Towards Conjoint Solidarity in Healthcare

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Abstract

Solidarity remains an ambiguous concept despite the long political tradition pertaining to concepts of fraternity, togetherness and collective values or goals. In healthcare ethics, it has been under-explored, perhaps due to the perception that it opposes individual autonomy. However, even where autonomy is interpreted as a liberal construct, the solidaristic act may be borne out of free choice, rather than stand in opposition to it. To complement the existing scholarship, the concept of 'conjoint solidarity' in healthcare, is proposed. Conjoint solidarity may be defined as *the shared goal of all healthcare stakeholders (encapsulating all healthcare professionals and service users) to accept or adopt a duty to assist one another to achieve improved healthcare outcomes.'* The practical application of both medical autonomy and conjoint solidarity is through the process of shared decision making. An epistemic approach may be applied to 'pool information' from healthcare professionals and patients to determine what improved healthcare outcomes are. This collective approach may also serve to address healthcare issues such exclusion, othering, paternalism and conflict of interest. Furthermore, in extending this relational approach to justice, consideration may be given to how improved healthcare may be attained in a manner which allows patients to also play their part. To this end, medical autonomy, conjoint solidarity and relational distributive justice may be considered inter-dependent constructs which, when fully utilised, may help improve healthcare.

TOWARDS CONJOINT SOLIDARITY IN HEALTHCARE

Introduction

There is little consensus upon a definition of solidarity which been described as a value[1], a principle of social morality[2] and a moral duty[3]. It may be a 'prescriptive' call to action or a

[1] Dawson A, Jennings B. (2012). The Place of Solidarity in Public Health Ethics. *Public Health Rev.* 34:65-79.
[2] Sass HM. (1992). Introduction: The Principle of Solidarity in Health Care Policy. *J Med Philos.* 17, 367-370.
[3] Scholz SJ. (2015) Seeking Solidarity. *Philos. Compass*. 725-735, doi: 10.1111/phc3.12255.

'descriptive' norm.[4] The various conceptualisations of solidarity do, however, incorporate similar features such as fellowship or shared bonds[5]; the shared goal or commitment; the commonality of purpose[6] and the idea of reciprocity which distinguishes the solidaristic act from one of charity or altruism. However, solidarity is not to be *confused* with reciprocity and its associated *expectation* of receiving in return[7]. Nor is it to be equated with purely emotive concepts such as empathy[8]. Instead, solidarity may be considered a *normative* moral obligation[9], or the *rational choice* to provide and receive support[10]. Interpretations of solidarity vary to such an extent that solidarity can be used to argue opposing sides of the same argument, yet irrespective of application there is often a preconception that solidarity refers to collective good in a way that is contrary to *individual* rights of autonomy.[11] Similarly, the pooling of collective resources through acts of solidarity as may be considered to oppose the principle of distributive justice and *its* focus upon equality and individual rights in relation to subsequent resource allocation. This paper proposes a new concept of conjoint solidarity in healthcare to contribute to current scholarship and debate by tackling such misconceptions and by addressing concerns such as exclusion and othering which may arise from *exclusive* forms of solidarity as applied to the healthcare setting. This will be addressed through the proposed model of conjoint solidarity, defined as '*the shared goal of all healthcare stakeholders (encapsulating all healthcare professionals and service users) to accept or adopt a duty to assist one another*

[4] Prainsack B. (2017) 'The 'We' in the 'Me': Solidarity and Healthcare in the Era of Personalised Medicine'. *Sci Technol Human Val*. 43(1), 21-44.
[5] Fullilove MT, Cantal-Dupart M. (2016). Medicine for the City: Perspective and Solidarity Tools for Making Urban Health. *J Bioeth Inq*. 13, 215-221.
[6] Davies B, Savulescu J. (2019) Solidarity and Responsibility in Health Care. *Public Health Ethics.*12(2),133-144.
[7] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[8] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[9] Scholz, Sally (2008). *Political Solidarity*. University Park, PA: University of Pennsylvania Press.
[10] Bayertz K. (1999) *Four Uses of "Solidarity".* In: Bayertz K. (eds) Solidarity. Philosophical Studies in Contemporary Culture, vol 5. Springer, Dordrecht. https://doi.org/10.1007/978-94-015-9245-1_1
[11]Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.

to achieve improved healthcare outcomes.' It will be argued that the *inclusive* nature of conjoint solidarity, which is founded upon a shared common goal of improved healthcare, will serve to demonstrate how autonomy, solidarity and justice are, as relational constructs, not only intertwined but interdependent.

SOLIDARITY

Origins and Modern Conceptualisations of Solidarity

Solidarity can be traced back to antiquity, when the basic social unit of Ancient Greece, the *oikos (οἶκος)*[12], came to signify the *bonds* which united those with a shared commitment to one another[13]. Aristotle's writing on *philia (φἰλία)*, or friendship, also referred to early forms of solidarity whereby '*citizens experience friendship with each other in that they wish each other well…and do things for each other even though they do not know each other*" [14]. Notably, in this early guise of *φἰλία,* an interdependence between the shared interests of solidarity and the self-interest individual is recognised, which is pertinent to the modern debate on the compatibility of solidarity with individual autonomy as will be addressed later. According to Aristotle, man must first care for his own self-interest before he can care the shared interests of the collective[15] - an early nod to the interdependence of between individual autonomy and collective solidarity[16]. Etymologically, solidarity appears to stem from the Roman Law of obligations whereby rights held by common debtors to repay a shared obligation were characterised as *obligatio in solidum*[17]. This early notion of *in solidum*

