



Relational Ethics for Public Health: Interpreting Solidarity and Care

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Abstract

This article defends ‘relational theorizing’ in bioethics and public health ethics and describes its importance. It then offers an interpretation of solidarity and care understood as normatively patterned and psychologically and socially structured modes of relationality; in a word, solidarity and care understood as ‘practices.’ Solidarity is characterized as affirming the moral standing of others and their membership in a community of equal dignity and respect. Care is characterized as paying attention to the moral (and mortal) being of others and their needs, suffering, and vulnerability. The wager of relational theorizing in health care and public health is that substantive ethical visions of solidarity and care will provide support for more just and egalitarian health care and public health policies.

Keywords Bioethics · Public health ethics · Solidarity · Care · Ethical theory

Public health ethics is fundamentally about the ethics of intervention—systemic, institutional, behavioral, and attitudinal. The practices, the institutions, and the professionals of public health intervene in many systems in order to protect and promote population health and well-being:

- Public health intervenes in natural ecosystems to protect health via public sanitation measures, clean air and safe drinking water regulations, and protections against exposure to various environmental toxins, carcinogens, and the like.
- It intervenes in the biological systems of the human body by triggering immune response with vaccines, aiding the natural immune defenses with antibiotics, and recently by altering the genome of insect vectors of disease.
- It intervenes in personal and social behavioral systems by education and laws intended to promote health, to control the spread of infectious disease, and to

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reduce risk-related activities and lifestyles, such as smoking, substance abuse, and behavior that may lead to accidental injury.

- Last, but not least, public health intervenes in cultural systems by providing scientific information, engaging in reasoned argument and persuasion, refashioning and reframing the symbols and meanings that people use to sustain a sense of self-esteem and self-efficacy. Public health appeals to personal self-interest, a sense of duty, and the connections and commitments shared in a moral community of equal rights, respect, and freedom under law.

What, then, is the foundation of ethically justified intervention, at least when it comes to medical care, health policy, and public health? My answer is: public policies informed by practices of right recognition, such as solidarity and practices of right relationship, such as care.

In this article I offer reflection on two topics involving fundamental matters of ethical recognition and relationship. These topics are ongoing themes in my own work and are recognizable and important in the fields of bioethics and public health ethics more generally. The first topic is a relational mode of theorizing in bioethics and public health ethics, what is distinctive about it and what it can contribute to a more just and beneficial health care system [9, 10]. The second topic is an interpretation of solidarity and care understood as normatively patterned and psychologically and socially structured modes of relationality; in a word, solidarity and care understood as ‘practices.’ Here I offer a brief characterization and comparison between the stance and posture of solidarity and that of care.

I trust that the pertinence of these theoretical and conceptual issues to medicine, law, and public health is self-evident. I won’t belabor the extent to which public support for just and equitable health policies and public health practices depends on strong sentiments of solidarity and support for the provision of care in society. Nor will I rehearse the striking political impediment created by a deficit of solidarity and care in a political culture; or the toll on health and well-being such a deficit extracts.

Theorizing in Public Health Ethics

Work in the field of bioethics and public health ethics over several decades has been marked by distinctive tendencies and discursive characteristics. Most often commented on in the domain of clinical bioethics is the emphasis given to respect for autonomous will formation by individuals in medical decisions and behavioral choices directly affecting them. In the domain of public health ethics and policy bioethics, it is the clash between an individualistic understanding of rights, liberty, and privacy, on the one hand, and a communitarian understanding of the common good and the health and well-being of society as a whole, on the other.

Note, however, that in addition to the difference between this kind of individualistic or libertarian perspective and a more communitarian perspective there is another fundamental tension involved in ethical theorizing and health affairs. This is the tension between viewing a human being as a subject who acts intentionally for reasons, and viewing him or her as an object whose actions are to be explained by causal

factors largely outside the understanding or the control of the person. Both clinical bioethics and public health ethics (within which I would include what is now being called ‘policy bioethics’) try not to lose sight of the human person as a subject. Forms of knowledge and action in clinical medicine runs the risk of doing so when it emphasizes a deterministic biological viewpoint. Knowledge and action in public health runs this risk by treating populations as fields within which individuals become merely vectors or by recourse to deterministic causal explanations of human behavior borrowed from the social sciences. The tension here has been long recognized in clinical bioethics, and safeguards have been put in place to protect the moral standing of the individual’s rights, interests, and dignity. In public health and health policy ethics, however the tension between treating individuals as subjects to be respected and held accountable for their actions, on the one hand, and treating individuals as objects whose actions are determined by exogenous sources, on the other, remains vexing.

