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2021

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### Recommended Citation

Kelly, Conor M., "From Quandary Cases to Ordinary Life: New Opportunities to Connect Social Ethics and Health Care Ethics" (2021). *Theology Faculty Research and Publications*. 831.

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# From Quandary Cases to Ordinary Life: New Opportunities to Connect Social Ethics and Health Care Ethics

*Conor M. Kelly*

**ABSTRACT:** In Christian bioethics, the call for a greater integration of social ethics and medical ethics is a popular refrain, yet lasting progress toward this goal has been elusive, in part due to the traditional emphasis on quandary cases in medical ethics. This article develops an alternative approach to moral discernment in health care, employing a theological interpretation of solidarity to promote greater social consciousness in ordinary health care decision making. This shifts the ethical analysis from abstract scenarios to everyday choices, elevating the moral significance of seemingly mundane concerns like antibiotic use and diet and exercise.

## INTRODUCTION

**I**N THE LAST TWENTY YEARS, there has been a growing emphasis on the interconnections between health care ethics and social ethics, especially in a Christian theological context.<sup>1</sup> What has emerged is a persistent anxiety that even though justice features prominently in the theoretical framing for bioethics, genuine social concerns do not receive the attention they deserve when practical health care decisions are made in real life situations. This anxiety reflects one of the standard critiques of the reliance on principlism in health care contexts, namely “that the ethical system propounded by Beauchamp and Childress lacks the necessary resources satisfactorily to handle the ethically complex situations

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<sup>1</sup>See, for example, Lisa Sowle Cahill, “Bioethics, Theology and Social Change,” *Journal of Religious Ethics* 31, no. 3 (Winter 2003): 363–398, at 376.

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created in the interface between medicine and social justice.”<sup>2</sup> Ethicists in general, and theological ethicists in particular, have sounded the alarm about this danger for quite some time, helping to steer the academic discussion of health care ethics toward a greater social consciousness in a host of applied areas.<sup>3</sup> Yet the perpetual appearance of this critique belies a deeper problem: ethicists must continue to emphasize the social dimensions of health care choices because they are aware of the fact that few health care decisions are made with social consequences in mind. Despite all the efforts at consciousness raising, there has yet to be a shift in conscience strong enough to change discernment habits. As a result, the link between health care ethics and social ethics is more an abstract theoretical vision than an applied reality.

This article serves as a response to this gap. Recognizing that the bridge between health care ethics and social ethics will only occur in a lasting fashion if theory connects to practice for everyone involved in the decision-making process, I propose a new emphasis on personal moral discernment and ordinary choices for health care ethics. To that end, this article unfolds in three parts.

First, it provides a constructive argument for greater social consciousness in health care decision-making, drawing on two reasons related to the nature of health care and one related to theological claims about the role of solidarity in the Christian moral life to assert that Christians have a particularly strong obligation to account for the social consequences of their health care choices.

The second part of the paper then outlines how Christians can better attend to this responsibility, using a new subspecies of solidarity that I have introduced elsewhere as “everyday solidarity” to identify practical ways for Christians to translate their theological commitments into their ordinary lives.

Finally, the third part of the paper describes how this emphasis on solidarity can transform moral discernment in health care contexts, reshaping the way agents consider what is at stake in mundane concerns like antibiotic use and diet and exercise. The end result is a viable vision for the habituation of a new, more socially aware form of discernment in personal agents, which can complement the ongoing reforms in medical ethics at the academic level to make the tenuous bridge between health care ethics and social ethics stronger and more likely to persist.

<sup>2</sup>Søren Holm, “Not Just Autonomy—The Principles of American Biomedical Ethics,” *Journal of Medical Ethics* 21, no. 6 (December 1995): 332–338, at 332.

<sup>3</sup>For an example related to physician assisted suicide, see Allen Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids, MI: William B. Eerdmans, 2003), 329–335.

## THE NEED FOR A GREATER SOCIAL CONSCIOUSNESS IN HEALTH CARE DECISION-MAKING

There are three reasons Christians should pay more attention to the social consequences of their health care decisions, two connected to the peculiar features of health care and one connected to the peculiar features of Christian theology. First, there is the fact that the health care system has finite resources. Although access to health care is not entirely a zero-sum game, there are nevertheless significant ways in which health care functions as a rivalrous good, particularly in certain contexts. Second, there is substantial evidence indicating that health and wellbeing are influenced by social factors, with the so-called social determinants of health contributing to global and local health disparities.

The finite nature of the healthcare system indicates that one's personal health care choices can in fact have a broader impact insofar as the strain one puts on the system can affect the resources available for the wellbeing of all. The role of social factors, meanwhile, reveals a larger mechanism by which one's personal choices can have ramifications on others' health and wellbeing through the contributions—both positive and negative—one makes to the existing social determinants of health in a given community. When considered in light of a Christian context that emphasizes, third, the importance of solidarity as a practical application of the call to imitate Christ, the faithful must recognize that health care cannot be adequately understood as a private good but must be seen, and morally evaluated, in a social light. In order to explain this implication, I will detail each of these factors in turn.

To begin with the question of finite resources, there is a push, particularly in certain circles of public discourse, to treat health care as a public good, which in economic terms would mean that it is nonexcludable and non-rivalrous.<sup>4</sup> This obviously would seem to call into question the notion that health care is built on finite resources because the non-rivalrous nature of public goods means that one person's use of them does not diminish another's ability to use them. If health care were indeed a public good, this would be a problem, but the truth is that only portions of the health care system operate as genuine public goods (in the economist's technical understanding of this term).

