Ethical framework for adult social care in COVID-19

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ABSTRACT

In March 2020, the Government produced a document entitled "*Responding to COVID-19: The Ethical Framework for Adult Social Care*" ('The Ethical Framework'). In this article, we summarise the key features of the proposed ethical framework and subject it to critical analysis. We highlight three primary issues. First, the emphasis placed on autonomy as the primary ethical principle. We argue if ever there was a context in which autonomy should dominate the ethical analysis, this is not it. Second, we examine the interface between ethics and law which is largely overlooked in the document. Finally, we explore the surprising lack of attention paid to the concept of responsibility and communal obligations within the framework.

OVERVIEW OF THE ETHICAL FRAMEWORK

The Ethical Framework is designed for 'planners and strategic policy makers at local, regional and national level to support response planning and organisation of adult social care' during COVID-19.[1] It is not restricted to setting out the ethical principles directly impacting on decision-makers, but rather sets out the general ethical principles that govern individual and societal responses to COVID-19 and hence the background against which particular adult social care decisions need to be made. The aim of the document is "to ensure that ample consideration is given to a series of ethical values and principles when organising and delivering social care for adults".[1] The Ethical Framework is particularly designed for "challenging decisions on how to redirect resources where they are most needed and to prioritise individual care needs".[1]

Anyone seeking to produce an ethical framework on any topic faces challenges. At the heart of these is the need to determine what is meant to go into it. Is it a case of applying a set of moral principles to ensure an acceptable outcome, or does it also include developing a process through with all of the relevant factual information is identified, gathered and weighed? Thus, to what extent are ethical frameworks concerned with ensuring acceptable outcomes versus devising acceptable decision-making processes? Closely tied to that is the question of what the aim of an ethical framework is. Is it to produce good decisions, or decisions which are well justified, again assuming such a distinction can be drawn?

The Ethical Framework early on states it seeks to "reinforce that consideration of any potential harm that might be suffered, and the needs of all individuals, are always central to decision-making".[1] We might consider that this is a part of good decision-making—that is to say, decisions issued by a rational, efficient and consistent process, rather than ethical decision-making. One could consider all potential harms and decide to maximise them for a particular group, for example. It does seem that the Government sees the document as only one aspect of decision-making because it states:

> *Alongside ethical considerations, every decision will require consideration of individual wellbeing, overall public good and the resources that are available.*[1]

This is somewhat strange statement in that it suggests that individual well-being or public good are not ethical considerations. Perhaps there are some ethical approaches which would consider neither of these factors but they would hardly be mainstream ones.

The Ethical Framework relies on a 'checklist' of factors. These are 'not exhaustive' but will 'ensure ethical considerations are taken into account'. The idea of a list of ethical principles will be familiar to medical ethicists through the approach of principlism.[2] As is well known, a primary challenge of such an approach is determining what to do when the principles clash. To deal with such a case, the Ethical Framework offers little beyond saying cases of conflicting principles "require a judgement to be made on the extent that a particular value or principle can be applied in the context of each particular decision". While understandable, the problem with such a response is that in any difficult case, the kind of case when a decision-maker might be minded to turn to the Ethical Framework, there will be a clash between the ethical principles. It seems no help is offered in ranking or balancing these principles. This severely limits the practical benefit of the Ethical Framework, although it might at least crystallise to a decision-maker why they are finding a particular decision difficult. The Framework does suggest that professional codes of conduct and legislation can be considered in applying the principles. We will return to this suggestion later.

The Principles listed in the Ethical Framework with their heading summary are as follows:

Respect

This principle is defined as recognising that every person and their human rights, personal choices, safety and dignity matters.

Reasonableness

This principle is defined as ensuring that decisions are rational, fair, practical and grounded in appropriate processes, available evidence and a clear justification.

Minimising harm

This principle is defined as striving to reduce the amount of physical, psychological, social and

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economic harm that the outbreak might cause to individuals and communities. In turn, this involves ensuring that individual organisations and society as a whole cope with and recover from it to their best ability.

Inclusiveness

This principle is defined as ensuring that people are given a fair opportunity to understand situations, be included in decisions that affect them, and offer their views and challenge. In turn, decisions and actions should aim to minimise inequalities as much as possible.

