



Bioethics met its COVID-19 Waterloo: The doctor knows best again

The late Robert Veatch, one of the United States' founders of bioethics, never tired of reminding us that the paradigm-shifting contribution that bioethics made to patient care was to liberate patients out of the hands of doctors, who were traditionally seen to know best, even when they decidedly did not know best. It seems to us that with the advent of COVID-19, health policy has come full-circle on this.

COVID-19 gave rise to a large number of purportedly "ethical" guidance documents aiming to assist health care providers and practitioners with responding to the ethical challenges that might arise in their response to the pandemic. Ethics has two primary functions: provide clear action guidance, and provide clear action justification. The documents in question arguably reflect the ultimate policy triumph of bioethical "principlism," and, perhaps surprisingly, as a corollary, the ultimate triumph of "doctor-knows-best."

Those involved in drafting the documents exploited a well-established conceptual flaw of principle-based approaches to health policy and bioethical principlism more generally: you grab a bag full of—typically nice sounding, but conflicting and disparate—"ethical principles," then tell people to keep them and their under-specified obligations in mind when faced with a particular ethical problem, and tick the ones they have used off their list. We cannot go here into a detailed analysis of each of the many COVID-19 ethical guidance documents, but we suggest that they share a number of features that probably explain why principlism is deployed as *the* convenient ethics component. On each occasion a number of well-sounding principles, that most reasonable people would have great difficulty finding fault with, are added—as a kind of preface—to what would otherwise be highly controversial policy documents. These principles are typically in conflict (think autonomy and beneficence, or utility and equity).¹ It is unclear how they relate to each other. And, in cases where two or more principles result in conflicting action guidance, we are no clearer about which of them ought to be prioritized. Most importantly, such principles do not, when specified to the degree that they tend to be in ethical guidelines, provide a clear-cut and conclusive answer to the question of who, in the here and now, should be offered treatment or a vaccine when it is not possible to treat or vaccinate all those who could benefit.

Although many of the ethical guidance documents that have been developed in response to the COVID-19 pandemic are reasonable, their "ethics" label is typically misleading, because they fail on the action guidance criterion, the action justification criterion, or on both of these counts. Let us have a look at our first exhibit: 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).² The question this document tackles is a serious one: given the initially limited availability of COVID-19 vaccines, who should receive them first? What we are faced with here is a typical question of justice in resource allocation decision-making. NACI has produced what it refers to—some-what optimistically—as an "algorithm" outlining the process of applying its Ethics, Equity, Feasibility and Acceptability (EEFA) framework to this question. In relation to each of a number of listed ethical principles, the guidelines provide a series of questions that NACI has considered, and, subsequently, detail the ways in which those considerations have been addressed (appendix B of the guidance). For instance, in relation to the principles of beneficence and non-maleficence, NACI asks, "Have the recommendations considered risks and benefits, and do benefits outweigh risks? Has the principle of reciprocity been considered to minimize harm, especially in epidemic contexts?". In response, NACI states that "risks and benefits have been considered in the guidance and summarized in the rationale for each recommendation. The ethical principles of proportionality, effectiveness, precaution and reciprocity have been applied to the guidance and explicitly discussed."

A key problem with the NACI guidance, one that is typical of many "ethical" guidelines developed in response to the COVID-19 pandemic, is that it does not detail the ways in which the competing moral obligations of its disparate ethical principles have been balanced with one another nor how potential conflicts between the principles have been resolved. For instance, it is unclear how NACI have balanced the principle of "reciprocity," according to which the "disproportionate burden[s] faced by those taking on additional risks to protect the public" should be minimized, with its justice-derived

¹For an example of an ethical guidance document that generates the latter conflict, see Ontario Health. (2020). Optimizing care through COVID-19 transmission scenarios: recommendations from Ontario Health. Retrieved from https://www.ontariohealth.ca/sites/ontariohealth/files/2020-10/Optimizing%20Care%20Through%20COVID-19%20Transmission%20Scenarios_EN.pdf (accessed Nov 19, 2020).

²National Health Advisory Committee on Immunization. (2020). Preliminary guidance on key populations for early COVID-19 immunization. Retrieved from <https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-key-populations-early-covid-19-immunization.html> (accessed Nov 19, 2020).

claim that “treating people and groups with equal concern and respect entails setting and applying prioritization criteria fairly.”