[12] Roy J. (1999).'Polis' and 'Oikos' in Classical Athens. *Greece Rome*. 46(1), 1-18.
[13] Smith C, Sorrell K. (2014) *On Social Solidarity*. In: Jeffries V. (eds) The Palgrave Handbook of Altruism, Morality, and Social Solidarity. New York: Palgrave Macmillan, p222.
[14] Jang M. (2018). Aristole's Political Friendship (Politike Philia) as Solidarity'. *LAPS*. 12, 417-433.
[15] Jang M. (2018). Aristole's Political Friendship (Politike Philia) as Solidarity'. *LAPS*. 12, 417-433.
[16] Jang M. (2018). Aristole's Political Friendship (Politike Philia) as Solidarity'. *LAPS*. 12, 417-433.
[17] Bayertz K. (1999) *Four Uses of "Solidarity".* In: Bayertz K. (eds) Solidarity. Philosophical Studies in Contemporary Culture, vol 5. Springer, Dordrecht. https://doi.org/10.1007/978-94-015-9245-1_1

encapsulates a conjoint *legal* duty incumbent on individuals to repay debt and, whilst under Roman law *patria potestas* refers to patriarchal rather than autonomous rights, the concept of *in solidum* holds at least some pertinence to modern solidarity[18]. Solidarity has also been explored in theological ethics as a cohesiveness amongst believers. Whilst not expressly mentioned in Old or New Testament, it is a central form of Catholic virtue[19] pertaining to the moral obligation to assist others which recently formed the basis of Vatican guidance for the uptake of the COVID-19 vaccine as an expression of public health solidarity.[20] [21] Solidarity has also been widely explored as a concept relating to political struggle[22]. Emerging in the 17th century during the French Revolution, notions of *fraternité*[23] and *solidarité*[24] were used to promote the national identity which bound citizens together. By the late 19th century, the term solidarity itself gained wide-spread traction and consideration, mainly by communitarians who considered the collective need of society as that which should take precedence.[25] [26] One communitarian variant was that of *ethnic* solidarity which arose alongside the rise of Nazism in the early twentieth century[27] [28] - the atrocities of which led to greater importance

[18] Britannica Encylopaedia. (2016) 'Patria potestas' Available at https://www.britannica.com/topic/patria-potestas. Accessed on 12 April 2021.
[19] Bārbat C. (2015) A Catholic view of the ethic principle of solidarity. Consequences at the ethic-social level. *Procedia Soc Behav Sci*. 183, 135-140.
[20] Bārbat C. (2015) A Catholic view of the ethic principle of solidarity. Consequences at the ethic-social level. *Procedia Soc Behav Sci*. 183, 135-140.
[21] Holy See Press Office. (29 December 2020). Note of the Vatican COVID-19 Commission in Collaboration with the Pontifical Academy for Life "Vaccine for all. 20 points for a fairer and healthier world". Available at https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/12/29/201229c.html Accessed on 10 April 2021
[22] Schmale W. (2017). European Solidarity: A Semantic History, European Review of History: The rise of European Solidarity in the Course of the Nineteenth Century. *Eur Rev Hist*. 24(6), 854-873.
[23] Gilbert J, Keane D. (2016) Equality Versus Fraternity? Rethinking France and its Minorities. *Int J Const Law*. 14(4), 883–905.
[24] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[25] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[26]Schmale W. (2017). European Solidarity: A Semantic History, European Review of History: The rise of European Solidarity in the Course of the Nineteenth Century. *Eur Rev Hist*. 24(6), 854-873.
[27] Russell, N. (2018) The Nazi Regime – Ideology, Ascendancy, and Consensus. In: Understanding Willing Participants. Vol 2. Palgrave Macmillan, Cham, 22-64.
[28] Schmale W (2017) European Solidarity: A Semantic History, European Review of History: Revue européenne d'histoire: The rise of European Solidarity in the Course of the Nineteenth Century. 24:6, 854-873, doi:10.1080/13507486.2017.1345869

subsequently being placed upon individual patient autonomy by way of the Nuremberg Code, which perhaps contributed to the neglect of solidarity in the field of bioethics.[29] It has also been suggested that communitarianism grew further still, in response to the liberalism of Rawl's influential publication '*A Theory of* Justice'.[30] Therein, Rawl considered that in fashioning an imaginary 'veil of ignorance' individuals would be unaware of any advantage or disadvantage they held, thus creating an theoretical equal platform known as the 'original position'. He hypothesised that from this original position the most likely collective rules which would be established were those which upheld principles of freedom, equal liberty and opportunity. Rawl describes this theory as an *"abstraction [of] the familiar theory of social contract"*[31]. It has been suggested that whilst social contract theorists do not expressly mention solidarity, they treat it as both *"an empirical fact and a positive goal*".[32] Social contract theory is based upon the premise that modern society was borne out of the collective agreement of individuals to unite so as to overcome hardships encountered living independently in a 'State of Nature'. Accordingly, individuals voluntarily surrendered their liberty to a governing authority in return for benefits. Rosseau considered social contract theory to be based upon "*mutual assistance*" with equal individuals dependent upon the *collective* for protection[33] - a concept which arguably underpins the modern European welfare state citizens are dependent upon the

[29] Nuremberg Military Tribunal. (1949). *Trials of War Crimes Before the Nuremberg Military Tribunals*. Vol 11. "The Medical Case" Control Council Law No.10. Nuremberg Oct 1946-April 1949. US Government Printing Office, Washington 25, D.C.
[30] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[31] Rawls J. (1971). A *Theory of Justice*. Oxford: Oxford University Press.
[32] Prainsack B, Buxy A. (2011) *Reflections on an emerging concept in bioethics*. London: Nuffield Council on Bioethics.
[33] Becker A, Reyelt M. (2001) Jaques Rousseau's Concept of Society and Government: A Study of the Social Contract. Seminar Paper. Wyoming: University of Wyoming.

