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"Love is Distance": Is That So? Lockdown Strategies, Medically Vulnerable People, and Relational Ethics

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I. INTRODUCTION

On March 17, Israel's Prime Minister, Mr. Benjamin Netanyahu, made a statement to the Israeli public. The statement addressed the decision to restrict movement and various activities in response to the rapid increase in the number of confirmed coronavirus patients. In presenting the decision to apply a strict policy of physical distancing,[1] the Prime Minister urged the public to act responsibly. Stay at home, avoid gathering, and do not visit other family members, he ordered the public, saying: "today I can say, [l]ove is distance."[2] His words were soon echoed by the CEO of the Ministry of Health, Mr. Moshe Bar Siman-Tov. Urging the public to avoid visiting elderly family members, he said: "It is a great pain, all of us have parents and we are having a hard time with this instruction. Nevertheless, at this time keeping parents safe means not visiting them."[3] In the days that followed, an extensive lockdown was enforced on the Israeli public.

Staying at home to protect the health of vulnerable relatives can certainly be described as an act of love. However, the restrictions on movement and activities adopted by the Israel Ministry of Health during the novel coronavirus (medically known as COVID-19) epidemic raise not only the questions "What is love?" or "What are you willing to do for the

1. This paper uses the phrase *physical distancing* and not *social distancing*. Although *social distancing* was the phrase used in the beginning of the COVID-19 pandemic, the World Health Organization (WHO) later announced preferring the phrase *physical distancing*. Stating this preference, the WHO explained that while physical distance is necessary it is critical that people stay socially connected. *See* World Health Organization, *COVID-19 Briefing* (Mar. 20, 2020), https://www.who.int/docs/default-source/coronaviruse/transcripts/who-audio-emergencies-coronavirus-press-conference-full-20mar2020.pdf?sfvrsn=1eafbff0.

2. *See* Tal Schneider, *The Prime Minister: "It is a Dangerous Epidemic, Not a Children Game; Love is Distance,"* GLOBES (Mar. 17, 2020), http://www.Globes.co.il/News/article.aspx?did=1001322267.

3. *See id.*

ones you love?", but also the bigger question of what principles and values should be applied by policymakers when using lockdown as a public health response to epidemics. This latter question is the focus of this paper.

With this aim in mind, this paper uses the COVID-19 pandemic in Israel and the public health policy adopted by Israeli authorities as the factual and legal framework for discussion. Nevertheless, the boundaries and implications of this paper extend beyond the COVID-19 pandemic and the policy adopted by Israeli health authorities during the pandemic. The purpose of this paper is to present a theoretical and critical framework for discussion in lockdown strategies. More specifically, it calls for the application of relational theories when adopting and planning a lockdown.

I will argue that planning lockdown strategies through the perspective of relational theories entails a commitment to the social nature of human beings. I will further argue that such a commitment demands that policymakers consider the special needs, preferences, and perceptions of medically vulnerable people, as well as the implications of different lockdown strategies on their wellbeing.

Before proceeding further, several comments regarding the scope of this paper are in order. First, lockdown is part of a bigger group of public health practices known as *physical distancing*. The practice of *physical distancing* includes a wide range of measures, e.g., putting on a mask, keeping a physical distance, and avoiding gatherings.[4] As the above discussion indicates, the focus of this paper is on the *lockdown*. Although other measures will be mentioned in the paper and are of relevance to the discussion, they will not be discussed in depth.

As the focus of this paper, it is important to understand what lockdown is. Although there is no clear and unified definition of this measure, it is possible to point to some of its properties. Analogous to quarantine and isolation, lockdown is a practice aimed at preventing the spread of a virus through limiting face-to-face encounters between individuals. Nevertheless, while quarantine is used to keep someone who might have been exposed to a virus away from others and isolation is used to separate people infected with the virus from others,[5] lockdown is a measure applied to communities and subgroups in general. As such, it may apply to individuals who were not confirmed as infected or exposed to the virus. In fact,

4. *See* Nicholas G. Evans, *The Ethics of Social Distancing*, THE PHILOSOPHERS' MAGAZINE (May 18, 2020), https://www.philosophersmag.com/essays/213-the-ethics-of-social-distancing?fbclid=IwAR3O1ZODQp7P36rALSOMqsFO-LktJ-u69H1uivG3Ys4s8ToSG7s61LMLuso.

5. *See When to Quarantine*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation.html.

one justification for its adoption is that some people may not be aware that they were infected or exposed to the virus, and thus might unknowingly present a risk to others.[6] Generally, lockdown includes stay-at-home orders; restrictions on movement and activities; shuttering of businesses, schools, and government offices; and banning or restricting leisure activities, public gatherings, and events. Lockdown is often subject to some exceptions, e.g., permission to leave the house for essential work, to engage in some form of physical exercise, or to buy essential items such as food and medicine. Lockdown measures may vary in scope and severity from state to state or from one geographic area to another area within the same state. They may also change over time in response to new epidemiological data.[7]

Second, while lockdown strategies often affect all members of the community, this paper focuses on one segment of the population: vulnerable individuals. Since vulnerability may take many forms, it is of importance to clarify what form of vulnerability is the subject of discussion.

In the context of this paper, vulnerability is conceptualized in terms of an increased risk of developing a severe illness if infected with the virus. Included in this category are individuals who belong to either of the following groups: (a) people 65 years and older or (b) individuals of any age with serious underlying health conditions, including high blood pressure, chronic lung disease, diabetes, obesity, asthma, and compromised immune systems.[8] In the discussion that follows, I will refer to such individuals as *at special risk* individuals/people, *medically vulnerable* individuals/people, or *vulnerable* individuals/people.

Focusing on this form of vulnerability, the paper does not address two other forms of vulnerability that are relevant to the planning of lockdown strategies: (a) vulnerability that is the result of socioeconomic characteristics (e.g., gender, race, employment, income, education, housing, nationality, or access to health services), which place certain individuals at a

6. *See Social Distancing*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

7. For a review of lockdown measures, *see, e.g.*, Cornelius Hirsch, *Europe's coronavirus lockdown measures compared*, POLITICO (Mar. 31, 2020), https://www.politico.eu/article/europes-coronavirus-lockdown-measures-compared/?fbclid=IwAR2PTXAofSC3vAnqAXYVrCOyJc_H9cyshoFjQgtQ3UfTDUr_C5LUUTedprM.

8. *See Older Adults,* CDC, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html; *People with Certain Medical Conditions,* CDC, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

higher risk to be infected or to be undertreated if infected;[9] and (b) vulnerability that is the result of having a disability. While some people with disabilities fall into the category of medically vulnerable due to age or underlying health conditions, most people with disabilities are not inherently at higher risk of becoming infected with COVID-19 or developing severe illness if infected.[10] Nevertheless, epidemics often disproportionately impact people with disabilities. Having special needs and being confined by attitudinal, environmental, and institutional barriers, people with disabilities are also considered to be vulnerable.[11]

Although the three forms of vulnerability have some similarities and may overlap with each other, each form of vulnerability presents different challenges for policymakers in the planning of lockdown strategies. In light of these differences, I chose to focus on medical vulnerability.

Third, this paper does not address the question of whether lockdown is a justified and proportionate public health response to epidemics or when it should be considered as such. Its focus is on the planning and ending of a lockdown, once a decision to use this measure or to end it was made. Accordingly, the discussion that follows is based on two assumptions: (a) lockdown is effective at preventing the spread of certain infectious diseases, including COVID-19,[12] and (b) under specific circumstances, its adoption is a justified and proportionate measure.

9. For this and other forms of vulnerability, *see* Joseph A. Lewnard and Nathan C. Lo, *Scientific and ethical basis for social-distancing interventions against COVID-19*, 20 LANCET INFECTIOUS DISEASES 631 (2020); Evans, *supra* note 4; Vicki Xafis, '*What is Inconvenient for You is Life-Saving for Me': How Health Inequities are playing out during the COVID-19 Pandemic*, ASIAN BIOETH REV. 1 (May 16, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7229879/.

10. *See People with Disabilities,* CDC, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-disabilities.html.

11. *See* United Nation Human Rights: Office of the High Commission, *Covid-19 and the Rights of Persons with Disabilities: Guidance* (Apr. 29, 2020), https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf.

12. For the effectiveness of lockdown in decreasing infection, *see* Dursun Delen et al., *No Place Like Home: Cross-National Data Analysis of the Efficacy of Social Distancing During the COVID-19 Pandemic*, 6 JMIR PUBLIC HEALTH & SURVEILLANCE 630 (2020); Christopher I. Jarvis et al., *Quantifying the impact of physical distance measures on the transmission of COVID-19 in the UK*, 18 BMC MEDICINE (May 7, 2020); Jay N. Shah et al., *Quarantine, isolation and lockdown: in context of COVID-19*, 7 JOURNAL OF PATAN ACADEMY OF HEALTH SCIENCES 48 (2020); Zheming Yuan et al., *A simple model to assess Wuhan lock-down effect and region efforts during COVID-19 epidemic in China Mainland*, BULL WORLD HEALTH ORGAN (2020),http://dx.doi.org/10.2471/BLT. 20.254045; Alexandre Medeiros de Figueiredo et al., *Impact of lockdown on COVID-19 incidence and mortality in China: an interrupted time series study*, BULL WORLD HEALTH ORGAN (2020) (Preprint), http://dx.doi.org/10.2471/BLT.20.256701; Ji T et al., *Lockdown Contained the Spread of 2019 Novel Coronavirus Disease in Huangshi City, China: Early Epidemiological Findings*, 71 CLINICAL INFECTIOUS DISEASES 1454 (2020); Samit Ghosal et al., *Impact of complete lockdown on total*

Keeping these limitations in mind, this paper is expected contribute to the discussion on public health strategies during the COVID-19 pandemic and future epidemics. First, in the absence of a vaccine or effective medical treatment, many countries adopted lockdown as the public health response to the COVID-19 pandemic.[13] The result was the adoption of different lockdown strategies, intense public and ethical discussions on these strategies, and accumulation of scientific and nonspecific data about the implications of lockdown strategies. As such, the COVID-19 pandemic provides a unique opportunity to discuss the ethics of lockdown strategies and is expected to contribute to the planning of public health responses in future epidemics.

Second, a quick look into blogs, Facebook groups, forums, newspapers, and academic papers reveals that the discussions that address lockdown strategies often focus on the question of whether the benefits of applying a lockdown (as well as when to apply it and for how long) exceed its negative effects on the economy.[14] Less attention is given to the ethics of planning a lockdown or of lifting it in general, and to the context of medically vulnerable individuals in particular. Thus, while the question of whether the protection of elderly people and at special risk individuals justifies the costs involved in applying a lockdown triggered bitter

infection and death rates: A hierarchical cluster analysis, 14 DIABETES METAB SYNDR. 707, 710-711 (2020); Vincenzo Alfano & Salvatore Ercolano, *The Efficacy of Lockdown Against COVID-19: A Cross-Country Panel Analysis*, 18 APPL HEALTH ECON HEALTH POLICY 509 (2020). Similarly, I assume that masks are most likely to help in reducing the spread of COVID-19. For the effectiveness of masks, *see*, *e.g.*, Ran Nir-Paz et al., *Absence of in-flight transmission of SARS-CoV-2 likely due to use of face masks on board*, 27 JOURNAL OF TRAVEL MEDICINE (2020), https://academic.oup.com/jtm/article/doi/10.1093/jtm/taaa117/5871227; Ma Qing-Xia et al., *Potential utilities of mask-wearing and instant hand hygiene for fighting SARS-CoV-2*, 92 J MED VIROL 1567 (2020); Guidance for Wearing Masks: Help Slow the Spread of COVID-19, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html.

13. *See* Joseph A. Lewnard & Nathan C. Lo, *Scientific and ethical basis for social-distancing interventions against COVID-19*, 20 LANCET INFECTIOUS DISEASES 631 (2020).

