Ethical Dilemmas and Future Implications of COVID-19

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INTRODUCTION

Numerous books and myriad articles have been written concerning the ethical dilemmas that emerged during the COVID-19 pandemic. One topic that had often remained in the background in healthcare suddenly took center stage—ethical reasoning. Though the pandemic was fundamentally a medical event, the measures required to address it carried profound moral implications. The longstanding structural inequalities in many Western countries, closely linked to income disparity, significantly influenced the epidemiology of COVID-19, yet there was no immediate medical solution.

The capacity to systematically approach, and reason through ethical dilemmas based on distinct moral principles has traditionally been the domain of philosophers and bioethicists. Nevertheless, the pandemic unequivocally underscored the importance of ethical considerations in the responses of healthcare professionals to the crisis, as well as in the way fellow citizens interacted with each other. Ethical reasoning, once relegated to the periphery, found itself at the heart of pandemic discourse.

In the present volume, I introduce the reader to various ethical perspectives that have played a role in shaping healthcare. In subsequent chapters, I used these ethical models to analyze specific issues that emerged during the COVID-19 pandemic. These issues include the potent influence of conspiracy theories, surveillance of citizens, COVID-19 testing, social distancing measures, vaccination, and end-of-life care, all from an ethical standpoint.

While several topics receive extensive attention in this volume, others are mentioned but not explored in as much depth. Subjects such as healthcare rationing and vaccination have been thoroughly examined elsewhere (Searight, 2013). This volume aims to provide a comprehensive ethical framework for understanding and addressing the complex issues raised by the pandemic.

This volume takes an alternative approach by devoting significant attention to topics that have received somewhat less scrutiny from an ethical perspective. It delves into areas like conspiracy beliefs, moral distress, and

injury, as well as privacy and surveillance issues, offering an ethical perspective on these topics.

While COVID-19 continues to pose a health threat, we now have some temporal distance from the terrifying days of the pandemic when our fellow citizens were suddenly falling ill and dying in vast numbers. During the peak of the pandemic, the immediate need for action and response often made it challenging to engage in an emotionally detached, analytical consideration of health decisions. Today, as more research and literature on the ethical aspects of responding to the COVID-19 pandemic become available, we have the opportunity to examine COVID-19's ethical challenges with a more balanced and objective perspective.

While the ethical implications of the pandemic for future outbreaks are explicitly discussed in the final chapter, the analysis of ethical dilemmas throughout the book will hopefully serve as a valuable resource for guiding our moral response to the future epidemics.

Before moving on, I would like to acknowledge the much-appreciated editorial work provided by Ms. Ege Tekgun. Her efforts, along with those of Ms. Madison Anderson have significantly improved the final product.

CHAPTER 1

BIOMEDICAL AND PUBLIC HEALTH ETHICS: AN INTEGRATIVE CHALLENGE

Ethics and COVID-19: An Introduction

The two fundamental functions of ethics are to guide action when there are competing interests and to provide a logical justification for that action (Lewis & Schulenk, 2022). Ethics is not a single, unified body of knowledge; rather it consists of various theories, each with its own definition of morality. When someone asks, "Is that ethical ?" or says “I don’t think this action is ethical,” the appropriate question is: ”Ethical according to which set of moral principles?” As will be seen shortly, the varying ethical models used in public health and biomedicine today, often lead to different decisions.

Ethical discourse gained significant prominence during the COVID-19 pandemic, primarily due to the conflict between prevailing moral philosophies focusing on individual freedom and well-being, and the urgent requirements of public health at a population level. In the United States, a society where individualism and autonomy hold paramount values, significant dilemmas arose in this context.

Psychologist Diana Baumrind’s work in child development studies illustrates this emphasis on independence as a cultural value within Western families. Baumrind (1967; 1991) outlined three parenting styles: authoritarian, permissive, and authoritative. The authoritative style, characterized by a clear structured set of rules combined with warmth and openness to negotiation, tends to cultivate independent individuals during adolescence and adulthood. This approach is often considered as the “best” parenting style, as it emphasizes individual independence, often associated with a “successful” outcome. However, more recent research and critiques (Chao, 1994) suggest that the preference for personal independence and its connection to psychological health may be culturally bound.

Throughout the COVID-19 pandemic, public health authorities and many government officials stressed the importance of actions that promoted social good. In societies such as the United States, which lack a strong tradition of collectivism and social solidarity, actions like lockdowns, quarantines, social distancing, mask-wearing, and vaccine mandates became subjects of contention. These recommendations, and even obligations in some regions, underscored a tension between the principles of social responsibility and individual liberty. Moreover, they rapidly took on political significance in many countries.

