Chapter 8
Principlist Pandemics: On Fraud, Ethical Guidelines, and the Importance of Procedural Transparency

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Abstract The COVID-19 pandemic has coincided with the proliferation of ethical guidance documents to assist public health authorities, health care providers, practitioners and staff with responding to ethical challenges posed by the pandemic. Like ethical guidelines relating to infectious disease that have preceded them, what unites many COVID-19 guidance documents is their dependency on an under-developed approach to bioethical principlism, a normative framework that attempts to guide actions based on a list of *prima facie*, unranked ethical principles. In this chapter, we aim to explore the limits and limitations of pandemic ethical guidance documents as, specifically, *ethics* documents—documents that fulfil the functions of ethics as a fundamentally normative discipline. This means not only determining whether such ethical guidance documents can, in principle, provide adequate action guidance and action justification, but also, more importantly where pandemics are concerned, determining whether they support *consistent* decision making and *transparent* processes of justification. Having highlighted the problems with merely furnishing ethical guidelines with *substantive* ethical content in terms of principles and values, we argue that organizations that develop these documents should focus on the *procedural* dimensions of action guidance and action justification, which extend to questions regarding the make-up of the committees, panels and groups that develop such guidelines, the public transparency of justifications for specific pandemic-related advice or interventions and the development of explicit procedures for transparent and consistent decision making.

Keywords COVID-19 · Pandemic ethics · Principlism · Ethical guidelines. · Ethics expert. · Rawls · WHO · Public health ethics

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8.1 Introduction

The COVID-19 pandemic has generated a vast amount of bioethical research, particularly with regards to ICU triage, disparities in the impact of COVID-19 on different ethnic and social groups, the mental health effects of lockdowns, immunization priorities, the employment of challenge studies for vaccine development, immunity "passports", immunization incentives and the vaccination of children. In addition, there appears to have been a greater than usual demand for the involvement of bioethicists in the public sphere, particularly in print and broadcast media. However, it is in the development of so-called COVID-19 ethical guidance or other advisory documents that bioethicists have had their biggest impact during the pandemic.

Although ethical guidelines pertaining to COVID-19 clinical and public health policy have been produced by governments, state and federal agencies, health care providers and professional bodies across the globe to assist health care practitioners and staff with responding to the ethical challenges posed by the pandemic, it should be noted that the "ethical frameworks" and recommendations presented in these documents are not altogether new. For instance, in the UK, both the Royal College of Physicians and the British Medical Association ("BMA") acknowledge that their respective frameworks are derived from previous guidance issued by the UK government in relation to the pandemic flu in 2009.[1] Furthermore, in terms of specific advice, there is already a significant body of literature on, for example, the ethics of scarce ICU resources, and the actual ethical recommendations put forward in COVID-19 ethical guidelines regarding the triaging of patients largely reiterate what has already been said.[2]

Given that international, national and local organizations have responded to the pressing need for practical guidance and given the calls for the production of authoritative government guidance where none exists, in this chapter we seek to determine whether the kind of ethical guidelines that have been—and are still being—generated fulfil the functions of ethics as a fundamentally normative academic discipline. Secondly, we will address the question of whether the guidance they purportedly offer meets the needs of patients, practitioners and the public, which, as John McMillan notes, we might expect of "good bioethics".[3] Thirdly, in the light of these needs, we will outline what ethical expertise should offer for the purpose of developing ethical guidelines (in a pandemic).

Broadly speaking, the ethical basis of a large number of COVID-19 clinical and public health guidance documents runs counter to the methodological drift in mainstream, Anglo-American bioethical research away from philosophically oriented principlist and more theory-driven approaches. Specifically, the primary form of COVID-19 ethical guidance is bioethical "principlism", albeit an overly narrow application of that approach. According to DeGrazia, principlism denotes any "ethical theory that (1) emphasizes principles, (2) features more than one basic principle, and (3) leaves at least some of its principles unranked relative to each other".[4] If we take the COVID-19 ethical guidance documents issued by the devolved governments in Scotland and Northern Ireland, the Royal College of Physicians (supported

by 15 other professional bodies) and the BMA as examples, we find sets of more or less overlapping and unranked "ethical principles" (e.g., autonomy, fairness, minimizing harm, accountability, respect, transparency and so on) together with varying specifications of those principles.[5] In these documents, the principles and their specifications are designated either as "ethical considerations" (to guide clinical decision making) or as an "ethical framework", which can also act as a kind of preface to more specific discussions regarding, for example, resource allocation, triage and risk management for health practitioners.