Unsurprisingly, the guidance fails to meet the justification standard. Nowhere is it explicitly detailed how, in what ways and by what means the “ethical principles of proportionality, effectiveness, precaution and reciprocity have been applied to the guidance.” The actual recommendations may well be a result of the application of the aforementioned “algorithm,” but it is impossible to evaluate that, because NACI does not undertake—let alone make explicit—the necessary work to provide that crucial justification. A case in point, “effectiveness” is not a self-evident principle; it is relative to some purpose.³ There is no single property that is “effectiveness,” and different conceptions of effectiveness entail different normative commitments.

This Canadian government guidance document for COVID-19 vaccine distribution is, in reality, a policy document that hides the undisclosed metaethical standards (if there are any) by which its “algorithm” have been applied. Something similar can be said of many such guidance documents. Let us—very briefly—look at exhibit B,⁴ again from Canada, this time from the province of British Columbia. The question it aims to address is whether health care professionals have a duty to provide care to COVID-19 patients.⁵ Its surprising conclusion is that health care professionals have such an obligation unless they face “certain and significant harm.” This is a standard designed to maximize the number of health care professionals required to report for duty. Given the absence of certainty when it comes to both infection risk as well as the absence of certainty when it comes to actual development of significant illness, it would be difficult for most health care professionals to be exempted. Among the “core” public health ethics principles “justifying” this conclusion are newcomers to the ethical principle rodeo, like “flexibility” and “working together,” next to more standard fare principles like utility maximization and respect for autonomy. The latter two are uncontroversially conflicting ideas. How should they be resolved (keeping in mind that no less than the lives of health care workers are at stake)? Well, the decider, likely a health care facility manager, will identify the applicable—probably conflicting—principles, and prioritize (somehow). As ever with principlist approaches to health policy, the priorities-setting strategy and the decision justification are as arbitrary as someone flipping a coin.

These problems have been compounded in the case of COVID-19 guidelines in the UK. In the absence of authoritative guidelines from the UK government, the void has been filled by separate documents produced by the devolved governments in Scotland and Northern Ireland,⁶ as well as ethical guidance documents issued by professional organizations, such as the Royal College of Physicians (supported by 15 other professional bodies),⁷ and the British Medical Association.⁸ Although there is a degree of overlap in the ethical principles employed in these respective guidelines, certain principles are mentioned in one but not others, and the specifications of the principles vary in ways that can have significant normative implications. Take, for example, the principle of “fairness,” which is specified in various different ways:

- “Every person should be treated justly as an individual so that decisions are rational, fair, practical, and grounded in appropriate processes, available evidence and a clear justification. Everyone matters equally, so people with an equal chance of benefiting from health and social care resources should have an equal chance of receiving them. Any assessments of potential benefits and harms from a health or social care intervention or its timing must respect individual rights” (Northern Ireland Department of Health);
- “Patients should be treated as individuals, with respect for their autonomy, and not discriminated against” (Scottish Government);
- “Frontline staff, policymakers, management and government have a responsibility to patients to ensure that any system used to assess patients for escalation or de-escalation of care does not disadvantage any one group disproportionately. Treatment should be provided, irrespective of the individual's background (eg disability), where it is considered that it will help the patient survive and not harm their long-term health and wellbeing” (Royal College of Physicians);
- “Everyone matters equally. People with an equal chance of benefiting from a resource should have an equal chance of receiving it – although it is not unfair to ask people to wait if they could get the same benefit later” (British Medical Association).

Even in the case of a single principle such as fairness, the different specifications make it extremely difficult for health care providers and practitioners to navigate between the different guidelines, leading to conflicting obligations: treating patients as individuals with respect for their autonomy, and providing a resource when they

³Ashcroft, R. (2002). What is clinical effectiveness? *Studies in History and Philosophy of Biological and Biomedical Sciences*, 33(2), 219–233; Upshur, R. (2013). What does public health ethics tell (or not tell) us about intervening in non-communicable diseases? *Journal of Bioethical Inquiry*, 10(1), 19–28.

⁴British Columbia Ministry of Health Provincial COVID-19 Task Force. (2020). COVID-19 ethics analysis: What is the ethical duty of health care workers to provide care during COVID-19 pandemic? Retrieved from https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/duty_to_care_during_covid_march_28_2020.pdf (accessed Nov 19, 2020).

⁵Schuklenk, U. (2020). What healthcare professionals owe us: Why their duty to treat during a pandemic is contingent on personal protective equipment (PPE). *Journal of Medical Ethics*, 46, 432–435.

⁶Scottish Government. (2020). COVID-19 guidance: Ethical advice and support framework. Retrieved from <https://www.gov.scot/publications/coronavirus-covid-19-ethical-advice-and-support-framework/> (accessed Nov 19, 2020); Department of Health. (2020). COVID-19 guidance: Ethical advice and support framework. Retrieved from <https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19-Guidance-Ethical-Advice-and-Support%20Framework.pdf> (accessed Nov 19, 2020).

