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EDITORIALS

Ethical road map through the covid-19 pandemic

We must follow the ethics, not just the science

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The covid-19 pandemic has created profound ethical challenges in health and social care, not only for current decisions about individuals but also for longer term and population level policy decisions. Already covid-19 has generated ethical questions about the prioritisation of treatment, protective equipment, and testing; the impact of covid-19 strategies on patients with other health conditions; the approaches taken to advance care planning and resuscitation decisions[1]; and the crisis in care homes.

Ethical questions continue to multiply as the pandemic progresses and new evidence emerges, including how best to distribute any new vaccines and treatments; how best to respond to evidence that disease severity and mortality are substantially greater in ethnic minority populations[2]; how to prioritise patients for care as medical services re-open; how to manage assessment of immunity and its implications; and how the health system should be configured to manage any future peaks in cases.

Science and values

The UK government repeatedly states that it is "following the science" by heeding the advice provided through the Scientific Advisory Group for Emergencies (SAGE). However, this implies that the science alone will tell us what to do. Not only does this rhetoric shift the responsibility for difficult decisions on to "the science", it is also wrong. Science may provide evidence on which to base decisions, but our values will determine what we do with that evidence and how we select the evidence to use. It is disingenuous and misleading to imply that value-free science leads the way. Both science and policy are value laden.

Values questions are being addressed primarily by professional organisations, although the UK government has independent advice, for example, from the Moral and Ethical Advisory Group.[3-6] Despite such efforts to plot an ethical path, the current approach is piecemeal, confusing, and risks needless duplication of effort. Concerns are mounting about a lack of transparency around the ethical agenda underpinning decisions, a lack of coordination, and the absence of clear national leadership.[7-12]

Ethical planning

As the UK prepares to emerge from lockdown, we urge our leaders to develop an ethical plan with at least the following three features.

Firstly, there should be nationally led and coordinated development of transparent, publicly shared ethical guidance that can provide the basis for clear, consistent, and defensible decisions in all healthcare and policy settings across the country. Such guidance could then be tailored to specific contexts.[9] Whatever its reach, guidance will require consultation with stakeholders with relevant expertise, including patients. Development processes must be transparent and the conclusions publicly accessible.

Secondly, ethics support structures should be formalised, coordinated, resourced, and embedded throughout the health and social care system to support the interpretation and application of national guidance. Ethics support can enhance the clarity, consistency, and defensibility of decisions made across the country and help share the substantial burden of urgent and complex decision making.

Ethics support services, such as clinical ethics committees, exist throughout the UK, although provision varies widely. Before and during the pandemic, the UK Clinical Ethics Network has sought to help coordinate ethics support and has offered advice on setting up such services.[3] However, the network is a charity, reliant on volunteers (like most ethics support currently offered in the UK). A recent legislative proposal, drafted after several high profile legal cases, sought to increase "access to clinical ethics committees throughout NHS hospitals."[13] Covid-19 highlights the urgent need for more formal clinical ethics support embedded across the health and social care system, and not just in hospitals.

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Thirdly, research is required to inform and support the development of ethical policy and guidance, and the interpretation of both. The UK has abundant expertise in healthcare ethics, supported by organisations such as the Nuffield Council on Bioethics, the Wellcome Trust, and research councils. Recent funding calls for urgent covid-19 research highlight the need for research on the ethical dimensions of the pandemic.[14] These organisations could coordinate to commission timely, focused, ethical research to help answer the many remaining ethical questions about pandemic responses.

None of the above can succeed without the overt support of leaders from government, the NHS and social care, and Public Health England. In plotting the way through this pandemic, we need to follow the ethics, not just the science. Every institution and organisation involved in the response must follow ethical principles, uphold ethical standards, and be publicly accountable for the decisions they make.

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Competing interests: We have read and understood BMJ policy on declaration of interests. AP is chair of the committee on ethical issues in medicine for the Royal College of Physicians, and a trustee of the Institute of Medical Ethics (IME). ZF serves on the executive of the Resuscitation Council UK and, with RH, the research committee of the IME. RH is vice chair of the UK Clinical Ethics Network (UKCEN) and a member of the ethics committees of the BMA and the Royal College of General Practitioners (RCGP), the Bristol clinical ethics advisory group, and the ALSPAC ethics and law committee; he is also a member of an expert review group for the Wellcome Trust. JI sits on the ethics committee of the RCGP and on the grants and awards committee of the IME. AS is a member of the board of trustees of UKCEN and the IME, a member of the UK National Screening Committee, and a member of University Hospitals Coventry and Warwickshire clinical ethics forum. DW is co-chair of the Oxford University Hospitals NHS Foundation Trust clinical ethics advisory group and a member of the ethics committees of the BMA and the Royal College of Paediatrics and Child Health. The views expressed are those of the authors.

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