# PUBLIC HEALTH, PUBLIC HEALTH ETHICS PRINCIPLISM, AND GOOD GOVERNANCE DURING THE COVID-19 PANDEMIC

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Abstract: *The COVID-19 pandemic brought about at least two normative challenges on unprecedented scale for liberal democracies. One concerned prioritization decisions when health care resources were constrained. The other, which arguably led to lasting damage to social cohesion and citizens' trust in government and government public health institutions, concerned policies introduced with the aim of reducing the spread of SARS-CoV2, some of which turned out to be mistaken. I discuss in this essay a few examples of misguided, liberty-limiting public health policies and describe how public health and public health ethics principlism provided cover for such policies. Citizens had reasons to be concerned about the duration of such liberty-infringing policies, the absence of predictable government policies, and the absence of transparent justifications for the policies that were implemented.*

KEY WORDS: public health ethics, principlism, COVID-19, bioethics, public health, governance, liberty

## I. Pandemic Policy Theatre

In 2020 governments globally were working toward limiting the spread of COVID-19. Their reasonable objective was to "flatten the curve"[1] of new infections in order to prevent hospital systems from "collapsing" under waves of seriously sick COVID-19 patients. It is worth pausing to ask what constitutes a "collapsed" hospital system. Many non-COVID-19 patients were unable to access hospital care due to prioritization decisions that put COVID-19 patients' clinical needs over their needs. For

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[1] Madhu Kumari Upadhyay and Khan Amir Maroof, "Understanding the Emerging and Reemerging Terminologies amid the COVID-19 Pandemic," *Journal of Family Medicine and Primary Care* 9, no. 12 (2020): 5881–87.

doi:10.1017/S0265052524000086

non-COVID-19 patients, the hospital system had collapsed already because care was unavailable to them in a timely fashion. For example, significant numbers of cancer patients lost out on timely diagnoses and/or treatment cycles.[2]

Some governments as well as many public health experts flirted briefly with the idea that COVID-zero was feasible epidemiologically and a socially sound strategy. The collapse of this policy in authoritarian China, in response to citizens' protests and economic realities, suggests that COVID-zero was probably never a realistic policy option.

Canadians were told in the province of Ontario that their freedom of movement needed to be restricted to achieve the desired flattening of the curve. The government of Ontario decided to shutter provincial parks and nature reserves,[3] making it illegal even to go alone for a bike ride on a deserted nature trail. Neither today nor at the time was there a scientific basis for these kinds of freedom-of-movement-limiting policies. SARS-CoV2 transmissions occurred primarily in crowded indoor places such as venues for weddings, concerts, church services, and the like; they did not occur on deserted nature trails. Policies like this ultimately did not entail a great deal of cost for well-off people in their spacious family homes with private gardens. However, the cost was significant for people of lesser means to whom access to public parks made the difference between being stuck in overcrowded, and/or abusive living arrangements and a brief, if temporary, respite. This observation is a recurring theme in this essay.

Europeans were treated to their own varieties of pandemic policy theatre. For instance, at one time, air travelers were compelled during flights from Zurich to Frankfurt to wear masks, but not in the busy airports in either city. The Canadian federal government, among other governments—including Australia, New Zealand, Hong Kong, and the U.K.—briefly introduced a policy whereby travelers deplaning international flights had to undergo SARS-CoV2 testing and they were required to quarantine in approved hotels until the results were in. The cost of these approved hotels was set very high, making air travel again a luxury enjoyed by the well-off. The effect was to deter Canadian citizens from exercising their constitutional right of freedom of movement. Given constitutional challenges, this was not made a direct policy; instead, travel was made sufficiently costly to deter Canadians from exercising their rights. Airplane loads of passengers

[2] Abdul Rahman Jazieh et al., "Impact of the COVID-19 Pandemic on Cancer Care: A Global Collaborative Study," *JCO Global Oncology* 6, no. 6 (2020): 1428–38; Antoine Eskander et al., "Access to Cancer Surgery in a Universal Health Care System During the COVID-19 Pandemic," *Journal of the American Medical Association Network Open* 4, no. 3 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777399; Mike Richards et al., "The Impact of the COVID-19 Pandemic on Cancer Care," *Nature Cancer* 1, no. 6 (2020): 565–67.

[3] Office of the Premier, "Ontario Extends Emergency Declaration to Stop the Spread of COVID-19: All Outdoor Recreational Amenities across Province Now Closed," March 30, 2020, https://news.ontario.ca/en/release/56523/ontario-extends-emergency-declaration-to-stop-the-spread-of-covid-19.

checking into public health authority-approved hotels at the same time ensured that travelers who had avoided becoming infected during their plane ride would get another chance of acquiring SARS-CoV2 during their crowded check-ins. This policy yielded detected infections, but not in numbers that made a discernible difference to the spread of COVID-19 in the country.

A reasonable, but absent, justification for such policies would have included a model that outlined which courses of action would translate into what kind of curve-flattening effect. Any restrictions on individual citizens' freedoms, including freedom of movement, needed to be weighed against these desired effects. It is impossible, for the purpose of this essay, to provide a comprehensive account of these costs. The global cost of pandemic policies is still being counted, a task made difficult, if not impossible, by the Russian invasion of Ukraine and its impact on the global economy.[4]

It may seem easy to be critical of such government policies in hindsight when they were introduced with the best of intentions during an emergency —or so one could argue. I am not persuaded by this. Too many of these policies made little sense when they were introduced and they clearly presented cases of government overreach, even if legislative frameworks were put in place that made such policies possible. Given their flaws, they were bound to undermine public trust in even reasonable pandemic measures. At the same time, governments routinely insisted that in implementing such policies they were merely "following the science." Initially, politicians proudly declared this in press conferences; eventually, they announced that they acted on the advice of their country's most senior public health official. As we will see below, this posturing had harmful consequences for the trust many citizens place in their governments as well as in science.