14. *See* Matti Häyry, *The COVID-19 Pandemic: A Month of Bioethics in Finland,* CAMB Q. HEALTHCARE ETHICS 1, 2–3 (2021), https://www.cambridge.org/core/services/aop-cambridge-core/content/view/AAB9DFABFEA34D8F0AF6E313B6D994BC/S0963180120000432a.pdf/covid19_pandemic_a_month_of_bioethics_in_finland.pdf; Derek Soled et al., *When Does the Cure Become Worse than the Disease? Applying Cost-Benefit Analysis to the Covid-19 Recovery*, Blog: BMJ J. (May 20, 2020), https://blogs.bmj.com/covid-19/2020/05/20/when-does-the-cure-become-worse-than-the-disease-applying-cost-benefit-analysis-to-the-covid-19-recovery/; J. Kahn, *The reopening dilemma: Saving lives vs. saving the economy is a false tradeoff, economists say*, FORTUNE (May 4, 2020), https://fortune.com/2020/05/04/reopening-reopen-economy-coronavirus-covid-19-lifting-lockdown-economists/.

controversies,[15] the question of whether and how the interests of medically vulnerable individuals should affect the planning of a lockdown failed to receive as much attention. This paper's aim is to close this gap by focusing on these issues.

Third, when the issue of vulnerability was addressed in the context of lockdown strategies, a rights-based liberal approach was often applied, conceptualizing the discussion in terms of rights versus public health.[16] The paper uses another theoretical framework for the discussion: relational theories, which are relatively new in the field of public health. As such, these are expected to expand the theoretical framework considered by policymakers when planning public health responses in general and lockdown strategies in particular.

Finally, in articulating the ethical guidelines for the planning of lockdown strategies, the paper lays the foundation for the adoption of specific lockdown strategies. The paper also illustrates the application of the suggested ethical guidelines to specific lockdown strategies. It follows, that in addition to its theoretical importance, the paper is also of practical importance.

The paper proceeds in four parts. The first part describes the lockdown strategies adopted by Israeli health authorities in response to the COVID-19 epidemic. The second part presents in-depth applications of relational theories to public health, describing the theoretical framework for the discussion. The third part suggests a relational account of lockdown strategies. Using the Israeli public health response as an example, and based on the theoretical framework, I will discuss the possible effects of relational theories on lockdown strategies as applied to medically vulnerable people. The fourth and last part concludes the paper.

15. *See*, *e.g.,* Marc Fisher, *He urged saving the economy over protecting those who are 'not productive' from the coronavirus. Then he faced America's wrath*, THE WASHINGTON POST (Mar. 25, 2020, 4:54 PM), https://www.washingtonpost.com/politics/coronavirus-tweet-economy-elderly/ 2020 /03/25/25a3581e-6e11-11ea-b148-e4ce3fbd85b5_story.html; Don Pittis, *Politicians who consider sacrificing the old for the sake of the economy face a backlash*, CBC (Mar. 26, 2020, 4:00 AM), https://www.cbc.ca/news/business/coronavirus-covid-economy-seniors-1.5510079; Alex Samuels, *Dan Patrick says "there are more important things than living and that's saving this country,"* THE TEXAS TRIBUNE (Apr. 21, 2020, 7:00 AM), https://www.texastribune.org/2020/04/21/texas-dan-patrick-economy-coronavirus/; Julian Jessop, *Is the Lockdown Worth It?*, IEA (Apr. 3, 2020), https:// iea.org.uk/is-the-lockdown-worth-it/.

16. *See*, *e.g.*, National COVID-19 Science Task Force (NCS-TF), *Continued confinement of those most vulnerable to COVID19*, at 3 (2020), https://sciencetaskforce.ch/wp-content/uploads/ 2020/10/Continued-confinement-of-those-most-vulnerable-to-COVID19-04May20-English.pdf.

II. THE THEORETICAL FRAMEWORK: RELATIONAL PUBLIC HEALTH ETHICS

Until recently, ethical discussions addressing public health interventions had two prominent features. First, they were mainly based on a classical liberal approach to human rights. Accordingly, public health interventions were often described and analyzed as a case of a collision between individuals' rights to liberty, dignity, privacy and equality, on the one side, and the need to protect the collective interest of public health, on the other side.[17] Second, the subject of the intervention—the individual—was considered to be a discrete social unit, isolated from other individuals and the community, self-interested, self-created, and self-directing.[18]

While still central to ethical discourse in public health interventions, this approach is now criticized by several scholars. The critics point to the fact that applying a rights-based liberal approach makes it much easier to prefer one interest over the other. Thus, a serious health risk to the public (e.g., a pandemic) often provides the needed justification for limiting individuals' rights.[19] On the other hand, focusing too heavily on the rights of the individual makes it difficult for policymakers to adopt and apply public health interventions.[20] It was also argued that it provides too narrow an ethical framework for the discussion on public health issues—one that weighs a short list of ethical concerns, mainly the right of the individual to autonomy, privacy, and equality versus the good of the community.[21]

Seeing the subject of intervention—the individual—as an isolated social unit was criticized as well. Its critics claimed that such an approach ignores the social nature of public health and fails to acknowledge the

17. *See* Françoise Baylis, *A Relational Account of Public Health Ethics*, 1 PUBLIC HEATH ETHICS 196, 197 (2008). The COVID-19 crisis provides several examples for the application of this approach. *See*, *e.g.*, National COVID-19 Science Task Force (NCS-TF), *supra* note 16; Neale McDevitt, *COVID-19 Q&A: Daniel Weinstock on ethics, social distancing and reopening elementary schools*, MCGILL REPORTER (Apr. 28, 2020), https://reporter.mcgill.ca/mcgill-experts-daniel-weinstock-on-ethics-social-distancing-and-reopening-elementary-schools/; World Health Organization, *Addressing Human Rights as Key to the COVID-19 Response* (Apr. 21, 2020), https://www.who.int/publications-detail/addressing-human-rights-as-key-to-the-covid-19-response.

18. *See* Chris Kaposky & Sarah Khraishi, *A Relational Analysis of Pandemic Critical Care Triage Protocols*, 5 THE INT'L J. OF FEMINIST APPROACHES TO BIOETHICS 70, 74 (2012); Nuala P. Kenny et al., *Re-visioning Public Health Ethics: A Relational Perspective*, 101 CAN. J. PUBLIC HEALTH 9, 10 (2010); Jocelyn Downie & Jennifer Llewellyn, *Relational Theory & Health Law and Policy*, HEALTH L. J. 193, 196 (special edition) (2008).

19. *See* Kenny et al., *supra* note 18, at 9.

20. *See* Wendy Austin, *Ethics in a Time of Contagion: A Relational Perspective*, 40 CJNR 10, 14 (2008).

21. *See* Baylis, *supra* note 17, at 198; Austin, *supra* note 20, at 17.

complex ways in which individuals are inseparable from one another and from their community.[22]

Against this criticism, an effort to provide a "population-focused ethic for public health"[23] was made. These efforts led several scholars to suggest a relational understanding of public health ethics[24] as a framework for planning public health interventions and as a means for the identification of public health problems.[25]

Inspired by feminist work regarding relational theories,[26] relational understanding of public health ethics perceives individuals as social human beings, interdependent and interconnected, inseparable from community, socially constructed and constituted.[27]

Of special importance to this paper is the understanding proposed by relational theory for the following ethical values: *personhood*, *autonomy*, *social justice*, *solidarity*, and *care*.

Starting with the notion of personhood, relational theory suggests that our social relationships and group affiliations play a significant role in the constitution and shaping of our identities.[28] According to this view, being a member in a particular group constitutes the individual identity by shaping the ways in which others see and respond to the individual.[29] More specifically, determinants such as race, class, gender, age, disability, ethnicity, culture, and nationality all play a role in forming and sustaining the personhood.[30] When applied to the domain of public health, this approach calls policymakers to pay attention to systematic patterns of privilege and disadvantage and to consider the possible implications of public health

22. *See* Kenny et al., *supra* note 18, at 9; Austin, *supra* note 20, at 17.

23. Kenny et al., *supra* note 18, at 9; *accord* Baylis, *supra* note 17, at 199–200.

24. Note that relational theory is not limited to public health discourse. It is a theory which influences the discourse in philosophy, ethics, and legal theory. *See* Downie & Llewellyn, *supra* note 18, at 193.

25. *See, e.g.,* Susan Sherwin & Katie Stockdale, *Whither Bioethics Now? The Promise of Relational Theory,* 10 INT'L J. OF FEMINIST APPROACH TO BIOETHICS 7 (2017).

26. *See, e.g.,* Susan Sherwin, *Relational Autonomy and Global Threats*, BEING RELATIONAL: REFLECTIONS ON RELATIONAL THEORY AND HEALTH LAW 13, 25 (Jocelyn Downie & Jennifer Llewellyn eds., 2012).

27. *See* Kenny et al., *supra* note 18, at 9; Baylis, *supra* note 17, at 199; Downie & Llewellyn, *supra* note 18, at 196–97; Sherwin, *supra* note 25, at 15, 25–26.

28. *See* Downie & Llewellyn, *supra* note 18, at 197; Sherwin, *supra* note 26, at 29; Kaposy & Khraishi, *supra* note 18, at 74–75.

29. *See* Baylis, *supra* note 17, at 201; Kaposy & Khraishi, *supra* note 18, at 75.

30. *See* Baylis, *supra* note 17, at 201; Kaposy & Khraishi, *supra* note 18, at 75–76; Kenney et al., *supra* note 18, at 10.

intervention on different social groups (e.g., disadvantaged individuals versus powered individuals).[31]

Another core value reframed by relational theories is the value of autonomy. As opposed to the liberal understanding of autonomy, which perceives autonomous individuals as rational, informed, of free-will and self-directed human beings, relational autonomy acknowledges the fact that individuals' decisions are shaped by social forces and are the product of the social relations. These forces and relations may promote or undermine individuals' autonomy. For example, this may occur through increasing or decreasing the number of available opportunities.[32] When applied to the context of public health, a relational understanding of autonomy directs policymakers to consider whether a given intervention is expected to support or compromise the autonomy of the individual. Moreover, it calls policymakers to be aware of the fact that public health interventions may have a different impact on the autonomy of different social groups as well as of the fact that preserving the autonomy of one group may come at the expense of the autonomy and welfare of others.[33]

Justice is another ethical concept influenced by relational theories. While public health discussions often address *justice* as *distributional justice* or *equality*, relational theories relate to *social justice*. When understood through the lens of relational thinking, *social justice* calls public health policymakers to look beyond the effect of a given intervention on individuals and consider its influence on the access of different social groups to social goods, such as rights and opportunities. Social justice further calls for correcting patterns of systematic injustice among different social groups and paying special attention to the most disadvantaged groups in society.[34] This also means that insofar as individuals participate in a practice that maintains social injustice, they have a responsibility to try to eliminate the injustice, whether as individuals or collaboratively with other individuals and organizations.[35]

Of special importance to this paper is the relational interpretation offered to the concept of *solidarity*.[36] Solidarity in its most elementary form is typically defined as an act of commitment to carry the costs of assisting

31. *See* Sherwin & Stockdale, *supra* note 25, at 9; Austin, *supra* note 20, at 19; Baylis, *supra* note 17, at 201.

32. *See* Baylis, *supra* note 17, at 202; Sherwin, *supra* note 26, at 26.

33. *See* Baylis, *supra* note 17, at 202; Kenny et al., *supra* note 18, at 10.

34. *See* Baylis, *supra* note 17, at 203–204; Kenny et al., *supra* note 18, at 10.

35. *See* Sherwin, *supra* note 26, at 30.