So as to gain some new purchase on these well-trodden issues, I propose to look at underlying modes of theoretical activity that operate behind the scenes and shape the controversies surrounding autonomy, libertarianism, and communitarianism. As a general observation, to which there are many exceptions and hybrids, I would say that there are two distinct modes of theorizing at work in the discourse of bioethics and public health ethics today. One is what I shall call an architectonic kind of theorizing and the other a relational kind of theorizing.¹

Architectonic theorizing in ethics centers around principles, while the focus of relational theorizing is on ongoing transactions forming patterns or “practices”. Architectonic theorizing works to construct foundational principles as the scaffolding for many other, more specific rules [1]. Its basic focus is most often a particular decision or action viewed synchronically as an episode isolated in time for the purpose of ethical analysis, rather than diachronically—as episodes emerging out of a historical past and toward a possible future. Its mission—and by extension the mission of a bioethics or a public health ethics that adopts this orientation—is to present rationally justified moral principles and rules to direct the functioning of institutions and the modes of action and interaction in a society [2, 3, 5]. The approach in bioethics usually referred to as ‘principlism’ is an instance of architectonic theorizing in this sense [1]. Moreover, architectonic theories contain many different substantive principles, some of which may stress the individualistic or libertarian pole by privileging the liberty of the individual over other values, while the principles offered by other architectonic theories may focus on social justice and be more communitarian or egalitarian in their focus. Concerning the issue of viewing the individual as a subject or an object, it seems to me that architectonic ethical theories tend to take the person as a subject, since it seems plausible to treat the moral imperatives stated

¹ Certainly, if the import of this distinction on bioethics and public health ethics is relatively new, the distinction itself and discussion of these theoretical forms are not new in moral philosophy and moral psychology. They were central to the debate 40 years ago between Lawrence Kohlberg and Carol Gilligan, which Jürgen Habermas tried to mediate with his communicative ethics. See Wren [25].

in principles as reasons for a subject's action rather than as causes of an object's action.² Relational theorizing is more complex on this score.

Relational theorizing is concerned with transdisciplinary modes of inquiry and forms of normative interpretation concerning the meaningful contexts of relational agency and institutional structures of power [14]. It strives to place the agency of individuals within a constitutive context of relationships and interdependencies. These are interdependencies among human beings—interdependencies inherent in institutionalized forms of power, mediated by historical and cultural meanings, and embodied lifeworlds and forms of life.³

Relationally theorized ethics concentrates on evolving patterns and structures of intentional activity, choice, and the exercise of power. These patterns of action can come from one or a few individuals or from larger populations and social groupings. They can be episodic or institutionalized; ephemeral or deeply embedded in regimes of power and forms of life. By taking patterns of action or practices rather than isolated or conceptually individuated acts as its focal point, relational theorizing has the potential to form a bridge between the subject endogenously moved to act on reasons and the object exogenously caused to act. This does not mean that a relational perspective eliminates the tension between a subject-centered and an object-centered viewpoint by some kind of synthesis. But it does mean that relational theorizing can tack back and forth between these two viewpoints so that they can be mutually illuminating rather than mutually negating. A relational approach needs to embed and embody the subject without thereby embracing either social–historical or biological determinism.

Moreover, relational theorizing often strives to be developmental so that the subject to be retained is not a timeless essence, but rather a changing entity in which latent potentialities are manifested over time as realized capabilities or functionings. How such latent potentials come to be actualized may require an exogenous explanation using categories drawn from the social and behavioral sciences. Relational theorizing often draws upon such explanations, just as contemporary public health policy and practice is often informed by the findings of social epidemiology concerning the social determinants of health.

Note that the explanations embraced by relational theorizing need not entail determinism or reductionism, much less objectification, however, because the actualized capabilities in question are themselves constitutive features of personhood, agency, and individuated self-realization within the broad repertoire of human species being

² Some versions of utilitarianism may be an exception to this, in so far as they take pain and pleasure as such to be the sources of good or evil in the world, quite independently of how these philosophical substances are embodied in, or experienced by, individual beings, and regardless of how such embodiment or experience is distributed in a society.

³ Relational bioethics is conceptually dynamic and pluralistic, frequently drawing on paradigm-shifting work in moral and political philosophy and on conceptual innovations ongoing in the humanities and the social sciences, including feminist theories, critical theories of various kinds, and orientations informed by philosophical pragmatism and hermeneutics, among others. The literature of relational bioethics and similar work in moral philosophy is large and growing. My sketch of it here is selective, glossing over important differences among particular thinkers, but I hope not misleading. My account draws upon [4, 6, 15] in particular.

and becoming [16]. Reductionistic categories may explain the how of this process, but they alone are ill-designed to comprehend the what (let alone the why) of this process. In order to articulate what is going on in developmental agency, relational theorizing makes a gestalt shift from explanation to understanding and turns its attention to the hermeneutic or interpretive aspects of human behavior, which substantially more than in any other species, depends upon the ability to interpretively apprehend what others are thinking in and through their agency, and to read the meaning such expressive agency conveys among agents as they interact together [8]. And the spaces of such mutual interpretation and self-understanding are what I, following many others, propose to refer to as ‘practices.’