In the field of bioethics principlism arose in the 1970s in response to what its developers saw as a lack of a unifying theory to guide ethical decisions. Tom Beauchamp and James Childress led the development of a shared normative framework that sought to incorporate long-standing clinical duties to maximize benefits and minimize harms, while also addressing concerns about justice and respect for patient autonomy.[6] They proposed four *prima facie* principles: respect for autonomy, beneficence, non-maleficence and justice. What later came to be known as "principlism" claimed to provide a common source of ethical guidance to which bioethicists from a range of theoretical backgrounds could appeal in their deliberations.

8.2 Philosophical Debates on Principlism

Although we cannot do justice here to the intricacies of these debates or account for all of the issues discussed over the past decades, we can highlight the main criticisms levelled against principlism, particularly as they continue to be relevant to the use of principlist elements in COVID-19 and other infectious disease pandemic ethical guidance documents, and we can outline the ways in which principlists responded to those issues.

According to Beauchamp and Childress, their normative framework was intended not as an ethical theory but as a guide for action, with the four categories of principles functioning as "relatively general norms of conduct that describe obligations, permissible actions and ideals of action".[7] Responding to early editions of their book, critics raised concerns not only about the lack of justification for the choice of principles and the lack of a priority ranking among them, but also about the problems with filling the gap between abstract principles and concrete judgments and the absence of any specified procedure for resolving the conflicts between the principles.[8] Despite Beauchamp and Childress' attempts to deal with some of these issues in later editions, critics of principlism still call into question the ability of the four principles to function as adequate action guides in biomedical contexts.[9]

Firstly, in relation to early versions of Beauchamp and Childress' normative framework, it was suggested that it fails to provide genuine action guidance because, although each of the four principles embodies what is taken to be a key concern in bioethics, there is no account of whether or, indeed, how they are related to each other.[10] The problem is most clearly seen when two or more of the principles conflict with one another (take, for example, the principles of respect for autonomy and

justice). Not only did there not appear to be an agreed-upon procedure for resolving conflicts, Beauchamp and Childress did not posit an underlying ethical theory to which one could appeal in order to understand or resolve such conflicts.[11] This led critics to suggest that principlism is merely "a sophisticated technique for dealing with problems ad hoc".[12]

Secondly, Beauchamp and Childress realized that the four categories of principles are too abstract to perform any substantial practical role in biomedical decision making. Consequently, they claimed that the development of principles requires "specification", a process of "judgment and decision making" with the aim of "reducing the indeterminacy of abstract norms and generating rules with action-guiding content".[13] Beginning with the fourth edition of their book, Beauchamp and Childress made use of principle specification, which, as Beauchamp claims (citing Henry Richardson), is achieved by "narrowing their scope…by 'spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided'".[14] However, critics argued that although the spelling out of these questions does encompass some morally relevant features of a situation, it does not help us to understand why they are relevant nor does it help us to understand what weight should be accorded each morally relevant feature when making moral decisions.[15] More importantly, the continuing lack of an underlying ethical theory meant that, for critics of principlism, no explanation could be offered for how these principles might be applied in specific instances.[16]

Beauchamp and Childress acknowledged that in order for users to employ the method of specification in a way that could support some specifications and not others, and thereby could assist with the application of the principles to specific situations and moral problems, specification needed to be connected to a model of action justification.[17] Without it, not only would specification support an ad hoc approach to bioethical decision making, the user would not be "aware of the real grounds for his moral decision", that is, "what is really guiding his action".[18]

Beauchamp and Childress responded to these issues by developing a metaethical basis for action justification that, simultaneously, could function as a constraint on the specification and balancing of their principles in order to support action guidance.[19] This involves an "integrated model" that combines a coherentist methodology of "wide reflective equilibrium" with "considered judgments" regarding "the set of universal norms shared by all persons committed to morality".[20] Accordingly, Beauchamp and Childress claim that a sufficient account of action justification entails: (i) coherence between principles, broader theoretical considerations and moral judgments and intuitions in which we have the highest confidence and the least bias; (ii) the restriction of the starting points for the method of reflective equilibrium to considered judgments that are acceptable without the support of reasons; and (iii) the formation of those considered judgments under specific epistemic conditions.[21]

According to Norbert Paulo, moral problems are conceived in principlism as conflicts between principles that are part of the specific framework's set of principles.[22] As we have seen, in order to guide action, principlism requires the balancing and specification of principles. For Beauchamp, a specified principle "is acceptable in a system of norms if it heightens the mutual support of other norms in the system that

have themselves survived in reflective equilibrium".[23] Furthermore, when attempting to deal with the conflicts between two or more principles, "which resolution is justified is, in principlism, ultimately a matter of coherence".[24] Consequently, as well as contributing to their approach to action justification, "coherence serves as a basic constraint on the specification and balancing of norms that guide actions".[25]

