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Health ethics in COVID-19: no better time for solidarity

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Dear Sir,

The coronavirus disease 2019 (COVID-19) pandemic has overwhelmed many health systems globally. The ethics of the times may be as challenging as the outbreak itself. Physicians who are familiar with Beauchamp and Childress' principles of bioethics – beneficence, non-maleficence, autonomy and justice – may find that these principles, rooted in individual liberalism, may not adequately address the stark tensions between public goods and private rights that a pandemic raises. For example, in isolating an infected patient, the dominant calculus is preventing harm to others, not individual autonomy or beneficence. When traditional principles clash, how should we act?

Solidarity is a prescient ethical lens through which to view the pandemic response. This is a term that is increasingly in the public consciousness, even lending its name to the Singapore government's supplementary budget.⁽¹⁾ Solidarity arises from a recognition of similarity in mutual vulnerability and interdependence,⁽²⁾ and manifests as shared practices that reflect a collective commitment to carry costs to assist others for a common good.⁽³⁾ Solidarity is distinct from: (a) empathy, which is an emotional connectedness with others; (b) reciprocity, which is a symmetrical arrangement to give in exchange for receiving something; or (c) charity, which is an asymmetric relationship in which the more privileged gives to the less privileged. Solidarity goes beyond altruistic goodwill to encompass the concept of 'being in the same boat'.

There are two practical dimensions to solidarity (Fig. 1). First, how mandatory or formalised is the obligation towards solidarity? This may range from (a) voluntary ad-hoc acts such as consumers supporting at-risk businesses; (b) social norms such as voluntary self-isolation when unwell; to (c) formal contracts or legal enforcement such as mandatory mask-wearing. All three categories of solidarity are important. Legal compulsion is necessary to implement critical aspects of pandemic control with a certainty that may not be achieved by

voluntary versions of solidarity. In other aspects, encouraging voluntary acts or changing social norms may be preferable to legal means because the law results in restriction of individual liberty. The stronger the voluntary commitment to solidarity, the less the need for legal enforcement.

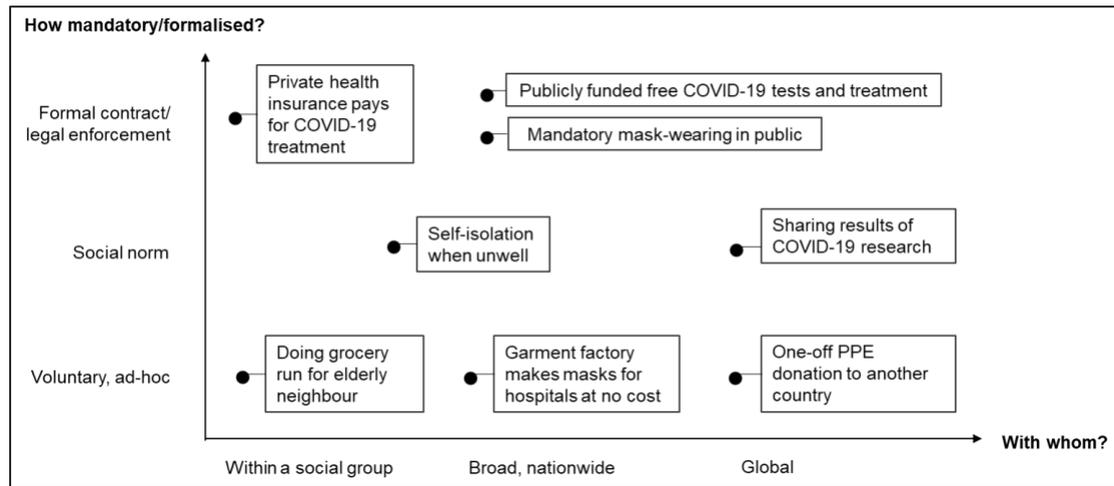


Fig. 1 Diagram shows the dimensions of solidarity. COVID-19: coronavirus disease 2019; PPE: personal protective equipment

The second dimension is: with whom do we stand in solidarity? This can range from (a) solidarity within members of a social group who identify strongly with one another; (b) broader nationwide solidarity; and (c) global solidarity. A narrower concept of solidarity excludes social groups whom one considers as outsiders, one example being attitudes towards migrant workers. But this narrow version is ultimately short-sighted because all of us bear the costs until COVID-19 is contained and economies are restarted. Pandemic containment is of mutual interest and should drive the broadest conceptualisation of solidarity. Beyond the nation-state, no country is safe until COVID-19 is contained worldwide. Nations should stand in solidarity with other nations who may not have the public health infrastructure to manage an outbreak, and contribute to collective action. This includes supporting international agencies

such as the World Health Organization, which the United States has regrettably defunded.⁽⁴⁾ Ensuring that all countries gain access to any available treatment or vaccine will be another testament of global solidarity.

There is no greater need or better time for solidarity – not just on the healthcare front, but from the whole of society.⁽⁵⁾ Solidarity can be cultivated by understanding our shared vulnerability. But we have to ensure that solidarity remains a clarion call for collective action, and not a divisive tool that excludes ‘the others’ in society.

Yours sincerely,

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