governing authority for protection in times of vulnerability[34]. Collectively, Locke[35], Hobbes[36] and Rousseau[37] proposed liberal interpretations of social contract theory. Locke, for example, proposed that benefits *deriving* from the social contract should include protection of individual rights of life, liberty and property.[38] To this end Hobbes suggests that social contract theory incorporates themes of individualism, absolutism and utilitarianism suggestive of compatibility between liberalism and rational solidarity. [39] [40] The premise is that where solidarity is borne out of individual, rational and deliberate choice to subscribe to a collective interest, rather than by way of presumption, solidarity cannot oppose liberalism. [41] Indeed, it could even be considered a product of it. Hetcher also proposed that subscription to the solidaristic group ('groupness') should be derived from individual rational choice to consume shared goods and subsequent acceptance of associated rules and obligations. More recently, Dean has proposed that individual rational choice to act in solidarity, or comradery, should instead align with the revival of communist ideals. Through acts of comradery, collective efforts are bound by the "*joy of committed struggle*"[42] to invoke individual discipline to undertake responsibilities otherwise avoided. This is not considered by Dean to represent a threat to individual liberty as participation in comradeship is through voluntary choice, which may have a *"liberating*

[34] Gourevitch V. (Ed). (1997) Rousseau The Social Contract and Other Later Political Writings. In Cambridge Texts in the History of Political Thought. Cambridge: Cambridge University Press.
[35] Locke, J. (1948 [1632]). *The Second Treatise of Civil Government and A Letter Concerning Toleration*. Oxford: Blackwell, 1948.
[36] Shapiro I (Ed). (2010). Hobbes, T [1651]. *Leviathan: Or the Matter, Forme, and Power of a Common-Wealth Ecclesiasticall and Civill*. New Haven, CT: Yale University Press.
[37] Becker A, Reyelt M. (2001) Jaques Rousseau's Concept of Society and Government: A Study of the Social Contract. Seminar Paper. Wyoming: University of Wyoming.
[38] Locke, J. (1948 [1632]). *The Second Treatise of Civil Government and A Letter Concerning Toleration*. Oxford: Blackwell, 1948.
[39] Shapiro I (Ed). (2010). Hobbes, T [1651]. *Leviathan: Or the Matter, Forme, and Power of a Common-Wealth Ecclesiasticall and Civill*. New Haven, CT: Yale University Press.
[40] Becker A, Reyelt M. (2001) Jaques Rousseau's Concept of Society and Government: A Study of the Social Contract. Seminar Paper. Wyoming: University of Wyoming.
[41] Hechter, Michael (1987). *Principles of Group Solidarity*. Berkeley: University of California Press.
[42] Dean J. (nd). We Need Comrades. *Jacobin* [online]. Available at https://www.jacobinmag.com/2019/11/comrades-political-organizing-discipline-jodi-dean Accessed on 12 April 2021

quality", in freeing the individual from 'obligations' of independence.[43] In contrast to such contractualism, Durkheim – through a substantial contribution to the scholarship - considered solidarity as a principle extended to *all* humanity - a form of community cohesion which may be categorised as either 'mechanical' or 'organic' solidarity according to societal development. 'Mechanical solidarity' develops in societies whereby individuals are linked by a feeling of sameness in relation to their roles or status in society. In contrast, 'organic solidarity' - which is associated with more advanced societies - develops when individuals with specialised roles develop a mutual reliance upon one another.[44] This is perhaps most pertinent to the healthcare 'society' where a mutual reliance develops between specialised members of the multi-disciplinary team and patients with their *own* the epistemic value.

Modern Concepts of Solidarity in Bioethics and Healthcare

Whilst the liberalism of countries such as the United States may favour the promotion of self-interested social models[45], the longstanding European solidaristic traditions of the 19th century gave rise to the European welfare state.[46] [47] The welfare state mandates national insurance contributions from its citizens in return for state support, such as the provision of public healthcare. Whilst it may be presumed that this would serve as a basis for subsequent development of solidarity in bioethics and healthcare, solidarity remains a neglected concept in this field[48], perhaps stifled by perceived difficulties in aligning solidarity with autonomy, justice and the perceived obligation to take some form of positive action to be deemed

[43] *Ibid*
[44] Durkheim E. (1984 [1893]). *The Division of Labour in Society*. London: Macmillan
[45] Sass, HM (1992). Introduction: The principle of solidarity in health care policy. The Journal of Medicine and Philosophy 17: 367-370.
[46] Ter Meulen R, Arts W, Muffels, R (2010) (eds). *Solidarity in Health and Social Care in Europe*. Dordrecht: Kluwer Academic Publishers.
[47] Baylis F, Kenny, NP, Sherwin, S. (2008). A Relational Account of Public Health Care Ethics. *Public Health Ethics* 1/3: 196-209.
[48] Dawson A, Jennings B. (2012) The Place of Solidarity in Public Health Ethics. *Public Health Rev.* 34, 65-79.

solidaristic[49]. The Nuffield Council on Bioethics commissioned Prainsack and Buyx to undertake a systematic analysis of the literature pertaining to solidarity in bioethics in 2011 and they subsequently published the findings alongside their three-tier model of solidarity applicable to bioethics. Such solidarity develops through the manifestation of commitments across interpersonal, collective and contractual levels. At the initial interpersonal level, *"…solidarity comprises manifestations of the willingness to carry costs to assist others with whom a person recognises sameness or similarity in at least one relevant respect"*. Only once sufficiently strong levels of solidarity are established, can solidarity extend across subsequent tiers. The second tier of solidarity is founded upon the "*manifestations of a collective commitment to carry costs to assist others*" which may include acting in solidarity to *"help each other in times of need, support disease research or organise communal healthcare*" and may give rise to models of broad or presumed consent. The third tier relates to manifestations of solidarity at contractual level, whereby there may be a legal duty to share a collective burden - such as evidenced by the welfare state.[50] Arguably, however, models of solidarity which are founded upon recognition of "*sameness or similarity*"[51] may exclude those perceived as different. Prainsack and Buyx provide the example of an individual who may not support a gambler whereby they cannot recognise *that particular vulnerability* in their own psyche. In healthcare, however, such exclusion could potentially impede care. In a recent publication Prainsack sought to address this by asserting that "*…similarities [should] weigh more heavily than … differences*"[52]. However, solidarity which is *founded* upon principles of sameness or similarity continues to present the risk of exclusion of those who do not meet this pre-requisite.