Whether Beauchamp and Childress' "integrated model" for action guidance and action justification has adequately addressed the three primary criticisms of principlism discussed above is still up for debate. However, as shall become clear in what follows, for the purpose of determining whether COVID-19 ethical guidelines fulfil the functions of ethics as a normative discipline, we need not consider these more recent debates here on the basis that no effort was made by the developers of ethical guidelines to deploy such an integrated model.[26]

8.3   Principlist Pandemic Guidelines and the Functions of Ethics

Ethics is a normative discipline, and this means that it has two primary functions: (1) to provide action guidance; (2) to provide action justification. While there are different views about how we should taxonomize bioethics and bioethically-informed public policy, it's reasonable to assume that, in virtue of being forms of ethics, they should share these functions and aim to provide guidance and justification for actions in normative matters related to health care and public and personal health in general.

Let us, for the sake of argument, assume that Beauchamp and Childress' "integrated" approach to principlism is able to deliver adequate action guidance and action justification. One of the problems with their normative framework is that it is solely dependent on the intuitions and/or judgments of the individual employing the method, whether that is, in an academic context, a bioethicist, legal scholar or theologian, or, in clinical circumstances, a health care practitioner or health care facility manager. There is no reason to believe that others will reach the same conclusion and, accordingly, act in the same way when they apply the same method to the same moral problem.[27] The result is that it is by no means clear whether such an approach can meet the needs of patients and the public in terms of, for instance, the consistency and predictability of particular policies in a given health care context. As McMillan argues, "good bioethics" should not only fulfil the functions of ethics, that is, action guidance and action justification, it should do so in a way that "connect[s] with the experiences of those impacted by, and making, decisions in health care".[28] In other words, bioethics should meet the needs of stakeholders, including patients, practitioners and the public.

It is a truism that patients, practitioners and the public will, particularly in pluralistic societies, have diverse and often conflicting needs where clinical or public health decision making is concerned. However, when it comes to national or global infectious disease, there are at least two types of need that members of these groups would

reasonably be expected to share given their shared experiences of civil rights infringements, the prioritization of public health and its associated obligations and the statutory and normative demands for certain forms of collective action and responsibility. As the BMA has recognized, when it comes to specific pandemic-related clinical and public health decisions, the first concerns the need for citizens to be "informed beforehand of the anticipated response".[29] The BMA acknowledges the fact that this presupposes that clinical and public health decision makers have a shared understanding of what that response will be. What patients, practitioners and the public share is the need for *consistent* application of the relevant ethical guidelines. More importantly, there is also a need for "legitimate" decisions, that is, "transparent and accountable decision-making processes, including explicit discussion of the ethical principles and reasoning upon which decisions are made".[30] In other words, we are not just talking about ethical guidelines fulfilling the demands of action justification, what is required are *publicly transparent* processes of justification.

Given that the success of guidelines in dealing with ethical, pandemic-related issues depends on health practitioner and provider uptake and the cooperation of patients and the public, it is vital that these groups not only perceive the recommendations contained in these documents to be ethically justifiable (even if they are not normatively acceptable to everyone), but also are able to determine the ways in which ethical guidance will be consistently applied by those charged with protecting their health and wellbeing. These are just some of the reasons for calls during the early stages of the COVID-19 pandemic to consult patients, practitioners and the public on the proposed content of COVID-19 ethical guidance documents and to facilitate development processes that are publicly transparent and accessible—an issue we will explore in the final section of this chapter.[31]

This leads us to the first question we seek to answer in this chapter: can principlist approaches to pandemic ethical guidance fulfil the functions of ethics as a fundamentally normative discipline?

Although it may appear as if we have answered this question already, the issues are not clear-cut when we consider the appropriation of principlist elements in COVID-19 ethical guidance documents. The key concern is that these ethical guidelines rely upon an under-developed approach to bioethical principlism. This is not particular to COVID-19 ethical guidance documents, but something which, as Gert, Culver and Clouser noted in the 1990s, has resulted from "the widespread popularization of principlism throughout the biomedical world, where it is not dealt with as carefully as it is in the hands of Beauchamp and Childress".[32] They argue that, in biomedical contexts, "the principles of principlism primarily function as checklists, naming issues worth remembering when one is considering a biomedical moral issue. 'Consider this … consider that … remember to look for …' is what they tell the agent; they do not embody an articulated, established, and unified moral system capable of providing useful guidance".[33] For Gert, Culver and Clouser, the upshot of this critique for ethical guidelines inspired by certain elements of principlism is that, firstly, with regards to action guidance, the principles are too abstract and empty to provide any help, and, secondly, the use of principles "simply masks ad hoc and unreasoned decisions and

judgments due to lack to a lack of adequate grounds for justification".[34] These criticisms resemble those made against Beauchamp and Childress' early iterations of their normative framework.

