

Whose values? Decision making in a COVID-19 emergency-management scenario

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Crises may present unprecedented challenges that require people to think outside their traditional boxes. During COVID-19, many of us have seen officials and experts come together to share information and simultaneously respond to an emerging issue. For an evaluator working at the coalface of the pandemic response it can be an opportunity to draw from their kete (basket) of evaluation tools and matrixes to support the decision-making process to be as defensible as possible. This praxis article describes the process of three evaluators reflecting and discussing one such scenario and exploring how an evaluation-specific tool based on normative ethical theories could provide some benefit.

Introduction

During a pandemic, decision makers must take swift action, weighing up the risks and benefits of different strategies to contain the virus while taking account of social, economic, and political pressures. Many issues can be anticipated, such as prioritisation of finite resources including personal protective equipment (PPE), testing,

and vaccine distribution, as evidenced by their inclusion in emergency plans.¹ Crises may also present unprecedented challenges that require people to think outside their traditional boxes. During COVID-19, many of us have seen officials and experts come together to share information and simultaneously respond to an emerging issue. For an evaluator working at the coalface of the pandemic response it can be an opportunity to draw from their kete (basket) of evaluation tools and matrixes to support the decision-making process to be as defensible as possible. This praxis article describes the process of three evaluators reflecting and discussing one such scenario and exploring how an evaluation-specific tool—which we call the values identification matrix, or VIM—could provide some benefit.

In this situation, different stakeholders from public health and emergency services in the US came together to quickly identify a solution to an emergent issue. Our post-hoc reflection and discussion explored how the VIM tool could be used to facilitate an understanding of how different stakeholders frame an issue; that is, the value perspectives they bring to the decision-making table—potentially in real time. We discovered that using the tool enables systematic identification of those who are absent and whose perspectives need to be considered to tackle the problem.

The article begins by introducing the real-life COVID-19 situation in which multiple stakeholders representing different public service agencies came together to discuss and generate a solution in an hour-long meeting. It then introduces three evaluation colleagues (the authors of this article) who met some time later, to reflect on the situation and consider how a values-analysis tool may have supported the decision-making process, had it been used. In the third section, the values-analysis tool is used retrospectively to explore how it may

1 Homeland Security Exercise and Evaluation Program (HSEEP). <https://www.fema.gov/emergency-managers/national-preparedness/exercises/hseep>

have supported a fuller understanding and definition of the problem. The fourth section reflects on the implications of using the tool in high-pressure situations, and what training evaluators might need to use the tool in similar circumstances.

Introduction to the COVID-19 context

The situation around which we have framed this article begins in a US county about the same geographical size as the Waikato region—25,000 sq km, and with a population of approximately one million residents, of which 52% are white, 37% Hispanic/Latina, and 3% African American. Approximately 19% of the county's population lives in poverty. As the county borders Mexico, there are many undocumented residents who, over time, have settled in the county and contribute to its economy. Given the high number of undocumented residents, the county population and the proportion of Hispanics is much higher than official counts.

Many of the undocumented residents have children who are born in the US, thus the children are legal residents. Their children go to school and can access healthcare. Their parents cannot get a job with employee benefits for fear of getting on the government's radar. Thus, they have no access to healthcare. These unusual circumstances place this population in a very difficult situation. Many of the undocumented residents hide from authority for fear of being deported and separated from their children who are US citizens. They often live and work in high-density conditions, providing essential services.

The evaluator (Ralph Renger) was contracted by this county's health department to evaluate the COVID-19 emergency response. In a pandemic in the US, the county public-health department assumes the lead role in co-ordinating the response, supported by the county office of emergency management (OEM). There are numerous counties in each state and each replicates this structure. Each county then reports to the

state health department which is supported by the state OEM.

The purpose of the evaluation was to evaluate the efficiency and effectiveness of the public-health department in co-ordinating the emergency response. The evaluation used the participant observation data-collection method. The evaluator was given access to intra- and interdepartmental communications, including virtual and phone meetings between the health department and co-ordinating community agencies, but directed never to interfere with the discussions and/or the response. The extent to which the co-ordination was efficient and effective was evaluated by analysing these communications using a cadre of systems principles (Renger, in press; Renger et al., in press; Renger, 2015).