## II. "Following the Science"

Politicians of all stripes announced early in the pandemic their COVID-19 policies under the banner of "following the science." Science, however, is unable to provide guidance on policy; it cannot be followed. Values must always be added to the decision matrix. Only after I determine what I am normatively aiming for can I make sense of and use data. Such normative information was typically withheld from the population. No effort was made to show that a given policy used the least liberty-infringing means available to achieve its objectives. Governments enacting liberty-infringing COVID-19 policies needed to show two things: (1) that the overall objective of the liberty-infringing policy outweighed the cost incurred by its implementation and (2) that the means deployed to achieve said objective were

[4] World Bank Office of the Chief Economist, *Weak Growth, High Inflation, and a Cost-of-Living Crisis* (Washington DC: International Bank for Reconstruction and Development / The World Bank, 2023), https://openknowledge.worldbank.org/server/api/core/bitstreams/004535c2-fbcd-4e96-9439-bc4bc502c2b3/content.

the least liberty-infringing means available. Neither of these two requirements was met. These criteria also constitute uncontroversial international human rights standards.[5]

For instance, in many countries schools were effectively closed for one to two years. They even remained closed in many jurisdictions after the widespread availability and uptake of vaccines. Schooling, or what went euphemistically for schooling, took place online. This caused severe harm to many children, including significant suboptimal learning outcomes[6] as well as serious longer-term health consequences. The German health minister, hardly a libertarian rebel when it came to COVID-19 public health policies, released a study highlighting the high price children paid because of these school closures.[7] He describes the closures as one of several erroneous policies that the German government implemented; he is not alone in this assessment.[8] Germany's education minister reports that 65 percent of the country's students have not been able to recover from the learning deficits they suffered because of the online education that was implemented. She notes that many children developed serious psychological problems that have remained with them, including a 75 percent increase of depression among school children.[9] Disproportionately hard hit were children from socioeconomically disadvantaged families. The unnecessary closure of outdoor sports facilities is reported to be causally linked to increases in the number of children who are overweight due to a lack of available facilities to engage in exercise over extended periods of time. Like the nature trails in Canada, outdoor sports facilities were shuttered in Germany. The minister warns that, unless drastic action is taken, especially children from socially disadvantaged families would become a "lost generation."[10] Evidence along similar lines has accumulated in the United States. Megan Kuhfeld and colleagues report that "during the 2020–21 school year, high-poverty schools continued to experience declines in math and had larger losses in

[5] For an international human rights document supporting this standard, see esp. Part II.C of American Association for the International Commission of Jurists, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* (Geneva: International Commission of Jurists, 1985), https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf.

[6] Megan Kuhfeld, James Soland, and Karyn Lewis, "Test-Score Patterns Across Three COVID-19-Impacted School Years" (EdWorkingPaper No. 22–521, Annenberg Institute at Brown University, 2022), https://doi.org/10.26300/ga82-6v47.

[7] Interministerielle Arbeitsgruppe, "Abschlussbericht: Gesundheitliche Auswirkungen auf Kinder und Jugendliche durch Corona" (Bundesgesundheitsministerium, Berlin/Bonn, February 8, 2023), https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/K/Kindergesundheit/Abschlussbericht_IMA_Kindergesundheit.pdf.

[8] Joseph T. Wu et al., "A Global Assessment of the Impact of School Closure in Reducing COVID-19 Spread," *Philosophical Transactions of the Royal Society A* 380, no. 2214 (2022), https://royalsocietypublishing.org/doi/10.1098/rsta.2021.0124.

[9] Interministerielle Arbeitsgruppe, "Abschlussbericht," 3–4.

[10] "Lauterbach bezeichnet lange Kita- und Schulschließungen als Fehler," *Deutsches Aerzteblatt*, January 30, 2023, https://www.aerzteblatt.de/nachrichten/140624/Lauterbach-bezeichnet-lange-Kita-und-Schulschliessungen-als-Fehler.

reading, whereas low-poverty schools avoided further losses in math and saw less severe losses in reading. The result is that the pandemic has taken a larger toll on students in high-poverty schools."[11]

The long-term consequences of lower educational attainment and serious mental health issues are well established; the former can, for instance, be linked to lower life expectancy. Dimitri Christakis and colleagues conclude that

> missed instruction during 2020 could be associated with an estimated 13.8 (95% CI 2.5–42.1) million years of life lost based on data from US studies and an estimated 0.8 (95% CI 0.1–2.4) million years of life lost based on data from European studies. This estimated loss in life expectancy was likely to be greater than would have been observed if leaving primary schools open had led to an expansion of the first wave of the pandemic.[12]

During the pandemic *non*-COVID deaths among children and adolescents in the United States increased at a high rate.[13] Ethnic minority youths were by far the hardest hit. I should acknowledge that it is notoriously difficult to demonstrate causality in these kinds of scenarios, so let me note the strong correlation between the implementation of COVID-19 policies and these outcomes.

Interestingly, these school policies were not done primarily to protect children from becoming infected. Rather, the objective was to prevent children from becoming infected who might then pass their infection on to elderly or otherwise vulnerable people known to be at higher risk of serious adverse clinical outcomes. The normative question here, then, is whether the sacrifices that this policy decision entailed for these children were outweighed by the benefits that accrued to other, older people. At the time, it was made clear—usually by elderly public health experts and policymakers—that such sacrifices could reasonably be expected of children. Yet no politician publicly argued that preserving the lives of XYZ elderly or otherwise clinically vulnerable people would justify XYZ quality-adjusted life-years lost by their society's children. Nor did they show that school closures were the most effective means of protecting the elderly or otherwise vulnerable people. While this was ostensibly undertaken under the label of "protecting public health," it was really about protecting the interests of some segments of the population by means of sacrificing the interests of

[11] Kuhfeld, Soland, and Lewis, "Test-Score Patterns," 9.

[12] Dimitri A. Christakis, Wil Van Cleve, and Frederick J. Zimmerman, "Estimation of U.S. Children's Educational Attainment and Years of Life Lost Associated with Primary School Closures During the Coronavirus Disease 2019 Pandemic," *Journal of the American Medical Association Network Open* 3, no. 11 (2020). See also, Dmitri A. Christakis, "Response to Concerns, Clarifications, and Corrections," in the Comments section of this article.

[13] Steven H. Woolf, Elizabeth R. Wolf, and Frederick P. Rivara, "The New Crisis of Increasing All-Cause Mortality in U.S. Children and Adolescents," *Journal of the American Medical Association Network* 329, no. 12 (2023): 975–76.

another segment of the population. Randall F. Moore persuasively explains this single-minded focus on that other segment of the population: "Human beings value and care for identified lives more than statistical lives, and humans do so because we are influenced by certain cognitive preferences that inhere in human nature. Natural selection has primed these cognitive preferences."[14] Children, and in particular children from socioeconomically disadvantaged backgrounds, were so significantly harmed that Alberto Giubilini coined the phrase "reverse ageism" for this kind of policy.[15] The normative, but never justified, decision to focus on identified as opposed to statistical lives (or life-years, another plausible measure) during pandemic times permitted any number of problematic policies. At issue here are questions about an inequitable burden being placed on these children to protect the interests of elderly or otherwise vulnerable people as well as questions about the proportionality and societal cost of the closures relative to the benefits that accrued.