[49] Bayertz K (1999) *Four Uses of "Solidarity"*. In Bayertz K. (eds) Philosophical Studies in Contemporary Culture. Vol 5. Springer, Dordrecht.
[50] Prainsack B, Buyx A. (2011) *Solidarity: Reflections on an Emerging Concept in Bioethics*. London: Nuffield Council on Bioethics
[51] Prainsack B, Buyx A. (2011) *Solidarity: Reflections on an Emerging Concept in Bioethics*. London: Nuffield Council on Bioethics
[52] Prainsack B. (2020). Solidarity in Times of Pandemics. *Democr Theory*. 7(2), 134-133

Whilst a "*willingness to carry costs*" indicates an autonomous decision to engage in solidaristic acts, Dawson and Jennings argue that costs are an unnecessary requirement of solidarity. Instead they propose solidarity should be a *value,* so entangled within our morality that it is an inherent component of ethical decision-making. Their model of solidarity calls us to 'stand up beside' one another - whether it be in sympathy or understanding – to rectifying disadvantage or injustice.[53] Whilst there may be the *potential* for associated negative consequences resulting from the act of standing alongside, this should not equate to costs. The idea of costs – or obligations – is included in the model of healthcare solidarity described Davies and Savulescu. The use their 'rights and obligations' model to argue that in order to enjoy the *right* of healthcare access, patients should be *obliged* to maintain a healthy lifestyle.[54] Whilst such active obligations would likely affect all members of society at some point, these are likely to disproportionately target the least healthy in society – and therefore those *most* in need of healthcare - by way of fine or exclusion. Such solidarity which penalises patients who fail to 'conform' may veer towards the paternalistic and so may serve to undermine autonomy.

Exclusive Solidarity in Healthcare and the Risk of Othering

It is pertinent to explore the manner in which solidarity based upon collective similarities can lead to exclusion, before the case is made for conjoint solidarity which is *inclusive* of all healthcare stakeholders. Exclusive solidarity is that which "*…[restricts] the criteria for inclusion and therefore solidarity to certain groups in the population*"[55]. In this way, those perceived as dissimilar are not included in the collective. Exclusion may therefore perpetuate

[53] Dawson A, Jennings B. (2012) The Place of Solidarity in Public Health Ethics. *Public Health Rev.* 34, 65-79.
[54] Davies B, Savulescu J. (2019) Solidarity and Responsibility in Health Care. *Public Health Ethics*. 12(2), 133-144.
[55] Hrast MF, Immergut EM, Rakar T, Boljka U, Burlacu D, Roescu A. (2018). *Healthcare Futures: Visions of Solidarity and the Sustainability of European Healthcare Systems*. In: Taylor-Gooby P., Leruth B. (eds) Attitudes, Aspirations and Welfare. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-75783-4_7

othering, the process that "*serves to mark and name those thought to be different from oneself*"[56] and may be used to describe "*instances of perpetuating prejudice, discrimination, and injustice either through deliberate or ignorant means*"[57]. Othering is widely explored in medical literature as a vehicle for discrimination against those with actual or perceived dissimilarities, which may or may not include factors such as "*gender, ethnicity or age*"[58]. Inclusive solidarity which is based upon similarity within a diverse healthcare setting can give rise to various guises of exclusion and othering which will create a fragmented approach to healthcare.

Patients may develop solidarity with all other patients through a shared vulnerability, yet this could mean that the healthy do not form strong bonds of solidarity with the sick – which is fundamental to the ongoing support of many European healthcare systems.[59] Othering which arises from specific patient demographics[60] may also promote intergenerational tensions and ageism, whereby the young fail to relate to elderly patient demographics, as described by Ayalon's commentary of the COVID-19 pandemic.[61] Othering may also be directed towards healthcare practitioners (HCPs) who are simply perceived as occupying a different role or it may be founded on the grounds of age[62] or race[63].

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[56] Weis L. (1995) Identity Formation and the Process of 'Othering': Unravelling Sexual Threads. *EDFN*. 9,17-33

[57] MacQuarrie C. (2010). *Othering*. In Mills AJ, Durepos D & Wiebe E (Eds.). *Encyclopedia of Case Study* Research. Thousand Oaks, CA: SAGE Publications, Inc, 636-639. doi: 10.4135/9781412957397.n238

[58] Kempenaar LE, Shanmugam S. (2018) Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach*. 40(9), 969-970 doi:10.1080/0142159X.2017.1403575

[59] Hrast MF, Immergut EM, Rakar T, Boljka U, Burlacu D, Roescu A. (2018). Healthcare Futures: Visions of Solidarity and the Sustainability of European Healthcare Systems. In: Taylor-Gooby P, Leruth B. (Eds) Attitudes, Aspirations and Welfare. Palgrave Macmillan: Cham. https://doi.org/10.1007/978-3-319-75783-4_7

[60] Chrisler JC, Barney A, Palatino B. (2016). Ageism can be Hazardous to Women's Health: Ageism, Sexism, and Stereotypes of Older Women in the Healthcare System. *J Soc Issues*. 72, 86-104.

[61] Ayalon L. (2020) There is Nothing New Under the Sun: Ageism and Intergenerational Tension in the Age of the COVID-19 Outbreak. *Int Psychoger*. 1-4. doi: 10.1017/s1041610220000575

[62] Lasher T. (2013). Young Doctor, Nervous Patients. *Anesthesiology*. 119(1), 231-232

[63] Vogel L. (2018). Doctors On Their Own When Dealing with Racism from Patients. *CMAJ*. 190(37), E1118-1119.