During the emergency response, the issue of reporting the geographic location of positive COVID-19 cases surfaced. During a video conference, officials set out their respective positions, with both making arguments in the best interest of doing their work professionally.

First responders (i.e., fire and law enforcement) requested that the location of those testing positive for COVID-19 be made available to them. At the time of the meeting, the county, as with many other US locations, was reporting shortages of gear including PPE. The first responders argued that having the location data was critical to ensure the safety of their officers. They also argued that they routinely have access to sensitive data; for example, records of paedophiles, domestic abusers, restraining orders, criminal records, and so forth. They contended that having access to such information without the public's permission was the "normal" way business was done.

On the other hand, the public-health officials were unwilling to release the location data for fear of the ripple effect it would have in eroding trust in the public-health department. The public-health officials argued that maintaining the confidentiality of those testing positive for COVID-19 was critical in ensuring that residents from

high-risk populations would continue to come forward to be tested. Without this co-operation, it would be impossible to monitor and contain the disease spread. They suggested that first responders simply treat all calls as though they were COVID-19 positive cases and take appropriate precautions.

Officials at the meeting suggested one remedy was to report the street addresses of COVID-19 positive clusters; for example, a nursing home, a hotel, or a public housing unit. This was summarily dismissed as too difficult to do from an information technology standpoint.

Following the meeting, first responders petitioned the state governor, who issued an executive order that the state health department release the location data for all positive COVID-19 cases in the state. The location data were subsequently integrated into the first responder databases.

How would this now play out? Ralph's view was that news of location data being shared would mean that fewer of the most vulnerable residents in the county would come forward to be tested for COVID-19. Due to their undocumented status, they would risk dying before presenting themselves to the healthcare system. However, many of the undocumented residents, who were the most vulnerable, were also working in high-density situations in closed environments (e.g., abattoirs) where they were much more likely to transmit the disease or become infected. If people were not being tested, then there would be no way to know the disease spread or a way to implement a containment strategy. With COVID-19's highly infectious nature, in communities like these in which members also often have no social safety net in terms of healthcare coverage, the consequences would likely be devastating.

Opportunity to reflect

During March 2020, the authors met via Zoom to discuss evaluation of COVID-19 responses as they had experienced them—Ralph

in the US, Amy Gullickson in Australia, and Mathea Roorda in New Zealand. As Ralph recounted the video-conference meeting described above, he noted he had been uneasy about some of the arguments set out by the attendees but did not feel able to intervene. He finished with the comment: “I really wished I’d had an ethicist in the room”, to which Mathea responded: “No, what you needed was an evaluator who could bring an understanding of values to the decision-making process.”

While values are clearly important to evaluation, there are few practical tools to support evaluators to systematically consider them. One is the VIM tool developed by Mathea (Roorda, 2020). The VIM tool brings together normative value perspectives from a branch of Western philosophy that deals with moral principles; that is, the rightness and wrongness of actions (Popkin & Stroll, 1993). Three competing perspectives are described in the literature: consequentialist, deontological, and virtue-based (Roorda & Gullickson, 2019). Table 1 provides a high-level summary of the perspectives, along with key principles that align with each, a definition, and examples of value terms that indicate this principle is being enacted.

Table 1. Summary of normative value perspectives

Normative perspective	Principle	Defined as	Examples of value terms indicating alignment with a principle
Consequentialist	Consequences	Maximum benefits, action that achieves the best outcome	Outcomes, effects, value for money, return on investment
Deontological	Duty	Meeting obligations (formal, informal)	Commitment, duty, obligation
	Rights/equity	Minimum protection, doing the right action; being fair, just, equitable	Rights, fair deal, equity
Virtue-based	Ethic of care	Being virtuous, trustworthy, loyal	Be kind, caring, trustworthy