There are at least five prevailing models of ethical discourse in biomedicine: principlism, deontology, utilitarianism, virtue-based ethics, and communitarianism. There are also narrower ethical considerations drawn from theories with a limited explanatory domain. For instance, the principle of reciprocity, the idea that if one sacrifices for the well-being of others, one should receive something in return, became significant during the pandemic. While John Rawls (1971) did discuss individual autonomy in relation to government and distributive justice, his work on the distribution of healthcare in the face of scarce resources was particularly relevant to the pandemic.

In the context of COVID-19, public health emerged as a predominant framework for assessment and intervention. However, in comparison to the ethical foundations of medical practice, the ethical models in public health are not well-developed. While biomedical ethics places a significant focus on individual patient care, public health is primarily concerned with the well-being of the entire population. As a result, moral decision-making in public health typically adopts a consequentialist approach, considering how specific public health interventions, such as mask-wearing or social distancing, impact the community as a whole (Holland, 2023). The COVID-19 pandemic provoked discussions on how biomedical ethics could be integrated into the realm of public health.

Professionals in the field of public health did not have the advantage of a rich history of well-developed ethical theories, as is the case in biomedicine. In medical practice, the relationship between physician and patient is fiduciary. The physician bears the responsibility to provide the best possible care to the patient, a duty that, from a Kantian perspective, is considered absolute. Virtue-based ethics, including the principles outlined in the Hippocratic Oath and the perspective of Pellegrino and Thomasma, further emphasize this responsibility (Searight, 2023).

The ultimate measure of success for public health interventions is the number of lives saved. During COVID-19, individual costs, such as unemployment and school closures, were considered secondary, and necessary sacrifices to save as many lives as possible. However, public health encountered challenges in reconciling its emphasis on consequentialism with the preservation of individual autonomy.

Historically, biomedical models have not adequately addressed healthcare disparities, a key focus within the field of public health (Price et al., 2018). In essence, while there have been attempts to integrate individual bioethical models with collectivist ethics, the tension between these two perspectives is inherent.

This chapter will briefly describe the prevailing models of public health and medical ethics that were invoked during the pandemic. One of the positive outcomes of the pandemic was its role in bringing ethical considerations to the forefront of public health and medical practice. Given its origins in epidemiology and community-based interventions, ethical issues in public health have traditionally revolved around data privacy and the justification for paternalism rather than addressing larger-scale matters like social lockdowns, quarantines, all of which pose more complex challenges to individual autonomy (Searight, 2023).

Utilitarianism

Utilitarianism is closely linked to the works of two 19th-century philosophers: John Stuart Mill (1806-1873) and Jeremy Bentham (1748-1832). Despite their different views on some issues, both Mill and Bentham generally concurred that morally right actions are those that yield the most benefit to the greatest number of people. Due to its focus on the outcomes or consequences of actions, utilitarianism is regarded as a subset of the broader philosophical perspective known as consequentialism (Holland, 2023).

Jeremy Bentham

Bentham developed much of his utilitarian philosophy while addressing various legal topics such as poor law reform, prison reform, punishment, policing, and international law. From Bentham's perspective, the motivation or intent behind an act was not particularly relevant. Instead, he contended that acts themselves could not be inherently deemed as good or bad —only the consequences of these acts could be morally evaluated.

In the legal domain, Bentham proposed that the appropriate punishment for an illegal act should be proportional to the harm it caused. However, in addition to considering the impact of punishment on the individual, Bentham also emphasized its societal value. This includes the extent to which an individual's punishment would serve as a deterrent for others committing the same act (Bentham, 1843)

Bentham argued that laws should be grounded in a form of rational self-interest, which may not be immediately apparent to individuals but is recognized by legislators when designing laws. He believed that this rational self-interest would encompass concern for the well-being of society as a whole.

In addition to positing that rational acts are those that yield the greatest pleasure and the least pain, Bentham advocated that legislation and policy should take into account the overall pain and pleasure experienced by society as a whole. This should be included in the assessment of the harm caused by offenses and the determination of appropriate punishments (Crimmins, 2021).

We will revisit Bentham's (1843) work when discussing the role of surveillance during the COVID-19 pandemic. His interest in prisons and rehabilitation led him to conceptualize what he considered an ideal penal institution.

John Stuart Mill

John Stuart Mill, although a utilitarian like Bentham, differed in his emphasis. Mill attempted to walk a finer line between individual well-being and societal good. He argued that morally right actions were those that resulted in the greatest happiness for the most people, whereas actions that brought the most harm to the majority were morally wrong. This principle is commonly referred to as "the greatest good for the greatest number."