Solidarity may also develop amongst HCPs themselves who may have shared experiences of the rigors of training. Yet *this* form of solidarity may exclude different specialities of HCP[64] or may lead to the othering of colleagues on the basis of sex or race[65]. Such solidarity may develop through the hardships of training, bringing the benefit of professional support networks and access to training opportunities. Indeed, many medical schools actively promote solidarity amongst their students through school-specific sports teams,[66] events[67] and buddy schemes[68] with the intent of developing the aforementioned support networks[69] [70]. Fear of exclusion from the collective can also lead to de-individualization of those within it. As a result, members become less inclined to speak out[71] which can erode individual virtue, accountability and empathy. It is in this way that whistle-blowers or those with differing views may be excluded, their actions or opinions viewed as different or as having failed to uphold their obligation to support colleagues.[72] [73] Zimbaro 2007 warns that in such circumstances individuals may be become subsumed within the collective. This may also lead to the perpetuation of self-interest within the collective. When this concerns a sub-group – particularly a subgroup of healthcare professionals - it could lead to conflict of interest. As a result, secondary interests, such as

[64] Kempenaar LE, Shanmugam S. (2018). Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach.* 40(9),969-970. doi:10.1080/0142159X.2017.1403575

[65] Limb M. (2014). NHS Doctors Face Racism, Exclusion and Discrimination Report Finds. *BMJ*. 349 doi: https://doi.org.10.1135/bmj.g4960

[66] Babenko O, Mosewich A. (2017). In Sport and Now in Medical School: Examining Students' Well-Being and Motivations for Learning. *Int J Med Educ.* 22(8), 336-342. Doi: 10.5116/ijme.59b7.8023.

[67] Shochet R, Colbert-Getz J, Levine R, Wright S (2013). Gauging Events That Influence Students' Perceptions of the Medical School Learning Environment: Findings from One Institution. *Acad Med.* 88(2), 246-252 doi: 10.1097/ACM.0b013e31827bfa14

[68] Akinla O. (2108). A Systematic Review of the Literature Describing the Outcomes of Near-Peer Mentoring Programmes for First Year Medical Students. *BMC Med Edu*. 18(1),1-10. doi:10.1186/s12909-018-1195-1

[69] Babenko O, Mosewich A. (2017). In Sport and Now in Medical School: Examining Students' Well-Being and Motivations for Learning. *Int J Med Educ.* 22(8),336-342. Doi: 10.5116/ijme.59b7.8023.

[70] Shochet R, Colbert-Getz J, Levine R, Wright S. (2013). Gauging Events That Influence Students' Perceptions of the Medical School Learning Environment: Findings from One Institution. *Acad Med.* 88(2), 246-252 doi: 10.1097/ACM.0b013e31827bfa14

[71] De Zulueta P(2013). Compassion in 21st Century Medicine: Is It Sustainable? *Clin Ethics.*8(4),119–128. https://doi.org/10.1177/1477750913502623

[72]Patrick K. Barriers to Whistleblowing in the NHS. *BMJ*. 2012;345:e6840. Doi:https://doi.org/10/1136/bmj.e6840

[73] Kempenaar LE, Shanmugam S (2018). Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach*. 40(9), 969-970 doi:10.1080/0142159X.2017.1403575

research interests or financial incentives, may supersede the primacy of *patient* interests. This raises further concern for care outcomes.

Solidarity amongst HCPs themselves may also exclude patients as they become subsumed within a collective which considers patients as dissimilar[74]. Kolers' describes how "*…physicians are likely to identify with other doctors, even contrary to patients' interests*" as they are "*much more likely to project themselves into the shoes of other physicians than into those of patients or families*".[75] This is often built upon the common misconception that patients are less knowledgeable or informed than doctors – a stance which fails to recognise the epistemic value of the patient. This may further promote the idea that patients represent a 'dissimilar' group[76] [77]. De Zulueta explains that "*doctors [may become] immersed in the white-coated group of individuals*"[78] which view patients as "*not [being] one of us*"[79] [80] - a process which can lead to disengagement and even de-humanization of patients which may inevitably fuel paternalism.[81] [82]. Such de-humanization[83] may also be perpetuated by treatment of the disease rather than the patient which may be fueled by dehumanizing[84] descriptors such as '*the*

[74] Kempenaar LE, Shanmugam S. Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach*. 2018; 40(9):969-970 doi:10.1080/0142159X.2017.1403575
[75] Kolers A. (2020). What Does Solidarity Do for Bioethics*? J Med Ethics*. (online) doi:10.1136/medethics-2019-106040
[76] De Zulueta P (2013). Compassion in 21st Century Medicine: Is It Sustainable? *Clin Ethics*. 8(4), 119–128. https://doi.org/10.1177/1477750913502623
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[78] De Zulueta P (2013). Compassion in 21st Century Medicine: Is It Sustainable? *Clin Ethics*. 8(4), 119–128. https://doi.org/10.1177/1477750913502623
[79] Kempenaar LE, Shanmugam S (2018). Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach*. 40(9), 969-970. doi:10.1080/0142159X.2017.1403575
[80] De Zulueta P (2013). Compassion in 21st Century Medicine: Is It Sustainable? *Clin Ethics*. 8(4), 119–128. https://doi.org/10.1177/1477750913502623
[81] De Zulueta P (2013). Compassion in 21st Century Medicine: Is It Sustainable? *Clin Ethics*. 8(4), 119–128. https://doi.org/10.1177/1477750913502623
[82] Zimbardo P. (2007) The Lucifer Effect. How Good People Turn Evil. *Rider Random House*. London.
[83] Kempenaar LE, Shanmugam S (2018). Inclusionary Othering: A Key Threshold Concept for Healthcare Education. *Med Teach*. 40(9), 969-970. doi:10.1080/0142159X.2017.1403575
[84] Zimbardo P. (2007) The Lucifer Effect. How Good People Turn Evil. *Rider Random House*. London.