Accountability

This principle is defined as holding people, and ourselves, to account for how and which decisions are made. In turn, this requires being transparent about why decisions are made and who is responsible for making and communicating them.

Flexibility

This principle is defined as being responsive, able and willing to adapt when faced with changed or new circumstances. It is vital that this principle is applied to the health and care workforce and wider sector, to facilitate agile and collaborative working.

Proportionality

This principle is defined as providing support that is proportional to needs and abilities of people, communities and staff, and the benefits and risks that are identified through decision-making processes.

Community

This principle is defined as a commitment to get through the outbreak together by supporting one another and strengthening our communities to the best of our ability.

Clearly, much could be said about these and how they might apply. We will focus on three particular issues.

INDIVIDUALISM AND AUTONOMY

While in the Ethical Framework there is no attempt to prioritise one principle over the other, we suggest that, in fact, the dominant values are based on individualism and autonomy. We can see that at various points in the documents, as we will explain shortly, but first we will consider whether that should should be the case. Of course there is a lively debate over whether autonomy is the paramount moral principle and this is not the place to enter those troubled waters. However, we suggest there are particular reasons to be doubtful of the elevation of autonomy in relation to COVID-19.

First, we still know very little about the impact, spread or longer-term issues around COVID-19. Certainly, members of the public are not in position to make fully informed decisions about their health at these times. Autonomy seems a peculiarly ill-suited doctrine given the inability of the general population to know the essential information necessary to make their decisions. It also is of limited application for those who lack the mental capacity to make autonomous decisions, many of whom will be at particular risk of infection.

Second, as COVID-19 dramatically shows us, our lives and health are bound up with each other. Decisions I make about what I do can have a profound impact on the health and well-being of others around me. In such circumstances (perhaps always true but evidently so now), the principle of self-determination seems to ring particularly hollow. Further, COVID-19 shows that health is not an individual or even just relational matter. Beyond the health of my body, or those of my loved ones, those on who I depend and those who rely on me, the health of my community matters. COVID-19 demonstrates that bodily health is best enjoyed in a healthy society of bodies.[3] I cannot seek my own health if all around me are ill. Much of Government response around COVID-19 has recognised this by requiring social distancing, requiring self-isolation where a family member has symptoms, and even the policy of herd immunity.

Yet, we do not see much recognition of this in the Ethical Framework and autonomy appears to be the underpinning value. This becomes apparent when one digs under the surface. Consider for example what the document says about respect:

To ensure people are treated with respect, those making decisions should

- *Provide people with the opportunity to express their views on matters that affect their care, support and treatment.*
- *Respect people's personal choices as much as possible, while considering and communicating implications for the present and future.*
- *Keep people as informed as possible of what is happening or what is expected to happen in any given circumstance.*
- *Where a person may lack capacity (as defined in the Mental Capacity Act), ensure that a person's best interests and support needs are considered by those who are responsible or have relevant legal authority to decide on their behalf.*
- *Strive to support people to get what they are entitled to, subject to available resources, ensuring that there is a fair judgement and clear justification for any decisions made on prioritisation.*

Here, respecting people boils down to protecting their autonomy: it is about giving them the opportunity to express their views and respecting their choices. Yet, there is much more to respecting a person than respecting their autonomy. Ensuring they have the basic materials for a minimally decent life; respecting their cultural and religious background; protecting them from abuse and so forth. Yet, in this document, Respect becomes denuded to respect for autonomy.

Similarly, the value of Inclusiveness becomes whittled down to essentially autonomy:

> ensuring that people are given a fair opportunity to understand situations, be included in decisions that affect them, and offer their views and challenge. In turn, decisions and actions should aim to minimise inequalities as much as possible.[1]

There is more to being inclusive than giving people a fair say in what happens to them. It is about sustaining a wide range of cultural and religious groups. It is about recognising the diversity of abilities people have and finding ways of valuing the different ways of contributing to society.