Public health initiatives, for instance, can function like public goods because, when successful, they improve health outcomes for an entire community in a nonexcludable, non-rivalrous way. Yet other aspects of health care are very clearly rivalrous, even if they are not entirely nonexcludable. The total number of hospital beds in a community is finite, for instance, and one person's use of a hospital bed certainly does limit others' ability to use hospital beds as the triage system in emergency rooms after natural disasters illustrates. Physicians only have

<sup>4</sup>"Health Care is a Public Good," *Common Ground Solutions*, last modified February 2, 2018. <https://commongroundsolutions.org/topic/health-care-is-a-public-good/>.

so much time in a clinic to see patients, so even if there are pressures to squeeze in more visits, there is eventually a limit to the number of patients who can be seen in a day. As one analysis of the U.S. health care system explains, “limits on health care resources—the number of caregivers, the amount of flu vaccine, the availability of diagnostic technology—are inevitable.”<sup>5</sup> This idea is certainly not foreign to the field of health care ethics, where the question of access to “scarce medical resources” is a frequent dimension of moral analysis and indeed functioned as an impetus for the field of bioethics in the first place.<sup>6</sup> Consequently, the notion that health care is a finite good should not be a controversial claim.

What may be more debatable, however, are the implications of this fact. Some would say that the potentially rivalrous nature of (some of) health care’s goods is merely an invitation for ingenuity or greater efficiency, so that we can end up with a bigger pie that puts more pieces on plates and leaves fewer crumbs in the serving dish. From this perspective, the finite nature of health care resources is not a problem that yields any meaningful personal responsibilities because its effects can always be mitigated with growth and creativity. Such an interpretation, however, is overly sanguine. There will always be some finite dimension to health care’s resources, no matter how creative we get, and this reality does have social implications, which give personal health care decisions added moral weight.

The clearest illustration of these social implications is the way that the current use of finite resources creates warped incentives that ultimately lead to more and better care for some and less and worse care for others. For example, because richer countries in the Organization for Economic Cooperation and Development consume a disproportionate amount of health care dollars compared to their population, health care professionals from countries in the global south have fled their home nations, drawn by the higher salaries, better working conditions, and systematic recruitment policies facilitated by the concentration of health care spending in the global north.<sup>7</sup> According to the World Health Organization (WHO), this migration process is one of the “key factors” creating

<sup>5</sup>David M. Craig, *Health Care as a Social Good: Religious Values and American Democracy* (Washington, DC: Georgetown University Press, 2014), 163.

<sup>6</sup>H. Tristram Engelhardt and Mark J. Cherry, eds., *Allocating Scarce Medical Resources: Roman Catholic Perspectives* (Washington, DC: Georgetown University Press, 2002); Robert Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (Oxford: Oxford University Press, 2013), 2.

<sup>7</sup>World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO Press, 2010), 4. Available online at [www.who.int/whr/2010/en](http://www.who.int/whr/2010/en); C. R. Hooper, “Adding Insult to Injury: The Healthcare Brain Drain,” *Journal of Medical Ethics* 34, no. 9 (2008): 684–687. Daniel Daly illustrates how personal health care decisions can contribute to these warped incentives in Daniel J. Daly, “Unreasonable Means: Proposing a New Category for Catholic End-of-Life Ethics,” *Christian Bioethics* 19, no. 1 (April 2013): 40–59.

a global health care system in which health care workers “are scarcest where they are most needed, especially in the poorest countries.”<sup>8</sup>

Hence, in a very real way, the use of resources by some leads to a lack of resources for others, albeit in a large-scale, structural fashion. The effects of warped incentives are not limited to a global context alone, however. In the United States, the main response to the challenge of finite resources has been to rely on market competition to resolve scarcity, but this encourages health care providers “to grow annual revenues by investing in the most profitable service lines and attracting the better-paying patients,” which contributes to a different domestic “brain drain” of qualified physicians from primary care positions to specialty practices.<sup>9</sup> Once again, the finite nature of health care resources carries palpable social consequences, meaning that a heightened social-consciousness in health care decision-making would be appropriate.

The second feature justifying a greater attention to the social consequences of personal health care choices—the impact of the social determinants of health—posits a direct link between social factors and health outcomes. At the most basic level, the WHO defines social determinants of health as “the conditions in which people are born, grow, live, work, and age,” using the concept to highlight the larger societal factors like “the distribution of money, power and resources at global, national and local levels” that facilitate or frustrate individuals’ efforts to secure good health outcomes.<sup>10</sup> Today, research into the social determinants of health has found that more income correlates with longer life expectancy, that economic inequality undermines health and well-being, that educational attainment has a lasting effect on health status, and that something as simple as moving from one zip code to the next can change a person’s health for life (to give just a few examples).<sup>11</sup> Collectively, all of these data indicate that social inequities are

<sup>8</sup>Amani Siyam and Mario Roberto Dal Poz, eds., *The Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis* (Geneva: WHO Press), 1. Available online at [https://www.who.int/hrh/migration/14075\\_MigrationofHealth\\_Workers.pdf?ua=1](https://www.who.int/hrh/migration/14075_MigrationofHealth_Workers.pdf?ua=1).

<sup>9</sup>Craig, *Health Care as a Social Good*, 165; Victoria Knight, “American Medical Students Less Likely to Choose to Become Primary Care Doctors,” *Kaiser Health News*, last modified July 3, 2019. <https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/>.

<sup>10</sup>World Health Organization, “About Social Determinants of Health,” accessed December 18, 2019. [https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/).