appendix in room 1' or *'the oncology case from yesterday'*[85]. In addressing this worrying trend of subconscious dehumanization of the patient Karan warned that it can lead to the erosion of empathy[86] - a value shown to correlate with improved outcomes including "*more accurate diagnosis and better care*"[87], improved patient engagement and overall job satisfaction[88]. The 2013 Francis Inquiry and subsequent report into the systematic failings of Mid-Staffordshire NHS Foundation Trust[89] - whilst by no means representative of all healthcare – serves as an example of the effects of patient dehumanisation. The report revealed that damaging culture had developed which put target-driven practice ahead of patient care [90]. The report described how "*staff [had] treated patients…with callous indifference*"[91] and, whilst it did not offer an ethical perspective as to the aetiology of such collective behaviour, it did identify a shared commitment to the achievement of Foundation Trust status. Arguably, this *could* have provided the foundations for exclusive solidarity which subsequently led to the exclusion and othering of those who did not share the commitment. The report suggests that HCPs who did not share this commitment were also excluded – by being *silenced, ignored or intimidated*"[92] – as they sought to instead address poor care standards. The Report recommends that "*emphasis [should of be put upon a].. commitment to common values throughout the system by all within it*".[93] By recognising that there should be *shared* commitment held by all those within

[85] Karan A. (2019) The Dehumanisation of The Patient. *BMJ*. 367, l6336.
[86] Karan A. (2019) The Dehumanisation of The Patient. *BMJ*. 367, l6336.
[87] Larson E, Yao X (2005). Clinical Empathy as Emotional Labour in the Patient-Physician Relationship. *JAMA*. 293, 1100–1106.
[88] Jeffrey D. (2016). 'Empathy, Sympathy and Compassion in Healthcare: Is There a Problem? Is There a Difference? Does it Matter?'. *J R Soc Med*. 109(12), 446–452. https://doi.org/10.1177/0141076816680120
[89] Francis, R QC. (2013). The Mid-Staffordshire NHS Foundation Public Inquiry (2013) 'Report of the Mid Staffordshire NHS Foundation Trust Inquiry. Executive Summary. HC 947
[90] Trueland, J. (2018). 'Target Driven, Fearful and Under Pressure – A Snapshot of Working in The NHS' *BMA News*. Accessed at https://www.bma.org.uk/news/2018/november/target-driven-fearful-and-under-pressure-a-snapshot-of-working-in-the-nhs
[91] Francis, R QC. (2013). *The Mid-Staffordshire NHS Foundation Public Inquiry*. *'Report of the Mid Staffordshire NHS Foundation Trust Inquiry. Executive Summary'*. HC 947
[92] Francis, R QC. (2013). *The Mid-Staffordshire NHS Foundation Public Inquiry*. *'Report of the Mid Staffordshire NHS Foundation Trust Inquiry. Executive Summary'*. HC 947
[93] Francis, R QC. (2013). *The Mid-Staffordshire NHS Foundation Public Inquiry*. *'Report of the Mid Staffordshire NHS Foundation Trust Inquiry. Executive Summary'*. HC 947

the healthcare system, it stands to reason that solidarity in healthcare must *include* patients and healthcare professionals (HCPs) alike.

Towards a Conceptualisation of Conjoint Solidarity

Dean also argues for an *inclusive* form of reflective solidarity, which concerns the "*mutual expectation of a responsible orientation to relationship" so that from 'responsibility".* From such responsibility derives the 'accountability' to steer relationships towards inclusivity of others and to reconsider collective boundaries of 'us' and then' by incorporation a third 'generalised other' in relation to concepts of 'we'.[94] In this way, a collective can give consideration to others in a way which may be lacking in traditional conceptualisations of solidarity. This, Dean proposes, creates the "*openness…[and]… accountability…to grasp …solidarity no longer blocks us from difference, but instead provides a bridge between identity and undersality".*[95] Similarly, Honneth's 'societal solidarity' considers that individuals, although different, share a value horizon from which societal soldairty derives[96]. Differences of gender, religion or race are, therefore, recognised in such contemporary constricts of solidarity. Part goes further to suggest that solidarity should be a dynamic concept subject to continual self-renewal and reaction to overcome any differences by the *"imaginative ability to see strangers, people as fellow suffers".*[97] Conjoint solidarity, as a descriptive norm, proposes an alternative form of inclusive solidarity which – rather than being based upon

[94] Dean J. (1996). *Solidarity of Strangers: Feminism after identify politics.* Berkeley: University of California Press.
[95] Dean J. (1996). *Solidarity of Strangers: Feminism after identify politics.* Berkeley: University of California Press.
[96] Honneth A. (1995). *The Struggle for Recognition. The Moral Grammar of Self-Conflicts*. Cambridge: MA Polity Press
[97] Rorty R. (1989). *Contingency, Irony and Solidarity.* Cambridge: Cambridge University Press.

similarity or difference – is founded upon a shared goal. Central to the foundations of conjoint solidarity is a relational interpretation of individual autonomy.

Bridging the Gap Between Solidarity and Autonomy

The proposed concept of conjoint solidarity shares an interdependence with relational autonomy through the practical act of shared decision making. In healthcare, such shared decision making supports informed consent - the practical facilitation of individual medical autonomy. There is *broad* agreement as to the *primacy*[98] of individual autonomy in healthcare and bioethics. Nonetheless, interpretations of autonomy are - in healthcare and beyond –so subjective that as a principle, it can be used to argue opposing sides of the same argument.[99] In legal philosophy, for example, liberal autonomy may be used to argue for individual rights of free speech, whilst relational autonomy is used to argue against hate speech.[100] Autonomy, as etymologically interpreted from its Greek origins – *αύτόνομος* - means self-law, which originally pertained to the self-governance of the Greek *polis* or state. It was Kant who first described the moral autonomy in relation to *individual* self-governance and the self-imposition of universal moral law upon oneself.[101] Subsequently, some interpretations of autonomy have taken an individualistic approach whereby completely "*self-sufficient, independent and self-reliant…self-realizing individual[s]… direct [their] efforts towards maximising … personal gains…*"[102]. However, this represents an *atomistic* form of autonomy which considers the intrinsic metaphysical identity to be independent of, and isolated from external relationships,

[98] Vaerlius J. (2006). The Value of Autonomy in Medical Ethics. *Med Health Care Philos*. 377-388. doi:10.1007/s11019-006-9000-z

[99] Mackenzie, C, Stoljar N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.