It might seem a little unfair to suggest the Framework is dominated by autonomy and individualism because after all Principle 8 is 'Community' and in the introduction there is a reference to both individuals and the common good: 'every decision will require consideration of individual wellbeing, overall public good and the resources that are available'.[1] However, we suggest this is a weak appreciation of the non-individualistic goods. In particular, there is no mention of relationships having value. We are presented with individuals and the common good as the two competing conceptions, but there are values within relationships, cultural groups, families and friends which are not captured in this polar distinction. This individualistic trope is repeated in the opening principle of minimising harm where individuals and

communities are mentioned and the key elements of minimising harm are listed:

- *Acknowledge and communicate that everyone has a role to play in minimising spread, for example, by practising thorough hand-washing or social distancing.*
- *Minimise the risk of complications in the event that someone is unwell.*
- *Provide regular and accurate updates within communities and organisations.*
- *Share learning from local, national and global experiences about the best way to treat and respond to the outbreak as understanding of COVID-19 develops.*
- *Enable care workers and volunteers to make informed decisions which support vulnerable people*

Here, the practical steps all relate to individuals and the only reference to communities or groups is that they should be kept informed. The importance of enabling communities and relationships to thrive as central to human well-being is invisible.

RELATIONSHIP BETWEEN LAW AND ETHICS

While noting that difficult decisions are made every day in the adult social care context, the Ethical Framework highlights that the ongoing coronavirus pandemic will require that such difficult decisions are made under new and exceptional pressures.[1] In this way, the pandemic might curtail the ability of professionals to make good ethical decisions by constraining the resources, information or time available when making such deliberations. Alternatively, the ethical decisions with which professionals are confronted might be more complex in and of themselves due to the scarcity of various resources. The Ethical Framework itself clearly contemplates difficult decisions regarding the prioritisation of care, or the redirection of resources away from some individuals and towards those most in need.[1] Furthermore, the easements to the Care Act 2014[4] provided by Section 15 of the Coronavirus Act 2020[5] remove from Local Authorities some of the duties held in respect of assessing and meeting adult social care needs. In that respect, while ethical duties might have previously been met by complying with the legal duties set out in the Care Act 2014,[4] the suspension of that Act subject to certain conditions leaves a void into which this Ethical Framework steps. To that end, the Ethical Framework has been drafted in full awareness of the quality of decisions professionals will be required to make and the reality that in many instances it will be a case of divining the least worst option, rather than attaining grand ethical ideals. The Ethical Framework then seeks to steer decision-makers in their attempt to find the best available option by providing a set of eight principles for their consideration.

As suggested in the overview of the Ethical Framework offered earlier, we might have good reason to doubt the action-guiding quality of the eight principles. In respect of the highly complex ethical questions that professionals will be confronted with throughout the pandemic, ethical principles will clash. Despite that, the Ethical Framework offers no commentary about how such clashes might be resolved or even any suggestion of a rough hierarchy for the application of the eight principles. Furthermore, professionals deliberating over a clash of principles will find no steer from the Coronavirus Act as it suspends all previous duties, leaving only those duties imposed by the Human Rights Act 1998[6] in place. To that end, from the Ethical Framework and the legislation taken together, the best option for professionals will be resolving a clash of principles in such a way as does not breach Convention rights. However, that sets the bar for the output of ethical decision-making rather low—in many situations ethically dubious but Convention-compliant decisions might be made. Human rights tend to set out what are the minimal requirements for a decent society, rather than setting out what is ethically ideal or even appropriate. One need only think of the Supreme Court judgement in *McDonald v Royal Borough of Kensington & Chelsea* (successfully appealed to the European Court of Human Rights in *McDonald v United Kingdom*) to see that this is all to often the case in adult social care.[7] In *McDonald*, the claimant had suffered a stroke leaving her with bladder problems that required her to make numerous trips to the toilet during both day and night. Due to mobility problems, she required assistance at night to use the commode. The claimant was not clinically incontinent, but instead required support getting to and from the toilet. Initially, the local authority put the necessary care in place to meet her needs but later decided to cut support to four nights a week and supply incontinence pads for the remainder. The Supreme Court found that such a policy on the part of the local authority was lawful as it considered the provision of incontinence pads an acceptable alternative to the provision of care through the night. *McDonald,* then, is a stark illustration of just how low an ethical bar might be set by consideration of Convention Rights. Furthermore, professionals might handle ethically complex questions that do not implicate Convention rights at all and so must resolve the clash of principles without any guidance whatsoever.