⁷Royal College of Physicians. (2020). Ethical dimensions of COVID-19 for frontline staff. Retrieved from <https://www.rcplondon.ac.uk/news/ethical-guidance-published-front-line-staff-dealing-pandemic> (accessed Nov 19, 2020).

⁸British Medical Association. (2020). COVID-19 – ethical issues. A guidance note. Retrieved from <https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf> (accessed Nov 19, 2020).

have an equal chance of benefitting from it as someone else. There are, of course, other normatively pertinent considerations that are not addressed: what sorts of characteristics define “equality” and how can practitioners make that comparison in practice?⁹ How does treating individual patients “equally” in isolated decision-making situations ensure that the system, within which these decisions take place, is “fair”?¹⁰ When we take into account the whole range of ethical principles being employed across these policy documents, and the differences between them, then the proliferation of ethical principles from different sources can generate conflicts and confusion, and increase the risk of inconsistency.¹¹

A long-standing criticism among philosopher-bioethicists of principlist approaches to health policy decision-making has been that if one designs an ethical guidance document that consists of conflicting normative rules or principles (note the seemingly arbitrary identification/selection process for these principles), one needs to furnish that document with clear guidance on how to resolve those conflicts. In the absence of explicit criteria for weighing and balancing competing ethical demands, one ends up with a guidance document that is unable to provide any explicitly justifiable ethical guidance to begin with. The result is that health care providers and practitioners are left to make adjudications and trade-offs on their own.¹² This means that policymakers, although purporting to “know best” to the extent that they have identified, selected and (under-) specified the ethical principles that they believe should guide health care providers and practitioners, can take minimal credit for guiding, and no credit for justifying, the decisions that are made at the coal face. In practice then, bioethical principlism and COVID-19 health policy guidance documents based on it, have taken us full-circle back to the policy of doctor-knows-best when it comes to patient care, and local health care providers know best when it comes to decisions about who will be the first to receive vaccination against COVID-19, who must report for duty in high risk environments, whether non-COVID related services and interventions will be de-prioritized and who will and won't receive them, etc. The only difference to the bad old days is that today's policies are better camouflaged by combining high-flying ethical principles with “preambles,” “prefaces,” “frameworks,” and, courtesy of NACI, “algorithms.”

Although the effect of principlism on COVID-19 health policy is to put the onus squarely on local hospitals, medical teams and doctors to deliver answers to the ethical dilemmas they face, the policy of “doctor-knows-best” that these policy documents have fomented

also implies that “policymakers know best.” Those that have written these guidelines are fully aware that the success of the documents in terms of helping resolve ethical dilemmas depends on health care provider and practitioner uptake and the cooperation of patients and the public. For instance, as the British Medical Association recognizes, “citizens accept[ing] the fairness and legitimacy of allocation decisions” will depend on them being “informed beforehand of the anticipated response,” and “transparent and accountable decision-making processes, including explicit discussion of the ethical principles and reasoning upon which decisions are made.”¹³ To the extent that policymakers like the British Medical Association are providing that information, then they probably consider it likely that these guidelines will lead to greater acceptance. However, policymakers cannot presume on the face of the guidelines as they are that patients, and the broader public, will, in fact, agree with them.¹⁴ If policymakers don't have good reasons to believe that the public will agree with them or if members of the public cannot determine, on the face of the documents, how the ethical principles will be applied by those who are charged with their care, then these guidelines will require substantial public consultation and input before policymakers can draw any reasonable conclusions regarding public acceptance. Otherwise, it is clear who thinks they know best.

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⁹For further discussion, see Mannelli, C. (2020). Whose life to save? Scarce resources allocation in the COVID-19 outbreak. *Journal of Medical Ethics*, 46, 364–366.

¹⁰Coggon, J., & Regmi, S. (2020). Covid-19: Government guidance on emergency rationing of critical care is needed to support professional decision making. *BMJ Opinion*, 24 April 2020 (online).

¹¹Huxtable, R. (2020). COVID-19: Where is the national ethical guidance? *BMC Medical Ethics*, 21(32) (online).

¹²Schuklenk, U., & Zhang, E. Y. (2014). Public health ethics and obesity prevention: The trouble with data and ethics. *Monash Bioethics Review*, 32(1–2), 121–140.

¹³British Medical Association, op. cit. note 8, p. 8.

¹⁴On the contrary, see, for example, Buckwalter, W., & Peterson, A. (2020). Public attitudes toward allocating scarce resources in the COVID-19 pandemic. *PLoS ONE*, 15(11), e0240651.