[100] Mackenzie, C, Stoljar N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.

[101] Kant, Immanuel, (2005 [1785]), *Groundwork for the Metaphysics of Morals* (translated by Abbott, T revised and edited by Denis L). Peterborough: Broadview Press.

[102] Code, L. (1991). "Second persons," in *What Can She Know? Feminist Theory and the Construction of Knowledge.* Lanham, MD. Rowman and Littlefield.

culture or society. It is to this end that individualism is refuted as a valid interpretation of autonomy by Baier, who holds the position that autonomy cannot possibly be truly independent as external influences shape individual development.[103] It is also important to distinguish between individualism and the concept of 'self-interest' in moral theory[104]. Individualism holds that individuals are the "*ultimate point of reference of moral obligations…[whilst] collective entities such as nations, peoples [and] societies…cannot fulfil this function*".[105] Notably, self-interest need not necessarily exclude external considerations such as "*nations, peoples and societies*".[106] In Nicomachean Ethics, it was Aristotle's view that individuals should primarily pursue their own *eudaimonia*.[107] Often confused with 'happiness', the pursuit of *eudaimonia* is more in line with upholding one's own self-interest or well-being than the emotion of happiness. Such a form of normative egoism is, however, *"...a more sophisticated phenomenon than first meets the eye".*[108] It is not to be confused with the self-indulgence of hedonism, nor the self-absorption of *egotism*. By distinction, the safeguarding of individual self-interest in the pursuit of Aristotelian eudaimonia should incorporate virtue ethics.[109] A virtuous decision in pursuit of eudaimonia should, therefore, consider virtues such as

[103] Baier A. (1985). *Postures of the Mind. Essays on Mind and Morals*. Minneapolis: University of Minnesota Press

[104] Smith T. (1998) Rights, Wrongs and Aristotelian Egoism: Illuminating the Rights/Care Dichotomy. *J Soc Philos*. 29(2), 5-14.

[105] Von der Pfordten D. (2012). Give Elements of Normative Ethics – A General Theory of Normative Individualism. *Ethical Theory Moral Pract*. 15, 449-471.

[106] Von der Pfordten D. (2012). Give Elements of Normative Ethics – A General Theory of Normative Individualism. *Ethical Theory Moral Pract*. 15, 449-471.

[107] Aristotle. (2000). *Aristotle: Nicomachean Ethics* (Cambridge Texts in the History of Philosophy) (R. Crisp, Ed.). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511802058 Chapter X, 183-204.

[108] Smith T. (1998). Rights, Wrongs and Aristotelian Egoism: Illuminating the Rights/Care Dichotomy. *J Soc Philos*. 29(2), 5-14.

[109] McKerlie E. (1998). Aristotle and Egoism. *South J Philos*. XXXVI, 36(4), 531-55.

friendship, justice and prudence and in doing so, take the interests of others into account.[110] [111] McKerlie clarifies that "*in acting to achieve my own eudaimonia [or self-interest] I will in fact be acting in ways that benefit other people*".[112] Of the cardinal virtue of prudence, Aquinas described how the individual *"first deliberates and consults others, seeking the best means and circumstances necessary to act honestly and correctly*"[113] before reaching a decision. Ferrari also clarifies that;

> *"…true individual prudence cannot exist in the mere pursuit of private interest but implies taking care of the social dimension as well…[therefore]..[m]ere egoistic behaviour is short-sighted rather than prudent, … it implies a wrong understanding of the individual himself/herself, deprived of the network of relationships which permits him/her to flourish*"[114].

The fulfilment of self-interests, therefore, *"....is not possible in isolation, but needs a community … [and in turn] the community ... without the individual's active contribution … cannot maintain and improve itself".*[115] Aristotle also goes further to consider that virtuous activity may also require "*sacrifice for the sake of others*" – a concept not dissimilar to that of solidarity.[116] To this end, the fulfilment of individual self-interest in healthcare through individual rights of autonomy is a relational construct which aligns with solidarity, rather than standing in opposition to it. However, as previously explored, self-interested *exclusive* forms

[110] Aristotle. (2000). *Aristotle: Nicomachean Ethics* (Cambridge Texts in the History of Philosophy) (R. Crisp, Ed.). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511802058 Chapter X, 183-204.
[111] McKerlie E. (1998). Aristotle and Egoism. *South J Philos*. XXXVI, 36(4), 531-555.
[112] McKerlie E. (1998). Aristotle and Egoism. *South J Philos*. XXXVI, 36(4), 531-555.
[113] Gardiner P. (2003). A Virtue Ethics Approach to Moral Dilemmas in Medicine. *J Med Ethics*. (29), 297-302.
[114] Ferrari G. (2017). The Relevance of Prudence to Environmental Ethics. *EJSTA*. 36(1), 126-164.
[115] Ferrari G. (2017). The Relevance of Prudence to Environmental Ethics. *EJSTA*. 36(1), 126-164.
[116]Aristotle (1984). Nichomachean Ethics. Translated by Ross WD. revised by Urmston JO. In the Complete Works of Aristotle. The Revised Oxford Translation LXXI: Princeton, New Jersey: Princeton University Press.

of solidarity can pose problems in healthcare. It is for this reason that the inclusivity of conjoint solidarity presents a vehicle for the *collective* pursuit of *eudaimonia,* or well-being through the shared goal of improved healthcare outcomes.