<sup>11</sup>Raj Chetty et al., “The Association between Income and Life Expectancy in the United States, 2001–2014,” *Journal of the American Medical Association* 315, no. 16 (2016): 1750–1776; Richard Wilkinson and Kate Pickett, *The Spirit Level: Why Greater Equality Makes Societies Stronger* (New York: Bloomsbury, 2010), esp. 73–102; Scott J. Adams, “Educational Attainment and Health: Evidence from a Sample of Older Adults,” *Education Economics* 10, no. 1 (April 2002): 97–109; Garth Graham, MaryLynn Ostrowski, Alyse Sabina, “Defeating the ZIP Code Health Paradigm: Data, Technology, and Collaboration are Key,” *Health Affairs Blog* (August 6, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150806.049730/full/>.

a major factor in health care outcomes—in fact, one study suggests that social circumstances and environmental factors have twice as much of an impact on premature death as “shortfalls in medical care”—revealing that health care decisions cannot be made with a narrow focus on the individual actor in mind.<sup>12</sup>

Obviously, undoing the negative effects of certain social determinants of health will require structural level changes, but this does not mean that personal health care choices have no role to play. On the contrary, scholars have identified “social capital and social cohesion” as key factors influencing the impact of social determinants of health, and existing research demonstrates that health outcomes are highly conditioned by the health status of a person’s existing social networks.<sup>13</sup> As a result, people have the potential to blunt the harmful effects of certain social determinants of health—at least in their immediate context—by working to improve their own health, for healthy lifestyles can be just as contagious as unhealthy choices.<sup>14</sup> If this undertaking is coupled with intentional efforts to broaden the reach of one’s social network, the benefits can be extended even farther, contributing to the creation of the very thing that public health advocates have identified as the greatest social determinant of health: healthy communities. Given the ways in which personal health care choices can thus have a social impact through their interplay with the larger social determinants of health, people should be encouraged to make these choices with a greater social awareness in mind.

Taken together, the finite nature of health care resources and the function of the social determinants of health justify the assertion that personal health care decisions can and do have social consequences. Ostensibly, this connection should prompt everyone to incorporate an assessment of social consequences into their evaluation of personal health care choices, but in a Christian theological context, the moral implications of this link are particularly powerful. Specifically, Christians have a distinct obligation to take action to address the negative effects of a system with finite resources and the harmful power of the social determinants of health as a result of Christianity’s promotion of solidarity as a theological value.

The prominence of solidarity is arguably most clear in the Catholic theological tradition, where solidarity functions as one of the “*permanent principles of*

<sup>12</sup>J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, “The Case for More Active Policy Attention to Health Promotion,” *Health Affairs* 21, no. 2 (March/April 2002): 78–93, at 83.

<sup>13</sup>National Academies of Sciences, Engineering, and Medicine, *A Framework for Educating Health Professionals to Address the Social Determinants of Health* (Washington, DC: National Academies Press, 2016), 57; Lynn M. Martire and Melissa M. Franks, “The Role of Social Networks in Adult Health: Introduction to the Special Issue,” *Health Psychology* 33, no. 6 (2014): 501–504, at 502.

<sup>14</sup>Nicholas A. Christakis and James H. Fowler, “The Spread of Obesity in a Large Social Network over 32 Years,” *New England Journal of Medicine* 357, no. 4 (July 26, 2007): 370–379, at 377–378.

*the Church's social doctrine.*"<sup>15</sup> In that context, solidarity is understood as both a fact, revealing the interconnectedness of all humans on the basis of their shared humanity, and a "normative obligation," declaring that these interconnections create moral responsibilities.<sup>16</sup> Such a claim is hardly unique to the Catholic account of solidarity, though, as Christian theologians writing from other denominational perspectives similarly connect solidarity with action. Rebecca Todd Peters, for instance, has insisted that "one of the key distinguishing factors of solidarity is that it is a state of being that demands that people who are in a relationship of solidarity be willing to act on behalf of one another as a result of the bond that they share."<sup>17</sup> With respect to the social consequences of personal health care choices, this understanding of solidarity indicates that the inevitable relationships created by the finite nature of health care resources and the force of the social determinants of health demand a moral response.

Such an interpretation is particularly true when one appreciates the Christological basis that makes solidarity "not merely . . . an ethical principle or virtue but . . . a way of being Christian, a way of relationship with Jesus."<sup>18</sup> After all, the Incarnation is itself a radical act of solidarity, in which God "bound himself to the fate of every human being," and the cross only amplifies the depth of this accompaniment, demonstrating that God's solidarity with humanity "reach[es] down to the deepest levels in human beings, to where the expectation of salvation is most necessary and, at the same time, seems most difficult to achieve—in suffering."<sup>19</sup> For Christians, then, the truest model of solidarity is Christ, and his example of solidarity stressed most emphatically a personal "identification with the marginalized and excluded."<sup>20</sup>

Liberation theology, which has contributed the most to the blossoming of solidarity in Christian theology, understood this essential aspect intimately, arguing that solidarity's primary orientation must always be toward the poor.<sup>21</sup>

<sup>15</sup>Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Vatican City: Libreria Editrice Vaticana, 2004), 160 (italics in original).

<sup>16</sup>Gerald J. Beyer, "The Meaning of Solidarity in Catholic Social Teaching," *Political Theology* 15, no. 1 (2014): 7–25, at 13.

<sup>17</sup>Rebecca Todd Peters, *Solidarity Ethics: Transformation in a Globalized World* (Minneapolis, MN: Fortress Press, 2014), 65.

<sup>18</sup>Meghan J. Clark, "Pope Francis and the Christological Dimensions of Solidarity in Catholic Social Teaching," *Theological Studies* 80, no. 1 (March 2019): 102–122, at 110.

<sup>19</sup>Bernard Häring and Valentino Salvoldi, *Tolerance: Toward an Ethic of Solidarity and Peace*, trans. Edmund C. Lane (New York: Alba House, 1995), 63; Jon Sobrino, *Christ the Liberator: A View from the Victims*, trans. Paul Burns (Maryknoll, NY: Orbis Books, 2001), 266.

<sup>20</sup>Clark, "Christological Dimensions of Solidarity," 111.

<sup>21</sup>Jon Sobrino, "Bearing with One Another in Faith," in Jon Sobrino and Juan Hernández Pico, *Theology of Christian Solidarity*, trans. Phillip Berryman (Maryknoll, NY: Orbis Books, 1985), 37.