Moreover, Mill (1998) advocated for a relatively unconstrained version of human autonomy, where individuals should have the freedom to act without limits unless their actions pose potential harm to others. He regarded this as a moral good in itself. Importantly, Mill recognized an individual's freedom to engage in "self-regarding acts," which are actions that may harm oneself but not others. In this sense, he shares similarities with some modern adherents of libertarianism. According to Mill, interfering with another's freedom merely for their own protection is unacceptable; there must be a

risk of harm to others. However, individual freedom is subject to limitations when it causes harm to others, and the prevention of harm to others is essentially the only valid reason for restricting individual autonomy. This guideline for restriction of free action is known as the harm principle.

Mill was a proponent of democratic government, yet he harbored concerns about governmental paternalism. Consistent with consequentialism, he argued that laws and sanctions against individuals should be determined by the extent to which an individual's actions harm others. Mill expressed concern about government intrusion into individual freedom. While he acknowledged the necessity of government for maintaining order and providing essential services, he cautioned against overreach that could unnecessarily restrict individual liberties. In Mill's vision of a democratic government, a vocal minority was valued for stimulating free debate and introducing new and innovative ideas. Rather than viewing dissent as a threat, he regarded it as a vital force for democracy.

Mill was also a strong advocate for education, firmly believing that democracy was best served when its citizens have the ability for independent critical thinking and making moral judgments. According to Mill, the capacity for critical moral analysis was an essential requirement for the effective functioning of a democracy.

In summary, Mill's philosophy seeks to balance individual freedom and societal welfare. He envisioned an informed, intellectually sophisticated citizenry using democratic processes and laws that would maximize the greatest good for the greatest number of people.

Consequentialism's Disturbing Implications

Critics of consequentialism have raised concerns about certain situations in which human beings might be used as a means to promote the welfare of others, potentially leading to some morally disturbing outcomes. Harris (1975) illustrated such a possibility through the concept of a "Survival Lottery." In this hypothetical scenario, a healthy individual is chosen to provide organs for five people who would otherwise die without a transplant. From a strict consequentialist standpoint, this act could be seen as morally permissible due to the greater number of lives saved.

While Harris (1975) presented the "Survival Lottery" as an abstract philosophical exercise, there have been some real-life situations in recent decades that bear a resemblance to it. For instance, in 2002, a British couple

sought a pre-implantation genetic assessment to determine if a potential child could serve as a perfect genetic match for their existing child suffering from Diamond-Blackfan anemia (Spriggs, 2005). This rare condition, associated with significant pain and disability, could only be cured by the implantation of stem cells from a perfect genetic match who did not have the disease.

When the couple's request for the genetic analysis was denied in the UK, they traveled to the United States. In the U.S., the mother gave birth to a child who was genetically matched to their critically ill son (Spriggs, 2005). This incident raises questions about consequentialist ethics, echoing the moral dilemmas presented in Harris's (1975) hypothetical "Survival Lottery."

Utilitarianism and COVID-19

Consequentialist utilitarianism has been illustrated in film and television portrayals of deadly, highly contagious epidemics. In several movies, like "Outbreak," and TV series such as "Containment," government officials quarantine communities afflicted with infectious diseases and even contemplate annihilating them to prevent further disease spread. These dramatized depictions of a cordon sanitaire have historical precedents, and more recently, they were observed during the Ebola pandemic.

The cordon sanitare was an approach frequently used for containment during the medieval period's Black Death, but it wasn't widely implemented until the closure of the border between Poland and Russia in 1918 to stop the spread of typhus. Such measures could potentially result in severe and inhumane conditions. In their most drastic forms, throughout history, all individuals within the demarcated area were abandoned to their own fate, to either die or survive until the disease outbreak subsided (McNeil, 2014)

During the Ebola crisis, cordons were established at the intersection of the borders of three African countries. Roads were blocked, and military personnel prevented those infected from leaving (McNeil, 2014). These cordons were rationalized on the grounds that they were necessary to inhibit the spread of an extremely virulent disease and prevent widespread infection and massive mortality rates.