In order to demonstrate how these problems manifest in concrete guidelines, we will focus, firstly, on the World Health Organization's ("WHO") "Guidance for Managing Ethical Issues in Infectious Disease Outbreaks".[35] Responding to the Ebola outbreak in West Africa between 2014 and 2016, the WHO formed an Ethics Panel and, subsequently, an Ethics Working Group, which was charged with developing general guidance to address ethical concerns associated with global infectious disease outbreaks, including Ebola, severe acute respiratory syndrome ("SARS"), pandemic influenza and multidrug-resistant tuberculosis. The questions this guidance seeks to address are serious ones, such as state obligations, vulnerability, the allocation of scare resources, restrictions on freedom of movement, the rights and responsibilities of frontline workers and medical interventions for the diagnosis, treatment and prevention of infectious disease. The WHO experts preface specific guidelines relating to each of these issues with a list and specifications of "relevant ethical principles": justice, beneficence, utility, respect for persons, liberty, reciprocity and solidarity. They recognize that "the process of ethical analysis involves identifying relevant principles, applying them to a particular situation, and making judgements about how to weigh competing principles when it is not possible to satisfy them all". [36]Furthermore, they acknowledge the needs of patients, practitioners and the public as detailed above, specifically, that the principle of solidarity commits the global community to apply principles "in a consistent manner, both within individual institutions and, to the extent possible, across geographic areas" with the development of "decision-making tools" to ensure that like cases are treated alike",[37] and that policymakers and providers should develop action guidance "with the genuine input of affected communities".[38] Despite these promising claims, the WHO guidance fails to facilitate or support these ends.

In terms of action guidance, the WHO experts claim that the application of the principles should be informed by "specific evidence" and ensure fairness and consistency.[39] If this evidence is not available, then "decisions should be based on reasoned, substantive arguments and informed by evidence from analogous situations, to the extent possible".[40] But these statements are question-begging. Without some sort of common procedure or theoretical framework that delineates "reasoned, substantive arguments" from those that aren't and that explains how "specific evidence" (whatever that may be) relates to each of the stated ethical principles, there is no reason to believe that the WHO's guidelines will deliver or, indeed, support *consistent* action guidance. In addition, when principles come into conflict (e.g., respect for persons and beneficence or utility and equity), the WHO's ethical guidelines merely state that when "balancing competing principles during infectious disease outbreaks, countries must respect their obligations under international human rights agreements".[41] Although this is an important and legitimate consideration where the infringement of people's civil liberties in a pandemic are concerned, it is by no means the only factor that can influence judgments about how conflicts between principles should be resolved. For instance, when offering guidance regarding the allocation

of scare resources, the WHO experts state that although "resource allocation deci-
sions should be guided by the ethical principles of utility and equity", "there is no
single correct way to resolve potential tensions between utility and equity; what is
important is that decisions are made through an inclusive and transparent process that
takes into account local circumstances".[42] Not only does this ethical guidance docu-
ment, therefore, fail to deliver adequate action guidance, it begs the question of how
"inclusive and transparent" processes and "local circumstances" should contribute
to principle balancing in practice.

The overarching issue is that there is no explicit connection between the WHO
experts' "relevant ethical principles" and their more focused discussions and recom-
mendations regarding pandemic-specific clinical and public health practice. There
are no details about how the principles have been applied to questions of resource
allocation, clinical obligations, restrictions on freedom of movement, medical appli-
cation of unproven interventions, and so on, in order to generate action guiding
advice. Unsurprisingly, the guidance also fails to meet the justification standard for
ethics. The specific guidelines may well be the result of the application of some
sort of procedure, but it is impossible to discern whether that is the case given that
the experts charged with development of these guidelines do not make explicit its
metaethical underpinnings. In important ways, then, the guidance is no more than an
ex cathedra announcement by the experts appointed by the WHO.

These issues are compounded when we abstract the principles and their spec-
ifications away from the specific recommendations regarding resource allocation,
triage, risk management, and so on, and employ them as an "ethical framework"
or as "ethical considerations" to guide clinical and public health decision making
during a pandemic. Take, for example, the "Public Health Ethics Framework" devel-
oped by the Government of Canada's Public Health Agency ("PHAC") in response
to the COVID-19 pandemic.[43] The developers of this framework state that it is based
on guidance and frameworks produced in Canada and internationally, including the
aforementioned WHO ethical guidance. It has also significantly influenced more
domain specific guidelines, including the "Preliminary Guidance on Key Populations
for Early COVID-19 Immunization", issued by the Government of Canada's National
Health Advisory Committee on Immunization (NACI), the issues with which we have
already addressed elsewhere.[44] Like those chosen by the WHO, the PHAC's experts
recognize that adequate ethical responses to pandemic-related clinical and public
health issues require decision makers to "identify competing values and interests,
weigh relevant considerations, identify options and make well-considered and justifi-
able decisions".[45] The framework begins with a list of ethical principles: trust, justice,
respect for persons, communities and human rights, promoting well-being, mini-
mizing harm and working together. It also contains a list of "procedural" principles,
which are meant to facilitate "a solid, shared understanding of what values, princi-
ples and considerations are important", and thereby to guide and justify ethical deci-
sion making. These are: accountability, openness and transparency, inclusiveness,
responsiveness and intersectionality. These principles are followed by the "Ethical
Framework", a five-step procedural method that aims to: (1) identify the issue and
gather the relevant facts; (2) identify and analyze ethical considerations and prioritize