There were global consequences, too. Western governments that took great pride in following "the science" ignored the global consequences of their national responses to COVID-19. Hundreds of millions of people in the global south fell back into abject poverty because of public health policies implemented in the global north, with dire, predictable consequences in terms of increased morbidity and mortality.[16] Public health officials who modeled possible COVID-19 policy responses did not ask how many life years would be lost *globally* as a result of policies they were implementing *locally*. They also did not ask how many lives would be lost either, suggesting that the focus on identified lives was a focus on identified lives like their own. Predictably, the global economy went into a tailspin that dragged down fastest the economically most vulnerable. Children in the global south were also much harder hit than children in the global north by school closures.

The problem is not only that public health experts made questionable empirical assumptions or failed to take harms like these into account; some of that is probably inevitable in a fast-moving pandemic. Policymakers should not have pretended to the public that their policies were based on sound science that they were "merely" and responsibly following. Controversial value judgments that were made were conflated with "following the science" or "following the scientific advice of the experts." Public health experts have—qua public health expertise—zero competence with regard to value judgments, yet their policy advice was impossible without such value

[14] Randall F. Moore, "Caring for Identified versus Statistical Lives: An Evolutionary View of Medical Distributive Justice," *Ethology and Sociobiology* 17, no. 6 (1996): 379–80.

[15] Alberto Giubilini, "Current Lockdown Is Ageist (Against the Young)," *Practical Ethics*, January 27, 2021, https://blog.practicalethics.ox.ac.uk/2021/01/current-lockdown-is-ageist-against-the-young/.

[16] Andy Sumner, Christopher Hoy, and Eduardo Ortiz-Juarez, "Estimates of the Impact of COVID-19 on Global Poverty" (WIDER Working Paper 2020/43, Helsinki, UNU-WIDER, 2020).

judgments. Finally, there was never such a thing as "the science" to begin with, as there was always a significant amount of expert disagreement. Let us take a closer look at public health, the driving force behind most COVID-19 policies.

## III. Public Health

Public health had arguably the most significant impact on COVID-19 health policy. Governments were advised by their public health officials. One would have expected that public health, as a discipline, was contributing unique expertise, based on its method of inquiry, to inform public policy. After all, as the handful of examples mentioned above has shown, public health interventions often result in infringements on individual liberties. It is not unreasonable that those at the receiving end of such policies would want clear science and transparent values that explain how a particular policy came about and how it was justified. It is often assumed that it is clear what "public health" is, that the label signifies a scientific discipline. Surprisingly, perhaps, that is not so.

Let us go back to the conceptual roots of public health. What do we mean —or what do public health experts or government public health agencies mean—by "public health"? We cannot seriously evaluate efforts aimed at defending public health if we do not know what it is. To start, we cannot take "public health" literally. Richard Mohr was right when he noted, at the height of the HIV pandemic in the United States:

> No literal sense exists in which there could be such thing as a public health. To say the public has a health is like saying the number seven has a color: such a thing cannot have such a property. You have health or you lack it and I have health or lack it, because we each have a body with organs that function or do not function.[17]

One could respond to Mohr by pointing out that nobody suggests anything as totalitarian as a societal body of sorts that has a health. His is a caricature of public health. Unfortunately, the situation is more complicated. The question of what is meant by "public health" is important because of a powerful historical reason as well as because public health measures often tend to violate individual freedoms. While Mohr is right to point out that public health, taken literally, makes no sense, who would argue otherwise? It turns out that, historically, some have. The German predecessor of what is today considered public health was called *Volksgesundheit*, best translated as "the people's (or the public's) health." Figure 1

[17] Richard Mohr, "AIDS, Gays, and State Coercion," *Bioethics* 1, no. 1 (1987): 47.


Figure 1. Cover of *Deutsche Volksgesundheit* (*German People's/Public's Health*).

shows an image of the cover sheet of a magazine called *Deutsche Volksgesundheit*, or *German People's/Public's Health.*[18]

Between 1933 and 1935, this was the German Nazis' flagship health publication.[19] Of course, just because healthy eating and anti-smoking campaigns were popular with the Nazi public health agency, that does not mean there is something wrong with healthy eating or with giving up smoking. One should deploy a reductio ad hitlerum argument with great caution.[20]

However, the *Deutsche Volksgesundheit*'s understanding of *Volk* (people/public) is exactly what Mohr is concerned with. The Nazis thought of the German people also always as a body that required protection against diseased elements. Who were the diseased elements? Jewish people, homosexuals, and people with disabilities, among others. This was expressed repeatedly in statements by Adolf Hitler and his propaganda minister, Joseph Goebbels:

> [The Jew] has always been a *parasite in the body of other peoples*…. 1914 witnessed the last flicker of the national *instinct for self-preservation* in opposition to the *progressive paralysis of our people's body*…. *The Jew represents an infectious illness* … Germany has no intention of giving

[18] Randall Bytwerk, "German Propaganda Archive," Calvin University, https://research.calvin.edu/german-propaganda-archive/dvg34-23.htm.

[19] Apparently, the magazine was shut down after it published content claiming that vaccination campaigns were part of a Jewish conspiracy against the German people, something that went too far even by the Nazi standards of the day.

[20] Silke Schicktanz, Susanne Michl, and Heiko Stoff, "Bioethics and the Argumentative Legacy of Atrocities in Medical History: Reflections on a Complex Relationship," *Bioethics* 35, no. 6 (2021): 499–507.

> in to this Jewish threat but intends to oppose it in time, if necessary by means of its most complete and radical extermin-, eh, elimination.[21]

I do not mean to imply that public health activities are akin to what occurred under the label of *Volksgesundheit* during the Third Reich. However, this history is a clarion call for what "public health" refers to.

Many activities that occur under the public health label are ethically defensible and desireable. Who would seriously argue, for instance, that polio vaccination campaigns are unethical? To choose another current-day example, limiting the freedom of movement of people with Ebola virus disease can be ethically defensible in order to prevent harm to others. However, when providing an ethical justification for policies like these, one could not use the unintelligible concept of public health that Mohr criticizes, if only to avoid being subjected to the Nazi charge. For instance, if one were a proponent of an objective list of health goods (as some varieties of utilitarianism are), one could argue for understanding public health as the aggregated form of individuals' health, take a prioritarian approach, or any other approach one considers defensible. However, such clarity is surprisingly absent in the public health literature. How do public health experts and practitioners conceptualize "public health"?