A version of the cordon sanitaire was implemented in Wuhan, China to reduce transmission of COVID-19. While some controversy persists, Wuhan is typically considered the epicenter of the epidemic. The Wuhan

cordon sanitaire remained in place for 75 days (Du et al., 2020; Tian, et al., 2020). During this period, robots were used to deliver meals, and travel to and from the region was severely restricted. In addition, airports were closed. Within Wuhan, a large-scale healthcare system was established, involving over 40,000 healthcare professionals who had come from different regions of China. An estimated 11 million citizens were isolated in this region. Residents were given "smart" rings and bracelets, which monitored and transmitted information about their temperature. The transmission index dropped from 1.0 in early February to less than 0.3 by early March (Wan et al., 2020). From a consequentialist perspective, there was a trade-off. Approximately 20% of residents surveyed, as well as a comparable percentage of healthcare professionals, reported significant depressive symptoms (Ni et al., 2020). In addition, employment activities and school attendance were restricted. However, there did appear to be significant improvement in anxiety and depressive symptoms once the lockdown was lifted (Lu et al., 2020). It should be noted that such a massive lockdown was largely successful because of the Communist/authoritarian government in China, where citizens have a history of adhering to government directives.

Rule Utilitarianism and Act Utilitarianism

Utilitarians distinguish between two primary forms: act utilitarianism, also known as direct utilitarianism, and rule utilitarianism (Holland, 2023). Act utilitarianism assesses the morality of an action based on its direct consequences. Conversely, rule utilitarianism applies another level of analysis, asserting that an act is moral if it aligns with pre-established rules. These rules, according to a utilitarian perspective, should be policies that maximize benefits for the majority (Holland, 2023).

Rule utilitarianism was invoked in various scenarios related to COVID-19, particularly in situations involving populations that had long suffered from structural inequalities (Searight, 2023). For instance, in Canada, indigenous peoples and First Nations communities were granted preferential access to vaccines when they became available. This rule was enacted because these minority groups lived in conditions where disease transmission was highly likely. Furthermore, systemic racism has been recognized as a factor limiting access to healthcare for some indigenous people (First Nations Health Authority, 2021).

A comprehensive utilitarian calculation would involve quantifying the negative impacts on mental health, education, and economic well-being

stemming from the measures employed to mitigate COVID-19. However, data on these impacts continue to evolve, and reaching a consensus on a harm-to-benefit ratio that encompasses these elements remains elusive. A significant hurdle to achieving such consensus is the challenge of comparing mortality to other harms. Indeed, it is a complex task to weigh the loss of human-life against a 20% rise in depressive symptoms, the setback of six months in educational progress, or a $10,000 decrease in income.

As a utilitarian who advocated for individual freedom, Mill (1998) held specific reservations about government overreach. Although not as severe as the restrictions in Wuhan, certain countries such as Australia and the United States, enforced rigorous lockdowns during the COVID-19 pandemic. These measures affected various establishments including restaurants, bars, commercial gyms, and sporting events. For a period, lockdowns were exceptionally strict, permitting people to leave their homes only for limited durations and specific purposes, such as purchasing groceries or collecting prescriptions.

Mill held concerns about the extent of government power over individuals. Particularly, those in line with Mill's views would worry about whether the COVID-19 lockdowns might set a "slippery slope," potentially paving the way for countries to prohibit large gatherings or suppress civil expressions of dissent. Notably, around the time of the Wuhan cordon, the Chinese government was intensifying its crackdown on free speech demonstrations in Hong Kong (Steinhoff, 2023).

In keeping with Mill's concerns, research has found that political demonstrations and related activities globally declined by approximately one-third during the pandemic compared to pre-pandemic levels (Grasse et al., 2021; Pavlik, 2021). Some governments appeared to preemptively quell protest movements by invoking COVID-19 restrictions on social gatherings, thereby eliminating demonstrations of dissent against existing regimes, such as in Iran.

Human Rights Watch estimates that "authorities in at least 51 countries have used laws and regulations, adopted to prevent the spread of Covid-19, as well as counterterrorism and other measures predating the pandemic, to arbitrarily arrest, detain, and prosecute critics of government responses to the coronavirus, or of policies unrelated to the pandemic, resulting in fines and imprisonment" (Grasse et al., 2021; Pavlik, 2021). The targeted individuals include journalists, bloggers, social media users, opposition political figures, human rights activists, academics, and healthcare

professionals (Grasse et al., 2021; Pavlik, 2021; Wood et al., 2022). Wood (2022) notes "violations of the rights to freedom of expression and assembly in 83 countries."

Reports indicate that across Africa, COVID-19 lockdowns were accompanied by physical repression by the state. A case study on political repression in Uganda revealed that opposition groups bore the brunt of the pandemic-era repression in that country (Wood et al., 2022). In a pandemic-related analysis, governments that had recently engaged in state violence against civilians have been more likely to enact lockdown and curfew policies. These policies were implemented earlier in the pandemic and persisted over longer periods (Barcelo et al., 2020).