the values and principles that will be upheld; (3) identify and assess options in light of the values and principles; (4) select the best course of action; (5) evaluate.

Beginning with action justification, although the application of the five-step "Ethical Framework" should, according to the document, be guided by the aforementioned "procedural" principles, there is no discussion of how, for instance, stakeholder engagement relates to the other "relevant facts" the users are meant to identify and consider as part of step one of the framework. For instance, no detail is given about how different stakeholder views and concerns relate to "the relevant facts, scientific evidence and other contextual factors". This generates a problem when we reach step three of the framework, which demands that users "prioritize values and principles" and assess "the pros and cons of each option". Relatedly, if a user or set of users have assessed the options as part of step three, then what should be done if, as possible in step four, stakeholders are found to be "uncomfortable" with the "best course of action"? The point is that without a stated basis or associated procedure for working through such procedural conflicts, justification ultimately becomes a matter for the individual user or set of users, which, by prioritizing the vague principle of "accountability", can, in principle, merely be derived from the prioritization of their own principles and values.

The "Public Health Ethics Framework" attempts to get around these issues by stating that the principles of effectiveness, proportionality, reciprocity and precaution should be considered when weighing options. But without some sort of explicit procedure, theoretical foundation or set of criteria that helps the user understand how these four principles relate to one another and how they should be applied in specific instances, the justificatory burden is still borne by the individual user or set of users. For instance, what should a user do if scientific evidence suggests that the most "effective" intervention generates more harm than a less effective approach? Equally, what should a user do if an intervention stands to yield overwhelming benefits for the majority of the population but, at the same time, risks substantive burdens for a fraction of the most vulnerable? Indeed, the Canadian document acknowledges that action justification can only be supplied by decision makers when the procedural principles conflict: "given that it may not be possible in some circumstances to uphold all values and principles equally, it will be important for decision makers to explain how they prioritized them, and to justify the trade-offs made in each situation".[46]

As we have already seen, conflicts can arise not just between procedural principles, but also between stated ethical principles. In this instance, step two of the "Public Health Ethics Framework" asks users to determine the ethical values, principles and considerations involved in the issue, the values and principles that are in conflict and the values or principles that are most important. Once again, these requirements are question begging because there is no explanation of how the competing moral obligations of disparate ethical principles or values should be balanced with one another nor how potential conflicts between the principles should be resolved. For instance, should respect for communities be prioritized over individual freedoms? Alternatively, should respect for persons be prioritized over the greater good of society? Or should justice be prioritized over life-years preserved? The issue is that any priority is ultimately possible within a principlist framework. Although the

PHAC experts provide neither, there are at least two ways to resolve conflicts; (1) ordering the principles hierarchically or lexically; or (2) by introducing an organizing principle. The issue is that if pandemic ethical guidance does not resolve conflicts between principles, one has to draw on other sources, such as intuition or judgment, which, as we have seen, means that action justification procedures or criteria cannot be provided by the guidance itself. Instead, actions and interventions are justified by the implicit values and motivations of individual users.[47]

Let us turn now to the second question of this chapter: can COVID-19 ethical guidance documents, in principle, generate guidance that meets the needs of patients, practitioners and the public?

In a policy brief developed by the WHO's Health Ethics & Governance team concerned with the ethical dimensions of COVID-19 mandatory vaccination, the guidelines for ethical processes of decision-making state that "legitimate public health authorities that are contemplating mandatory vaccination policies should use transparent, deliberative procedures to consider the ethical issues outlined in this document in an explicit ethical analysis".[48] Such statements are legitimate and vital, and reflect those we have already encountered in the WHO and Canadian government's respective ethical guidance documents. However, as we have seen, on the one hand, COVID-19 ethical guidelines developed in the light of bioethical principlism have failed to make explicit the necessary metaethical basis for their ethical recommendations nor do they offer health practitioners any means of justifying decisions resulting from the application of the stated principles. On the other hand, by not providing users with procedures or criteria for specifying principles (and the relationships between them) or for resolving inevitable conflicts, the burden of applying principles to specific pandemic-related issues will be shouldered by individual providers, teams or specific individuals. Thus, despite what appears to be a consensus between the developers of COVID-19 ethical guidance documents for the need for *consistent* application of ethical guidelines and *publicly transparent* processes of justification, extant ethical guidelines derived from bioethical principlism do not give stakeholders a reason to believe that they will be applied consistently. Furthermore, the lack of adequate action justification criteria compromises the ability of stakeholders—the public writ large in particular—to determine the normative legitimacy of any clinical or public health decisions that result from the application of these guidelines.