Many evaluation scholars (e.g., Greene et al., 2006; House & Howe, 1999; Shadish et al., 1991) have acknowledged the relevance of normative perspectives to identifying dimensions of value, yet there is little evidence of explicit engagement with them in evaluation practice. Drawing on work by Mepham et al. (2006) and Newman and Brown (1996), Mathea conducted an empirical study to develop and test a matrix to help evaluators systematically identify value perspectives as relevant to a particular evaluand and context. Underpinning the matrix is a view that there is more than one way to conceptualise right/wrong or good/bad. In this respect, the matrix embraces a pluralist approach to identifying what is important or of value. Also underpinning the matrix is a view that surfacing all relevant value perspectives is part of the essential skill set of evaluators. As Greene (2011) has observed, the primary purpose of evaluation is to: “render judgements of merit and worth that are grounded in defensible empirical evidence and argument and *that are anchored in chosen values*” (p. 85, emphasis added).

The VIM tool was developed as part of a broader tool to help evaluators develop defensible criteria for an evaluation. In our discussion, Mathea suggested to Ralph that the VIM tool might be modified as a rapid values assessment tool. As such, it could serve to support the evaluator to identify the value perspectives evident, as well as those missing, in the decision-making process. Amy had been taking notes to capture the details of the meeting Ralph observed, so Mathea took her matrix to it to see if it could work retrospectively as a first test.

The approach taken

The first step was to identify the groups with unique stakes in COVID-19 response being discussed. Three distinct groups were identified. The first were officials from fire services, emergency medical services, and police. In the context of the intervention, all shared a similar interest

in the intervention in that their staff were responding to emergencies where they might come into close contact with people infected with the COVID-19 virus. Safety of these first responders was the highest priority of these groups. Owing to this shared interest, they were categorised as one group. The second group were public-health officials. Their interest was to ensure people got tested if they were unwell, to be able to track, respond, and contain the spread of the disease. The third group were vulnerable populations such as undocumented individuals, whose interests included the health of their families but also staying below the radar of government agencies. This third group was not represented in the meeting, but had a clear stake in the outcome based on Ralph's description of the context.

Mathea mapped the perspectives of the three groups as they aligned with the four normative principles (Table 2). These perspective statements identified what seemed most important for each stakeholder group. Perspectives that referred to outcomes (and specifically weighing up the best outcome for that stakeholder group) were listed under the column "consequences". Perspectives that were concerned with obligations or the duty of that stakeholder group with regard to the intervention were listed under "obligations". In this case, the perspective voiced by public-health officials focused on their obligations to the public, rather than the public's right to have information kept confidential. The only rights-based perspective evident in the discussion referred to ownership of information. The first responders noted that, because each first responder agency owned their own record management systems (RMS), they had a right to store information about individuals as it helped them prepare, if required, when they attended an emergency callout.

The value perspectives for vulnerable people were absent in the discussion. Implicitly, vulnerable people were a concern for the public-health officials (i.e., they know that correct information is critical

to keeping people safe). However, in this case, the public-health officials were concerned about the public generally; not vulnerable people per se.

Table 2. Mapping of value perspectives for an emergency response meeting

	Consequences	Obligations	Rights/equity	Ethic of care
Public-health officials	We have to weigh up what will give the best health outcome for the greater public. People likely to provide misinformation because they do not want officials to know their whereabouts. The outcome is that more people may become infected/die.	We promise we will keep patient information confidential; preserving trust is the only way to ensure we get decent information.		
First responders	We also have to weigh up what will give our first responders the best health outcome: a potentially delayed response to an emergency so that they have time to access proper PPE will give us an outcome of fewer infected staff.	Our first priority is to our staff; we need to protect them.	First responder organisations have rights to other types of sensitive data in our RMS; we should have rights to these data as well.	First responders can gear up with PPE en route if they have the information about infections; they can treat each response differently/ appropriately to care for their own safety and the safety of others.
Vulnerable people				

Reflections

In recounting his experience of the meeting, it was clear Ralph did not need a tool to know that the perspectives of vulnerable people were absent from the decision-making process. However, he was in a challenging position, having been directed to not interfere with the discussions and/or the response. How then might mapping out the value perspectives of different stakeholder groups have supported the decision making in this situation?