In the U.S., excerpts from court rulings regarding COVID-19 restrictions reflect Mill's influence on legal reasoning. For example, in responding to the request for an extension of the stay-at-home order in Wisconsin, Justice Kelly of the Wisconsin Supreme Court wrote: "This comprehensive claim to control virtually every aspect of a person's life is something we normally associate with a prison, not a free society governed by the rule of law" (Wood et al., 2022).

In a similar vein, Justice Bradley raised a crucial question: "Isn't it the very definition of tyranny for one person to order people to be imprisoned for going to work among other ordinarily lawful activities?" (Wood et al. 2022; p. 10).

In Sweden, where COVID-19 restrictions were minimized, a government official provided a utilitarian argument in response to criticism for not requiring lockdowns—those who were already dying in poor health and had limited life expectancy, stating: "People who will die a few months later are dying now. And that's taking months from their lives, so that's maybe not nice, but compare that to the effects of the lockdown" (Wood, 2022; p.11).

Medical Ethics, Physician Duty, and Patient Autonomy

Public health, an area dedicated to improving population-level well-being, can sometimes conflict with a physician's professional responsibilities. Ethical considerations in public health are largely driven by utilitarianism, particularly in circumstances of resource scarcity. Public health often displays a level of impersonality uncommon in individual patient care, as it tends to label individuals with illnesses as mere "cases." Population-level rationing criteria rely on risk factors incorporated into quantitative

algorithms, yet these risk factors often originate from substantial structural inequalities, such as pre-existing conditions like type 2 diabetes or cardiovascular disease. These inequalities can be overlooked from a strictly utilitarian perspective, which might disregard a history of discrimination and structural violence as irrelevant.

In contrast, healthcare providers often adhere to a deontological perspective, recognizing an absolute duty to their patients. This approach, also known as principlism, prioritizes maximizing patient autonomy, delivering care that serves their best interests, and minimizing harm. Principlism, which emphasizes individual rights and duties, stands as the prevailing model of medical ethics in the United States (Searight, 2023).

Virtue ethics, as articulated by Pelligrino and Thomasma (1993), emphasize the physician's fiduciary duty and dedication to the patient's well-being. In contrast, public health ethics focus on the well-being of society as a whole. In situations with limited resources, public health ethics aim to optimize the use of those resources, with the goal of saving as many lives as possible. During a pandemic, these competing models present a constant dilemma, as individually-focused medical ethics and population-focused public health ethics attempt to navigate the complex landscape of healthcare.

Deontology

Deontology, typically associated with Immanuel Kant (1724-1804), is a moral philosophy that focuses on adhering to moral duties and principles when making ethical decisions. These moral principles are universal and not subject to situational modification. Deontology is often contrasted with consequentialism, which emphasizes the outcomes or consequences of actions. In many respects, deontology is almost the polar opposite of utilitarianism (Holand, 2023). The outcome of an act is essentially irrelevant; it is the intent or motivation for the act that holds importance.

Deontological theories, as proposed by Immanuel Kant, highlight the importance of following moral rules and duties. According to Kantian deontology, actions are morally right if they align with a universal moral law, which he called the categorical imperative. The categorical imperative states that individuals should act in a way that allows their actions to be described by a universal law that remains consistent across contexts or cultures.

Again, Kant's moral theory is a direct rejection of the consequentialist approach to moral dilemmas (Garbutt & Davies, 2011). According to Kant, certain types of actions are inherently wrong because their guiding principles or maxims cannot be universally adopted by all rational beings as moral law. Furthermore, Kant contends that all human beings possess intrinsic worth and dignity, asserting that they should never be used merely as a means to an end. Even prior to the emergence of COVID-19, healthcare systems that involved treatment allocation decisions, such as the National Health Service in the United Kingdom, often witnessed a conflict between consequentialism and a physician's duty to their patient (Garbutt & Davies, 2011). The UK General Medical Council's (GMC) code for good medical practice begins with this premise: "You must make care of the patient your first concern." Garbutt and Davies (2011) highlight the implications of this directive: "Note the key point here that it is the individual patient who is the focus of attention, and not the wider needs of the healthcare system or the country's economy" (p. .4).

Healthcare professionals who embrace deontology often encounter significant moral dilemmas with many of the proposed strategies for rationing care during the pandemic. Due to their absolute duty to their patient, healthcare professionals guided by deontology would have objections to the withdrawal of a ventilator from a patient whose condition is deteriorating, even if the prognosis is bleak, in order to provide the technology to a patient with a better chance of survival. The idea of sacrificing any patient regardless of age or health status, who has inherent dignity and worth for the benefit of another is tantamount to using a human being as a means to an end. Another example of the categorical imperative is that a very large number of healthcare professionals do not consider physician-assisted death to be appropriate under any condition. For them, the degree of suffering or the patient's limited lifespan is considered irrelevant, as intentionally ending a patient's life prematurely is viewed as simply wrong. Surveys conducted in the United States have found that approximately half of physician respondents do not believe that euthanasia or physician-assisted death should be legalized. In European countries, the proportion of physicians supporting such legislation is even lower (Emanuel et al., 2016).

