



Solidarity, sustainability and medical ethics

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In this issue of the Journal of Medical Ethics arguments are cogently made that sustainability and solidarity should be considered as core medical ethical principles, and that more explicit attention should be given to the complex context in which a decision is made.

Munthe *et al* propose that sustainability should become an established principle for justifying healthcare resource allocation, and should be an explicit factor in procuring drugs and other resources.¹ They argue that the current operational norms which guide decision making (need, prognosis, equal treatment and cost-effectiveness) can lead to what they call '*negative dynamics*': the gradual depletion of resource available for healthcare.

They illustrate this first by examining some well recognised examples of 'positive dynamics' which are considered in health policy: immunisation programmes are funded because lead to reduction or absence of disease in the population, thus freeing up resource for other uses; public health measures are offset by future cost reductions or income increases for healthcare via reduction of sick leave.

'Negative dynamics' however, are not routinely considered in operational decisions and they persuasively argue that they should be. Resource depletion (not only fiscal resource, but environmental and human resource) has a negative effect on future cycles of healthcare. As an illustrative example, they discuss the emission of resistance-driving residue in the production of antibiotics. The accepted principles, particularly of cost effectiveness, drive producers to make antibiotics cheaply, without consideration of gradual contribution to antibiotic resistance. If a principle of sustainability was included when considering procurement, subsidy and prioritisation, this would provide an incentive to change production practices. This argument can be extended to many aspects of the healthcare; system including how we recruit, train and treat our staff; how we invest in infrastructure and how we plan for pandemics. Munthe *et al* go on to provide a robust definition of their sustainability principle, and to address possible objections. It is an excellent example of reasoned ethical argument which has the potential to change clinical practice.

With the roll out of vaccinations for COVID-19 across the globe, Julian Savulescu proposes an algorithm for when mandatory vaccination might be ethically justified.² Drawing and expanding upon the 2007 Nuffield Council of Bioethics report he suggests that four criteria are required: 1. There is a grave threat to public health 2. The vaccine is safe and effective 3. Mandatory vaccination has a superior cost/benefit profile compared with other alternatives 4. The level of coercion is proportionate. Discussing the value judgement associated with each criterion, he concludes that, at least initially (where uncertainty around safety is greater), mandatory vaccination for COVID-19 would be ethically problematic.

He goes on to explore alternative approaches, including non-financial (eg, immunisation passports) and financial incentives. He argues that individuals could essentially be paid for the risk they are undertaking (by being early adopters of a vaccine) for societal benefit, but to do this government would need to be 'transparent, explicit and comprehensive in disclosure of data', a standard which unfortunately has not always (or even often?) been kept. The danger that payment might signal a lack of confidence in safety is real. Clearly payment should only be offered for a vaccine which was considered safe enough to be used in any circumstances; payment for a vaccine which was not considered safe without payment would not be morally acceptable. Payment may also erode the sense of solidarity that people feel when contributing to societal well-being; to ensure that this was maintained he suggests the option of 'donating back' the fee to the NHS could be made available. People could be rewarded for taking the vaccine with an increasing sense of civic duty as they not only protect themselves and the vulnerable, but contribute to the (fiscal) sustainability of the health service which treats them.

While Savulescu acknowledges the worth of solidarity, Avery Kolers proposes that solidarity plays not just an *auxiliary* part in the interests of acknowledged bioethical values (justice,

beneficence etc) but has a *freestanding* role, which should be independently assessed.³ He acknowledges that solidarity per se is not valuable: there is solidarity, he notes, among a firing squad and within a terrorist cell. He develops Prainsack and Buyx metaphor of solidarity as the putty of justice⁴ and suggests five individually necessary and sufficient conditions of morally valuable solidarity: it must be (1) norm grounded (2) acknowledged (3) political (4) action and (5) on others' behalf. He suggests that solidarity (with X) is morally required 'when it constitutes equitable treatment of X such as to countermand or resist inequitable treatment of X'. He notes that moral dilemmas may arise where solidarity with X may lead to inequitable treatment of Y and emphasises that solidarity with the most vulnerable in society will help address inequities in healthcare and in healthcare institutions.

The complexities and competing moral demands of healthcare institutions, and primary care in particular, are explored by Spicer *et al*, who question the use of normative moral theories to determine the 'best' actions.⁵ They argue that *the context* in which ethical decisions are made is not sufficiently acknowledged; if complex contextual factors are not considered, then predictions about outcomes will be flawed, as will the resulting ethical analyses.

Examples of contextual factors which might influence decision-making include power relations within the staff and external regulators (including achieving externally determined quality markers and 'standard' practice) and the need to maintain both group and individual professional identities.

It is often helpful to peel back the layers of complexity in order to reveal a specific ethical question. Before coming to a conclusion, however, we must remember to reapply the layers and reconsider the question in the context of its complex environment. Integrating this proposal with others in the journal, this might include considerations of sustainability and solidarity.

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REFERENCES

- 1 Munthe C, Fumagalli D, Malmqvist E. Sustainability principle for the ethics of healthcare resource allocation. *J Med Ethics* 2021;47:90–7.
- 2 Savulescu J. Good reasons to vaccinate: mandatory or payment for risk? *J Med Ethics* 2021;47:78–85.

- 3 Kolers A. What does solidarity do for bioethics? *J Med Ethics* 2021;47:122–8.
- 4 Prainsack B, Buyx A. *Solidarity in Biomedicine and Beyond (Cambridge Bioethics and Law)*. Cambridge: Cambridge University Press, 2017.
- 5 Spicer J, Ahluwalia S, Shah R. Moral flux in primary care : the effect of complexity. *J Med Ethics* 2021;47:86–9.