8.4 Procedural Considerations for the Development of "Good" Ethical Guidance

It is not our intention to suggest anything other than honorable motives on part of those involved in the production of principlist approaches to pandemic ethical guidance. As individuals, they typically volunteered their time, and expert committees, panels, commissions and the like had difficult—if not impossible-to-meet—expectations to fulfil. However, even prior to the COVID-19 pandemic, questions were raised

about the very legitimacy of these types of committees, panels and commissions.[49] On the one hand, answers to difficult normative questions were required, answers that oftentimes meant, if policy makers decided to act on them, that some people's lives would be prioritized over others', be it during triage decision making in ICUs or during the initial phases of the roll-out of vaccines. On the other hand, ethics committees, panels and commissions were operating in liberal democracies with their own foundational values (enshrined in constitutions and the like) and with a citizenry that held a wide range of diverse values. Of course, offering a straightforward consequentialist, deontological or virtue ethical analysis and guidance would not serve any practical purpose because each of these varieties of ethics frameworks would not speak to those citizens who hold other values. These frameworks may also have been in conflict with a given society's foundational values. It is not surprising, then, that principlism became popular, because it could have been seen to accommodate a more diverse set of values than other theory-driven frameworks.

As we have noted, "good" bioethics and, by extension, (bio)ethical guidance requires transparent decision-making processes, specifically, explicit, public discussion of the reasons and reasoning upon which public health and pandemic-related clinical decisions are made.[50] In liberal democracies, those who govern depend on the consent of the majority of those who are governed. Given that, during pandemics, policy options are considered that oftentimes infringe on individual freedoms, it matters a great deal that the governed are provided with considered, well-reasoned justifications, particularly as the "success" of such infringements is dependent on public cooperation. People whose liberty rights are infringed upon deserve a transparent justification that explains how a particular policy came about and why the objective it aims to support or achieve is deemed to be of sufficient importance that it justifies the infringement. This does not mean that people whose rights are infringed will necessarily agree with those justifications, but they are owed an explanation of the normative considerations, values and motivations on which such policies are based. What is unsatisfactory is "bullet-point ethics" like that endorsed in, for instance, the ethics guidance of PHAC's experts. The reason for this is that such ethical guidance documents also serve, importantly "as an ethical backstop in times of, for instance public health emergencies […] It seems [then] unacceptable that they can be used to justify any action or none at all".[51]

Most of COVID-19 ethical guidance documents were authored by groups of (bio)ethicists (as well as, oftentimes, others with no particular ethics expertise). These groups needed to come up with some sort of consensus about specific guidelines for ICU triage, immunization priorities, the management of risk for health professionals and so on, and about specific ethical frameworks to guide public health and clinical decision making in general. If members of these groups were chosen to ensure diversity across different demographic groups, then it is reasonable to assume that they would have been unlikely to reach a consensus on any single value that should drive specific interventions or decision making in general. In relation to triage, for example, utilitarians may have agreed that lives preserved, or life-years preserved ought to be maximized, but that would not cut any ice with ethicists or others determined to prioritize equity. If advocates of utility and advocates of equity meet in a group, then

it is conceptually impossible to end up with a coherent consensus document. When agreement regarding a single "organizing" principle or value cannot be reached, principlism becomes *pro tanto* "useful" as a normative framework: it allows all and sundry to contribute their values in the form of an ethical principle to the laundry list of values "that matter" or "to be considered" thereby postponing negotiations over particular policy recommendations until another day. This arguably explains the material content of the ethical guidance documents we discussed in this chapter: they mirror the values of those appointed to author these documents. They also explain the absence of any serious effort aimed at justifying why particular controversial principles were taken to trump other competing controversial principles (e.g., why equity should be prioritized over life-years preserved, or vice versa).