Identifying Christ as the paradigmatic model for solidarity thus results in an added responsibility for Christians to incorporate the social impacts of their personal health care choices into their ethical discernment because the brunt of the burden of an unequal utilization of finite health care resources and of the social determinants of health is borne by those in conditions of poverty. Of course, this still leaves the question of how one might best attend to these responsibilities in the concrete complexities of ordinary life. Fortunately, solidarity can function as more than just a diagnostic tool highlighting the issues that ought to be of concern; it can also provide the resources to achieve the ends it identifies, as long as one is willing to adapt it for everyday use.

### EVERYDAY SOLIDARITY FOR GREATER SOCIAL-CONSCIOUSNESS IN HEALTH CARE DECISION-MAKING

As I explain in more detail elsewhere, solidarity has the ability to promote greater social consciousness in moral discernment, but only if some of the ambiguities surrounding its moral function are addressed.<sup>22</sup> The best way to do this is to envision a new species within the larger genus of solidarity that functions to sharpen solidarity's normative power and to demonstrate how it applies to personal agents' ordinary choices. My solution to these challenges is a species called "everyday solidarity" that preserves solidarity's generic emphasis on the moral obligations a person has to those with whom he or she is connected (even tangentially) while also more precisely identifying how one can determine the actual implications of those obligations in practice. Significantly, this new species has the potential to facilitate the kind of social consciousness in health care decision-making that ought to be a hallmark of the Christian response to the finite resources of the health care system and the influence of social determinants of health. Therefore, I outline the basic contours of everyday solidarity here so that the third part of this article can address the analysis of health care choices in light of everyday solidarity.

Essentially, everyday solidarity is a single concept with a twofold function, one that can be described as the principle of everyday solidarity and one that can be described as the virtue of everyday solidarity. This combined approach narrows the ambiguous vision of solidarity as a principle, an attitude, a duty, and a virtue into two complementary functions that preserve what William Frankena has described as the potency of virtues and the insight of principles so that they can work together in a coherent moral system.<sup>23</sup> Significantly, this new species offers

<sup>22</sup>Ideas in this section are developed more fully in Conor M. Kelly, "Everyday Solidarity: A Framework for Integrating Theological Ethics and Ordinary Life," *Theological Studies* 81, no. 2 (June 2020): 414–437.

<sup>23</sup>William K. Frankena, *Ethics*, 2nd ed. (Englewood Cliffs, NJ: Prentice-Hall, 1973), 65. On the competing visions of solidarity's normative function, see Kevin P. Doran, *Solidarity: A Synthesis of Personalism and Communalism in the Thought of Karol Wojtyła/Pope John Paul II* (New York: Peter Lang, 1996), 191–193; see also Marie Vianney Bilgrien,

additional details to establish how each of these functions should guide moral discernment, creating a helpful framework for personal health care decisions.

First, building on the description of principles as “general frameworks of moral consideration by which particular decisions about action are to be governed,” everyday solidarity functions as a principle by shaping moral discernment so that agents are more attentive to the relationships in which they exist and to the effects of their actions on the people behind those relationships.<sup>24</sup> Thus, the principle of everyday solidarity primes moral agents to approach specific moral decisions with a broader frame of reference in mind, drawing on the relational emphases of Christianity’s theological anthropology to insist that every choice, no matter how seemingly private, inevitably has some reverberations throughout the broader social fabric. By emphasizing this fact and stressing its moral salience, the principle of everyday solidarity militates against the tendency to evaluate moral choices on the basis of their immediate costs and benefits to the agent and instead replaces this default assumption with a more theologically justifiable accentuation on an action’s effects on the common good. Consequently, everyday solidarity promotes the agent’s *relational* flourishing, directly counteracting the “indifference, ignorance, egoism, and selfishness” that womanist theologian M. Shawn Copeland has described as the quintessential “obstacles to solidarity” by empowering agents to make different decisions that better honor their mutual interdependence with others.<sup>25</sup>

Everyday solidarity’s work as a virtue then provides an essential complement to its role as a principle, introducing an additional avenue for strengthening the impact of this expanded social consciousness. More specifically, the virtue of everyday solidarity captures the common assertion of theologians that solidarity’s orientation to action must include concerted efforts to reform structures of oppression and not just personal actions in isolation.<sup>26</sup> Although it may seem odd to stress this function as a work of virtue, because scholars typically evaluate virtue in relation to individual moral agents rather than collective contexts, there is a compelling case to be made for interpreting solidarity as a “social virtue.”<sup>27</sup> Indeed, in Catholic social teaching, solidarity’s role as a virtue is explicitly linked

*Solidarity: A Principle, an Attitude, a Duty? Or the Virtue for an Interdependent World?* (New York: Peter Lang, 1999).

<sup>24</sup>Richard B. Hays, *The Moral Vision of the New Testament: Community, Cross, New Creation; A Contemporary Introduction to New Testament Ethics* (New York: HarperCollins, 1996), 209.

<sup>25</sup>M. Shawn Copeland, “Toward a Critical Christian Feminist Theology of Solidarity,” in *Women and Theology*, ed. Mary Ann Hinsdale and Phyllis H. Kaminski (Maryknoll, NY: Orbis Books, 1995), 3–38, at 24.

<sup>26</sup>Peters, *Solidarity Ethics*, 66–67; Ada María Isasi-Díaz, *Mujerista Theology: A Theology for the Twenty-First Century* (Maryknoll, NY: Orbis, 1996), 89–90.