## IV. Vagueness Galore

Public health has moved on from the dark days of Nazi Germany. Today, it tends to see itself as a progressive force in health policy, but vague, metaphorical language remains a standard feature of much of today's public health literature. The reader is often left to make sense of public health statements rather than such statements making sense.

The difficulty in defining what public health is, is perhaps best exemplified in the *Encyclopedia of Public Health*'s entry "Definition of Public Health." The entry contains *no* definition of "public health." It mentions that "the central goal of public health activities [is] to increase health at the population level. The ruling principle of public health is to deal with the health of the population in its totality," but it leaves nebulous what is meant by "health of the population in its totality."[22] One could charitably interpret "totality" as vaguely aiming for aggregation, but perhaps the entry's authors have some other totality in mind.

The Public Health Agency of Canada, which has wide-ranging regulatory powers, also fails to define its subject:

[21] Andreas Musolff, ed., *Metaphor, Nation, and the Holocaust: The Concept of the Body Politic* (London: Routledge, 2010), 2.

[22] Natalie M. Schmitt and Jochen Schmitt, "Definition of Public Health," in *Encyclopedia of Public Health*, ed. Wilhelm Kirch (Dordrecht: Springer, 2008), 222.

> Public health organizations view the population as the "patient", compared to healthcare institutions that provide one-on-one services to individuals…. By its nature, the work of public health is often invisible and behind the scenes. However, its impact on the collective health of populations is profound.[23]

A population cannot be a patient, though, with or without inverted commas. If a population can have a collective health of sorts, it can only possess it in a metaphorical sense that requires explanation. Without additional clarification as to the meaning of these statements, they do not make sense, regardless of whether one thinks that the activities the agency engages in are valuable.

The Canadian Public Health Agency is not alone in offering conceptual vagueness, as a cursory look at some of the public health literature shows:

> "Government intervention as public health" involves public officials taking appropriate measures pursuant to specific legal authority … to protect the health of the public…. (Rothstein 2002) … Public health is primarily concerned with the health of the entire population, rather [than] the health of individuals … (Childress et al. 2002).[24]

The first statement in the quotation above, by Mark Rothstein, states that government uses its legal authority to act in order to "protect the health of the public."[25] While that describes the activities of public health agencies in many jurisdictions, what the "health of the public" is remains unclear. Meanwhile, James Childress and his colleagues draw a distinction between traditional medicine's focus on individuals and public health's focus on the population[26] not dissimilar to the way the Public Health Agency of Canada does. It is uncontroversial what the health of an individual is, but it is unclear what Childress and his colleagues have in mind in stating that public health is primarily concerned with the "health of entire populations." That statement, on a reasonable understanding of population, could be considered circular: "Public health is primarily concerned with the health of the public." What health could a population meaningfully be said to possess that is not comprised of the (possibly aggregated) health of the individuals who make up that population? If it is the aggregation of individual people's health, the health of those individuals remains the primary

[23] Chief Public Health Officer of Canada, *A Vision to Transform Canada's Public Health System: Report on the State of Public Health in Canada 2021* (Ottawa: Government of Canada, 2021), 41, cpho-report-eng.pdf (canada.ca).

[24] Marcel Verweij and Angus Dawson, "The Meaning of 'Public' in 'Public Health'," as cited in *Ethics, Prevention, and Public Health*, ed. Angus Dawson and Marcel Verweij (Oxford: Clarendon Press, 2007), 15.

[25] Mark Rothstein, "Rethinking the Meaning of Public Health," *Journal of Law, Medicine, and Ethics* 30, no. 2 (2002): 144–49.

[26] James Childress et al., "Public Health Ethics: Mapping the Terrain," *Journal of Law, Medicine, and Ethics* 30, no. 2 (2002): 170–78.

consideration; without their health, what is called "the health of the population" would not exist.

Unless a consensus exists on something like the already mentioned objective list theory of individual health, it is obvious that a given society's citizens will not hold uniform views about what trade-offs on their liberties they would be willing to tolerate in order to achieve particular health outcomes for themselves. After all, liberty is essential to living one's own life. When it comes to infectious diseases and the need to implement individual-liberty-infringing policies, government agencies are—quite rightly—not always required to seek individuals' consent. Sometimes, though, particular liberty-infringing policies are not uncontroversial. Any action perceived to be an overreach by large parts of the population—as was the case with some COVID-19 policies—will have negative consequences for societal cohesion. People are bound to rebel. They are bound to lose trust in their government and its public health agencies. The reasons for this have to do with the normative dimensions of health. Some of us decide to live healthier lives in order to live longer, while others opt to live a bit faster and die perhaps a bit younger. The latter are not necessarily victims of their circumstances. None of us lives the healthiest life that we would be able to live. All of us, daily, make lifestyle choices that have negative impacts on our health and longevity. The reason for this is that health is only one valuable thing among others in our lives.

Some public health writers are cognizant of the normative implications of public health practices, even if they fail to shed light on the "public" in public health. Damien Contandriopoulos, for example, states the following about the "soul" of public health:

> First, its goal of fostering individual and collective health and well-being implies benevolence. Second, interventions ought to rest on principles tested through scientific approaches…. [E]quity became its third core pillar: interventions should aim at reducing health disparities between individuals and between groups.[27]

He rightly suggests that it is possible to foster individual health through paternalistic, benevolent intervention and, more questionably beyond that, to foster collective health in some nebulous sense, but he goes further. Contandriopoulos also claims that public health is a scientific discipline, which is, as we will see below, a questionable view of this field's activities. He additionally states that equity is a relevant feature of public health by aiming to reduce health disparities between individuals and between groups. If equity is so understood, it could be achieved by a concerted leveling-down effort where nobody is better off, but many are worse off. Of course, this would conflict with the first goal of fostering individual

[27] Damien Contandriopolous, "The Year Public Health Lost Its Soul: A Critical View of the COVID-19 Response," *Canadian Journal of Public Health* 112, no. 6 (2021): 970–72.

health and possibly that mysterious collective health. Contandriopoulos oversimplifies the goal of equity by equating it with a commitment to reduce all health disparities. Any careful defense of equity should describe its goal as reducing *ethically objectionable* health disparities, which would require some way of distinguishing between objectionable and unobjectionable health disparities.