Jonathan Moreno hit upon the fundamental problem with attempting to develop the sorts of pandemic ethical guidance documents that we have considered here when he commented that "empirically, moral truth is in fact less likely to be achieved by groups, which are vulnerable to corruptions of political processes and interpersonal dynamics, than by well informed and reflective individuals".[52] However, as noted in the context of Beauchamp and Childress' "integrated" approach, there is also no reason to believe that a well-informed and reflective individual will deliver conclusions and decisions that all, or even a majority of, members of pluralistic societies will take to be morally legitimate. These related concerns lead us to suggest that ethical guidance documents, rather than attempting to merely provide "substantive" ethical content in terms of explicit principles and values, must primarily focus on making transparent the "procedural" conditions that have been fulfilled in generating and thereby justifying specific advice, and developing procedures that deliver transparent and consistent decision making. What considerations should inform the development of procedurally oriented pandemic ethical guidance?

The first consideration in the development of procedurally oriented ethical guidance ought to be transparency about how expert members have been appointed, by whom and with what mandate. There should be a transparent process that explains to the public, patients and practitioners how and why, say, a consequentialist was chosen as an expert on a committee while the equally available contractualist was not chosen, or vice versa. After all, the values expressed by specific ethical advice do not fall from heaven, and, as we have seen, they are almost always contested. Secondly, and relatedly, those chosen to develop such ethical guidelines ought to reasonably reflect the diversity of normative views prevalent in a given population.

Whoever gets appointed to serve as an ethics expert for a group, panel or committee will have their own ethical commitments. Given that the guidance documents to which they contribute will, to some extent, reflect those commitments, appointment procedures matter. Minou Friele reports that in Germany the first appointees to the country's national ethics council were criticized as being too close to, and handpicked by, the then Chancellor.[53] Caribbean-based bioethicist Cheryl Cox-MacPherson has flagged the failure of international guideline-producing bodies to consult stakeholders in the global south.[54] In the absence of genuine stakeholder consultation and participation, "the wider public might well begin to see a given national bioethics commission no longer as a group of professionals discharging their professional obligations in

an unbiased manner, but instead as a group selected by the power of the day to conveniently serve an already pre-determined ideological agenda".[55]

The WHO has recognized the importance of transparency. It has produced a manual that governs the structures and processes of expert advisory panels and committees.[56] While the manual is far from perfect—note, for instance, the document's pervasive sexism—it highlights that the organization is cognizant that appointments to these sorts of panels and committees are never an exclusively expertise-based decision; they are also always significantly political decisions that require the ability of the appointer to explain why and how someone was appointed. The WHO's track record in terms of appointing uncontroversially the most knowledgeable global experts remains sketchy at best, despite its manual.[57]

Focusing on the procedural content of ethical guidelines, Norman Daniels and James Sabin have proposed and defended criteria that aim to establish a fair procedure for developing criteria for how scarce health care resources ought to be distributed.[58] Firstly, they stipulate that the criteria chosen must be made public and they must be justified. In other words, it is insufficient for the expert authors of such guidance documents to merely state, for instance, that equity or utility require XYZ or, worse, to preface advice with a list of ethical principles and then fail to connect recommendations for a specific intervention with those principles. Instead, when delivering specific advice or advocating for a specific intervention, they must explain the reasons for that advice or intervention and why, for instance, it necessitates prioritizing equity over utility (or vice versa). Secondly, Daniels and Sabin suggest that justifiable criteria are constituted by reasons, evidence and principles that a reasonable, well-informed person working toward a societally justifiable *modus operandi* could accept. Importantly, they also suggest that there ought to be in-built review and dispute resolution mechanisms. Those who disagree must be able to have their day in court, as it were.

This all seems probably quite obvious to the fair-minded observer, but authorities in many jurisdictions have kept these guidelines and criteria a secret, no doubt to avoid a public debate (and potential panic).[59] Equally, their ethics experts were almost always handpicked by government officials. There were no transparent public appointment procedures.

Two lessons can be drawn from these observations when it comes to developing pandemic ethical guidance focused on procedural conditions. First, and as we have discussed throughout, it is vital to get the buy-in from stakeholders who will be governed by the ethical guidance document regarding the transparency of the justifications provided by the hand-picked experts. There must also be a public consultation and a clear and transparent explanation of the ways in which the feedback received will be considered and incorporated into the final guidance. As Alex Friedman notes, "without greater opportunities for public participation…it is unclear how the process can hope to confer legitimacy on the decisions that it produces, or why it would be fair or reasonable to expect people not to object and fight back with any means necessary, including litigation, whenever they are disadvantaged for reasons that they do not understand or do not agree with".[60] Second, ethical guidance documents must be published widely. They cannot remain the policy makers' "dirty secret" as has

all too often been the case during the COVID-19 pandemic. This kind of conduct is incompatible with the proper functioning of life in a liberal democratic society.