<sup>27</sup>Meghan J. Clark, “Anatomy of a Social Virtue: Solidarity and Corresponding Vices,” *Political Theology* 15 (2014): 26–39.

to the question of structural transformation, such that the *Compendium of the Social Doctrine of the Church* describes solidarity “as a moral virtue that determines the order of institutions,” and John Paul II deployed the virtue of solidarity as the essential corrective to structures of sin.<sup>28</sup> Adopting this orientation, everyday solidarity functions with parts of both an intellectual virtue and a moral virtue.

On one hand, it prompts an awareness of the larger social structures unjustly restricting the relational flourishing of others, serving as a quasi-intellectual virtue. On the other hand, it empowers a practical response to this awareness by stimulating action to transform these problematic structures so that they better serve the common good, revealing elements of a moral virtue. With both these effects, the virtue of everyday solidarity gives concrete significance to John Paul II’s influential description of the virtue of solidarity as “a firm and persevering determination to commit oneself to the common good,” showing how personal agents can embody this commitment to “the good of all and of each individual” in a meaningful way.<sup>29</sup>

As a tool for moral discernment, everyday solidarity orients agents to the common good, but it does so in a theological context. This caveat is quite important, for some equate the common good with the collective good and therefore pursue a utilitarian maximization of aggregate benefits. By insisting that the common good “does not consist in the simple sum of the particular goods of each subject of a social entity,” the Catholic account of the common good orients social cooperation to the flourishing of each person as an inherently relational human being.<sup>30</sup> The point of pursuing the common good in a theological context is therefore not to maximize total average utility but instead to promote the genuine wellbeing of all. As a principle and a virtue oriented to the common good, then, everyday solidarity incorporates a social consciousness in moral decision-making that facilitates the relational flourishing of the human person who, in theological terms, “cannot fully find himself [or herself] except through a sincere gift of [self].”<sup>31</sup> The end goal of everyday solidarity is to create more socially aware and, for that reason, more socially fulfilled moral agents through its twofold function as a principle and a virtue.

Given its twofold functions, this new species of everyday solidarity has the potential to reshape moral discernment, creating a closer link between the theological commitments of the Christian faith and the ordinary lives of the faithful. As a basic distillation of the call to follow Christ, and as a reasonable interpretation of the command to love one’s neighbor as oneself, everyday solidarity creates a

<sup>28</sup>Pontifical Council for Justice and Peace, *Compendium*, 193 (italics in original); John Paul II, *Sollicitudo Rei Socialis* (December 30, 1987), 36–40.

<sup>29</sup>John Paul II, *Sollicitudo Rei Socialis*, 38.

<sup>30</sup>Pontifical Council for Justice and Peace, *Compendium*, 164 (italics in original).

<sup>31</sup>*Gaudium et Spes* (December 7, 1965), 24. [http://www.vatican.va/archive/hist\\_councils/ii\\_vatican\\_council/documents/vat-ii\\_const\\_19651207\\_gaudium-et-spes\\_en.html](http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html).

bridge that enables faith to shape moral choices more frequently and more consistently. The most significant effect of this reinvigorated connection is the challenge that everyday solidarity offers to the U.S. culture's individualistic assumptions, rejecting the "everyone for himself or herself" mentality that obscures the larger consequences of moral choices. Since it is precisely this mentality that is so forceful in the sphere of health care—typically championed as part of autonomy's role as the regnant principle of health care ethics—this new species of everyday solidarity serves as an especially helpful tool for raising social consciousness in health care decision-making. Indeed, everyday solidarity's operations as a principle and as a virtue together lay out a practical path for attending to the social consequences of one's personal health care decisions in light of the finite nature of health care resources and the influence of the social determinants of health.

### SOLIDARITY, SOCIAL CONSCIOUSNESS, AND THE TRANSFORMATION OF HEALTH CARE DECISION-MAKING

As I indicated at the outset, I think that the most profound payoff from this shift toward solidarity in health care decision-making is a greater emphasis on a person's ordinary choices and less attention on the quandary cases. I want to clarify, however, that this is not to suggest that everyday solidarity has nothing to say to the more traditional questions of bioethics. On the contrary, as I have argued before, a greater social consciousness in general and a greater incorporation of solidarity in particular can significantly reshape the analysis of something as particular and as case-specific as the distinction between ordinary and extraordinary means in end-of-life care.<sup>32</sup> Nevertheless, an important point—indeed, *the* important point—that an application of solidarity brings to health care ethics is its judgment that people have a responsibility to assess the moral implications of their choices long before they have to make a judgment about ordinary and extraordinary means at the end of life. As an imitation of Christ, whose own ministry demonstrated a profound preferential option for the poor, solidarity demands a similar degree of attention to ordinary choices, and the specific form of everyday solidarity facilitates this kind of analysis, something I would like to illustrate by considering two practical examples: antibiotic use and diet and exercise. In each case, I will explain the significance of the issue from the perspective of a social consciousness informed by the Christian understanding of solidarity and then discuss how everyday solidarity's functions as a principle and as a virtue can sharpen the moral evaluation of personal choices in these areas.

First, antibiotic use creates consequential social concerns because of the way that an overreliance on these medications can contribute to antibiotic resistance. This presents serious challenges for a health care system with finite

<sup>32</sup>See Conor M. Kelly, "Grace at the End of Life: Rethinking Ordinary and Extraordinary Means in a Global Context," *Journal of Moral Theology* 8, no. 1 (January 2019): 89–113.

resources because antibiotic-resistant infections are much more costly to treat than their normal counterparts. In fact, one study determined that antibiotic resistance increased treatment costs in the United States by about \$1,400 per case, translating into an annual toll of more than \$2 billion in this country alone.<sup>33</sup> More concerning, antibiotic resistance leads to powerful microbes, which not only make people sicker but also significantly raise mortality rates. Hence, the Centers for Disease Control and Prevention has declared antibiotic resistance “one of the biggest public health challenges of our time.”<sup>34</sup> While some form of resistance is inevitable, as a result of natural genetic mutations, there has been a marked increase in the rates of antibiotic resistance since 2000.<sup>35</sup> Experts have concluded that “misuse and over-use of antibiotics” is behind the acceleration of antibiotic resistance, which puts personal decisions about antibiotic use at the heart of this problem.<sup>36</sup>