36. *See* Bruce Jennings, *Relational Ethics for Public Health: Interpreting Solidarity and Care*, 27 HEALTH CARE ANALYSIS 4, 10 (2019).

others with whom the individual finds similarity in some relevant respect.[37] Criticizing this definition as limiting the practice of solidarity to intimate and communal bonds, relational theorists suggested *affirmation*, *recognition*, or *attentiveness* to others as the pillars of solidarity.[38] Hence, when understood as a relational concept, solidarity involves the recognition of the moral standing of others and calls for intervention when others are unjustly excluded and ignored.[39]

When applied to the context of public health, relational solidarity calls policymakers and individuals to be responsive to the risks and needs of others, especially members of socially disadvantaged groups.[40] More specifically, it calls individuals to accept responsibility for their actions and to be accountable to others, particularly when it concerns members of disadvantaged groups.[41]

Notwithstanding its call for moral responsibility and accountability to others, relational solidarity also acknowledges the fact that individuals' ability to act with solidarity to protect the health of others is influenced by group affiliation, personal determinants, social forces, and the relationships of the individual with others.[42]

Finally, attention should be paid to the moral idea of *care*. While not exclusive to feminist philosophy, care has a central role in feminist ethics. In this context, ethics of care is rooted in "receptivity, relatedness, and responsiveness."[43] A relational understanding of care is based on a paradigm of caring relationships. Care is a relationship in which one person cares for another who receives care, characterized by attentiveness,

37. *See* Barbara Prainsack & Alena Buyx, *Thinking ethical and regulatory frameworks in medicine from the perspective of solidarity on both sides of the Atlantic*, 37 THEORETICAL MED. BIOETHICS 489, 493 (2016); Barbara Prainsack & Alena Buyx, NUFFIELD COUNCIL ON BIOETHICS, SOLIDARITY: REFLECTIONS ON AN EMERGING CONCEPT IN BIOETHICS 46 (Nov. 2011), http://nuffieldbioethics.org/wp-content/uploads/2014/07/Solidarity_report_FINAL.pdf.

38. *See* Baylis, *supra* note 17, at 204–205; Jennings, *supra* note 36; Bruce Jennings, *Solidarity and Care as Relational Practices*, 32 BIOETHICS 553, 557 (2018).

39. *See* Jennings, *supra* note 36; Jennings, *supra* note 38, at 557. Jennings, whose work offers a relational account of solidarity, suggested three levels of solidarity: *standing up for*, meaning to stand up against exclusion and oppression of the other; *standing up with*, which involves adopting a more internal perspective to the experiences and lifeworld of the other; and *standing up as*, which directs to the comprehension of differences between individuals, and involves its respect and protection. *See* Jennings, *supra* note 38, at 557–558.

40. *See* Baylis, *supra* note 17, at 204–205.

41. *See id.* at 205.

42. *See* Sherwin & Stockdale, *supra* note 25, at 15.

43. *See* NEL NODDINGS, CARING: A RELATIONAL APPROACH TO ETHICS AND MORAL EDUCATION (2d rev. ed. 2013).

empathy, and sympathetic responsiveness,[44] whose aim is to prevent the evil of "invisibility, disregard and abandonment."[45]

Bruce Jennings presented three levels of care: "attentive rehabilitation of the other," which means to take steps to restore functions of the other in need; *attentive companionship*, which includes physically spending time with the other and keeping direct communication with him; and *attentive commitment*, which represents a stronger and deeper sense of caring connection. For example, this includes building new public systems for the provision of care services using democratic political reforms.[46] Of the three levels of care, the second level, attentive companionship, is the most relevant to the discussion that follows.

III. THE NORMATIVE FRAMEWORK

A. General

Starting from February 2nd, the government of Israel adopted various restrictions on movement and activities, attempting to stop the COVID-19 pandemic. Common to all these restrictions was the use of physical distancing as the public health response to the pandemic.[47] These restrictions can be divided into at least seven groups:

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44. *See* Thaddeus Metz & Sarah Clark Miller, *Relational Ethics*, THE INT'L ENCYCLOPEDIA OF ETHICS (2016).

45. *See* Jennings, *supra* note 36.

46. *See* Jennings, *supra* note 38, at 560.

47. The adoption of physical distancing rules was not limited to Israel. While countries differ in the scope and strictness of the restrictions adopted, physical distancing has been the major public health response in many countries. *See* Stephen Duckett et al., *Australia's response to the COVID-19 pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 7, 2020), https://www.cambridge.org/core/blog/2020/04/07/australias-response-to-the-coronavirus-pandemic/; Stateside Team, *2020 State and Local Legislative Actions Related to COVID-19*, STATESIDE (Jan. 21, 2020), https:// www.stateside.com/blog/2020-state-and-local-government-responses-covid-19; HuffPost Canada Staff, Closures In Canada For Coronavirus: What's Officially Closed Across Provinces And Territories, HUFFPOST (Apr. 15, 2020), https://www.huffingtonpost.ca/entry/canada-closures-corona virus_ca_5e6e779ac5b6747ef11f4366; Cornelius Hirsch, *Europe's coronavirus lockdown measures compared*, POLITICO (Mar. 31, 2020), https://www.politico.eu/article/europes-coronavirus-lockdown-measures-compared/; Michael Calnan, *England's response to the coronavirus pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 6, 2020), https://www.cambridge.org/core/blog/2020/04/06/ englands-response-to-the-coronavirus-pandemic/; Zeynep Or et al., *France's response to the coronavirus pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 6, 2020), https://www.cambridge.org/core/blog/2020/04/06/frances-response-to-the-coronavirus-pandemic/; Sophia Schlette et al., *Germany's response to the coronavirus pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 8, 2020), https://www.cambridge.org/core/blog/2020/04/08/germanys-response-to-the-coronavirus-pandemic/; Iris Bosa et al., *Italy's response to the coronavirus pandemic – Original post*, CAMBRIDGE

1. Isolation, i.e., isolation of individuals who were infected with the virus, who were in close contact with a confirmed patient or who returned from abroad.[48]
2. Prohibitions on gathering beyond a specific number of individuals.[49]
3. Closing of educational institutions or limiting their activity.[50]
4. Shutting workplaces as well as private and public providers of goods and services (e.g., banks, stores, malls, theaters, parks, museums, libraries, gyms, and pools), limiting their activity or otherwise regulating it.[51]
5. Compelling individuals to take specific protective measures, e.g., put on a mask in public places and keep a distance of at least two meters from other people.[52]
6. National and regional lockdown.[53]
7. Lockdown of long-term care facilities.[54]

In addition to these obligatory restrictions, the Israeli Ministry of Health published from time to time recommendations to the public. Unlike legal restrictions, these recommendations were not legally binding.

CORE BLOG (Apr. 16, 2020), https://www.cambridge.org/core/blog/2020/04/16/italys-response-to-the-coronavirus-pandemic/; Tsung-Mei Cheng, *New Jersey's Response to the Coronavirus Pandemic – Update*, CAMBRIDGE CORE BLOG (May 15, 2020), https://www.cambridge.org/core/blog/2020/04/10/new-jerseys-response-to-the-coronavirus-pandemic/; Shirley Johnson-Lans, *New York's Response to the Covid-19 Pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 7, 2020), https://www.cambridge.org/core/blog/2020/04/07/new-yorks-response-to-the-coronavirus-pandemic/; Thomas R. Oliver & Ajay K. Sethi, *Wisconsin's Response to the coronavirus pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 10, 2020) https://www.cambridge.org/core/blog/2020/04/10/wisconsins-response-to-the-coronavirus-pandemic/; Ayotunde Monica Uko, *Minnesota's Response to the Coronavirus Pandemic – Update*, CAMBRIDGE CORE BLOG (Apr. 9, 2020), https://www.cambridge.org/core/blog/2020/04/09/minnesotas-response-to-the-coronavirus-pandemic/; Philipp Trein & Victor G. Rodwin Wagnerm, *Switzerland's response to the coronavirus pandemic – Original post*, CAMBRIDGE CORE BLOG (Apr. 8, 2020), https://www.cambridge.org/core/blog/2020/04/08/ switzerlands-response-to-the-coronavirus-pandemic/.

48. *See, e.g.,* Public Health Order, The Novel Corona Virus: Home Isolation and Various Instructions (Temporary Order), Apr. 19, 2020, art. 2, 2a.4, 2a.1, 2b, 3.

49. *Id*. art. 3a (a), (b).

50. *See* Public Health Order, The Novel Corona Virus: Limiting the Activity of Educational Institutions (Temporary Order), Apr. 4, 2020.

51. *See, e.g.,* Public Health Order, *supra* note 48, at art. 3(a), 3(c), 3(d).

52. *See, e.g.,* Public Health Order, *supra* note 48, at art. 3(e); Emergency Regulations, The Novel Corona Virus: Restriction of Activity, Apr. 25, 2020, art. 3.

53. *See, e.g.,* Emergency Regulations, *supra* note 52, at art. 2; Emergency Regulations, The Novel Corona Virus: Restricted Area, Apr. 6, 2020.

54. For a detailed discussion regarding lockdown of long-term care facilities, see *infra* Part III.C.

While all instructions are relevant in some sense to the discussion in this paper, the last two are of special importance and will be discussed in depth in the next sections.

B. National and Regional Lockdown

Starting in March and until the mid-April 2020, strict restrictions were applied to the Israeli public in response to a rapid increase in the number of confirmed coronavirus patients. Emergency regulations obligated the public to stay at home, and going out was permitted only for specific purposes, e.g., purchasing food, medicine, or other essential products, receiving essential services, and providing medical or other assistance to a person in need. Sports activities were limited to one of the following options: one person and two fixed participants or persons living in the same residence and restricted to a specific distance from home. Leaving the residence for other purposes was limited to one person or to persons living in the same residence for a short time and within a distance fixed in law.[55] Other instructions prohibited or otherwise limited the operation of private and public providers of services and goods.[56] The cumulative result of these rules was general lockdown, whose severity and scope changed from time to time.[57]

Thus, during Jewish and Islamic holidays, a strict lockdown regime was adopted. Aimed at preventing families gathering, emergency regulations prohibited residents from leaving their city of residence, except for the purchase of food, medicine, or other essential products, or for the acceptance of essential services, provided that one of these could not be purchased or received in the city of residence.[58]

Discovering clusters of confirmed patients in specific areas led to the declaration of these areas as restricted. Once declared as a restricted area, severe restrictions were applied to the population regarding entrance and exit from the area. Entrance and exit were permitted only for essential

55. *See*, *e.g.,* Emergency Regulations, *supra* note 52, at art. 2.

56. *See, e.g.,* Emergency Regulations, *supra* note 52, at art. 5.

57. *See* Ruth Waitzberg & Moriah Ellen, *Israel's response to the coronavirus pandemic – Original post* (Apr. 2020), https://www.cambridge.org/core/blog/2020/04/09/israels-response-to-the-coronavirus-pandemic/.

58. *See* Emergency Regulations, Novel Coronavirus – Restriction of Activity (Amendment 3), Apr. 7, 2020; Emergency Regulations, Novel Coronavirus – Restriction of Activity (Amendment 4), Apr. 14, 2020; Emergency Regulations, Novel Coronavirus – Restriction of Activity (Amendment 6), Apr. 22, 2020.

needs or for the provision of essential services. These restrictions joined the general restrictions imposed all over the country.[59]

References to medically or otherwise vulnerable people in legislation applying national or regional lockdown orders were numerous. As already noted, acceptance or provision of medical or welfare care and aiding a person experiencing difficulties or distress were acknowledged as essential activities and therefore permitted, notwithstanding general restrictions on movement. In addition, a protest led by organizations for people with disabilities resulted in their exclusion from several restrictions. First, the prohibition on operating a zoo, safari, or national parks was limited to allow an organized activity of people with disabilities on the premises.[60] Second, enforcement teams were instructed not to enforce the prohibition on leaving the residence for a fixed distance on people with disabilities.[61] Note that while the instructions addressed people with disabilities in general, they were presented to the public as referring to "[p]eople with disability who are on the autistic spectrum, people with mental or cognitive disability or similar disabilities."[62] Finally, people on the autistic spectrum were allowed to participate in group sporting activities, notwithstanding the restriction on such an activity.[63]

In addition to the adoption of legal restrictions, health authorities published recommendations and explanations to the public from time to time. While of no legal force, these recommendations often addressed the legal rules, their rationale, and stressed the importance of following them. They also suggested that the public take additional precautions that were stricter than the ones obligated by law.