Practices are *forms of agency and activity in which diverse human capabilities or potentialities are actualized in the social and material worlds* [20]. By engaging in these well-defined activities, individuals pursue the attainment of excellence and seek to actualize potential capabilities. In this way, cultures and societies provide pathways for the development of flourishing lives, well lived. It is through practices that virtues of character are developed, rights are respected and duties fulfilled, and beneficial collective consequences are pursued and obtained.

As I close this metatheoretical discussion of architectonic and relational theorizing, and what is distinctive about the latter, I am now moving in the direction of more substantive ethical arguments that are not entailed by all versions of relational theorizing as such. In a vibrant time of conceptual innovation in critical social theory and policy studies, there is one broad area of relational theorizing that particularly interests me, and I think the work being done by those within the relational theory often referred to as ‘capability theory’ offers significant promise along these lines. This is not to say that the project being undertaken by capability theorists is the only pathway for relational theorizing as a whole. On the contrary, many feminist, multi-culturalist, and Marxist relational theorists have been highly critical of capability theory. Nonetheless, for the purpose of exploring recognition (solidarity) and relationality (care) as core normative concepts in public health ethics, I think that drawing on capability theory is promising. It brings theory and practice together in new ways, precisely by being primarily a theory of practices.

In the work I am doing in bioethics and public health ethics on the concepts of solidarity, community, and the common good, I seek to contribute to the articulation of a normative ethics of the good that is philosophically richer than utilitarianism and that provides a needed supplement to largely architectonic theories of human rights. I seek to contribute to a *critical* theory of recognition and relationality, namely, a theory that is not intended to be an ideal or full-compliance theory only, but is deliberate about its engagement with concrete social problems and practices in health and social well-being. These problems include defining and sustaining quality of life, redressing global health disparities, promoting development and healthy flourishing across the life span.

Solidarity and Care as Relational Practices

What forms of moral agency should we be looking for in the ongoing practices we evaluate? This does not imply that we must embrace essentialized and ethnocentric conceptions of the good as normative for everyone in a pluralistic society—theories of the good that are too ‘thick’—any more than it implies that conceptions of the right must be abstract and formal—theories of the right that are too ‘thin’. But it does raise the following question: Are our prevailing modes of discourse up to the task of answering substantive questions about what exactly should be practiced within practices? In particular, what kinds of recognitions and relationships are enacted there?

This is not a crucial question for architectonic theorizing, which is not primarily interested in evaluating social practices, but tends to focus on forms of moral agency that are understood to instantiate the fulfillment or violation of fundamental ethical principles and second order rules. This theorizing places such instantiation at the heart of bioethics and public health ethics. Even if it were to explicitly look at patterns of action and practices, as Rawls does when he speaks of justice in social institutions and in the basic structure of society, it would be the representation of principle within the pattern or practice that would matter ethically.

Relational theorizing takes moral agency and the practices it creates seriously in a significantly different way, I think. Practices are not merely constructive, not merely housing for the right and the good, justice and beneficence. Practices are co-creative in that they produce and reproduce substantive moral agency of certain kinds even as they are produced and reproduced themselves by moral agency.

The interplay between the agency of persons and agency within practices is yet another variation of the subject versus object problem discussed earlier. Now the problem concerns how persons and groups are recognized as moral subjects of value rather than merely as moral objects that are instruments of value. There are many facets involved in seeing persons and groups as moral subjects of values because there are a plurality of values that moral subjects pursue and sustain in the world through their agency and relationality. Here I single out two of them. One is to affirm moral standing in the other; the second is to pay moral attention to the other. Such affirmation and recognition promotes the value of justice by giving others what they are rightly due. Such attention and regard promotes the values of fidelity and gratitude by rightly responding to the needs of others. Solidarity is the practice of affirming the moral standing of others—their rights, freedom, dignity, and membership in the communities of consideration. Care is the practice of attentiveness and attending to the moral (and mortal) being of others—their welfare, suffering, need, and vulnerability. Membership solidaristically acknowledged and attention caringly sustained are two of the principal social and moral determinants of health and human flourishing.

