accepted ethical guidance. These principles can be brought together by using the techniques of deliberative democracy to review the ethical frameworks that have been developed during the pandemic for revision as necessary. Government should then reaffirm its commitment to using them.

In the short term, this offers a mechanism for addressing the fragmentation of values that is currently seen in many Western societies. Whether it has an impact in future pandemics will depend largely on whether governments stick to their plans or abandon them. No amount of ethical preparedness can prevent leaders believing that the situation is unique and that the plan has to be ignored. Improved planning does not guarantee that the lessons will be learned, but this should not prevent us from trying. The success of our future responses to emergencies is probably more dependent on the renewal of

democratic government than on any specific steps taken within public ethics. Thus the integration of clinical and public health ethics with wider concerns about social justice is crucial.

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