Of special importance to this paper are the recommendations that addressed medically vulnerable individuals. Similar to the entire population,

59. *See* Emergency Regulations, The Novel Corona Virus: Restricted Area, Apr. 6, 2020.

60. *See* Emergency Regulations, The Novel Corona Virus – Restriction of Activity (Amendment 5), Apr. 19, 2020.

61. *See* THE MINISTRY OF JUSTICE AND THE COMMISSION FOR EQUAL RIGHTS FOR PEOPLE WITH DISABILITIES, *Guidelines for Enforcement Teams When Meeting a Person with Disabilitie*s (25/9/20), הנחיה לצוותי אכיפה - מרחק מעל 100 מטר (www.gov.il).

62. *See* THE COMMISSION FOR EQUAL RIGHTS FOR PEOPLE WITH DISABILITIES, *Going Out to Public Space-People with Disabilities* (May 4, 2020), https://www.gov.il/he/departments/general/ going_out_public_space; The Commission for Equal Rights for People with Disabilities (@Netzivut-Mugbaluyot), FACEBOOK (Mar. 26, 2020), https://www.facebook.com/NetzivutMug baluyot/posts/2608711802572130.

63. *See* Letter from Prof. Itamar Grotto, Associate Director General, Ministry of Health, to ALUT (Mar. 29, 2020), https://govextra.gov.il/media/15512/mmk-169845820.pdf. Note that while the letter addressed people with disabilities in general, it was sent to ALUT, which is an association for children and adults with autism. Moreover, this permission was not published or presented as applying to other people with disabilities.

vulnerable individuals staying at their homes were permitted to go out subject to the restrictions set by law.[64] Nevertheless, they were strongly recommended to stay at home, and avoid gathering and physical closeness with others, including family members.[65] They were also recommended not to arrive at workplaces and to work from home if required and possible.[66] At the same time, the public was urged not to visit their relatives, especially elderly people.[67] Calls to follow these recommendations increased during the Jewish holidays, especially before Passover Eve, which one of the most widely celebrated Jewish holidays.[68]

Groups at special risk were also recommended to avoid going out to shop. Acknowledging the needs of this population for food, medicine, and other essential products, people at special risk were advised to use deliveries and to be aided by family members, volunteers, and social services.[69] The recommendations also stressed the need to keep physical distance when receiving and providing such aid or services. For example, elderly people were advised to ask family members to enter the house themselves or leave groceries outside their door.[70]

Acknowledging the special needs of vulnerable people, special services were suggested to this population by the Ministry for Labor, Welfare and Social Services; for example, it provided prepared meals to senior citizens who met specific criteria.[71] In addition, specific solutions were offered to medically vulnerable people by municipalities, private businesses, and social organizations. These solutions were not uniform, limited in scope, and not legally binding. Thus, for example, several municipalities

64. As we shall see in the next part, the state of law which applied to vulnerable populations staying in long term facilities was different.

65. *See* MINISTRY OF HEALTH, *Guidelines for Coping with the Novel Corona Virus- Updated to 20/4/2020-Update Num. 15* (Apr. 14, 2020) (The author has a copy).

66. *See id.*

67. *See* Schneider, *supra* note 2.

68. *See* MINISTRY OF HEALTH, *supra* note 65; Ministry of Health, *A Briefing on Corona by Adv. Uri Schwartz, the Legal Adviser of the Ministry of Health,* YOUTUBE (May 1, 2020), https://www.youtube.com/watch?v=-NP1YjY9k44; Ministry of Health, *A Briefing on the Subject of Corona, Led by Director General of the Ministry of Health, Moshe Bar Siman Tov,* YOUTUBE (Mar. 31, 2020), https://www.youtube.com/watch?v=hOCCGNLZ1Zw.

69. *See* MINISTRY OF HEALTH, *supra* note 65.

70. *See* MINISTRY OF LABOR, WELFARE AND SOCIAL SERVICES, *The "Golden Guards" operation to distribute hot food rations to senior citizens gaining momentum; To date, more than a million rations have been distributed* (Apr. 2, 2020), https://www.gov.il/he/Departments/news/molsa -corona-news-spokesperson-02-04-2020.

71. *See id.*; *Important Information for Senior Citizens During the Coronavirus Crisis*, KOL-ZCHUT (Jan. 18, 2021), https://www.kolzchut.org.il/en/Important_Information_for_Senior_Citizens_during_the_Coronavirus_Crisis.

decided to open parks and playgrounds for children with disabilities, while others made no exclusions.[72] Some supermarkets and pharmacies designated special shopping hours or provided special delivery services for elder shoppers.[73] Volunteers also suggested free deliveries of food and medicines for elderly people who needed help, while others suggested technological guidance for elderly people so they would be able to keep in touch with their family and friends.[74]

Starting in mid-April and until the writing of this paper, lockdown measures have been gradually removed or relaxed. As of May 10th, 2020, the general prohibition on going out to public places was cancelled, subject to some restrictions.[75] Moreover, gatherings of people living together in two different households were permitted, thus allowing visitations of families, including elder relatives.[76]

Nevertheless, vulnerable populations were still given special recommendations.[77] They were recommended not to go out (unless for the acceptance of essential services) and to avoid hosting other people in their

72. *See*, *e.g.*, Avihai Haim, *Corona Days: What Municipalities Offer to Children with Disabilities?* (Apr. 22, 2020), ימי קורונה: מה מציעות העיריות לילדים מיוחדים | שווים (shavvim.co.il).

73. *See*, *e.g.,* Elad Haimovitch, *Keeping Adults from the Corona: Supermarkets in "Rehovot" Will Open in the Mornings Only to the Elderly*, ARIM NEWS (Mar. 27, 2020), https://www.arimnews.co.il/night/33747; Hani Yudel, *Which Supermarkets are Open at Special Hours for Elderly Only?*, MOKTE (Mar. 29, 2020), אילו חנויות מזון פתוחות בשעות מיוחדות למבוגרים בלבד? אירועי היום | מוטקה (motke.co.il). These initiations were not unique to Israel and appeared in other countries as well. *See, e.g.,* Rosie Perper, *Here are all the major grocery-store chains around the world running special hours for the elderly and vulnerable to prevent the coronavirus spread*, BUSINESS INSIDER (Mar. 19, 2020), https://www.businessinsider.com/coronavirus-stores-special-hours-elderly-vulnerable-list-2020-3; Russell Redman, *Whole Foods puts seniors and at-risk customers first with online grocery pickup*, SN SUPERMARKET NEWS (Apr. 30, 2020), https:// www.supermarketnews.com/online-retail/whole-foods-puts-seniors-and-risk-customers-first-online-grocery-pickup.

74. *See*, *e.g.,* Haimovitch, *supra* note 73; Yudel, *supra* note 73.

75. *See* Ruth Waitzberg & Moriah Ellen, *Israel's Response to the Corona-Virus Pandemic – New Update*, CAMBRIDGE UNIVERSITY PRESS (May 15, 2020), https://www.cambridge.org/core/blog/2020/04/09/israels-response-to-the-coronavirus-pandemic/; Public Health Order, The Novel Corona Virus: Home Insulation and Various Instructions (Temporary Order) (May 10, 2020), art. 3a(c); Emergency Regulations, The Novel Corona Virus: Restrictions of Activity (May 10, 2020); MINISTRY OF HEALTH, *Instructions for a New Routine* (May 12, 2020).

76. *See* Public Health Order, The Novel Corona Virus: Home Insulation and Various Instructions (Temporary Order), (May 10, 2020), art. 3A (b); MINISTRY OF HEALTH, *Instructions for a New Routine* (May 12, 2020) (The author has a copy).

77. The Ministry of Health made it clear that instructions regarding vulnerable populations were recommendations and not binding legal rules. Therefore, vulnerable populations were not legally prevented from going outside or participating in social activities permitted by law. *See* MINISTRY OF HEALTH, *Instructions Addressing the Transitional Period During the Corona Routine* (Apr. 30, 2020), https://www.health.gov.il/hozer/bz-214453920.pdf.

residence.[78] These recommendations stayed in force even after the general prohibition on going out to public places was cancelled.[79] In fact, as the general lockdown was lifted, the Ministry of Health articulated stricter recommendations for people at maximum risk for severe illness or death if infected. These individuals were advised to stay in full isolation, excluding a spouse or a caregiver, and to go outside under safe conditions only. According to the criteria adopted in this document, five percent of the general population and fifty percent of the population above the age of seventy were to be categorized as an at–maximum–risk population.[80]

When family gatherings were finally permitted, special attention was given to visitations of grandparents. Thus, the public was advised to limit visitation to one nuclear family, to avoid gathering at their homes, and to limit the number of visitors so that keeping two meters distance would be possible. Visitors were advised to wash their hands; avoid kissing, hugging, and any other form of touching; keep the windows and doors open; and be seated in an open area where possible.[81]

People with previous medical conditions were also advised not to go to their workplaces.[82] Moreover, while employers were allowed to increase the number of employees in a workplace, an amendment to the law, accepted on April 19th, determined that employers should not allow employees over the age of sixty-seven to enter or stay in the workplace.[83] This restriction was canceled shortly after its enactment.[84]

C. Lockdown in Long-Term Facilities

As the COVID-19 pandemic spread in Israel, specific restrictions were imposed on people staying in long-term facilities (geriatric institutions, nursing homes, group homes for people with disabilities, assisted living facilities, senior citizen homes, and other welfare institutions). The

78. *See* MINISTRY OF HEALTH, *Instructions for a New Routine* (Apr. 26, 2020) (The author has a copy).

79. *See* MINISTRY OF HEALTH, *Instructions for a New Routine* (May 12, 2020), *supra* note 76.

80. *See* MINISTRY OF HEALTH, *Instructions Addressing the Transitional Period During the Corona Routine* (Apr. 30, 2020), https://www.health.gov.il/hozer/bz-214453920.pdf.

81. *See* MINISTRY OF HEALTH, *Instructions for a New Routine* (May 12, 2020), *supra* note 76.

82. *See* MINISTRY OF HEALTH, *Instructions for a New Routine* (Apr. 26, 2020), *supra* note 78.

83. *See* Emergency Regulations, Limiting the Number of Employees in a Workplace for the Purpose of Decreasing the Spread of the Novel Corona Virus (Amendment 4) (Apr. 19, 2020), https://www.gov.il/he/departments/policies/dec4994_2020.

84. *See* Emergency Regulations, Limiting the Number of Employees in a Workplace for the Purpose of Decreasing the Spread of the Novel Corona Virus (Amendment 7) (May 3, 2020), https://www.gov.il/he/departments/policies/dec5037_2020.

adoption of such restrictions was based on the increased risk of developing severe illness faced by many of the tenants of these institutions; the tenant's physical or cognitive difficulty in following safety instructions; and the characteristics of the institutional setting.