Principlism

Beauchamp (2016) states that the four principles of medical ethics, developed in collaboration with James Childress (Beauchamp & Childress, 2001) emerged as a response to various philosophical shifts in American medicine. One such factor was the predominant medical ethics paradigm,

which had traditionally prioritized beneficence—acting in what the practitioner believes to be the patient's best interest. However, this approach often puts less consideration to the patient's perspective.

This led to the incorporation of the principle of autonomy, highlighting that a key objective of medical ethics is to foster and uphold patients' right to self-determination. This shift aligns with the growing consumer movement in numerous countries, advocating for greater patient involvement in healthcare decisions (Gusmano et al., 2019).

Moreover, Beauchamp (1976) pointed out that social justice, an important element in Catholic ethical reasoning, had not received adequate attention within the field of medical ethics. Therefore, he proposes that the conventional beneficence-and-care-based model of medical ethics should be supplemented with a principle that respects patient autonomy and includes social justice.

This ethical framework has been widely debated since its initial publication. Originating in the United States in the late 1970s, principlism has played a central role as the guiding paradigm for biomedical ethics, particularly in clinical settings. The four principles are as follows:

1. Autonomy: This principle promotes patients' decision-making capabilities by providing them with information about their medical conditions and treatment options, thereby optimizing their independence and self-determination. True autonomy is predicated on having adequate information to make an informed decision.
2. Beneficence: This tenet requires healthcare providers to act in the best interests of their patients. Providers have a duty to recommend and deliver interventions they believe will benefit the patient. This duty, in theory, should not be influenced by cost or institutional policies.
3. Non-maleficence: This principle, a variant of the Hippocratic Oath's maxim "Do no harm," obligates healthcare professionals to avoid any action that would deliberately harm their patients. It also requires them not to overlook possible treatments that could be beneficial.
4. Justice: This principle emphasizes the fair treatment of individuals and the respect of patients' rights. While not its primary focus, it is sometimes seen as an obligation to follow all relevant laws regarding patient care (Beauchamp, 1976; Beauchamp & Childress, 2016).

Beauchamp and Childress' (2001) work, therefore, introduces these principles as a means to balance the intentions of healthcare providers with the evolving rights and perspectives of patients. It also take into account the broader societal implications of medical decision-making.

Beauchamp and Childress (2001) believed that there should be some degree of flexibility in addressing ethical dilemmas. They intentionally did not give rigid prescriptions or dictates. Instead, the principles are meant to serve as guidelines or dimensions to consider when addressing moral dilemmas in patient care. One criticism of this system has been the lack of hierarchy among the principles. Depending on the situation, relative priorities of the four principles may be established, although some commentators have argued that autonomy holds a special significance as "first among equals." (Gillon, 2003). These principles may sometimes conflict with each other and balancing them is a key challenge in medical ethics. Overall, these principles are intended to guide ethical decision-making in healthcare. This framework has been widely embraced across cultures and has become the most commonly used approach for addressing ethical dilemmas in medicine, not only in the United States but also in many other countries.

Critics have suggested that the absence of clear priorities among the principles limits the model's effectiveness in resolving ethical dilemmas. One of its strengths has been its flexibility; however, the same flexibility has also been considered as a weakness since the framework provides dimensions for analysis but does not necessarily provide a straightforward path to a course of action.

Some European bioethicists have challenged Beauchamp and Childress' (2001) model. Häyry (2003), setting up a competition between old and new world ethics, suggests that the American "invasion" has not always been received positively. According to Häyry (2003) "Many people in Europe, and particularly in Continental Europe, believe that the values of the Old World are under attack. In bioethics, the four "Georgetown" principles are often identified as the invader, and most American attempts to deal with moral issues are viewed with suspicion. European policies, it is argued, should be based on European values, which are more reflective, communal, and ethical than the pragmatic codes imported from the United States" (Häyry , 2003, p. 199).