However, in addition to outlining the eight ethical principles earlier, the Ethical Framework devolves responsibility to a range of other instruments and practices in order to ensure the attainment of ethical outcomes in the delivery of Adult Social Care during the period of the coronavirus pandemic. For instance, both in the introduction to the Ethical Framework and in the description of the eight principles contained within, regular reference is made to the role of other official guidance and statutory duties, as well as professional responsibilities in ensuring ethical decision-making:

> Decisions will need to be made in accordance with the law and official guidance issued and applicable at the time, and while meeting statutory duties and professional responsibilities.[1]

As such, professionals working within local authorities that have made use of s. 15. of the Coronavirus Act[5] are required to make decisions taking account of the Guidance and the Coronavirus Act, and also the Care and Support Statutory Guidance[8] accompanying the implementation of the Care Act 2014[4] (some of which the 2020 Act suspends), Care Act Easements: Guidance for Local Authorities[9] as well as the standards and responsibilities imposed by professional regulators. In the Adult Social Care context, the professional regulators include Social Work England and The Health and Care Professionals Council, as well as the Nursing and Midwifery Council and the General Medical Council.

What emerges from an assessment of all the instruments that the Ethical Framework points to is a heavy reliance on professional codes of conduct and professional standards for the attainment of ethical standards. Appendix C to the Care Act Easements Guidance[8] purports to offer guidance on the prioritisation of care and its delivery but in doing so refers the reader back to the Ethical Framework that initially directed her there in the first place and to professional judgement, standards and oversight. Section 6 of the Care and Support Statutory Guidance corresponds to duties under the Care Act 2014 that s. 15 of the Coronavirus Act disapplies, with Sections 6.8–9 describing the roles and responsibilities of the professionals involved in

identifying and assessing adult social care needs. This section identifies social workers and occupational therapists as the key professionals involved in the identification and assessment of needs and notes that their training and conduct with respect to these responsibilities must meet the standards set out by their respective professional regulators. As such, we can see that much of the documentation accompanying the Ethical Framework, as well as the Framework itself, conceives of professional codes of conduct or standards issued by the professional regulators as capable of offering some assistance in the resolution of tricky ethical questions surrounding the prioritisation of care or the redirection of resources.

In that way then, when neither the law nor the Ethical Framework are offering action guiding force to professionals deliberating on the ethical dilemmas brought about by the coronavirus pandemic and its impact on the delivery of adult social care, those professionals might well turn to the literature of their professional regulators for assistance. The desirability of this as a state of affairs will be analysed in the next section.

Analysing the relationship

The conclusion reached previously regarding the relationship between law and ethics as evidenced by the interaction between the legislation and the ethical guidance might look somewhat familiar. The tendency of law and ethics to play games of pass the parcel or hot potato, shuffling authority for decision-making between each other with endless circularity is not unique to the adult social care context. Medical lawyers and bioethicists are used to describing this problem in medical law. Foster and Miola have noted the interaction between law and ethics that ultimately results in doctors making complex decisions in accordance with their own, individual consciences rather than the applicable law or the ethical guidance of their professional regulators.[10]

We suggest that this problem as it manifests in medical practice is even more acute in the adult social care context and that this should be a cause for serious concern and attention. In a large part, this concern is generated by the fact that the activities of professional regulators in adult social care are vastly different to those of the General Medical Council in the context of medical practice. While there might be concerns about the authority or action guiding force of the ethical guidelines issued by the General Medical Council, the reality is that the guidance is of far more practical assistance than any of the guidance available from either Social Work England or the Health and Care Professions Council.

The General Medical Council sets out 32 pieces of ethical guidance across a range of issues that might be faced in practice, from confidentiality to research to consent and shared decision-making.[11] In respect of confidentiality, the GMC sets out seven pieces of guidance covering different challenges or scenarios and provides a decision tree for clinicians to follow in order to ascertain whether sharing information in a given circumstance would be considered ethical or not.[12] Thus, while the guidance itself might abrogate ultimate authority to the law for determining whether the decision made might be considered rightful (and in turn the law passes such authority back again), the guidance does parameterize decision-making in a significant way, articulating both ethical floors that ought not be breached and ethical ceilings that might be aspired to. As such, the ethical guidance issued by the GMC might be considered to be of some practical assistance to decision-makers, in turn narrowing the scope of the acceptable exercise of individual conscience.