Thus, starting in March 2020, strict restrictions were imposed on elderly people living in nursing homes or senior citizens' homes.[85] Visitations were completely banned and meetings with family members were allowed only outside the institution.[86] Tenants unable to leave the institution were excluded from this prohibition. In these cases, a visit of one family member of the first degree or a legal guardian was permitted.[87] Tenants were allowed to leave the facility only for the purpose of meeting family members, provided that the latter were not sick or in isolation, and able to take care of the tenant.[88] Visitations at facilities for individuals with disabilities, who are additionally over the age of fifty or in a geriatric state, were also banned unless a family member of first degree or a guardian asked to meet a tenant.[89] In addition, strict restrictions were imposed on activities inside long-term institutions. For example, mutual activities and dining together were strongly advised against and, when maintained, were bound to rules of physical distancing.[90]

The above restrictions stayed in force until April 21st. From this time onward, and with the decrease in the numbers of confirmed patients and infections, the above instructions were gradually relaxed. Visitations of one visitor (a family member, guardian, main care provider, or a significant other) were allowed for all tenants, and every institution was obligated to take the necessary steps to enable such visitations, subject to the management's discretion and other restrictions concerning the place, duration, and number of visitations per day.[91] Tenants living in welfare

85. *See* Director General, Ministry of Work, Welfare and Social Services, *Circulate 004-2020-003 Preparation of Welfare Services for Coping with the Corona Virus-COVID-19-Circulate num.* 4 (Mar. 12, 2020), https://www.gov.il/he/departments/policies/molsa-corona-executive-circu lars-004-2020-003.

86. *Id.* at 5.2, 5.4.

87. *Id.* at 5.5.

88. *Id.* at 3.12.

89. *Id.* at 6.2.

90. *Id.* at 6.2; MINISTRY OF HEALTH, *Instructions to Limit the Exposure While Coping with the Corona Outbreak in Long Term Inpatient Setting* (Apr. 21, 2020), https://www.health.gov.il/Subjects/Geriatrics/magen/elderly-care-reducing-exposure-outpatient-setting.pdf, at 6.

91. *See id.* at 1.2; MINISTRY OF HEALTH, MOTHERS AND FATHERS SHIELD, *National Plan for Protecting Tenants of Institutions for Elderly, Procedure for Visitations in Institutions for Elderly and People with Disabilities* (Apr. 21, 2020), https://www.health.gov.il/Subjects/Geriatrics/magen/ institution-visit-procedure.pdf.

facilities were allowed to exit the institutions for family visitations and to utilize the public space—subject to specific instructions and restrictions (e.g., wearing a mask, keeping a distance of two meters).[92] Tenants staying in facilities for people with disabilities were allowed to visit their families, provided that such a visitation was considered to be of therapeutic value.[93] Most tenants were also allowed to go out to special education facilities, day care for adults, and employment facilities.[94]

D. Conclusions

Several conclusions derive from the analysis of the legal framework: First, for a period of time, a strict lockdown policy was adopted by the Israeli government as the main public health response to the epidemic, during which considerable restrictions on movement and other activities were applied to the public. Subject to numerous exclusions, medically or otherwise vulnerable people were subject to the same restrictions.

Second, familial closeness, in and of itself, did not exclude family members from lockdown restrictions. Instead, sharing the same residence was adopted as the criteria for such exclusions. As a result, social connections between family members that did not share the same residence were severely restricted. This policy was also applied to medically vulnerable family members.

Third, caring for medically vulnerable people through face-to-face encounters was limited to the provision of medical or other assistance.

Fourth, even when going out was allowed, medically vulnerable people were strongly advised to stay at home, not attend workplaces, avoid face-to-face encounters if possible, and take extra care when going out or meeting with family members. The same messages were delivered to the relatives of medically vulnerable people.

92. *See* MINISTRY OF HEALTH, *Instructions for the Prevention of Corona for a Tenant Leaving and Returning to Welfare Facilities* (Apr. 26, 2020), https://www.health.gov.il/Subjects/ Geriatrics/magen/magen-precautionary-guidelines.pdf.

93. *See* MINISTRY OF HEALTH, MOTHERS AND FATHERS SHIELD, *National Plan for Protecting Tenants of Institutions for Elderly, Instructions for Family Visitations of Tenants Leaving in Facilities for People with Disabilities* (Apr. 30, 2020), https://www.health.gov.il/Subjects/Geriatrics /magen/magen-family-visit-guidelines.pdf.

94. *See* MINISTRY OF LABOR, WELFARE AND SOCIAL SERVICES, *Returning to New Routine-Phase 1* (May 4, 2020), https://www.gov.il/BlobFolder/policy/molsa-back-to-routine-part1/he/Populations_Disabilities_molsa-back-to-routine-part1.pdf. Tenants with a high risk to develop severe illness were excluded from this instruction.

Fifth, few initiatives were undertaken to provide medically vulnerable people safe public spaces. Nevertheless, they were limited in scope, not uniform, and not legally binding.

Sixth, segmentation of the population into risk groups was part of the strategy adopted by the Israeli Ministry of Health when lifting the lockdown.

Finally, medically vulnerable people staying in long-term facilities were subject to stricter lockdown measures which further limited their ability to meet with family members, friends, and other tenants; take part in social activities; and go out.

IV. PLANNING LOCKDOWN STRATEGIES: APPLYING A RELATIONAL PUBLIC-HEALTH PERSPECTIVE

Keeping in mind the lockdown strategy adopted by the Israel Ministry of Health, this part applies a relational perspective to the planning of lockdown strategies. The first part of the discussion suggests a critical overview of the justifications for applying strict lockdown rules on medically vulnerable people. In the second part, I articulate the ethical guidelines that policymakers should consider when planning lockdown strategies. Then, in the third part, I present some practical recommendations.

A. The Justifications for Applying Strict Lockdown Strategy on Vulnerable People: A Critical Overview

The first possible justification for applying a strict lockdown strategy on vulnerable people is rooted in a rights-based liberal approach. According to this approach, the risk posed to public interests by the infection of medically vulnerable individuals justifies the restriction of their freedoms.

This justification starts by pointing to the fact that—facing an increased risk to develop severe illness—vulnerable people, if infected, may overwhelm the health system.[95] Consideration should also be given to the increased risk of vulnerable people that could die if infected. Apart from the loss of lives, which is a negative outcome in itself, attention should also be given to the emotional effects such a loss has on a community and its members. Whether it is the loss of a family member, a friend, or an important member of the community; the view of bodies accumulated; or

95. *See* Julian Savulescu & James Cameron, *Why Lockdown of the Elderly is not Ageist and Why Levelling Down Equality is Wrong*, 46 J. MED. ETHICS 717 (2020).

acknowledging the number of lives that were lost, the emotional wellness of the community and its members may be endangered.

Others claim that the public interest in preserving the economy overcomes the rights of vulnerable people. An example for the adoption of such an approach can be found in discussions addressing strategies for lifting the lockdown. Many claim that the interest in preserving the economy necessitates lifting the lockdown, while keeping vulnerable people shielded in their homes. Supporters of this approach point to the benefits of such a strategy—it would enable the economy to recover while protecting the most vulnerable from the virus.[96]

By applying a relational theory to public health, I would like to challenge this justification. This does not mean that I reject the idea that under certain circumstances an individual's freedoms should be restricted for the public good. Nevertheless, I think that the justifications presented above for restricting vulnerable people's freedoms are superficial, mainly because they ignore the fact that people are social human beings, interdependent, and socially constructed. Thus, in weighing the benefits and costs of restricting vulnerable people's freedoms, these justifications ignore the importance of social connections to human existence. They fail to acknowledge the role social relationships play in the constitution and shaping of our identities, as well as in the preservation of our mental and physical wellbeing.[97] There is a growing body of research indicating that chronic loneliness and isolation, especially among elderly people, contributes to a cycle of illness, health care utilization, and decreased wellbeing.[98] Data also suggest that depression, anxiety, and stress were increased in elderly people and patients with cognitive impairment under continued

96. For such an approach, *see*, *e.g.*, Daron Acemoglu et al., *The Road to Recovery: How Targeted Lockdowns for Seniors Can Help the U.S. Reopen*, TIME (May 21, 2020), https://time.com/5840194/targeted-lockdowns-coronavirus/; HM GOVERNMENT, *OUR PLAN TO REBUILD: The UK Government's COVID-19 Recovery Strategy* (May 2020), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/884760/Our_plan_to_rebuild_The_UK_Government_s_COVID-19_recovery_strategy.pdf; Agomoni Ganguli-Mitra et al., *Segmenting Communities as Public Health Strategy: A View from the Social Sciences and Humanities*, 5 WELLCOME OPEN RES. 104 (2020), https://doi.org/10.12688/wellcomeopenres.15975.1.

97. For a similar claim, *see* Evans, *supra* note 4; National COVID-19 Science Task Force (NCS-TF), *supra* note 16.

98. *See* Kerstin Gerst-Emerson & Jayani Jayawardhana, *Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults*, 105 AM. J. PUB. HEALTH. 1013 (2015); C. Waldegrave, *Health and Well-Being Impacts of Both Social Connection and Loneliness Among Older People*, INNOVATION IN AGING 1000 (2017); Pedro L. Valenzuela et al., *Coronavirus Lockdown: Forced Inactivity for the Oldest Old*?, 21 J. AM. MED. DIR. ASS'N 988 (2020).

lockdown.[99] It is therefore not surprising that some ethicists expressed a concern over the effects of a prolonged lockdown on the physical and mental wellness of vulnerable people.[100]

Moreover, these justifications ignore patterns of systematic social injustice toward medically vulnerable people, and thus carry the risk of deepening it. Medically vulnerable people are often the subject of exclusion and discrimination due to their age or disability. Keeping them in a prolonged lockdown while allowing all others to return to the public sphere carries the risk of increasing the exclusion and discrimination that these groups already experience.[101] Out of sight, excluded from the public sphere, and banned or unable to take part in social activities, vulnerable individuals will soon become invisible.[102] Their access to social goods, such as rights and opportunities, will be further limited. A society whose elderly and disabled are confined to their residences might forgo efforts aimed to enable them to be part of social life, for example, by ensuring accessibility to public premises. It follows that the costs involved in applying a continued lockdown on medically vulnerable people extend the emotional and physical deterioration, which are the result of prolonged loneliness. It includes the costs involved in social injustice.

99. *See* B. Lara et al., *Neuropsychiatric Symptoms and Quality of Life in Spanish Patients with Alzheimer's Disease During the COVID-19 Lockdown*, 27 EUR. J. NEUROLOGY 1744 (2020); Ziggi Ivan Santini et al., *Social Disconnectedness, Perceived Isolation, and Symptoms of Depression and Anxiety Among Older Americans (NSHAP): A Longitudinal Mediation Analysis*, 5 LANCET PUB. HEALTH 62 (2020). These findings are supported by experiences of vulnerable people while being under lockdown. *See, e.g.*, Gloria Jackson as told to Eli Saslow, '*I Apologize to God for Feeling this Way',* WASHINGTON POST (May 2, 2020), https://www.washingtonpost.com/nation/2020/05/02/elderly-woman-coronavirus-lonely-expendable/?arc404=true; Amir Alon, *"Do not forget me": Residents of nursing homes are demanding the removal of restrictions,* YNET (May 5, 2020), https://www.msn.com/he-il/news/other/אל-תשכחני-דיירי-בתי-האבות-דורשים-להסיר-את-המגבלות/ar-BB13BqsB.

100. *See*, *e.g.*, Caroline Abrahams, *Is a lengthy lockdown for older people on the way?,* AGEUK (Apr. 26, 2020), https://www.ageuk.org.uk/discover/2020/04/lengthy-lockdown-coronavirus/; Kate Proctor, *longer lockdown for over-70s 'could create sense of victimisation',* THE GUARDIAN (Apr. 28, 2020), https://www.theguardian.com/society/2020/apr/28/longer-lockdown-for-over-70s-could-create-sense-of-victimisation; Eva Feder Kittay, *Invisible vulnerables during COVID-19: Persons with intellectual disabilities forgotten in the COVID-19 pandemic,* QUOI MEDIA GROUP (June 27, 2020), https://quoimedia.com/invisible-vulnerables/; Silvia Camporesi, *It didn't have to be this way*, AEON (Apr. 27, 2020), https://aeon.co/essays/a-bioethicist-on-the-hidden-costs-of-lockdown-in-italy?fbclid=IwAR0PtF2TA0r1NCyvd16DKPLb-6yVDcP-aAmu9ho8CqL-wu1R3DdjsbmmqSM; Pnina Sharvit Baruch, *Emerging from the Coronavirus Crisis: What Say the Elder Population*?, INSS INSIGHT No. 1303 (Apr. 21, 2020), https://www.inss.org.il/publication/seniors-and-coronavirus/.