Significantly, these personal health decisions have meaningful social implications because antibiotic resistance creates health consequences that reinforce the effects of the social determinants of health and that are compounded by them. For example, scholars have found “an association between a range of dimensions of poverty and antimicrobial-resistant infections across all countries” as well as higher rates of antibiotic resistant infections in countries with lower per capita income, despite the fact that lower and middle income countries have less access to antibiotics.<sup>37</sup> Additionally, one study found that economic constraints can contribute to the likelihood that a person will not finish a complete course of antibiotics, which is a risk factor contributing to antibiotic resistance.<sup>38</sup> How

<sup>33</sup>Kenneth E. Thorpe, Peter Joski, and Kenton J. Johnston, “Antibiotic-Resistant Infection Treatment Costs Have Doubled Since 2002, Now Exceeding \$2 Billion Annually,” *Health Affairs* 37, no. 4 (April 2018): 662–669.

<sup>34</sup>Centers for Disease Control and Prevention, “Antibiotic/Antimicrobial Resistance,” last modified November 5, 2019 (accessed December 20, 2019). <https://www.cdc.gov/drugresistance/index.html>.

<sup>35</sup>Thorpe, Joski, and Johnston, “Antibiotic-Resistant Infection Treatment Costs,” 664, 665.

<sup>36</sup>White House, *National Action Plan for Combating Antibiotic-Resistant Bacteria* (March 2015), 5, available online at [https://www.cdc.gov/drugresistance/pdf/national\\_action\\_plan\\_for\\_combating\\_antibiotic-resistant\\_bacteria.pdf](https://www.cdc.gov/drugresistance/pdf/national_action_plan_for_combating_antibiotic-resistant_bacteria.pdf).

<sup>37</sup>V. Alividza et al., “Investigating the Impact of Poverty on Colonization and Infection with Drug-Resistant Organisms in Humans: A Systematic Review,” *Infectious Diseases of Poverty* 7 (2018): 76:1–76:11, quote at 76:8; Alessia Savoldi et al., “Gross National Income and Antibiotic Resistance in Invasive Isolates: Analysis of the Tope-Ranked Antibiotic-resistant Bacteria on the 2017 WHO Priority List,” *Journal of Antimicrobial Chemotherapy* 74 (2019): 3619–3625; Michael Millar, “Inequality and Antibiotic Resistance: A Contractualist Perspective,” *Bioethics* 33, no. 7 (2019): 749–755, at 750.

<sup>38</sup>Altaf Ali Mangi et al., “Evaluation of Irrational Use of Antibiotic and Correlation of Economical Constraints to Antibiotic Resistance,” *ISRA Medical Journal* 9, no. 2 (March/April 2017): 106–110.

one uses antibiotics is therefore a personal choice with real social consequences, particularly for those whose situations of poverty or poor health already make them vulnerable.

As both a principle and a virtue, everyday solidarity can help to clarify one's personal responsibilities in relation to antibiotic use. While there is a natural tendency to assume that one's own behavior does not represent a misuse of antibiotics, that is likely the case only if one refuses to use antibiotics altogether, because recent estimates have concluded that nearly a third of all oral antibiotic prescriptions in ambulatory care settings are unnecessary, and as many as half of all prescriptions for antibiotics to treat respiratory symptoms are given inappropriately, "representing 34 million antibiotic prescriptions annually."<sup>39</sup> Obviously, health care providers play a role in this, but one of the factors contributing to overuse of antibiotics is pushy patients (or in the case of pediatric patients, pushy parents), who come in expecting a cure and presume antibiotics will provide it.<sup>40</sup> While there is not much comfort when a visit to the doctor yields the simple "watch and wait" advice, an appreciation of the importance of solidarity can help to take the sting out of this appropriate cautionary strategy. In fact, given that simple awareness of the dangers of antibiotic resistance has been shown to correlate with an increased willingness to watch and wait, an awareness of this danger alongside the relational concerns of the principle of everyday solidarity should strengthen this resolve.<sup>41</sup> Genuine solidarity will require patients and providers working in tandem on this issue to have the most dramatic impact, but encouraging social consciousness on the patient side can help to encourage greater cooperation toward this end.

At the same time, there are also larger forces at work in the problem of antibiotic resistance, so the virtue of everyday solidarity's concern for structural influences helps moral agents to appreciate this issue more holistically. One practical effect of the virtue of everyday solidarity's structural hermeneutic is a renewed emphasis on the impact of antibiotic abuse in non-medical contexts. "Even if we were to control the majority of avoidable or inappropriate antibiotic use in humans," one scholar explained, "up to 70 percent of all antibiotics are used for agricultural purposes . . . [where] their use is generally aimed at increasing

<sup>39</sup>Katherine E. Fleming-Dutra et al., "Prevalence of Inappropriate Antibiotic Prescriptions among US Ambulatory Care Visits, 2010–2011," *JAMA* 315, no. 17 (2016): 1864–1873, at 1869.

<sup>40</sup>David H. Freedman, "The Worst Patients in the World," *The Atlantic* (July 2019). <https://www.theatlantic.com/magazine/archive/2019/07/american-health-care-spending/590623/>.