Eric Vogelstein and Guha Krishnamurthi persuasively argue that equity considerations should play no significant role in COVID-19 policy frameworks.[28] They point out "that defenders of equity criteria have yet to discharge their burden of explaining why mitigating health disparities —a morally important goal in its own right—outweighs, ethically speaking, the additional lives that would be lost to COVID if such criteria were used to allocate scarce life-saving treatment."[29] On this account, equity considerations do not trump the aim to improve—based on an objective values list—the aggregation of individuals' health. As Vogelstein and Krishnamurthi note, "the primary conditions of individual liability for unjust COVID outcomes are not met, and because individual liability is the only type of responsibility for injustice that would justify the large welfare sacrifices that equity criteria require many patients to make, such criteria are themselves unjustified."[30] Equity considerations can easily conflict with the goal of maximizing the aggregation of good individual health.

It shall suffice to note here that there does not seem to be a consensus in the public health field or discipline on the definition—or even the meaning of public health—or on the values that should plausibly guide its practitioners.[31] Clinicians, epidemiologists, sociologists, anthropologists, and others can and do claim the public health mantle for themselves, with each discipline contributing its own method and all working toward the goal of furthering something they call "public health." There seems not to be a coherent, transparent method of scientific analysis that public health could deploy to meet its government mandates, because it is not a scientific discipline predisposed to a unified method. That is not to say that some disciplines making contributions to public health (for example, epidemiology and biostatistics) are not based on sound scientific methods, but it is to say that public health qua public health is arguably not.

[28] Eric Vogelstein and Guha Krishnamurthi, "Equity and COVID-19 Treatment Allocation: A Questionable Criterion," *Bioethics* 37, no. 3 (2023): 226–38.

[29] Vogelstein and Krishnamurthi, "Equity and COVID-19 Treatment Allocation," 232.

[30] Vogelstein and Krishnamurthi, "Equity and COVID-19 Treatment Allocation," 236.

[31] I thank an anonymous reviewer of *Social Philosophy & Policy* for drawing this distinction. I am not arguing here that "public health" cannot be meaningfully conceptualized. For instance, aggregation in an objective-list approach would permit one to make sense of public health, but this is not something one finds endorsed by the government agencies or authors of the documents I here discuss. One example of an academic effort trying to make sense of the "public" in "public health" is John Coggon's seminal *What Makes Health Public?* (Cambridge: Cambridge University Press, 2012).

## V. Ethics in the Pandemic Policy Response

Ethicists played an impactful role in the design and justification of COVID-19 policies. In many countries national or regional ethics advisory bodies were asked to provide ethical guidance. Ethicists were also embedded in high-level expert task forces and commissions that provided advice to governments.

The primary functions of ethics in a situation like the evolving COVID-19 pandemic arguably are: (1) provide action guidance and (2) provide action justification. If ethics advice is capable of delivering on those two counts, the social benefit is significant. Policies will not appear to be arbitrary; instead, they will be predictable and transparent because they are derived from a coherent normative framework. Citizens will be able to grasp what causes particular policies to be implemented. A further benefit is that such an approach sheds light on when liberty-limiting policies will end, because the ethical reasons for their implementation are clear. This does not mean that everyone will agree with these policies or that everyone will support the ethical reasons for their coming into force. What it does mean is that people will be able to appreciate why a given liberty-limiting policy exists and they will be able to appreciate what it will take to see such policies coming to an end. All of this is of great importance in a time of crisis.

This, however, is not the road on which public health ethics experts chose to travel. Bioethical principlism gained unprecedented prominence in COVID-19 policy documents.

## VI. Principles

Let us turn to a paradigmatic approach to public health ethics that has proven popular in policy documents produced during public health crises, including COVID-19. An observer unfamiliar with the conceptual travails of public health might be tempted to assume that normative frameworks driving public health ethics and public health policy are consequentialist, if not utilitarian, in nature. Surprisingly, this was not the approach taken by public health experts and public health ethicists in their policy response to COVID-19. The most prevalent ethical framework used to guide policy responses during this pandemic was public health ethics principlism. While principlism was not the only approach, as broadly consequentialist frameworks were also defended, it was by far the most prominent approach taken in ethical guidance documents.

Tom Beauchamp and Jim Childress's textbook *Principles of Biomedical Ethics* is an academic bestseller in its eighth edition at the time of this writing.[32] They present four prima facie mid-level moral principles that

[32] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2020).

they claim provide the normative foundation for more specific rules in biomedical ethics. These principles are:

(1) respect for individual autonomy,
(2) non-maleficence,
(3) beneficence, and
(4) justice.

Defenders of the principles-approach consider these principles capable of guiding and justifying ethical decision-making in health policy. Each of these principles can be overridden if we have good reasons for doing so. It is worth noting that even if principlism is a coherent ethical theory —which I do not think it is—it is clearly meant to be used in the context of medical and clinical decisions about individual patient care. If one were to apply this approach to public health, one would make the conceptual mistake of acting as if the public is an individual.[33]

K. Danner Clouser and Bernard Gert subject bioethical principlism to what I consider largely sound philosophical criticism.[34] Noting the lack of systematic unity in this approach, given its conflicting values, they argue that bioethical principlism cannot accomplish what it claims it can, because this theory is unable to resolve inevitable conflicts between the principles. For example, in terms of COVID-19 policies, beneficence and justice might require liberty-restricting policies, while respect for personal autonomy might demand the opposite. A libertarian understanding of justice combined with strong support for personal autonomy might not permit liberty-restricting policies, while a socialist understanding of justice might call for liberty-restricting policies.

Given that there is no one ethical theory principlists could adopt that would permit a health policymaker to decide which principle trumps a competing principle, it is difficult to see how principlism can be a plausible, action-guiding, and action-justifying ethical framework. The absence of an ethical theory that would permit the health policymaker to adjudicate and decide is a problem this approach cannot overcome. Given the lack of a unified theory that would permit us to make sense of such varied principles and the unclear relationship between these principles, there seems no way to operationalize this approach. As Eric Zhang and I argue, "What looked as a conceptual advantage to [Beauchamp and Childress], namely the ability to settle on mid-level principles in the absence of a consensus on foundational ethical theories, is a fatal conceptual flaw to Clouser and Gert."[35]

It is understandable that Beauchamp and Childress choose conflicting ethical principles, given their ambitious claim that most people would be

[33] I owe this insight to Alberto Giubilini.
[34] K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15, no. 2 (1990): 219–36.
[35] Udo Schuklenk and Eric Y. Zhang, "Public Health Ethics and Obesity Prevention: The Trouble with Data and Ethics," *Monash Bioethics Review* 32, nos. 1–2 (2014): 130.

able to support some or all of them. People hold a wide range of diverse values dear to their hearts. Clouser and Gert show that, when conflicts between these principles arise, there is no common ground on which such disagreements can be adjudicated. While adjudicating mechanisms exist in unified moral theories, principlism's deliberate avoidance of such a moral theory is its methodological downfall.