Given the directive to Ralph to be an observer only, it is unlikely the VIM tool would have been of much use to the decision-making process in this situation. Ralph was correct—he did need an ethicist in the room; someone to point out the ethical implications of stakeholders’ views! However, when we discussed possible responses, based on the matrix, we discovered a few things. Had he decided to speak out, the matrix may have put him in a strong position to demonstrate the different value perspectives at play in the discussion. Had he been given the opportunity, he could have used the matrix to clarify stakeholders’ respective value perspectives and to ask about the value perspectives of those missing from the decision-making process. We also considered the likelihood that anyone acting as an expert in the room who had not been invited to the table would be rejected outright due to the high-stakes, time-pressured nature of the conversation. That led us to explore other possible ways to get these perspectives into the conversation. Evaluators are usually expected to be people who ask questions, even when in an observation role (we just can’t help ourselves, right?). This expectation, along with the mapping using the matrix, might have provided Ralph a way to inquire about what he was observing. Curiosity and inquiry could have offered a way to introduce these perspectives into the conversation in a way that led to engagement with the ideas (Bowen, 1985; Friedman, 2007). Table 3 presents possible questions in italics.

Table 3. Possible questions to ask emergency response participants

	Consequences	Obligations	Rights/equity	Ethic of care
Public-health officials	We have to weigh up what will give us the best outcome. People are likely to provide misinformation because they do not want officials to know their whereabouts. The outcome is that more people may become infected/die.	We promise we will keep patient information confidential; preserving trust is the only way to ensure we get decent information. <i>What is our duty to vulnerable populations?</i>		<i>How can we ensure we are caring for the health of all the communities, particularly the most vulnerable?</i>
First responders	We also have to weigh up what will give us the best outcome: a potentially delayed response to an emergency so that they have time to access proper PPE will give us an outcome of fewer infected staff.	Our first priority is to our staff; we need to protect them.	First responder organisations have rights to other types of sensitive data in our RMS; we should have rights to these data as well.	First responders can gear up with PPE en route if they have the information about infections; they can treat each response differently/ appropriately to care for their own safety and the safety of others.
Vulnerable people	<i>It seems like we are missing the outcomes that are likely for the vulnerable communities in this scenario. What are the consequences of the choices we are discussing for them?</i>	<i>What are the duties this group operates under—duties to family or community? How could we harness that to help us in the response scenario?</i>	<i>This population doesn't have rights, legally, but what are their rights as humans? How will this decision uphold their rights?</i>	<i>These communities are often tight-knit and family-based. How might an ethic of care help us to help them in this scenario?</i>

In our conversation, we talked through what might be needed to prepare an evaluator to be able to use the matrix in a real-time, high-stakes setting like this one:

1. A clear understanding of the normative principles in the framework. These ideas are not a normal part of evaluation training, so it is likely the evaluator will require some learning and practice to have them correctly understood and at top of mind.
2. Retrospective practice—perhaps by using the matrix while listening to recordings of prior sessions. This would allow for identification of the key groups, categorisation of their value propositions, and generation of potential questions to surface missing perspectives. These could potentially be raised in one-on-one meetings with clients where the stakes were lower, and might then influence future meetings.
3. Live-fire exercises—with the meetings being recorded on Zoom, the evaluator would be free to use the matrix to take notes and capture perspectives and try generating questions during future meetings. Since the role was observation only, there would be no need to speak up until the evaluator felt comfortable enough with what he or she had mapped in the matrix to do so.

In addition to providing insights into value perspectives that might otherwise be missed, the matrix also can help evaluators guard against using their own values to decide what is important. Evaluators who work in isolation risk emphasising their own values in making evaluative judgements. Using the matrix can help evaluators be systematic in identifying ALL relevant values.

Judgements based on values are the territory of evaluators, and values permeate organisations and programmes (Gullickson & Hannum, 2019). Rather than limiting our sphere of influence to evaluation questions, data collection, and synthesising judgements, this reflection demonstrates that our tools can also assist in real-time

situations where values are enacted in decision making. If the outcome we say we seek as a profession is social justice, then we have a duty to use our skills in service of equity, rights, and justice, to ensure that the organisations we work with strive toward an ethic of care, and not just efficient, effective, or financial outcomes. Using the matrix in real time provides a pathway to increase our influence to that end.

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