This is not the case in respect of the guidance issued by Social Work England or the Health and Care Professions Council which leaves the exercise of individual conscience almost unbounded. The only ethical standards or codes of conduct articulated by either body are expressed in the vaguest of terms. For instance, the professional standards published by Social Work England require regulatees to 'respect human rights', 'value each person as an individual' and 'work with people to promote their well-being'.[13] The 'Standards of Conduct, Ethics and Performance' set out by the Health and Care Professions Council require regulatees to do such things as 'communicate effectively and appropriately', 'manage risk' and 'respect confidentiality'.[14] This is not altogether surprising and, in ordinary circumstances, might be less problematic. However, in the context of the coronavirus pandemic, where the legal duties imposed under the Care Act 2014 that might have previously ensured good ethical outcomes are suspended, these professional standards are being delegated functions that they cannot possibly fulfil. This leaves key social care professionals bereft of appropriate guidance to support their decision-making, thus rendering individual conscience and morality the key determinant of ethical decisions. In turn, this leaves those in receipt of social care vulnerable to inconsistent and even ethically problematic decision-making.

CARE AND OBLIGATIONS

Two important conclusions can be drawn from the previous two sections. The first is that the focus on autonomy and individuality articulated in the Ethical Framework is at best unhelpful when it comes to aiding decision-makers deliberating on ethically fraught and practically complex care prioritisation decisions. The second is that the professional standards and codes of conduct that the Ethical Framework places reliance on for the attainment of ethical outcomes are not up to the task either. The result is a troubling one for those tasked with making decisions in adult social care during the pandemic. The Ethical Framework published by the Government to help decision-making leaves professionals bereft of a clear way forward where ethical principles clash. Similarly, the duties imposed on decision-makers as a matter of professional regulation will not aid them in determining the ethically correct course of action, nor will the law as it expressly suspends a range of legal duties that might have otherwise supported ethical decision-making.

One solution might be for decision-makers to determine their responsibilities by reference to the values of autonomy and individuality. Given the thrust of the Ethical Framework and its focus on autonomy which is also shared by the documents it refers to in order to support decision-making, it might be reasonable for decision-makers to appoint autonomy as the sovereign virtue, and decide whose needs to assess and meet accordingly. Such a move is, however, problematic for two reasons beyond those already discussed earlier.

The first is that such reasoning provides little justification or explanation to those who due to the pandemic and the Care Act easements will not receive the care or support that they would have done in a pre-pandemic era when all provisions of the Care Act still had full force. Failure to assess and meet needs within the adult social care context will likely always entail some denigration of autonomy and/or respect for individuality and, to that extent, it makes little sense to describe the rationale for such a decision as autonomy based. The best explanation that one might provide is that the violation of autonomy in one case is less than that in another and it is this difference in the extent of the violation that justifies the failure to assess and meet care needs. Such a response is however likely cold comfort to those whose needs will not be met and presents an atomistic and even

combative picture of relations between members of the same community seeking support from a shared, communal resource.

Second and relatedly, this sort of response assumes that autonomy violations are commensurate and therefore comparable in such a way that we might rank all of the possible autonomy implications of failing to assess and meet social care needs and ensure that we provide care to those whose autonomy is most acutely curtailed. It is unlikely that such a ranking is indeed possible and, even if it were, focusing on the extent of autonomy violations would obscure the denigration of other values that we have reason to promote, thus leading to suboptimal ethical decision-making in any case. For instance, for individuals with severe disabilities whose autonomously willed options are limited by their condition, harm to autonomy might be difficult to demonstrate. Likewise, for an individual lacking mental capacity and therefore also lacking the ability to formulate autonomous wishes, recourse to the principle of autonomy might obscure a range of other harms suffered. As such, it is unhelpful to think of base obligations and responsibilities in respect of prioritisation decisions as generated by respect for autonomy or individuality. To do so fails to provide intelligible justification to beneficiaries of those obligations when we make decisions not to discharge them and imposes on decision-makers a responsibility that they can rarely fulfil.