101. For a similar argument, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16; Baruch, *supra* note 100.

102. For a similar argument, *see* Ganguli-Mitra et al., *supra* note 96; John Harris, *Coronavirus has deepened prejudice against older people*, THE GUARDIAN (Apr. 26, 2020), https://www.theguardian.com/commentisfree/2020/apr/26/prejudice-older-people-coronavirus.

Another shortcoming of a rights-based individualistic justification is that it fails to acknowledge the interdependence of members of the community. While vulnerable people are dependent on others, others are also dependent on them. For many, familial or communal relationships with people considered to be medically vulnerable are of practical importance. Grandparents take care of their grandchildren, thus allowing parents of young children to work. The retired elderly and people with pre-medical conditions who are unable to work often contribute to society by volunteering, thus saving the costs of employing workers and enabling the provision of services despite a resource shortage. Vulnerable people who continue to work, despite their age or medical condition, have the experience and unique insights attached to old age and different life experiences. Finally, vulnerable people, especially elderly people, have an important role in the preservation of specific economic sectors such as travel and leisure.[103] As these examples illustrate, allowing vulnerable people to preserve their social functions does not only benefit them. There is a real monetary value to others and to the society that should be considered when addressing possible public health responses.

In sum, from a relational perspective, confining medically vulnerable people to their residences for a prolonged period involves considerable costs to vulnerable people as well as to society.

At the same time, the results of different lockdown strategies are not yet fully known. In addition, there is evidence that the risk of infection can be decreased by protective measures (i.e., putting on a mask and keeping two meters of distance).[104] When considered all together, the weakness of the justification presented above is revealed.

A rights-based liberal approach may justify the confinement of medically vulnerable people to their homes for another reason: focusing on their right to be treated as an equal and valuable human being, some have argued that the desire to shield vulnerable people by confining them to their

103. For a similar argument, *see* Abrahams, *supra* note 100.

104. See Stephen John, *The Ethics of Lockdown: Communication, Consequences, and the Separateness of Persons*, KENNY INST. OF ETHICS J. (2020) (Special Issue), https://kiej.georgetown.edu/ethics-of-lockdown-special-issue/; Max Fisher, *Reopenings Mark a New Phase: Global 'Trial-and-Error' Played out in Lives*, N.Y. TIMES (May 7, 2020), https://www.nytimes.com/2020/05/07/world/europe/coronavirus-reopening-costs.html; Ivan Semeniuk, *The leeway factor: As coronavirus lockdowns lift, how far can we return to normal without trigging a second wave?,* THE GLOBE AND MAIL (May 23, 2020), https://www.theglobeandmail.com/canada/article-the-leeway-factor-as-coronavirus-lockdowns-lift-how-far-can-we/; Baruch, *supra* note 100.

residence is an honest expression of the value society places on their lives.[105]

While caring for the lives of vulnerable people is an expression of the value society ascribes to them, putting them in lockdown is a poor way to express their value—mainly because it is an easy solution that requires little from other members of society. From a relational perspective, caring for vulnerable people and valuing them requires more than that. It requires policymakers to acknowledge that being alive means more than staying alive. Having social connections with others, being part of a community, and participating in social activities are among the things that make us human. Showing respect for the lives and value of vulnerable people should express this idea. Therefore, efforts should be made not only to protect vulnerable people from infections but also to enable them to keep their social connections and be part of society.

Another possible justification for applying a strict lockdown policy on vulnerable people is rooted in the principle of autonomy. According to this argument, vulnerable people who demand to be excluded from strict lockdown orders, or to be allowed to go out when the lockdown is lifted, are not acting autonomously. Their demands are the result of a misunderstanding of the risks they face and the benefits of staying at home (for them and for the community). As such, they do not reflect their real preferences and should be ignored.

However, this justification has two flaws. First, it ignores the importance and centrality of social connections to human lives. For many vulnerable people who are not able to meet with family members and friends, having limited opportunities to maintain social connections, being excluded from social activity, and being forced to stay at home—in short, being lonely—is much worse than death. Others may feel that it is a risk worth taking considering the life they have already lived and their short life expectancy (whether due to age or illness). For these people, losing what remained of their life is not such a devastating possibility compared to the personal costs involved in losing social connections.[106] These people may be fully aware of the increased risk they face and fully understand its severity but nevertheless make an autonomous decision not to stay at

105. *See* National COVID-19 Science Task Force (NCS-TF), *supra* note 16; Proctor, *supra* note 100.

106. For a similar claim, *see* Marianne Taylor, *Marianne Taylor: The lockdown exit plan is ageist. Over-70s can decide what's best for their health*, THE HERALD (Apr. 27, 2020), https://www.heraldscotland.com/news/18407213.marianne-taylor-lockdown-exit-plan-ageist-over-70s-can-decide-best-health/.

home. Whether it is because they consider the alternative to be worse, or because they think that dying is not such a terrible thing, from their perspective, it is an informed decision, and, as such, it should be respected.[107]

Nevertheless, the principle of autonomy might provide another justification for applying a strict lockdown policy to vulnerable people. According to this justification, looking at the behavior of vulnerable people during the pandemic reveals that they stay at home even when no legal order compels them to do so.[108] Such a practice suggests that the real preference of vulnerable people, at least those who are informed and rational, is to stay at home, thus protecting themselves as well as the public interest. Therefore, recommending or compelling them through law to stay at home does not infringe on their autonomy. It only clarifies and specifies the rules applied to them and others during the pandemic.

While many vulnerable people choose to stay at home regardless of legal rules that compel them to do so, relational theories question the claim that these choices necessarily reflect their real preference. Instead, it suggests that their choices are shaped by social forces and are the product of social relations. For vulnerable people to leave their residence, others (that is, those who are not vulnerable) should comply with physical distance rules aimed to decrease risk of infection, such as putting on a mask and keeping two meters from one another. Others should also be willing to give up their convenience, preferences, and priorities, to some extent, for example, by shortening their shopping hours to allow vulnerable individuals to shop safely. In contrast, when others do not comply with physical distancing rules or are unwilling to place the needs of others before their own, vulnerable people do not have a real choice but to protect themselves by staying at home. It therefore might be the case that vulnerable people

107. For a similar approach, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16; Taylor, *supra* note 106; Louise Aronson, *Coronavirus reveals just how little compassion we have for older people*, VOX (Mar. 27, 2020), https://www.vox.com/the-highlight/2020/3/27/ 21195762/coronavirus-older-people-quarantine-loneliness-health; Baruch, *supra* note 100; Suerie Moon et al., *Continued Confinement of Those Most Vulnerable to COVID-19*, KENNEDY INST. OF ETHICS J. (2020) (special issue), https://kiej.georgetown.edu/continued-confinement-covid-19-special-issue/.

108. *See* Gideon Oko, *The number of respirators does not skyrocket-because the elderly simply do not leave the house*, N12 (Mar. 7, 2020, 6:09 PM), https://www.mako.co.il/news-lifestyle/2020_q3/Article-d149e5c79251371027.htm; Romy Ellenbogen, *As Florida relaxes COVID restrictions, many still choose to stay at home*, TAMPA BAY TIMES (May 29, 2020), https://www.tampabay.com/news/health/2020/05/29/as-florida-relaxes-covid-restrictions-many-still-choose-to-stay-at-home/; Alyson Rudd, *Coronavirus lockdown: vulnerable young choose to stay home despite rules lifting*, THE TIMES (June 6, 2020), https://www.thetimes.co.uk/article/coronavi rus-lockdown-vulnerable-young-choose-to-stay-home-despite-rules-lifting-0w53z96kr.

choose to stay at home because social forces do not leave them any other option, not because this is really what they want.

To conclude, when observed from the perspective of relational theories, the principle of autonomy cannot provide a sound justification for applying a strict lockdown strategy to medically vulnerable people.

B. Planning a Lockdown: The Ethical Principles

A prominent feature of lockdown strategies is their inevitable influence on social connections. It is therefore not only natural but also imperative to adopt a relational perspective when planning lockdowns.

Applying a relational perspective to the discussion, policymakers should be guided by several principles. First and foremost, social connections have a crucial part in maintaining our physical and mental wellbeing. Therefore, when adopting lockdown as a public health response to an epidemic or discussing strategies to lift it, consideration should be given not only to the public interest in preventing the spread of the epidemic or in preserving the economy, but should also be given to the negative effects of limiting an individual's opportunities to maintain and create social connections. While this is true for all individuals, special attention should be given to the effects of prolonged loneliness on vulnerable people. As noted above, numerous studies indicate that prolonged loneliness has a significant contribution to the mental and physical deterioration of vulnerable people.[109] Acknowledging the importance of social connections for vulnerable individuals, policymakers should consider these findings when weighing the costs and benefits of different lockdown strategies.

That does not necessarily mean that vulnerable people cannot be subject to restrictions during an epidemic. Protecting other vulnerable individuals may justify such restrictions. Nevertheless, relational ethics urges policymakers to seek creative strategies that will provide vulnerable people the protection they need (thus protecting the public interest), while also allowing them to keep their social connections, participate in social activities, and be part of the public sphere.

Second, special attention should be given to the fact that vulnerable people often experience lockdown differently from non-vulnerable people. Thus, elderly people living in their homes may experience loneliness more intensely than others, simply because most of them live alone or with one other person (a spouse or a caregiver). A considerable number of

109. *Id.*

vulnerable people are unable to entertain themselves during a lockdown through sports, cooking, or DIY projects, because they are physically unable to take part in such activities or are unable to finance them. For them, meeting family members and friends, taking part in social activities, or just taking a walk outside are crucial parts of their lives. Finally, while many can use technological devices to communicate with family, friends, and the outer world, vulnerable people (especially elderly people) often do not have the required skills or the technology to do so.[110] When observed from the perspective of relational theories, these examples call policymakers to be attentive to the special experience of vulnerable people during a lockdown.

Third, policymakers should be aware of the possible connection or overlap between medical vulnerability and other types of vulnerability. There are findings connecting medical risk factors—such as high blood pressure, diabetes, and obesity—to socioeconomic determinants. Being socially disadvantaged (due to gender, race, ethnicity, education, and economic status) increases the probability of being medically vulnerable.[111] Moving to the COVID-19 pandemic, it is therefore reasonable to assume that socially-disadvantaged individuals face an increased risk of developing severe illness if infected.[112] In addition, a considerable part of medically vulnerable people are elderly people and people with disabilities who are the subject of discrimination and exclusion in many other contexts. A relational approach to public health calls policymakers to consider these connections when planning lockdown strategies. To be more specific, policymakers should address at least two questions: How does having several vulnerabilities affect the experience of the individual during lockdown?

110. *See* BT, *Fears for over-70s struggling with digital isolation during lockdown*, TOTAL TELECOM (May 14, 2020), https://www.totaltele.com/505918/Fears-for-over-70s-struggling-with-digital-isolation-during-lockdown; Natalie Spagnuolo & Michael Orsini, *COVID-19 visitation bans for people in institutions put many at risk in other ways*, CBC (Mar. 29, 2020), https://www.cbc.ca/news/opinion/opinion-covid-19-public-health-institutions-risk-1.5510546.

111. *See* Paula Braveman, Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REPS. 19 (SUPP. 2 2014); Paula A. Braveman et al., *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH S186 (SUPP. 1 2010).