Without a coherent ethical theory that these principles are derived from, they are reduced to mere bullet points for discussion or a checklist of things to keep in mind when confronted with an ethical problem. Typically, this conceptual problem is addressed through a procedural response. Expert ethics advisory bodies tend to use a deliberative process involving "reflective equilibrium," but that is just shorthand for "people who are appointed by someone in government as ethics experts and who agree that a particular principle trumps the others in a situation they are concerned with." A different committee comprised of different experts could well reach the opposite conclusion. Reflective equilibrium—in the absence of a foundational, coherent ethical theory—constitutes an evasion of the conceptual challenge.

The World Health Organization (WHO) had a working group that produced, in the aftermath of the 2014–2015 Ebola virus disease outbreak, its own principlist ethics document for infectious disease outbreaks.[36] It was as unworkable as the COVID-19 documents I will discuss in the following section. Some of those involved in the production of the WHO's 2016 document tacitly acknowledge as much in 2021:

> The rapid spread of the current pandemic and the associated uncertainty make it particularly challenging to decide which principles must be given priority …. Moreover, procedural ethics raises questions about who should decide …. Guidance beyond that which exists in the 2016 document is needed on *how* to balance ethical principles when making complex public health decisions.[37]

These concerns are justified, except that "balancing ethical principles" is impossible in the absence of a unified ethical theory capable of negotiating these sorts of conflicts.

## VII. Public Health Ethics Principlism Fails the COVID-19 Challenge

COVID-19 gave rise to a large number of purportedly "ethical" guidance documents that aimed to assist governments, health-care providers, and

[36] World Health Organization, *Guidance for Managing Ethical Issues in Infectious Disease Outbreaks* (Geneva: WHO, 2016), https://apps.who.int/iris/bitstream/handle/10665/250580/9789241549837-eng.pdf.

[37] Abha Saxena et al., "WHO Guidance on Ethics in Outbreaks and the COVID-19 Pandemic: A Critical Appraisal," *Journal of Medical Ethics* 47, no. 6 (2021): 367–73.

practitioners with responding to ethical challenges that might arise in response to the pandemic. However, those involved in drafting these documents typically ignored the above-described, well-known conceptual flaw of principlist approaches to health policy. In the case of COVID-19 policy documents, the ethical principles invoked are as appealing and uncontroversial as those of bioethical principlism, but they tend to be much greater in number. In each case, it is unclear how the principles relate to each other, why they rather than others were chosen, and what decision-makers are supposed to do when they encounter a situation where more than one of the conflicting principles could be chosen. This is obviously problematic during a fast-moving infectious disease outbreak.

In addition, in most countries these laundry lists of ethical principles were never submitted to the sovereign—that is, the citizens—for approval; they were created by fairly small groups of people. Absent were adjudication criteria that could serve as the basis for public accountability. An important implication of this critique—against the backdrop of liberal democratic values—is that this conceptual flaw, combined with the vagueness of "public health," permitted authoritarian decision-making.

Below are a few examples of such bullet-point ethics documents. In each instance, they are incapable of providing either ethical guidance or justification for the guidance given. This made them unfit for their purpose.

In 2020 the United States National Academies of Sciences, Engineering and Medicine published their *Framework for Equitable Allocation of COVID-19 Vaccine.*[38] The U.S. Centers for Disease Control (CDC) utilized this framework in their own vaccine recommendations[39] and any states in the U.S. followed CDC guidance. *Framework for Equitable Allocation of COVID-19 Vaccine* includes the following set of ethical principles:

(1) Maximum benefit,
(2) Equal concern,
(3) Mitigation of health inequities,
(4) Fairness,
(5) Transparency, and
(6) Evidence-based.

None of these principles on its own is controversial, but they are meant to address difficult allocation and prioritization decisions. For this set of principles to guide decision-makers on ethically defensible decisions in a fair

[38] National Academies of Sciences, Engineering, and Medicine, *Framework for Equitable Allocation of COVID-19 Vaccine* (Washington, DC: The National Academies Press, 2020), https://nap.nationalacademies.org/read/25917/chapter/1.

[39] Nancy McClung et al., "The Advisory Committee on Immunization Practices' Ethical Principles for Allocating Initial Supplies of COVID-19 Vaccine—United States, 2020," *Centers for Disease Control Morbidity and Mortality Weekly Report* 69, no. 47 (November 27, 2020): 1782–86, https://www.cdc.gov/mmwr/volumes/69/wr/mm6947e3.htm?s_cid=mm6947e3_w.

and transparent manner would require either internal cohesion of these ethical principles or a hierarchy indicating how top-ranked principles trump lower-ranked principles. That, however, is not what this report offers. "Maximum benefit" can easily conflict with "mitigation of health inequities" and also with "equal concern." How, then, should a decision-maker adjudicate conflicting survival interests of citizens? Instead of telling decision-makers—and the American public—who or what objective should be prioritized and why, the report states that "[w]hen conflicts arise, their resolution will require judicious balancing by trusted parties."[40] That sounds ominously like "reflective equilibrium" and means, "You figure it out; I can't help you here." The "trusted parties" were often public health officials or expert panel members who were unaccountable to the citizens at the time of decision-making and, as we will see below, were not trusted by about half of the population. Governments might have been able to fire them, but that was a mostly theoretical option during a time of crisis when politicians were keen to be seen acting on the advice of experts. The expert advisory panels appointed by governments were typically created in a manner lacking transparency and accountability.

Canadians in the province of British Columbia were treated to an even longer list of ethical principles.[41] The British Columbia Ministry of Health and its Centre for Disease Control identifies eight of them:

(1) Harm Principle,
(2) Utility,
(3) Distributive Justice,
(4) Respect,
(5) Cultural Safety,
(6) Least Coercive and Restrictive Means,
(7) Reciprocity, and
(8) Proportionality.

These authors attempt to provide decision-makers with some direction on how to use these values in their decision-making:

> Identify and Analyze the Principles and Values. What are the principles and values pertaining to this decision? Which principles and values conflict? What principles and values are being affirmed? What principles and values are being negated? Which principles and values will be upheld and prioritized and what is the rationale/justification for the prioritizations?[42]

[40] National Academies of Sciences, Engineering, and Medicine, *Framework for Equitable Allocation*, 100.

[41] BC Centre for Disease Control, "COVID-19 Ethical Decision-Making Framework," December 24, 2020, http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Ethical_Decision_Making_Framework.pdf.