What then is the alternative? We suggest that if the animating spirit of the Ethical Framework was, instead of one autonomy and individuality, one of community and a shared commons, both of these problems might be overcome. In *Law's Empire*, Ronald Dworkin considered the existence of a set of associative obligations conferring responsibilities on members of a community.[15] These associative obligations are special and personal in nature. They obtain distinctly within the group, rather than as more general obligations that might be owed ordinarily to non-members of the group. Further, these associative obligations run directly between members of the group insofar as they entail responsibilities owed to one and other rather than consisting only in rights held collectively by members to be enforced against the state. Finally, the practices of the group and the associative obligations between members demonstrate an equal concern for all members of the group, derived from more general responsibilities of concern for the well-being of all members. As Dworkin puts it:

> Associative obligations can be sustained among people who share a general and diffuse sense of members' special rights and responsibilities from or toward one another, a sense of what sort and level of sacrifice one maybe expected to make for another.[15]

In this way then, we can conceive of a communal obligations owed by all members of the community, rooted in concern for and equal treatment of one another. While Dworkin was an adherent of liberalism, rather than communitarianism, as Eerik Lagerspetz points out, Dworkin's account of associative obligation is truly communitarian in nature given that one becomes subject to such obligation not by choice.[16] Thus, instead of conceiving of potential recipients of adult social care as nothing more than just that, the Ethical Framework might conceive of them as agents within a shared system, connected to society and sharing in associative obligations and therefore bearing some reciprocal obligations to the community within which they live. In this way, we might explain the failure to identify and meet care needs as a function of the web of benefits and obligations associated with membership of the community. Clearly, the extent of benefits and the burdens of obligations will not be borne equally by the community, but they can nonetheless explain why it may be acceptable for a local authority to choose not to meet some needs in prioritising others. In this way, then the Ethical Framework could offer a cogent ethical explanation for not meeting social care needs during the pandemic.

Some might fear that inflecting the guidance with a communitarian approach might dissolve into dire utilitarianism, subordinating the needs of the individual to the needs of the community in the pursuit of squeezing maximal utility out of the struggling social care system. However, Dworkin's account would not permit of utilitarianism given that such an approach to decision-making would fail to demonstrate the concern for and equal treatment of members of the community that is constitutive of associative obligations. As such, we can be sure that a communitarian orientation need not be insensitive to the needs of individuals and can provide some minimally acceptable conditions for the purposes of decision-making.

Second, focusing on the communal aspects of care giving brings a wider range of actors into the picture. Thus, when a decision-maker is deliberating on whose care to prioritise, consideration of the community ought to be made, bearing in mind the need for equal concern for members of the community. As such, the decision-maker ought to contemplate the consequences of meeting the needs of the individual or failing to do so from a variety of standpoints: that of the individual, their family, professional care givers, informal care givers, the social care system and the community at large, recognising all of the intersections and overlaps between all of these groups. In this way, we ought to recognise that decision-makers owe obligations to communities, as well as individuals in the way that they make their decisions.

In addition to remedying problems apparent within the Ethical Framework, a communitarian orientation offers a further benefit. A communitarian ethic directs the blame or moral approbation for shortcomings within the system towards the rightful target of such reactive attitudes—political failure. As such, the communitarian orientation equips us with the tools necessary to critique the status quo and identify the source of systemic failings. Communitarianism has a rich history of shining a light on the ways in which liberal ideologies with their universalising logic of rights and entitlements—as reflected in the Ethical Framework itself—erode the range of relational connections, rendering superfluous obligations owed to and by communities.[17] When in following the Guidance we might be forced to point at individual decision-makers where unethical outcomes obtain, a communitarian orientation shifts approbation away from the individual decisions and towards political causes, decisions and failings.

CONCLUSION

It might seems somewhat churlish to complain about the details of the Ethical Framework, given that this was not a document that the Government needed to produce. Indeed, one could easily imagine politicians taking that view that 'to hell with ethics, let's do what needs to be done to defeat the virus'. So, the fact an attempt was made to produce an Ethical Framework is to be welcomed. However, we have in this article sought to express some concerns about the focus and efficacy of the document. It is not surprising that autonomy and individualism play such a prominent role in the Ethical Framework, given their eminence in ethical thinking generally. However, we have argued that, in fact, the issues raised by COVID-19 are precisely the kind where autonomy should count for little. Indeed it is a time for particular

weight to be given to importance of communal and care values. We have also sought to explore how the Framework indicates a failure to understand the role and nature of professional guidance, especially for social workers and how it interacts with legal regulations. A key lesson from this analysis is that when doing ethics and producing guidance, it is crucial to be clear about the nature and purpose of the guidance produced.

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