I single out solidarity for this discussion because central ethical issues with which health policy and public health must deal—such as just access to health care, civic and financial support for social insurance and social welfare policies,

the intergenerational justice issues that bedevil the transition to an aging society, and the mitigation of global climate change—require that solidarity be taken seriously and not dismissed as an obsolete idea from a bygone political era [12, 17, 18, 21]. On the other hand, care is an extremely influential normative concept in bioethics and has been for several decades. But the practices of care, no less than those of solidarity, are vulnerable in the current ideological climate of financialized global capitalism and neoliberalism, which is undermining the foundations of the post-war liberal welfare state, and they require reaffirmation and bolstering discursively and politically. They should be addressed by bioethics and public health ethics because they are essential to solving the core problems with which health policy and public health must grapple.

What the recipients of solidarity need, and the agents of solidarity provide, is *affirmation*. In contrast, what the recipients of care need, and the agents of care provide, is *attention*.

Solidarity begins with the recognition of reciprocal and symbiotic interdependence among members of a moral community and then intervenes in—interrupts—an ongoing community when it is unjustly exclusionary and refuses to recognize—give due consideration to—the moral standing of some within it. Solidarity inherently leads us to view our own lives and agency as bound together with the rights, well-being, health, and dignity of others here and now. The practice of solidarity discerns the latent capacities of individual persons whose developmental flourishing is being thwarted, such as young children apprehended with their parents as undocumented immigrants and then coercively separated from their parents. Solidarity also discerns the latent possibilities of a given community at a given time. It builds on senses of historical memory and tradition, and it feeds on the gratitude felt when one remembers the service and contributions that others have made to one's way of life in the past, or when one has the moral imagination to foresee the contributions that newcomers and nonconformists can make in the future.

I take the fundamental posture of solidarity to be: standing up beside another, thereby signaling publicly one's recognition of that person's (or group's) moral standing. In addition, there are three distinct postures agents who practice solidarity assume toward others whose moral standing is in need of defense. The first is *standing up for*—a protective advocacy that requires little empathy and may be paternalistic. The second and third are *standing up with* and *standing up as*—kinds of relationships that bring the self-understandings of people closer together in a way that promotes rather than erases diversity and distinctiveness.

Care begins, not with physical or psychological immaturity or impairment, but with recognition of the evil of invisibility, disregard, and abandonment. The need for care is indeed universal, both biologically and culturally. But being erased and deserted, reduced to bare self-reliance, having to fend for oneself alone—these conditions are neither universal nor inevitable. They are latent potentials in the human condition the actualization of which the practice of care was morally and culturally invented to prevent. And failure to do so not only diminishes the humanity of those who did not receive care, but also diminishes those who failed to give it.

I take the fundamental posture of the practice of care to be: paying attention to. Just as recognition of the moral standing of the other comes through the

solidaristic posture of standing up beside, so too recognition of the moral considerability of the other comes through the directed gaze of attentive care. There are also three distinct postures those who practice care assume toward others who require moral attention. The first is *attentive rehabilitation*, which, like standing-up-for solidarity, is primarily functionally oriented and can be overbearing. The second and third are *attentive companionship* and *attentive commitment*, each of which deepen the relationship of care and move the care provider and care recipient (if possible) closer toward an understanding the humanity that they share [7, 13, 22, 23].

To move into a mode of attentive companionship and commitment in the care process is clearly a step beyond rehabilitation. I suggest that it is gratitude that germinates such a step. It may be the gratitude felt for the newly arrived life of an infant, and the realization of how vital the assurance of non-abandonment will be to the developmental flourishing of the child. It may be intergenerational gratitude that is reciprocal, as when adult children alter their own lives and priorities to assure companionship to an ailing or lonely parent. It may be a sense of obligation or debt based on remembering the constructive activities of the other, which indirectly has been of significant social and individual benefit to the attentive companion.

In architectonic ethical theorizing the concept of gratitude has not been widely discussed compared with other concepts, but it has been related to the establishment of moral and political obligations and the question of the voluntary or non-voluntary origins of those obligations [19, 24]. In relational theorizing it has received even less attention, although some of what I am ascribing to the notion here has been explored in connection with other concepts, such as reciprocity, loyalty, and love.

Mindful of the etymology of the term, I don't primarily see gratitude as an obligation to be fulfilled in return for past benefit or service so much as a donative gesture and motivation, having little to do with a quid pro quo, and much to do with giving of oneself in ways that are appropriate to the honor and recognition that should be bestowed by the practice of care on another. Just as the recognition of another's moral standing, such as it is, in solidarity does not entail that the phase of standing up as will ever be reached, so too there is no guarantee or moral requirement that a practice of care transition beyond rehabilitative support and reach to the levels of attentive companionship and commitment. I suspect that a more adequate consideration of care and gratitude will also require a consideration of care and forgiveness.

I think this is a further line of research for the development of relational theorizing in public health ethics. However that may be, the large wager of relational theorizing in health care and public health is that substantive ethical visions of solidarity and care will ignite the moral imagination of the twenty-first century and will provide support for more just and egalitarian health care and public health policies.

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