

A Care Ethical Analysis of COVID-19 Policymaking: How to Set up Research with Societal Impact?

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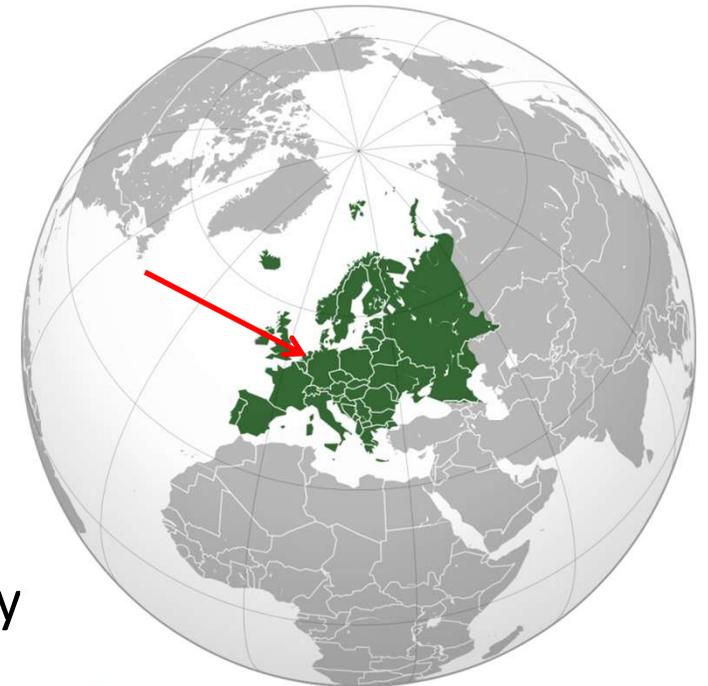


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Every research is contextual

The Netherlands (Kingdom):

- 17.500.000 inhabitants
- Rich, densely populated, good infrastructure
- Ethnic groups: Dutch (75,5%);
Non-European (16,6); European (7,9%);
- No religion (54%); Christianity (38%); other (8%)
- Important values: autonomy, equality, transparency
- Non-hierarchical culture of consensus
- Liberal legislation on abortion, soft-drugs, prostitution,
euthanasia: 'transparency and control'



News 24th April 2021: Neighborhoods who struggle with poverty & vaccination



- Showing up at vaccination: 30-40%;
- Chance of transmission twice as big;
- Chance of dying of COVID-19 twice as big;
- No confidence in government;
- Mis-information ('vaccine causes infertility'), fear, doubt;
- Underlying morbidities: diabetes, lung diseases, obesitas;
- Information about vaccination does not reach 35% of population: they do not receive it or understand it.

The ambition of care ethics

“To recognize the value of care calls into question the structure of values in our society. Care is not a parochial concern of women, a type of secondary moral question, or the work of the least well-off in society. Care is a central concern of human life. **It is time that we began to change our political and social institutions to reflect this truth.**” (Tronto 1993, 180)

25 June 2020: Research call ‘societal dynamics’ by *The Netherlands Organisation for Health Research and Development* (state budget) – deadline 3 weeks later; start before September 15, 2021.

“Be reasonable: Take your responsibility as a citizen”

In the Netherlands the government showed strong leadership by presenting a policy with two clear aims:

a) Limiting infection and mortality among vulnerable groups; (Who is labelled as vulnerable? Who has the power of definition?)

b) Preventing a collapse of the health care system (ICU capacity limited: Germany 5x capacity) (What implicit hierarchy is behind this choice?).

Prime minister Mark Rutte going to work

Challenges of our research design

1) How to get money for care ethical research?

- Care ethics is seen as 'onesided' or 'biased' and not mainstream like medical ethics or bioethics;

2) How to choose and give voice to vulnerable groups?

- Groups labelled as vulnerable are many, they are hard to reach and/or subject to restrictions;

3) How to have societal impact?

- We want to change the world and not end up in a drawer;

Ethical justification of the restriction policy

Three things were striking:

- 1) central concepts like common good, equality and vulnerability were used without being conscious of their moral content, and different ethical theories were used for fragmentary justifications;
- 2) the concept of 'care' was being used in a new way: no longer for the health care sector, but as a common practice connected with building a coherent society;
- 3) although in Dutch society autonomy and democracy are high values, many decisions about the needs of vulnerable groups were taken without hearing these groups.

Research goals

1. A comprehensive ethical analysis of the policy choices that were made on a national level during the COVID-19 crisis;
2. Developing an ethical framework, supported by relevant stakeholders, and for a caring society that is sufficiently resilient to deal with future crises.