112. *See Assessing Risk Factors for Severe COVID-19 Illness*, CDC (Nov. 30, 3030), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/assessing-risk-factors.html; Wyatt Koma et al., *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*, KAISER FAMILY FOUNDATION (KFF) (May 7, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/.

How are different lockdown strategies expected to affect the individual's vulnerability in other contexts for the long run?[113]

Fourth, while providing food, medical treatment, and other essential services to vulnerable people is a necessary condition for maintaining their physical and mental wellbeing, it is not enough. From a relational perspective, *care* means more than providing individuals their basic needs. Care includes showing attentiveness, empathy, and sympathy; preventing vulnerable people from becoming invisible; and making sure they will not be abandoned. As a practical matter, it requires the enabling and maintaining of direct and meaningful communication with vulnerable people, which will allow them to share their thoughts, experiences, and fears. According to this approach, leaving groceries and medicines at the door or providing prepared meals for vulnerable people, though important, should not be considered as providing vulnerable people the care they need.[114]

Fifth, decisions about lockdown strategies should consider the preferences and risk perceptions of vulnerable people.[115] A refusal to stay at home, irrespective of the increased risk to develop a severe illness (which may seem to be irrational at first glance), may, in fact, reflect a conscious decision to take that risk. Applying this insight when planning lockdown strategies means, first and foremost, that vulnerable people should be given the opportunity to present their preferences to policymakers (directly or through representation groups) and that policymakers should seriously consider them.[116] It also means that vulnerable people should be given the opportunity to make autonomous decisions whether to stay at home. That means that they should be provided with full and accurate

113. For the claim that in the planning of public health strategies, policy makers should consider how social inequalities will be exacerbated, *see* Ganguli-Mitra et al., *supra* note 96.

114. For a similar approach, *see*, *e.g.*, Acemoglu et al., *supra* note 96. Acemoglu et al. do not ignore the need to maintain the social connections of vulnerable people under lockdown, but seemingly do give more weight to the need to provide them essential services.

115. For a similar claim, *see* Moon et al., *supra* note 107.

116. For a similar approach, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16. *See also* Ayesha Ahmad et al., *What does it mean to be made vulnerable in the era of COVID-19?*, 395 THE LANCET 1481 (May 9, 2020), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930979-X; Ganguli-Mitra et all, *supra* note 96. The decision as to whether to stay at home or not was voiced by vulnerable people themselves. *See*, *e.g.*, Haim Omer, *Old people of all nations, unite! You have nothing to lose except your confinement cells!* (Apr. 11, 2020), https://www.haimomer-nvr.com/post/old-people-of-all-nations-unite-you-have-nothing-to-lose-except-your-confinement-cells. On the general advantages of engaging the public in the planning of public health strategies during epidemics, *see* Nancy M. Baum et al., "*Listen to the People": Public Deliberation About Social Distancing Measures in a Pandemic*, 9(11) AM. J. BIOETHICS 4, 4 (2009); ROSS UPSUR, JOINT CENTRE FOR BIOETHICS PANDEMIC ETHICS WORKING GROUP, *Public Engagement on Social Distancing in a Pandemic: A Canadian Perspective*, 9(11) AM. J. BIOETHICS 15, 15 (2009).

information regarding the consequences of different courses of actions.[117] This information should include findings regarding the increased risk to develop severe disease if infected, the medical treatment they might expect if infected (e.g., their entitlement to medical treatment according to priority rules in the case of a shortage of ventilation machines), the risk they pose to others if infected, and the ways to keep social connections while staying at home.

Sixth, when planning lockdown strategies, policymakers should consider the possible effects of preserving the autonomy of nonvulnerable individuals on the autonomy and welfare of vulnerable people. Policymakers should also acknowledge that public health interventions and the choices made by others might deepen or maintain social injustice toward the vulnerable.[118] Keeping this in mind, policymakers should consider the expected effect of different lockdown strategies on vulnerable people's access to public goods. Moreover, when behaviors that increase or sustain social injustice toward the vulnerable are identified, policymakers should take measures to prevent them. Individuals should also be encouraged and compelled (if necessary) to act in (relational) solidarity toward vulnerable people. They should be made accountable for their behavior and its effects on the needs and opportunities of vulnerable people. Vulnerable people should not carry alone the burden of protecting themselves from infection. Others should share this burden with them and take the necessary measures for their protection.[119]

Finally, policymakers should be attentive to the needs of vulnerable people who autonomously choose to stay at home. Their preferences and needs should not be overlooked. That means providing them the physical and emotional support they need while they are at home.

Taking all seven insights into consideration, policymakers should search for creative strategies. Such strategies should strive to provide vulnerable people the protection they need (thus protecting the public interest as well), while allowing them to keep their social connections, participate in social activities, and be part of the public sphere, to the extent they choose. That does not mean that vulnerable people cannot be subject to restrictions during an epidemic. Like nonvulnerable people, vulnerable people might justly have their rights and freedoms restricted under certain

117. For a similar approach, *see* Taylor, *supra* note 106.

118. *Id.*

119. Others have the same approach. *See* Sarah-Vaughan Brakman, *Social distancing isn't a personal choice. It's an ethical duty*, VOX (Apr. 9, 2020), https://www.vox.com/future-perfect/2020/4/9/21213425/coronavirus-covid-19-social-distancing-solidarity-ethics.

circumstances. Nevertheless, when making decisions regarding such restrictions, policymakers should be guided by the insights presented above.

C. Planning a Lockdown: Practical Solutions

Guided by the ethical guidelines set above, I will present in this part several practical recommendations for policymakers.

Before I begin, several comments are in order. To start with, I do not think that there are any magical or perfect solutions to the challenges policymakers face during epidemics, especially one such as the COVID-19 pandemic. Often, they are forced to choose the least bad solution. Moreover, I do not ignore the possible shortcomings of the recommendations suggested below. At the same time, I believe that when choosing among possible strategies, serious consideration should be given to the needs, wishes, and welfare of medically vulnerable people. As opposed to the policy adopted by the Israeli government, whose main aim was to "flatten the curve," policymakers should acknowledge that preserving public health also means maintaining the relational aspects of human existence and being attentive to the implications of lockdown strategies on vulnerable people.

Second, the strategy presented below is only one possible strategy. While suggesting an ethical framework for discussion, the ethical guidelines presented above enable the adoption of different solutions.

Third, it is not my intention to present a comprehensive lockdown strategy. My aim is to illustrate the practical implications of the ethical guidelines articulated above. Accordingly, the following discussion addresses only some of the challenges that policymakers face. Policymakers will most likely be required to consider additional issues.

Fourth, socioeconomic determinants, culture and religion, the characteristics of the health care system, legal and constitutional arrangements, and epidemiological statistics might all justify the adoption of different public health strategies in different countries, or even in different regions of the same country.

Finally, some of my suggestions require the cooperation of several state authorities, human and technological resources, budgets, and the public. While aware of this fact, I believe that the benefits of considering the needs, preferences, and welfare of vulnerable people should not be ignored as well.

Keeping these comments in mind, I turn to the recommendations. The first recommendation addresses the process of articulating a lockdown strategy. As I already claimed, vulnerable people should be given a voice

in the planning of such strategies. First and foremost, this means that policymakers should be attentive and responsive to demands made by vulnerable people. However, considering that vulnerable people often do not have the energy and resources required to fight for their rights, policymakers should voluntarily take steps to determine what their wishes, preferences, and needs are (e.g., by conducting surveys among vulnerable people). Policymakers should also be aware of the fact that medically vulnerable people are not a homogeneous group. They may differ from one another in their needs and preferences. Moreover, as the Israeli experience illustrates, while some vulnerable people enjoy the representation of a powerful advocative organization, many others do not have that advantage. Nevertheless, their rights should not be overlooked. Therefore, an effort should be made to determine what the needs and preferences of different groups are.

The second recommendation addresses the challenge of implementing the chosen strategy. Considering that most measures require the cooperation of the public, which brings the difficulty of enforcing the measures, policymakers should acknowledge the importance of nonlegal policies. For example, this entails providing full, correct, and updated information to the public about the costs and benefits of applying strict lockdown measures on vulnerable people and encouraging people to act in solidarity toward vulnerable people.

Third, vulnerable people who live at home should be excluded from general lockdown orders, thus allowing them to go out during a lockdown. Such exclusions can be conditioned on the presentation of a medical or other official certificate, restricted to certain geographic areas or public facilities (e.g., parks), and conditioned on the use of preventive measures (e.g., putting on masks and/or keeping a distance of two meters) to prevent vulnerable people from infecting others. Consideration should be given to the fact that some vulnerable people cannot leave their homes without assistance. When this is the case, special permission to leave the house should also be given to the care provider.[120]

The lockdown strategy adopted by the Israeli government provides some example for the adoption of such a strategy. As noted above, notwithstanding the adoption of a strict lockdown policy, people with disabilities meeting certain conditions were partly excluded from lockdown orders. At the same time, the shortcomings of this strategy should also be

120. Such a permission should be documented and should include the name of the persons it applies to and their addresses.

acknowledged. While excluding some vulnerable people from lockdown, it left many other vulnerable people under strict lockdown (e.g., elderly people), for whom going out was of considerable benefit from a relational perspective. The Israeli experience should therefore be a reminder that differentiating between vulnerable people should not be random or arbitrary but based on sound reasons.

Fourth, the public sphere should be made safe for vulnerable people. This means, first and foremost, imposing duties to put on masks and keep physical distance, and strictly enforcing these responsibilities. Special attention should be given to public and private providers of essential services (e.g., food, medicine, medical care, financial services). Such providers should be obligated to designate special hours, defined areas, or a special queue for vulnerable people who wish to use it.[121] As the experience in Israel and other countries indicates, while some service providers voluntarily adopted such measures, many others did not follow this initiative, thus limiting vulnerable people's access to the public sphere.

The same also applies to employers of vulnerable workers. Vulnerable people should not be excluded from workplaces and forced to work from home based on their vulnerability. Subject to public health instructions that apply to all workplaces (e.g., number of workers that can attend the workplace) and professional considerations (e.g., the ability to perform the work under these restrictions), employers should not only enable vulnerable people to attend the workplace if they wish to do so but they should also take the measures necessary to provide them a safe workplace. For example, this could be accomplished by dividing workers into fixed groups, and designating separate work hours, days, and areas for each group.[122]

Fifth, policymakers should consider creative strategies that will allow vulnerable people to keep familial and social connections during a lockdown, for example, by allowing vulnerable people living in their homes to meet one fixed nuclear family whose members share the same household. To prevent spreading the virus, encounters should be limited to one fixed family, restricted to a certain number of people, and conditioned on the

121. For similar recommendations, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16.

122. For a recommendation to adopt a cyclic routine for all workers, *see* Abigail Klein Leichman, *Israeli experts propose radical post-corona exit strategy*, ISRAEL 21C- UNCOVERING ISRAEL (May 13, 2020), https://www.israel21c.org/israeli-experts-propose-radical-post-corona-exit-strategy/. This strategy can be used for the purpose of separating vulnerable workers from non-vulnerable workers.

use of protective measures.[123] Choosing the "easy" solution of prohibiting any familial encounters with vulnerable people, such as the one adopted by the Israeli government during Jewish holidays, should be considered as a last resort and adopted only after other strategies were examined and rejected.