<sup>41</sup>See Arnon Broides, Olga Bereza, Noga Lavi-Givon, Yariv Fruchtman, Eli Gazala, and Eugene Leibovitz, "Parental Acceptability of the Watchful Waiting Approach in Pediatric Acute Otitis Media," *World Journal of Clinical Pediatrics* 5, no. 2 (May 2016): 198–205.

growth potential for livestock and reducing time to market.”<sup>42</sup> This tendency is directly related to the structural reliance on large-scale factory farms in U.S. food production, which in turn stems from the meat-heavy diet that is most prevalent in the United States. Given these links, the virtue of everyday solidarity reveals that people can chip away at the problem of antibiotic resistance by embracing the same strategies that theological ethicists have been advocating as an appropriate response to the climate crisis: eating less meat and selecting organic meats when possible.<sup>43</sup> Although this may not seem like a health care decision at first, the expanded social consciousness facilitated by a turn toward solidarity helps to illuminate the ways in which this ordinary choice has significant health care consequences.

Second, apart from antibiotic resistance, diets have other health care impacts, so solidarity’s broader social consciousness also turns attention to the moral impact of one’s diet and exercise habits. The simple line between diet and exercise and social implications is through health care’s finite resources. Less healthy diets lead to less healthy people, who utilize more of the health care system’s finite resources than they would otherwise use if they made healthier food choices. The so-called western diet, with its emphasis on meats and processed foods, is particularly dangerous in this regard.<sup>44</sup> Exercise, meanwhile, aligns with health outcomes in a similar fashion, with studies finding predictive correlates between walking speed and life expectancy as well as links between grip strength and a number of deadly conditions.<sup>45</sup> Plus, running has been shown to correlate with a dramatic improvement in life expectancy.<sup>46</sup> What all of these connections illustrate is that some of the most consequential health care decisions are the ones that we seldom regard as morally significant—or even as health care related. If people were concerned to minimize their negative impact on others in the health care system, as the principle of everyday solidarity certainly suggests they should be, then the best decision one could make would likely be to go for a walk or a

<sup>42</sup>John R. Butterly, “Antibiotic Resistance and Infection Control,” in *Diseases of Poverty: Epidemiology, Infectious Diseases, and Modern Plagues*, ed. Lisa V. Adams and John R. Butterly (Hanover, NH: Dartmouth College Press, 2015), 169–182, at 178.

<sup>43</sup>Julie Hanlon Rubio, “Toward a Just Way of Eating,” in *Green Discipleship: Catholic Theological Ethics and the Environment*, ed. Tobias Winwright (Winona, MN: Anselm Academic, 2011), 360–378, at 372–373.

<sup>44</sup>Jacqueline Gamble, “Why Nutrition Matters in Healthcare,” *The Ochsner Journal* 8, no. 2 (Summer 2008): 61–64.

<sup>45</sup>Stephanie Studenski et al., “Gait Speed and Survival in Older Adults,” *Journal of the American Medical Association* 305, no. 1 (2011): 50–58; Carlos A. Celis-Morales et al., “Associations of Grip Strength with Cardiovascular, Respiratory, and Cancer Outcomes and All Cause Mortality: Prospective Cohort Study of Half a Million UK Biobank Participants,” *British Medical Journal* 361 (2018). <http://dx.doi.org/10.1136/bmj.k1651>.

<sup>46</sup>Robert M. Kaplan, *More Than Medicine: The Broken Promise of American Health* (Cambridge, MA: Harvard University Press, 2019), 127.

run. Choosing not to eat well and to lead a sedentary lifestyle is thus not only a choice that can be subject to moral criticism, but one that should be subject to exactly that form of criticism for the impact it has on finite health care resources.

Of course, the “choice” to lead an unhealthy lifestyle is not always made freely, and often results from larger structural constraints. Proper moral scrutiny of diet and exercise decisions must account for this fact, which is precisely why the virtue of everyday solidarity must complement the principle. As the virtue prompting a response to structural sins, the virtue of everyday solidarity applies in this context by asking moral agents to consider their complicity in larger social structures that contribute to the prevalence of these poor choices surrounding diet and exercise, reintroducing the social determinants of health. On the diet side, the structural perspective points to the role of food deserts in limiting people’s abilities to purchase healthy foods. Since food deserts in the United States correlate with race and income, the societal effects of these structures is not hard to recognize.<sup>47</sup> Moral agents motivated by the virtue of everyday solidarity can challenge these structures of sin by supporting cooperative food arrangements like farmers markets, community supported agriculture delivery systems, and pop-up stores that interrupt the normal food economy and create new opportunities for healthy food choices in underserved areas.<sup>48</sup> Certainly, they can also pressure established grocery store chains—particularly those that specialize in bringing reasonable prices to consumers—to open new locations in areas that they have typically shunned, but the current supply chains are not designed to bring fresh food to many of the current food deserts, so disruptive actions will also need to be an important part of the structural reform strategy, at least initially.<sup>49</sup>

With respect to exercise, the virtue of everyday solidarity’s attention to structural pressures would make much of the fact that leisure time has become increasingly oriented to isolating activities like watching television and using digital technologies.<sup>50</sup> This shift toward private leisure pursuits has slowly and steadily eroded social capital, as Robert Putnam famously document in *Bowling*

<sup>47</sup>United States Department of Agriculture, *Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences*, Report to Congress (Washington, DC: Economic Research Service, 2009), 47.

<sup>48</sup>For one example of how cooperative arrangements can challenge food insecurity, and how they can promote theological values, see Margaret R. Pfeil, “Becoming *Synergoi*: Food, Justice, and Economic Cooperation,” in *The Almighty and the Dollar: Reflections on Economic Justice for All*, ed. Mark J. Allman (Winona, WI: Anselm Academic, 2012), 228–241.

<sup>49</sup>Andrew Deener, “The Origins of the Food Desert: Urban Inequality as Infrastructural Exclusion,” *Social Forces* 95, no. 3 (March 2017): 1285–1309 at 1299–1302.