Challenges for our research design

1) How to get money for care ethical research?

- Care ethics is seen as 'onesided' or 'biased' and not mainstream like medical ethics or bioethics;
- Our argument: Care ethics is qualified to do the job because:
 - 1) it considers ethical theories as answers to historical challenges, and is not rigid but departs from diversity, contextuality and particularity (Walker 2007);
 - 2) it views stakeholders as people who have a specific kind of (experiential) knowledge relevant to ethical reflection (Walker 2007);
 - 3) it aims at giving a voice to people in vulnerable groups to make their own decision, relevant to them (Tronto 2013);
 - 4) it emphasizes the intrinsic connection between the personal and the political' (Tronto 1993);
 - 5) it works with critical insights like vulnerability, corporeality, relationality that can critically illuminate the ethical dimension of policy choices (Leget et al. 2017)

Challenges for our research design

2) How to choose and give voice to vulnerable groups?

- Groups defined as vulnerable are many, they are hard to reach and/or subject to restrictions;

	Much influence	Little influence
Much media attention	Older people living in health care facilities	Patients receiving palliative care
Little media attention	People with mental disabilities	Refugees and migrants

Challenges for our research design

3) How to have societal impact?

- We want to change the world and not end up in a drawer;

- Involving different stakeholders from the start, and designing a feedback-loop involving:
 - Policy makers on different levels (national, branche, health care institutions)
 - Round table with colleagues from different bioethics depts (against 'care ethics is biased')
 - Members from the Care Ethics Research Consortium
 - Policymakers of the Ministry of Health, Welfare and Sports

Combining different methods

Five work-packages	Methods	Time
1) Reconstructing the moral logic of policy documents (1 March – 1 September 2020: the first COVID-wave)	Discourse analysis	6 months
2) Understanding lived experiences of people who belong to the four groups labelled as vulnerable	Interviews	12 months (overlap)
3) Investigating the alternative solutions that have been developed in the practices around these four groups	Interviews	6 months
4) Confronting our findings with the experiences and solutions in two other societal sectors: culture and education	Interviews	3 months
5) Developing a <u>care ethical policy framework</u> for a caring and sustainable society, that is also able to deal with a future pandemic	Writing	3 months

Our core team



- Adrienne de Ruiten (main researcher)



- Pieter Dronkers (research lead and ambassador for refugees)



- Carlo Leget (ambassador for palliative care)



- Sara Dekking (former policy advisor Ministry of Health)



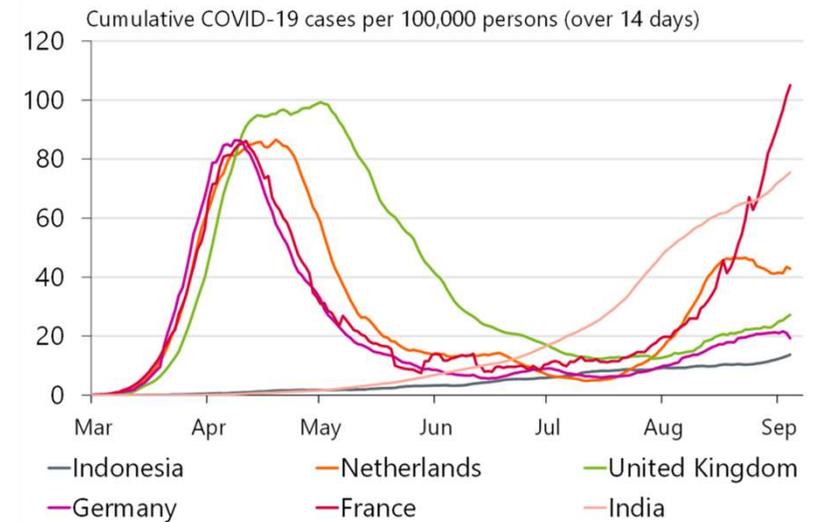
- Alistair Niemeijer (ambassador for people with mental disabilities)



- Els van Wijngaarden (ambassador for older people)

First findings

- 1) There are a number of inconsistencies and problems with the moral logic of policy documents;
- 2) The landscape is constantly changing, and new insights are being developed (e.g. isolation of older citizens);
- 3) Other research groups are coming up with findings that are highly relevant for our project.



Questions

- What do you think of our research design? Recommendations? Questions? Ideas?
- Are you familiar with an ethical framework for policy making in your country that can inspire us to build a Dutch version at the end of our project?

Thank you
for your attention!

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