[42] BC Centre for Disease Control, "COVID-19 Ethical Decision-Making Framework," 6.

How does this ultimately translate into predictable policy? Were a parent, school, or business to attempt planning their lives around likely future policy by looking at this list, they would remain in the dark regarding what practical policies they could expect from decision-makers. Public health ethics principlism thus fails decision-makers as well as those affected by their decisions. For instance, utility, cultural safety, and distributive justice are bound to conflict with each other. The proposed process for adjudicating these value-conflicts is the already familiar "that is up to the decision-maker." At least in this framework they are asked to explain their preferences, but there is no standard of evaluation for determining whether they got it right or wrong. In fairness to the authors of this document, they note that these principles can conflict with each other. Still, this is essentially a checklist where decision-makers can check the boxes of values they have considered as well as keep track of which principles did not apply or had to be discarded in favor of values the decision-makers of the day considered more important. Whoever ended up as the decision-maker had free rein to pick the values they considered most important.

In 2020 Canada's federal government also had to decide which groups to prioritize for vaccination, given that initially there would be much higher demand for the available vaccines than there were vaccine doses. Like governments elsewhere, Canada established an expert advisory body—in this case, the National Health Advisory Committee on Immunization (NACI).[43] NACI published what it refers to, somewhat euphemistically, as an "algorithm" outlining the process of applying an Ethics, Equity, Feasibility, and Acceptability (EEFA) framework to the prioritization issue. Ethicists might be surprised to learn that equity considerations are not here only part of the overall ethical analysis, but rather, ended up as equally important as ethics in this document. This document features the NACI experts' choice of various principles; the guidelines then list questions that NACI has considered, but fails to explain how those questions have been addressed. NACI guidance, much like that of other documents discussed above, cannot explain the unexplainable, namely, how the competing moral obligations of its disparate ethical principles can be balanced with one another. NACI claims, for instance, that the "ethical principles of proportionality, effectiveness, precaution and reciprocity have been applied to the guidance," but it is unclear how that actually happened. For example, "effectiveness" is not a self-evident principle; it is relative to some purpose. There is no one property that is "effectiveness"; different conceptions of effectiveness entail different normative commitments. Decision-makers were asked to undertake these

[43] National Health Advisory Committee on Immunization, "Preliminary Guidance on Key Populations for Early COVID-19 Immunization," November 3, 2020, https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-key-populations-early-covid-19-immunization.html#a1.

difficult balancing acts involving conflicting values on their own and, importantly, based on their own values as opposed to their society's foundational values found in, say, its Constitution. This COVID-19 vaccine-distribution guidance document fails to justify its recommendations in a transparent manner. In doing so, it avoids democratic accountability.

Public health ethics principlism—and the COVID-19 health policy guidance documents that were based on it—enabled an authoritarian situation where "decision-maker-knows-best" when it came to who would first receive vaccination against COVID-19, who must report for duty in high-risk environments, whether non-COVID-related services and interventions would be de-prioritized, and who would or would not receive them. Those policies were well-camouflaged by combining uncontroversial ethical principles with "preambles," "frameworks," and "algorithms." Public health ethics principlism is, at its core, an invitation for decision-makers to pick from among a hodgepodge of conflicting principles those they find most appealing and make them public policy.

## VIII. Is the Approach of "Ethics by Committee" Flawed?

In most liberal democracies, expert committees were set up during the pandemic by governments or health authorities. Some bioethicists were appointed to serve on those committees, while many of their colleagues were not. What led to someone rather than someone else getting appointed and invited to influence policy? In many jurisdictions, the grounds on which these selection decisions were made remained in the dark. Worse yet, in some jurisdictions, the composition of such committees was not even disclosed to the public. While not ideal, one can empathize to some extent. Some of those opposed to government pandemic policies did not hesitate to threaten violence against known individual expert committee members. Individual high-profile experts—many of whom worked pro bono—paid a high personal price[44] for their association with policies that growing segments of society were opposed to, especially as the pandemic dragged on and as a large percentage of the population got vaccinated.

Questionable committee-appointment procedures aside, if the documents produced by these public health ethicists offered sound, coherent ethical guidance, citizens would have been able to understand why and how a particular policy came about. Unfortunately, those guidance documents often ended up being melting pots of nice-sounding but incoherent ethical principles that failed to be action-guiding, action-justifying, or both.

[44] Regina Royan et al., "Physician and Biomedical Scientist Harassment on Social Media During the COVID-19 Pandemic," *Journal of the American Medical Association Network Open* 6, no. 6 (2023).

They provided ethics cover for controversial policy decisions that were not justified to those who were directly affected by them.

Jonathan D. Moreno hits the nail on its head when writing—in a different context, many years ago—about these kinds of ethics-by-committee efforts: "empirically, moral truth is in fact less likely to be achieved by groups, which are vulnerable to the corruptions of political processes and interpersonal dynamics, than by well-informed and reflective individuals."[45] Ironically, during the COVID-19 pandemic, once one became an expert guideline writer, one qualified to write further guidelines and became considered even more of an expert. Future research will likely show that some guideline writers had their names attached to normatively conflicting guidance documents, depending on who else drafted those documents with them, which would prove Moreno's point.

Perhaps none of this matters because such documents, one might argue, should not be held to the same standards applied in the context of academic peer review. However, in a liberal democracy, citizens are owed explanations for controversial policy advice that flows from such guidelines. When an expert committee advises decision-makers to shut down public schools for one to two years, citizens deserve a values-based explanation, given the damage such a policy inflicts inequitably on many citizens.

Citizens are also owed transparency on the procedures that govern expert committees' deliberations, including how they responded to any public feedback on their guidance documents. During COVID-19, these documents were not typically subjected to public consultations. They were drafted behind closed doors by said experts, without oversight or external review. However, citizens are entitled to know whether the experts considered their constitutional rights and whether the proposed policy could achieve a defensible objective while minimally impairing their civil liberties and considering possible alternative courses of action.

I opened this essay by describing a number of policies that limited individual liberties or caused otherwise significant harm and that were arguably unjustifiable at the time they were implemented. Some of those harms were probably inevitable in a rapidly evolving pandemic where the facts one has available are not as reliable as one would like them to be. However, the significant harms inflicted on, for instance, children may have been avoidable, if more coherent ethical frameworks of analysis had been deployed. A different harm has occurred that I will focus on last, the consequences of which liberal Western democracies will have to grapple with for years to come.

[45] Jonathan D. Moreno, "Consensus by Committee: Philosophical and Social Aspects of Ethics Committees," in *The Concept of Moral Consensus*, ed. Kurt Bayertz (Dordrecht: Kluwer, 1994), 157.