Sixth, continued confinement of vulnerable people to their homes (whether by legislation or through recommendations) while permitting others to go out should not be considered as an acceptable strategy for lifting a lockdown. When a decision to lift or ease a lockdown is made, reasonable measures should be taken so vulnerable people will have the same opportunities to maintain their social life as any other person has without risking infection. Physical distance strategies should be strictly enforced, and the obligation to designate special hours and areas for vulnerable people should be applied to all services and businesses whose operation was approved (i.e., essential as well as nonessential).[124] As the discussion in the third part reveals, this was not the strategy adopted by the Israeli government. In fact, a key component of the strategy adopted by the Israeli government was lifting the lockdown while strongly recommending that special risk populations stay at home, thus isolating them from the community for a considerable period.[125]

The case of vulnerable people living in long-term facilities poses a special challenge for policymakers in the planning of lockdown strategies. On the one hand, they should be given the opportunity to maintain social connections. On the other hand, the characteristics of such facilities increase the risk of spreading of infectious diseases inside the facility, thus putting vulnerable people living there at a greater risk.[126] Moreover, while some tenants might be willing to take the risk, others might not be willing or competent to make such a decision. Attention should also be given to

123. For a similar approach, *see* Baruch, *supra* note 100.

124. At the same time, policymakers should consider the costs involved in designating special hours and protected areas for vulnerable people. These costs may justify restricting the duty to take such measures to services and businesses that meet certain criterions, thus permitting others to reopen notwithstanding their inability to make the required adjustments. For a similar recommendation, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16, at 8.

125. *Id.* at 2.

126. *See* Temet M. McMichael et al., *Epidemiology of COVID-19 in a Long-Term Care Facility in King County, Washington,* 382 NEW ENGLAND J. MED. 2005 (2020); *Surveillance of COVID-19 at Long-Term Care Facilities in the EU/EEA*, EUROPEAN CENTER FOR DISEASE PREVENTION AND CONTROL, 3–4 (2020), https://www.ecdc.europa.eu/sites/default/files/documents/ covid-19-long-term-care-facilities-surveillance-guidance.pdf; Chih-Cheng Lai et al., *COVID-19 in Long-Term Care Facilities: An Upcoming Threat that Cannot Be Ignored*, 53 J MICROBIOL. IMMUNOL. INFECT. 444, 445 (2020).

the need to prevent the infection of staff members. As the COVID-19 experience illustrates, infection among health workers may not only endanger the workers and increase the risk that the virus will spread inside and outside the facility, but it may also result in a shortage of staff, thus leaving tenants of such facilities without the care and services they need.[127]

It follows that lockdown strategies that apply to vulnerable people living in their homes cannot be necessarily applied to people living in long-term facilities. Applying a relational perspective, policymakers should not ignore the fact that keeping the autonomy and wellbeing of some tenants may negatively affect the autonomy and wellbeing of other tenants as well as the public interest. Therefore, policymakers should strive to balance the needs and preferences of vulnerable people regarding social connections, on the one hand, and the interest of preventing the spread of infectious diseases inside long-term facilities, on the other hand.

Keeping this aim in mind, I suggest the following recommendations. First, in the planning of lockdown strategies, attention should be given to the differences between long-term facilities. Long-term facilities are different from one another in many aspects, such as the number of tenants, their cognitive and physical condition, the purpose and nature of the facility, and the size of the facility. Therefore, one strategy does not necessarily fit all. Moreover, the same facility may have different wards or units whose characteristics justify the adoption of different strategies in the same facility.

Second, restricting a tenant's freedom to leave the facility, meet family members or friends, and take part in social activities should be considered as a last resort. Applying such restrictions should be considered only after other options were considered and rejected as being too risky for other tenants. The same is true for the adoption of technological substitutes. While technological devices can be used to ease the loneliness of vulnerable people staying in long-term facilities, they should not be considered as an equivalent to face-to-face encounters. Therefore, they should be used only after other options were considered.

Third, restricting tenants' freedom to go out, or otherwise restricting their social encounters (e.g., meeting with family members), should be

127. *See* Carrie Teegardin & Brad Schrade, *Staffing shortages threaten care at nursing homes, assisted living facilities*, ATLANTA JOURNAL-CONSTITUTION (June 25, 2020), https://www.ajc.com/news/state—regional/hundreds-georgia-long-term-care-workers-have-virus/ivPUwmBFTcNFNRZSI2H4WM/; Avalon Zoppo & Rebecca Everett, *Coronavirus is racing through N.J. nursing homes. A lack of healthy staff is making the crisis worse.*, NJ.COM (Apr. 9, 2020), https://www. nj.com/news/2020/04/theyre-terrified-nj-nursing-homes-face-staff-shortages-amid-worker-infections .html.

limited in time and not exceed what is necessary. Its extent and nature should be considered from time to time and maintained only if no other option exists. In addition, efforts should be made to enable vulnerable people to participate in some form of social interaction, for example, maintaining social activity in small, fixed, and defined groups.[128]

When applied to the strategy adopted by Israeli health authorities, these recommendations reveal its shortcomings. For example, elderly people living in assisted living facilities were prohibited to leave the facility, except for the purpose of meeting family members. Thus, even when elderly people living at home were permitted to go out for other purposes (e.g., sport activities), elderly people living in assisted facilities could not do so. They were subject to the same lockdown rules that were applied to nursing homes, notwithstanding the differences between the facilities. As opposed to elderly people staying in nursing homes, elderly people living in assisted facilities often have their own apartment (alone or with a spouse); they are independent and do not need nursing care. As a result, the risk that they will infect other tenants or staff members is smaller than the risk in nursing homes.[129] Moreover, the risk that they will infect other tenants or staff members can be further controlled through restricting their encounters with other tenants and subjecting them to severe protective measures. Thus, tenants living in assisted living facilities will be able to choose whether to go out and be subject to severe restrictions while in the facility or staying in the facility and have more opportunities to take part in social activities. In addition, infection of workers and by workers could be prevented through keeping unnecessary encounters with tenants to the minimum, working in capsules, using technological measures when possible, and strictly enforcing the use of protective measures.

Finally, I would like to address the claim that vulnerable people are not a homogeneous group, and therefore should not be subject to the same lockdown strategy. More specifically, this claim calls policymakers to differentiate between the healthy elderly and elderly people suffering from pre-existing medical conditions. According to this approach, while the latter should be ordered or recommended to stay at home, the former should not be confined to their homes as the risk they face is similar to the risk

128. For a similar approach, *see* National COVID-19 Science Task Force (NCS-TF), *supra* note 16, at 4–5.

129. *See* Grace Y. Jenq et al., *Preventing COVID-19 in Assisted Living Facilities—A Balancing Act*, 180 JAMA INTERNAL MED. 1106 (2020), https://jamanetwork.com/journals/jamainternal medicine/fullarticle/2766447.

young people face.[130] This approach is based on segmentation of the community into risk groups while attaching permissible levels of activities to each group.[131] For the purpose of this paper, I will assume that such a segmentation is possible and of a sound medical basis. Nonetheless, policymakers should acknowledge the shortcomings of the segmentation: it maintains the differentiation between vulnerable people and nonvulnerable people, which was presented and criticized above. The proposed segmentation only suggests a different criterion for *vulnerability*, thus decreasing the number of people that will be forced or recommended to stay at home because of their *vulnerable* classification. Nevertheless, it is still expected to leave a considerable number of people under lockdown. There is also the risk that as the number of vulnerable people confined to their homes decreases, policymakers and the public will be less troubled by the possible effects of subjecting vulnerable people to a strict lockdown strategy.[132] At the same time, weakened by their medical condition or socioeconomic status, vulnerable people might find it hard to fight for their freedoms. As a result, they might be forgotten and continue to be confined to their homes for a long period of time. It follows that, although having the advantage of decreasing the number of vulnerable people that will be subject to lockdown, such a strategy should not be adopted.

V. SUMMARY

COVID-19 is going to stay with us, at least for a while, and thus the need to keep physical distance will stay as well. Although most countries eased lockdown orders to some extent, recurrent outbreaks of the virus

130. *See* Moon et al., *supra* note 107; Caroline Wheeler et al., *Coronavirus lockdown: set free healthy over-70s, say doctors*, THE SUNDAY TIMES (May 3, 2020), https://www.thetimes.co.uk/article/coronavirus-lockdown-set-free-healthy-over-70s-say-doctors-lxhvf8vzb; UK News, *'Don't exclude healthy pensioners from lockdown easing' say doctors' leaders*, EXPRESS & STAR (May 3, 2020), https://www.expressandstar.com/news/uk-news/2020/05/03/lifting-lockdown-on-basis-of-age -tells-elderly-their-lives-dont-count-peer/; Kate Ng, *Coronavirus: Over-70s 'willing to risk prison' to break self-isolation if it continues, Tory peer warns*, INDEPENDENT (May 3, 2020), https:// www.independent.co.uk/news/uk/home-news/coronavirus-over-70s-lockdown-break-rules-prison-a9496261.html; Taylor, *supra* note 106.

131. Such a strategy was suggested by experts in the Committee of the Israeli Ministry of Social Equality. *See* Itamar Eichner, *The Institution for National Security will Address a Strategy Which will Enable Senior Citizens Going Out*, YNET (Apr. 21, 2020, 5:35 PM), https://www.ynet .co.il/articles/0,7340,L-5718576,00.html; Gila Gamliel, *The Exit Strategy of Senior Citizens*, THE MARKER (May 3, 2020), https://www.themarker.com/news/.premium-1.8816997?ga=2.114325696.6 31836288 .1590577817-646841432.1589186425.

132. For a similar argument, *see* Daniel Smith, *What should the government do about over 70s in the lockdown?* WALESONLINE (May 4, 2020), https://www.walesonline.co.uk/news/uk-news/ what-should-government-over-70s-18197446.

require health authorities to consider whether, when, and how lockdown should be applied (once again). Israel provides a good example for such a dynamic. Approximately two months after gradually lifting the lockdown, Israel is facing a dramatic increase in the number of confirmed COVID-19 cases.[133] To stop the spreading of the virus, the Israeli government decided to apply a lockdown strategy on cities experiencing high infection rates.[134] Moreover, history suggests that even after the eradication of the COVID-19 pandemic, through vaccine or otherwise, other viruses will likely take its place. Some will leave us no choice but to return to lockdown.

The question of what ethical guidelines should be applied in the planning of lockdown strategies is of considerable relevance to the current outbreak, as well as to future ones. While a liberal rights-based approach is of value to such a discussion, applying a relational perspective yields important insights. Returning to the words of Israel's Prime Minister—"love is distance"—a relational perspective suggests that love is more than just keeping distance from vulnerable people; it is noticing them and being attentive to their special needs. It is being willing to carry the costs involved in fulfilling these needs, preserving vulnerable people's wellbeing, and giving them the opportunity to be part of the public sphere and participate in social activities, even in times of epidemics. Love is seeing people as part of the social texture of the community and caring for them by not abandoning them.

When translated into specific recommendations, these insights demand that policymakers look for creative solutions when planning lockdown strategies. Once such strategies are adopted, members of the community are called to act in solidarity and cooperate with these strategies. The above discussion points to the fact that vulnerable people do not necessarily share with policymakers or other members of the community the same perceptions regarding what constitutes "health" or "wellness" and what is "good." To put it simply, it calls policymakers to acknowledge the fact that, for some vulnerable people, being alive means more than staying alive.

133. *See* Joshua Mitnick, *Israel's Cautionary Coronavirus Tale*, FOREIGN POLICY (FP) (July 22, 2020), https://foreignpolicy.com/2020/07/22/israel-coronavirus-second-wave-netanyahu/; Ynet News, *Second Wave: Israel registers record-breaking 1,300 new daily Covid-19 infections*, CTECH BY CALCALIST (July 8, 2020), https://www.calcalistech.com/ctech/articles/0,7340,L-3838476,00.html.

134. *See, e.g.*, Approval for the Declaration of Beitar Ilit as a Restricted Area Under the Order Regarding the Declaration of a Restricted Area (Novel Corona Virus 2019) (Judea and Samaria) (num.1843) (Temporary Order) 2020; Declaring Neighborhoods in Ashdod and Lod as a Restricted Area According to Emergency Regulations (Novel Corona Virus) (Restricted Area) 2020.