Explanatory frameworks and managing randomness

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Epidemics, the medical historian Charles Rosenberg argued, typically have four Acts, as in a play. In Act I, which he termed 'Progressive revelation', 'merchants', 'municipal authorities' and 'the complacency of ordinary men and women', alike are reluctant to acknowledge an epidemic because of its threat to their 'economic and institutional interests' and to 'their accustomed way of doing things': gradually however, 'inexorably accumulating deaths and sicknesses' bring 'ultimate, if unwilling, recognition'. In Act II, 'Managing randomness', 'collective agreement' is sought on an 'explanatory framework' to manage the epidemic's 'dismaying arbitrariness'. Such frameworks, in previous centuries mainly religious, are now more 'secular and mechanistic', but again also moral and social: explanation for example of the 'differential susceptibility of particular individuals' is sought in terms of 'risk-enhancing behaviour' and 'style of life', but also of environmental and social factors, such as 'residence and occupation', providing 'a vehicle for social criticism as well as a rationale for social control'. In Act III, 'Negotiating public response', pressure is generated for 'decisive and visible community response', often taking the form of 'collective rites integrating cognitive and emotional elements'. Such rites, including not only 'the imposition of a quarantine' and 'procedures to cleanse and disinfect', but also religious, or now more often moral or social rituals, afford 'the reassurance of familiar frames of explanation and logically consequent policies that provide both meaning and the promise of efficacy'. Finally, In Act IV, 'Subsidence and retrospection', 'incidence of the disease gradually declines', and questions are raised 'for retrospective moral judgement' about 'what "lasting impact" particular incidents have had and what "lessons" have been learnt. Have the dead died in vain? Has a heedless society reverted to its accustomed ways of doing things as soon as denial became once more a plausible option?'[1]

Rosenberg was writing in 1989, in response to AIDS: but many of his observations remain relevant to the challenges of COVID-19 19. Because COVID-19 is a pandemic however the Acts are progressing at a different pace in different countries and not necessarily in strict sequence. Not all politicians or 'ordinary people' worldwide for example, seem yet to have exited from Act I: there appears some significant temporal overlap between Acts II and III; and although the 'subsidence' of Act IV is not yet in sight, many questions for retrospective moral judgement are already being asked.

Such Act IV questions and Act II's explanatory frameworks are likely to be of particular interest to medical ethics: but of no less interest perhaps are ethical aspects of the 'collective rites' of Act III, for example in the recent weekly ritual in the UK of 'clapping for the NHS'. In the *COVID-19 Current Controversies* section of this month's issue, this is illustrated by Catriona Cox's paper, '"Healthcare Heroes": problems with media focus on heroism from healthcare workers during the COVID-19 pandemic'[2] in which she argues that 'the heroism narrative can be damaging, as it stifles meaningful discussion' about the limits of the duty of care and 'the importance of reciprocity'. The uses and abuses of metaphor in the current context also are discussed in 'Children of COVID-19: pawns, pathfinders or partners?'[3] by Victor Larcher and Joe Brierley. 'Children's interests', they argue 'are vital considerations in any recovery plan, but the question remains as how to address them within the context of how society views children'.

Other contributions to this section, related more perhaps to Act II questions, include two papers concerned with international aspects of the pandemic differences. In their clinical ethics paper on 'global allocation of a COVID-19 19 vaccine', and with distributive justice for developing countries in mind, Yangzi Liu and colleagues[4] propose a 'multivalue ethical framework' that aims to fairly balance efficiency and effectiveness with equity. Also in relation to global issues, including those of the pandemic, Keona Jeane Wynne and colleagues, in an extended essay on 'applying a population-level bioethics lens to palliative care in humanitarian contexts'[5] seek to broaden the 'clinical bioethics perspective' of recent WHO guidance on palliative care in these contexts, to the perspective of population health: this, they argue, 'does not concern itself with either individual "duties" (as in clinical bioethics) or overall utility (as in traditional public health) but with equity' in aiming 'to reduce and eliminate health-related gaps between groups'. And in a further paper in this section, on 'Triage of critical care resources in COVID-19' by Lynette Reid,[6] the concept of equity again is emphasised, in this instance in relation to resource allocation and the importance of not allowing 'maximising outcomes' to outweigh 'concerns of justice, specifically egalitarian concerns, social justice concerns and non-discrimination concerns'.

The remaining papers in this month's *COVID-19 Current Controversies* section also illustrate how ethical theory can helpfully illuminate interpretative frameworks in a time of pandemic uncertainty. In his paper on 'ethical approaches to the COVID-19 pandemic', David Jeffrey[7] argues that 'a relational approach to ethics which includes solidarity, relational autonomy, duty, equity, trust and reciprocity as core values' is the most appropriate response to current ethical challenges posed by 'isolation and social distancing, duty of care and fair access to treatment'. Focusing on the last of these, in their paper on 'Surgery during COVID-19 crisis conditions: can we protect our integrity against the odds?', Jack Macleod and colleagues[8] consult professional guidelines and make use of the ethical framework of the four principles to address currently critical issues including 'balancing the benefit of surgery against the unknown risk of developing COVID-19 and its associated complications' and under what circumstances alternatives to the surgical gold standard may or may not be justified. No less urgent current issues are addressed in 'Ethical guidelines for deliberately infecting volunteers with COVID-19' by Adair Richards,[9] who examines arguments for and against the use of human challenge studies in the light of utilitarian, Kantian and virtue ethics perspectives and concludes with suggested guidance for regulators, researchers and ethics committees.

In his 1989 reflections on the AIDS epidemic, Charles Rosenberg observed: 'We have become accustomed in the last half-century to thinking of ourselves as no longer subject to the incursions of such ills (as epidemics): death from acute infectious disease has seemed – like famine

– limited to the developing world. Life-threatening infectious ills had become, almost by definition, amenable to therapeutic or prophylactic intervention. AIDS has reminded us that this sense of assurance might have been premature, the attitudinal product of a particular historical moment'[10] . Lest we forget, COVID-19 has reminded us, if anything more forcefully than did AIDS, of just how fragile that sense of assurance was. In the historical moment of the present pandemic however, contributors to the pages of the Journal of Medical Ethics – and to the lively JME blog[11] - clearly demonstrate how critical and creative ethical thinking can begin to inform and shape the ways in which medicine and society can constructively respond to the challenges of COVID-19 and perhaps even prepare a little better for what lies beyond Act IV.

Contributions elsewhere in this issue demonstrate no less critical, creative and constructive approaches to practical and philosophical issues in medical ethics. This month's *Ethics Roundtable*[12–15] concerns legal and regulatory problems encountered by clinicians seeking to employ and conduct relevant research on a new and much more rapid genetic test which can enable them to prevent antibiotic induced hearing loss in an estimated 180 neonates each year in the UK: the discussion, involving clinical geneticists and a leading scholar in medical ethics and law, identifies how the regulatory problem arose from well-intentioned legislation which was subsequently overtaken by scientific developments, and then suggests how this might now be remedied in practice by legal review. A more theoretical debate, although with significant implications for practice, is conducted in this month's *Feature Article* by Philip Reed on 'Expressivism at the Beginning and End of Life'[16] and in the accompanying commentaries.[17–22] Analysis of the 'expressivist' argument (that practices such as abortion and euthanasia express negative attitudes toward existing persons with disabilities) by Reed and in the commentaries reveals illuminating differences between the strengths and weaknesses of the argument at the different ends of life and also in what is understood by 'disability', providing much food for thought by both defenders and critics of expressivism. As in the series of responses to papers previously published in the Journal, which conclude this month's issue, fruitful debate on this subject seems likely to continue.

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