8.5   Conclusion

The COVID-19 ethical guidance documents that have proliferated during the pandemic highlight fundamental issues with approaches that focus predominantly on the substantive ethical content of such documents in terms of principles. Given that these documents rely on a narrow application of bioethical principlism, they cannot deliver either adequate action guidance or action justification (usually both), let alone the guidance and justifications necessary to meet the needs of patients, practitioners and the public. Taking into consideration the competing values that citizens within a pluralistic society will hold means that attempts to overcome the problems with principlism cannot fall back on single principle theories (e.g., utilitarianism) or inflexible, atemporal moral norms (e.g., deontology) without adequate, publicly transparent justifications for the decisions and interventions that are derived from those theories. Indeed, the same applies to principle-based approaches: substantive ethical recommendations derived from a set of *prima facie* and unranked principles require reasons and reasoning that those affected can perceive as legitimate even if they do not endorse the recommendations themselves. Shifting focus away from substantive ethical content to the procedural dimensions of action guidance and action justification allows those that develop pandemic-related ethical guidelines the flexibility to shape legitimate responses to ethical challenges in light of their own commitments and values (to the extent that such responses also—in a publicly transparent way—respond to the commitments and values representative of the public, patients and stakeholders). At the same time, however, it places the onus on guideline-developing organizations to ensure diversity in terms of the experts they choose to appoint to their committees and panels, and it demands that these committees and panels take (very) seriously the requirements for publicly transparent justifications as well as explicit procedures for transparent and consistent decision making.

Notes

1.   Royal College of Physicians (2021); British Medical Association (2021).
2.   Mannelli (2020).
3.   McMillan (2018).
4.   DeGrazia (2003).
5.   Scottish Government (2020); Department of Health (2020), Royal College of Physicians, "Ethical Dimensions of COVID-19 for Frontline Staff;" BMA, "COVID-19 – Ethical Issues."
6.   Beauchamp and Childress (2013).
7.   Beauchamp (2010).
8.   Schöne-Seifert (2006); Gert et al. (1997).

9.   Gert et al. (2006).
10.   Gert et al. (2006, p. 75).
11.   Ibid., 87.
12.   Ibid.
13.   Beauchamp and Childress, Principles of Biomedical Ethics, p. 17.
14.   Beauchamp (2011).
15.   Gert et al. (2006, p. 89).
16.   Ibid.
17.   Beauchamp and Childress, Principles of Biomedical Ethics, p. 19.
18.   Gert et al. (2006, p. 88).
19.   Schöne-Seifert (2006), "Danger and Merits of Principlism."
20.   Beauchamp and Childress, Principles of Biomedical Ethics, 3, 404, 408.
21.   Ibid., 409.
22.   Paulo (2016).
23.   Beauchamp (2010, p. 159).
24.   Paulo (2016, p. 114).
25.   Beauchamp and Childress, Principles of Biomedical Ethics, p. 408.
26.   For issues concerning Beauchamp and Childress' most recent approach to
      balancing and specifying principles, see, for example, Tom Tomlinson (2012),
      Paulo (2016). For issues concerning their approach to the common morality,
      see, for example, DeGrazia (2003), Turner (2003), Paulo (2016). For the limits
      and limitations of Beauchamp and Childress' appropriation of reflective equi-
      librium as a means of action guidance and action justification, see, for example,
      Arras (2009), Tomlinson (2012). And for broader issues concerning reflec-
      tive equilibrium as a method for ethical inquiry, see, for example, Kelly and
      McGrath (2010), Scanlon (2014), McPherson (2015), Cath (2016), de Maagt
      (2017).
27.   Earp et al. (2021).
28.   McMillan, The Methods of Bioethics, p. 36.
29.   BMA(2021, p. 8).
30.   Ibid.
31.   Archard (2020), Coggon and Regmi (2020), Fritz et al. (2020), Huxtable
      (2020), Wilkinson (2020).
32.   Gert et al. (2006, p. 72).
33.   Ibid., 75.
34.   Gert, Culver and Clouser, Bioethics: A Systematic Approach, 2nd ed., p. 101.
35.   WHO (2016).
36.   Ibid., 8.
37.   Ibid., 22.
38.   Ibid., 10.
39.   Ibid.
40.   Ibid., 9.
41.   Ibid.
42.   Ibid., 21.
43.   Government of Canada (2021).

44. Lewis and Schuklenk (2021).
45. Government of Canada (2021).
46. Ibid.
47. Paulo (2016, p. 156).
48. WHO (2021).
49. Friele (2003).
50. BMA (2021, p. 8).
51. Schuklenk (2013).
52. Moreno (1994).
53. Friele (2003).
54. Macpherson (2004).
55. Schuklenk (2004).
56. WHO (2007).
57. Schuklenk (2015).
58. Daniels and Sabin (2002).
59. Schuklenk (2020).
60. Friedman (2008).

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