Medical ethics, equity and social justice

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As John McMillan notes in January's editorial,[1] many countries are reflecting on how they responded to the COVID-19 pandemic, what went wrong and how responses to such system shocks can be better managed in the future. However, while it is tempting to think that the COVID-19 pandemic is over and that what is now needed is a reflection on how countries could have responded better, some of the underlying issues and problems COVID-19 both highlighted and created are still with us. The legacy of the pandemic has continued particularly for healthcare workers at all levels, who have had to continue providing services with little time to rest and reflect and with new 'shocks' to the systems to cope with. For example, in England, industrial action by junior doctors has put already fragile systems under pressure, and the issues that staff are campaigning about remain unaddressed. Many of these issues are not distinctive to COVID-19, but as has been noted, 'From an ethical perspective, the COVID-19 pandemic is like a prism: it helps us see the spectrum of issues clearly and distinctly.'[2] A key element of how we should approach future shocks to healthcare systems, disaster planning, and it is highly likely there will be future shocks, is to ensure the ethical preparedness[3] of both systems and those who work in them. A number of papers in this issue of the Journal of Medical Ethics consider how particular ethical issues that came to the fore during the pandemic could be approached. The insights from these papers can be used to inform policy and practice in healthcare systems across the globe, so, hopefully, these systems will be better prepared for the next time. One area that prompted considerable discussion during the pandemic was vaccinations, both in terms of global access to COVID-19 vaccinations and the moral obligations of both individuals and healthcare systems as to who should be vaccinated and how far that should be enforced. While these debates over vaccinations are not new,[4] COVID-19 gave an urgency to these questions.

Petrovic[5] discusses the merits of a 'vax tax'. Such a tax has been suggested as a means of addressing the disparity in access to vaccines between lower and middle-income countries (LMIC) and higher income countries that occurred during the COVID-19 pandemic. Petrovic argues that such a proposal, while having merit in trying to address the issue of countries hording vaccines once their population has reached a certain coverage rate, or LMIC not being able to afford the vaccines, such a tax is insufficient on its own. As Petrovic notes, 'When thinking about problems of fairness and justice regarding the distribution of healthcare goods, it is essential to acknowledge that the paradigm of market economics will never allow us to achieve equality.'[5]

Graso *et al*[6] conducted an empirical study on peoples' perceptions of risks of COVID-19 in the USA. They considered how much people blamed or scapegoated the unvaccinated for the undesirable consequences of the pandemic, and whether political ideology moderated the scapegoating effects. They found that 'liberals' were more likely to scapegoat the unvaccinated than 'conservatives' and that the public significantly overestimated the risks of COVID-19, which exacerbated the scapegoating of the unvaccinated. This paper illustrates how new classes of discrimination and prejudice can arise and that public health policies should be attentive to the possible effects of their messaging.

In Smith's paper,[7] issues raised by policies on the vaccination of healthcare professionals is considered, focussing on whether mandating those already employed to subsequently have a vaccination is ethically acceptable. In England, this policy was debated during the pandemic and the government passed an amendment to legislation in 2022 that made vaccination against COVID-19 a condition of employment for healthcare workers.[8] This caused significant controversy and the timeline for instituting the new requirements was extended, until in January 2022, the government did a U-turn and reversed these requirements. Medical bodies welcomed the reversal of the plan, which they had warned would exacerbate chronic workforce shortages in the health service by causing thousands of staff to lose their jobs.[9] Smith presents an argument that mandated vaccination requirements are just as acceptable for existing employees as prospective ones, whereas in a response, Paetkau,[10] criticises this view and argues that 'vaccination can be considered a requirement for prospective employees while not being required for existing employees'.[10]

The papers in this issue underscore the significance of ensuring fair access to healthcare resources. They consider the intricate dynamics of promoting equity in healthcare and, apparent in a number of the papers, is a shift away from solely examining individual practitioners and their actions to a broader consideration of how healthcare systems and their constituent institutions can actively contribute to the advancement of equity in healthcare provision and the promotion of social justice. How the complex structure of healthcare systems can be harnessed to foster equity, fairness and inclusivity in the healthcare and medical arena is an ongoing research area of critical importance and ethical debate needs to be at the heart of this endeavour.

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