## IX. The Price We Paid

The Asian Development Bank (ADB), among others, rightly identifies four pillars of good governance as accountability, participation, predictability, and transparency.[46] Predictability justifiably features prominently as a major principle of good governance. As the ADB puts it: "The importance of predictability cannot be overstated since, without it, the orderly existence of citizens and institutions would be impossible."[47] Predictability of COVID-19 policies did not exist. One of the reasons had to do with the fact that infection numbers and assumptions about their impact on health care systems varied significantly. However, as we have seen, the conceptual chaos concerning ethical guidance was significant and undoubtedly contributed to the absence of accountability, participation, predictability, and transparency.

This failure had societal-level consequences. We know that there were significant differences between how different social segments responded to COVID-19 policies, with the oldest most likely to support restrictive government policies, perhaps based on a reasonable assessment of their own risk profile, while younger people were more likely to be opposed to restrictive government policies, which may also have been a reasonable assessment of their own risk profile.

To put some numbers to this, in early 2022, 14 percent of Canadians declared themselves "angry" about their country's COVID-19 response and any restrictions imposed on the population. A further 29 percent reported themselves vaccinated and advocated for the need to "live with the virus," without choosing the label "angry" to describe their state of mind. These numbers are higher for those in the 15–34 age range, with 15 percent declaring their anger and 36 percent in favor of living with the virus. For those in the 35–54 age range, the percentage points were 20 percent and 30 percent, respectively. In all age brackets from 15–54, 50–51 percent of respondents were—with differing strength of conviction—in favor of lifting restrictions. Support for such a policy was lowest among the more vulnerable elderly. Among the 55+ age cohort, they were 8 percent and 23 percent, respectively.[48]

How satisfied were Canadians, then, with their government's pandemic response? While the majority was supportive, that majority was not overwhelming. Forty percent of those interviewed declared that they were somewhat or very dissatisfied with the federal government's pandemic policies. Forty-five percent said the same about their provincial

[46] Asian Development Bank, *Governance: Sound Development Management* (Manila: ADB, 1995), https://www.adb.org/sites/default/files/institutional-document/32027/govpolicy.pdf.

[47] Asian Development Bank, *Governance*, 10.

[48] Leger, "North American Tracker," February 10, 2022, https://legermarketing.wpenginepowered.com/wp-content/uploads/2022/02/Legers-North-American-Tracker-February-10th-2022.pdf.

governments. In other words, a high percentage of Canadians were unhappy to very angry with the COVID-19 policies that various levels of federal and provincial governments put in place. The survey leaves open the possibility that at least some of those people might have wanted stricter policies rather than fewer restrictions.

Either way, 40–45 percent of Canadians were not persuaded by their government's "following the science" or "following the advice of" public health officials' mantras. Canadians were not unique in their response. An Organization for Economic Cooperation and Development (OECD) survey of 50,000 people across twenty-two countries reported remarkably similar results, leading the OECD to suggest that citizens must be given a greater voice in determining the values that should drive public policy.[49]

The main contention of this essay is that people had good reason to be dissatisfied with COVID-19 pandemic policies because, based on the information they were provided with, they were unable to assess whether those policies were justifiable. At least some of those liberty-limiting policies were arguably indefensible and caused significant harm to vulnerable people.

More disconcerting, because of the effect on societal cohesion, is the finding that, as a result of how the pandemic was managed, a large percentage of Canadian citizens report an erosion of trust in their government, ranging from "a little" (36 percent) to "a lot" (27 percent). Sixty-one percent of Canadians reported a *permanent* erosion of trust in their federal government. Roughly the same figures were reported for provincial governments and 46–49 percent reported erosion of trust in the federal and provincial Chief Medical Officers of Health.[50] The latter is equally troubling, as it suggests that the scientific agencies responsible for much of the government's response to the pandemic saw levels of trust in their work permanently decline in about half of the population. I acknowledge that it is difficult to ascertain how many of those who claim today a permanent erosion of trust will do so in a few months' time, but at a minimum such responses indicate a high degree of dissatisfaction with their government's COVID-19 response.

This may be a function of the lack of predictability of policies triggered by the unsuitable value frameworks driving those policies. It may have been due to the existence of obviously failed COVID-19 containment policies of the kinds that I began this essay with. Perhaps it was a combination of these.

It is reasonable to ask whether clarity in the normative justification of liberty-limiting policies would have made an appreciable difference to these figures. I think they would have, at least with regard to people who were open to persuasion and justification. This clarity would also have led to greater predictability in terms of the substance of policies, which in turn

[49] Organization for Economic Cooperation and Development, *Building Trust to Reinforce Democracy: Main Findings from the 2021 OECD Survey on Drivers of Trust in Public Institutions* (Paris: OECD Publishing, 2022).

[50] Leger, "North American Tracker."

supports what the ADB describes as the "orderly existence of citizens and institutions." I am not suggesting that such clarity would have done away with all opposition, but it may have reduced it, because policies would not have appeared to many as both overly draconian and arbitrary. Scientific knowledge accumulated rapidly and, at times, it may have been necessary to acknowledge uncertainty vis-à-vis the empirical assumptions underlying a particular policy. Expert and politician honesty could have helped to create an important social capital, namely, trust in institutions.

## X. Conclusions

The lack of an intelligible definition of "public health" utilized by decision-makers, combined with the use of public health ethics principlism as the primary source of ethics guidance and direction, led to misguided, harmful COVID-19 policies. This had detrimental consequences for societal cohesion and societal trust in governments and their public health agencies. Given that significant liberty-infringing policies were implemented, the absence of transparent adjudication criteria to serve as the basis for public accountability concerning public health measures in liberal democracies was unacceptable. Western liberal democracies experienced a general disregard for democratic values and decision-making procedures when their citizens were subjected to public health directives. Those countries paid a high price in terms of reportedly damaged trust of citizens in their governments and their institutions.

Preparations for future pandemics should include broad public consultations over the values that should direct decision-making and policies. Citizens in liberal democracies have good reason to take for granted that constitutional values should take priority over the personal ethical values of those appointed to serve on public health ethics committees. When constitutional values are insufficient to guide policy, other ethical values must, of course, be considered. However, such values should be developed during broad and inclusive social-consultation processes; they must not be the result of deliberations made by a few government-chosen ethicists behind closed doors. Broad social support for these values is essential to avoid the kind of large-scale societal discord and mistrust in government that Western democracies suffered as a result of their approach to COVID-19 policymaking.

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