Of note, the difference of opinion between European and American bioethicists does not appear to center around the concept of a limited set of principles to frame ethical dilemmas. Rather the issue lies in the nature of

those principles themselves. For instance, the Barcelona Declaration (Kemp & Rendtorff, 2008; Rendtorff & Kemp, 2000), which resulted from several years of collaboration among European bioethicists, recommended the principles of autonomy, dignity integrity, and invulnerability. Other principles such as, "precaution" and "solidarity," have also been suggested. Häyry (2003) suggests that dignity is a more prominent principle in the European ethical scheme compared to autonomy. It is noted that there are situations in which one's autonomy may be limited, such as in the case of a newborn infant or someone with significant cognitive impairment. Dignity, in this context, conveys the "personhood" of those who may not have the capacity for autonomous decision-making**.**

The precaution principle shares similarities with the concept of "prudence" found in virtue ethics, addressing the importance of transparency when all relevant information is not available. The precautionary principle has been invoked in discussions of the ethics of climate change (Häyry, 2003). It recognizes that the long-term consequences of certain health decisions are sometimes unknown and advocates some degree of caution in such situations. (Häyry, 2003). In the context of COVID-19, public health guidelines were based upon the best available evidence at the time. As more information was gathered, these guidelines and recommendations to the public evolved. For example, it was initially believed that vaccination shots would provide long-term immunity. However, subsequent observation has revealed that this is not always the case and even those who'have been vaccinated can still develop COVID-19. It is very likely that COVID-19 vaccinations may become an annual or semi-annual event. Unfortunately, as will be discussed in later chapters, these changes in recommendations provided fodder for conspiracy theorists to undermine the credibility of the recommendations from public health authorities (Searight, 2023).

Finally, using the template of principlism while substituting different dimensions, Upshur (2002) proposed that public health ethics should be guided by the following principles: the harm principle, least coercive means, reciprocity, and transparency.

1. Harm Principle: This is essentially an adaptation of Mill's philosophy and asserts that individual liberty can only be curtailed to prevent harm to others (Holland, 2023).
2. Least Coercive Means: This principle addresses issues such as quarantine. The guideline here is that when individual freedom is necessarily infringed upon, it should be done with minimal constraint.

3. Reciprocity: This dimension holds that governments placing constraints on individual freedom for the community's well-being are obliged to provide some sort of compensation to those individuals who comply. For example, during the COVID-19 pandemic, the UK government paid up to 80% of wages and provided some job guarantees during the pandemic (Holland, 2023).
4. Transparency: This principle calls for open decision-making and policy development for public health interventions, with input from all affected parties (Holland, 2023). This principle is particularly important in preventing the misuse of public health restrictions by the government to quell dissent.

These principles collectively emphasize a balanced and fair approach to public health decision-making, considering both individual and collective needs, and ensuring open and transparent processes (Holland, 2023; Upshur, 2002).

Communitarian Ethics

Communitarian ethics applied to healthcare can be seen as a response to the de-contextualized individualism inherent in moral frameworks such as principlism and deontology. Communitarianism is not an explicitly defined set of principles but is grounded in the concept that individuals do not exist in isolation but are invariably part of various social networks (Holland, 2023).

This perspective of communitarian ethics became particularly salient in the United States during discussions around public health measures, such as mask-wearing, social distancing, and vaccination. Critics argued that these interventions infringed upon individual liberty (Holland, 2023). The prevalent emphasis on the individual's right to pursue happiness and liberty without considering their interconnectedness with society is a central criticism posed by communitarian ethics.

Communitarianism is acutely aware that individual decisions can have ripple effects through social networks. To balance the "rugged individualism" deeply ingrained in American mythology, communitarians propose the importance of shared interests, social solidarity, and a certain level of responsibility towards our fellow human beings (Holland, 2023).

The dimension of social responsibility was evident during the vaccination debates that existed even before the onset of COVID-19 (Goldenberg,

2022). The notion that an individual's immunity status could impact the health of others highlights the need to strike a balance between individual rights and the welfare of the community in healthcare decision-making. This perspective necessitates a consideration of the impacts of healthcare choices, not just on the individual patient, but also on the wider community and society as a whole.

Communitarian ethics, therefore, stress the value of the social responsibilities and obligations that individuals have toward their community within the broader healthcare context. However, communitarianism has also been applied to specific communities whose interests may not align with mainstream society. For instance, when conducting research with Native American populations, it is necessary to involve and obtain consent from tribal elders before recruiting from the community.

Native American communities have displayed caution towards the COVID-19 vaccine. This hesitancy has its roots in the historical harm inflicted by the Eurocentric medical establishment, which has cultivated a climate of caution. For example, in the 1960s and early 70s, medical providers within the Indian Health Service performed complete hysterectomies on women without their consent. Notably, two 15-year-old girls were subjected to appendectomies but were unknowingly sterilized as well (Lawrence, 2000).