<sup>50</sup>For data on how people use their free time, see Bureau of Labor Statistics, “Average Hours Per Day Spent in Selected Leisure and Sports Activities by Age,” *American Time Use Survey*, June 19, 2019. <https://www.bls.gov/charts/american-time-use/activity-leisure.htm>; “Growth in Time Spent with Media Is Slowing,” *eMarketer*, last modified June 6, 2016, <https://www.emarketer.com/Article/Growth-Time-Spent-with-Media-Slowing/1014042>.



*Alone*.<sup>51</sup> One consequence of this change has been the collapse of collective leisure pursuits like sports, which increasingly require organized leagues in place of the informal “sandlot” games that used to provide regular opportunities for exercise.<sup>52</sup> These new leagues require upfront costs, limiting access to exercise for those with fewer resources.<sup>53</sup> Moral agents can combat these tendencies by working to dismantle the cost barriers, either by sponsoring registration “scholarships” or by increasing their support for public parks and other shared spaces. The point is to expand the opportunities for active free time pursuits in order to make it easier for more people to make the kinds of lifestyle choices that the principle of everyday solidarity would encourage.<sup>54</sup>

While antibiotics, and diet and exercise are just two examples, they nonetheless offer a reasonable account of the ways in which an emphasis on solidarity can shape health care choices in concrete situations. Still, there are two points about the overall impact of everyday solidarity in health care decision-making that deserve clarification. First, the promotion of a greater social consciousness is not necessarily going to reveal outright conflicts between personal wellbeing and communal benefit. In the case of diet and exercise, for instance, what is good for the community (i.e., taking care of oneself in order to minimize stress on the finite resources of the health care system and to promote more positive health outcomes throughout one’s social network) is also very much in the best interest of the individual. The value of adding a social dimension to these decisions is therefore not that it suggests a completely different outcome than one might arrive at through personal analysis alone—although this would be true in some cases, like vaccination.<sup>55</sup> Instead, the real impact lies in everyday solidarity’s ability to make the appropriate outcome more likely, by adding a sense of social responsibility to one’s health care choices. In this way, the added social consciousness combats inertia, helping people to overcome the tendency to think that they can easily tolerate sacrifices to their personal health because they will only undermine their own wellbeing in isolation.

Second, and relatedly, an increased attention to social consciousness should not be understood as an invitation to sacrifice one’s own health so that others can have more health care resources. Given the preceding recognition that personal

<sup>51</sup>Robert D. Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York: Simon and Schuster, 2000), 230–231.

<sup>52</sup>Jay C. Kimiecik, “Play Ball? Reflections on My Father’s Youth Baseball Experiences and Why They Matter,” *American Journal of Play* 8, no. 3 (April 2016): 379–395

<sup>53</sup>Joseph M. Ellis and Hemant Sharma, “Can’t Play Here: The Decline of Pick-up Soccer and Social Capital in the USA,” *Soccer and Society* 14, no. 3 (2013): 364–385, esp. 377.

<sup>54</sup>For more on the structural implications of the virtue of everyday solidarity in leisure and recreation see Conor M. Kelly, *The Fullness of Free Time: A Theological Account of Leisure and Recreation in the Moral Life* (Washington, DC: Georgetown University Press, 2020).

<sup>55</sup>See Conor M. Kelly, “On Pediatric Vaccines and Catholic Social Teaching,” *Horizons* 45, no. 2 (December 2018): 287–316, at 298–299, 305.

and communal wellbeing are not always in conflict, this strategy will often backfire in the long run as neglect of one's own health for a period of time can lead to more severe health challenges that ultimately take more resources to treat when they are finally intolerable than they would have taken to address at the outset. Additionally, this vision misunderstands everyday solidarity's pursuit of relational flourishing and the theological notion of the common good it presumes, for such an approach denies the relational responsibilities one has to oneself, which are essential to full flourishing as a social being.<sup>56</sup> Given its theological orientations, everyday solidarity empowers agents to evaluate ordinary choices in a more holistic fashion, laying the foundations for a more socially aware form of moral discernment that more readily leads to the realization of the good of all and of each, just as ethicists have been trying to promote.

### CONCLUSION

Ultimately, the best way to capture the significance of this project is to note that the issues that rise to the top in a solidarity-based analysis of health care ethics are not the issues that garner the most attention in more traditional approaches. The entire point of appealing to solidarity is to shift the conversation, so that people can finally recognize the social impact of the choices that they typically like to treat as private and inconsequential. Such a transformation in the focus of moral discernment is essential if health care ethics is ever going to embrace the links with social ethics that theological ethicists have attempted to accentuate in recent years.

The alternative is to rely on health care providers to act as gatekeepers, attempting to dissuade patients from using unnecessary treatments in order to minimize an individual's burden on the system overall. These decisions can have a big impact because the estimated cost of unnecessary treatments in the United States alone is more than \$200 billion annually.<sup>57</sup> Yet providers have an impossible task if they are the only ones responsible for injecting a concern for distributive justice into the health care system because "physicians' advocacy for patients is paramount, regardless of whether it inhibits fair distribution of resources."<sup>58</sup> The only way to turn this tide is to create the conditions for a collaboration between patients and providers on the question of social responsibility, so that the interests of justice and autonomy do not have to be understood as ones of inherent conflict. Solidarity is the key to achieving this collaboration, and we

<sup>56</sup>James Keenan, "Proposing Cardinal Virtues," *Theological Studies* 56, no. 4 (December 1995): 709–729, at 723–724, 726–728.

<sup>57</sup>Heather Lyu et al., "Overtreatment in the United States," *PLoS One* 12, no. 9 (20197): e0181970.

<sup>58</sup>Christina Dineen, "Is Justice a Virtue? Examining the Role of Justice Considerations in Micro-Level Health Care Rationing," *International Journal of Ethics* 7, no. 1 (2011): 1–7.

will know that the conditions have been met when we finally begin to focus less on quandary cases and more on ordinary life in health care ethics.

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