When the COVID-19 vaccine became available, many indigenous communities chose to receive their vaccines through Indian Health Service clinics. Despite past abuses, this decision provided these communities with some degree of control over vaccine distribution. Prioritization was given to tribal leaders and council members, even if they were younger than the officially designated age cutoff for receiving the vaccine (Tanasoca & Dryzek, 2022). This approach enabled tribal members to craft their messages that aligned with their community's values.

In line with the principles of solidarity, the vaccination campaign emphasized the significance of collective survival over individual risk. The campaign underscored the vital importance of preserving tribal culture, customs, and language as part of the vaccination message. This theme of cultural survival was paired with information about the heightened susceptibility of Native people to the virus and their disproportionate mortality. The ethical responsibility to get vaccinated was framed within the larger context of individuals' duties towards their community and cultural heritage, extending beyond their immediate families (Tanasoca & Dryzek, 2022).

With the active involvement of tribal leaders, these messages appeared particularly effective in overcoming vaccine hesitancy. A survey conducted across tribes in forty-six states revealed that a significant portion of community members were motivated to get vaccinated due to a deep sense of duty to protect their community and preserve cultural practices. Remarkably, nearly three-quarters of those surveyed indicated that their decision to get vaccinated was driven by their commitment to their community rather than solely their health (Tanasoca & Dryzek, 2022).

Indeed, the essence of communitarianism resides in its cultural relativism and understanding of the unique dynamics within individual communities. Consequently, a specific, universally applicable list of principles cannot be generated. Nevertheless, there are some common themes found in communitarian thought, which may include active citizenship, fairness, and solidarity. Community members are encouraged to be actively engaged in their communities, not only through service but also through political participation.

One overarching belief is that an individual's well-being is best served through active community membership. These values are at the heart of Afro-communitarianism (Cordero-Rodrigues & Metz, 2021) Even the etiological explanations for many illnesses are based upon social relationships, which may include connections to the spirits of deceased ancestors. Rather than self-development, many African ethical systems prioritize social harmony as a valued endpoint. The key virtues of Ubuntu, an African ethical system, encompass hospitality, generosity, and benevolence (Cordeiro-Rodrigues & Metz, 2021). This perspective underscores community interconnectedness and the importance of collective well-being, offering valuable insights into global health ethics.

The Native American community's approach to vaccine distribution provides a clear illustration of how healthcare policies and decisions can be more effectively developed when they are guided by the community members themselves, rather than being imposed by external health authorities.

Further, cultures often have longstanding traditions and rituals related to end-of-life care. Before the COVID-19 pandemic, decisions regarding life support termination were not made solely by an individual. Instead, these critical decisions often involved the extended family and relevant community members (Searight & Gafford, 2005). This challenge to autonomy

highlights the importance of communal decision-making in situations where the values and beliefs of the community play an essential role.

In conclusion, communitarianism is fundamentally about recognizing the role of the collective and ensuring that shared values and needs guide policies and practices, all while still respecting individual rights and needs.

Virtue Ethics

Historically speaking, virtue ethics is probably the oldest of all moral philosophies, with its roots dating back to ancient Greeks such as Aristotle and the Stoics (Taylor, 2010) . Virtue ethics is primarily concerned with the moral character of individuals, more specifically, healthcare providers in this context. It posits that professionals with strong moral character are more likely to make ethically appropriate decisions. Pellegrino and Thomasma (1993) have extensively written about the set of virtues characterizing a "morally good" healthcare professional. These virtues include qualities such as courage, prudence, fidelity to trust, intellectual honesty, benevolence, compassion, and truthfulness.

This perspective encourages the nurturing of characteristics such as honesty, empathy, patience, and courage, which are considered critical for the effective delivery of healthcare services. One way to better understand virtue ethics is to consider individuals whom we admire for their virtues. This person could be a mentor, a colleague, or a historical figure in healthcare whose virtues or moral character have inspired us. Reflecting on the virtues that these role models embody can help healthcare providers identify, understand, and strive toward virtuous excellence. In healthcare, this means acknowledging that ethical decisions often need to take into account a complex array of factors including medical knowledge, empathy, and the unique circumstances and values of each patient. This approach contrasts with deontological ethics, which emphasizes duties and rules and might not fully capture the complexity of real-life situations.

In contrast to the other models of medical ethics in which some external principles or rules are followed, virtue ethics places morality within the individual. While there is debate about the extent to which virtues are genetically based versus acquired (Walker, 2009), the consensus is that virtues can be developed and cultivated. Virtue ethics has also adopted Aristotle's concept of the golden mean. With respect to any virtue, too little or too much can lead to morally inappropriate actions. In the general public as a whole, adherence to COVID-19 public health restrictions would be