Notably, liberals take a more fundamental view of atomistic autonomy which is *further* grounded in concepts of *'self'*. In political theory, liberal autonomy represents a negative right which should *not* be infringed upon by wider societal institutions. John Stuart Mill's '*Of Liberty'*, considers autonomy to be "*one of the central elements of well-being*", upon which the individual self can flourish.[117] [118] Both Kantian self-governance and Rawlsian liberalism are rooted in conceptualisations of autonomy pertaining to the rational, self-legislative capacity of persons. Kant aligns morality with rationality by recognising individuals as free moral agents – a requirement thought unnecessary by contemporaries such as Dworkin.[119] [120] For Kant, a moral action is not that which is influenced by human *"desires, appetites, wants and interests"* but the "*higher authority*" of rationality. He further asserts – by way of his Categorical Imperative - that individuals must act *"only on that maxim which you can at the same time will be to a universal law"* and in doings so adds the caveat that autonomous decisions should be reasonably applicable to all.[121] [122] According to Rehg, Kant portrays "*... a universal moral community*", membership of which "*...constitutes a real social bond that enables harmonious cooperation in everyday life*".[123] Such 'membership' can promote a "*commitment to…cooperation...[which is] grounded in the mutual recognition of the dignity of persons*

[117] Mill JS. (1867) *On Liberty*. London: Longmans, Green and Co.
[118] Gray J. (2000). Mill's Liberalism and Liberalism's Posterity. *J Ethics*. 4 (1/2),137–165
[119] Dworkin G. (1988) *The Theory and Practice of Autonomy.* Cambridge: Cambridge University Press, 334-47.
[120] Campbell, L. (2017). Kant, Autonomy and Bioethics. *Ethics Med Public Health.* 3(3), 381-392
[121] Kant, I. (2005 [1785]). *Groundwork for the Metaphysics of Morals*, translated by T. Abbott, revised and edited by L. Denis, Peterborough: Broadview Press, 2005.
[122] Campbell, L. (2017). Kant, Autonomy and Bioethics. *Ethics Med Public Health.* 3(3); 381-392
[123] Rehg W. (2007). Solidarity and the Common Good: An Analytical Framework. *J Soc Philos*.38(1),7-21

capable of autonomy..".[124] In this way, autonomy which recognises the moral community can be both rational and relational.[125] Rawls takes a differing approach by considering *political* liberty to be subject to the requirement of 'endorsement'. According to Rawl, liberty is only justifiable, legitimate and valid, so long as it is acceptable to the individuals it affects, and institutions are only valid if endorsed by individuals subject to their power.[126] It may therefore be said that Rawlsian liberalism is also grounded in a relational 'social contract' which is also pertinent to Kantian self-governance.[127] Both Kant and Rawl acknowledge that interpretations of autonomy – and even liberalism – require a *social* dimension. Consider autonomy as interpreted a normative concept of self-realization as is proposed by Aristotle in Nicomachean ethics[128] - Meyers's asserts that to this send autonomy is a *competency* encompassing various capacities required to achieve 'self-realization'.[129] Such capacities are developed, reinforced or even inhibited by the social context or environment.[130] Accordingly, Wolf considers normative competence, or capacity, to be a central requirement of autonomy, in building upon Kantian constructs of autonomy[131]. Autonomy is also *"understood as the capacity for rational self-regulation"*[132] according to Korsgaard. Such capacity or competence to make decisions is, as Meyers proposed, influenced by social interaction.[133] This is reflected in the medico-legal interpretation of autonomy whereby the capable adult – or indeed, the competent child of sufficient maturity or understanding[134] - can exercise rights of medical autonomy through informed consent.

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[124] Rehg W. (2007). Solidarity and the Common Good: An Analytical Framework. *J Soc Philos*.38(1),7-21
[125] O'Neill O. (2009). *Autonomy and Trust in Bioethics*. Cambridge UK, Cambridge University Press
[126] Rawls J. (1993), *Political Liberalism*, New York: Columbia University Press; 144-50
[127] Hampton J. (1980). Contacts and Choices: Does Rawls Have a Social Contract Theory? *J Philos*. 77(6), 315-338
[128] Aristotle (1984). Nichomachean Ethics. Translated by Ross WD. revised by Urmston JO. In the Complete Works of Aristotle. The Revised Oxford Translation LXXI: Princeton, New Jersey: Princeton University Press.
[129] Meyers DT. (1989). *Self, Society, and Personal Choice*, New York: Columbia University Press.
[130] Meyers DT. (1989). *Self, Society, and Personal Choice*, New York: Columbia University Press.
[131] Wolf S. (1990). *Freedom and Reason*, New York: Oxford University Press.
[132] Korsgaard CM. (1996). *The Sources of Normativity*, New York: Cambridge University Press.
[133] Meyers DT. (1989). *Self, Society, and Personal Choice*, New York: Columbia University Press.
[134] *Gillick v West Norfolk & Wisbeck Area Health Authority* [1986] AC 112 HL

Relational autonomy as a concept in its own right has developed in the field of feminist ethics and may be defined as the *"shared conviction…that persons are socially embedded and that agents' identities are formed within the context of social relationships…shaped by a complex of intersecting social determinants, such as race, class, gender and ethnicity"* [135]. This alternative, societal interpretation of selfhood and autonomy considers that relations with others actually *shape* our being, and therefore influence self-governance, rule or determination in relation to autonomy[136]. It proposes that the very values which individuals hold as their own be derived from their environment.[137] Links to society and societal identity - whether that relates to race, culture or religion - subsequently shapes *individual* identity and subsequently has a baring on autonomous decision-making.[138] In terms of medical autonomy, a patient's autonomous decision is *reliant* upon information they obtain from HCPs. Indeed, MacLean argues that *the way in which* information is given to patients can shape their views and subsequently influence 'autonomous decision making'. To this end, MacLean proposes that in order to *fully* facilitate patient autonomy a truly relational approach is required. This involves an engaging *di*alogue rather than an advisory *mono*logue to afford patients and HCPs the opportunity to persuade and challenge one another so as to address misconceptions or misinformation.

Conjoint Solidarity to Improve Healthcare Outcomes

[135] Mackenzie, C, Stoljar N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.
[136] Mackenzie, C, Stoljar N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.
[137] Taylor C. (1991). *The Ethics of Authenticity*, Cambridge, MA: Harvard University Press.
[138] Sandel MJ. (1999 [1982]). *Liberalism and the Limits of Justice.* Cambridge: Cambridge University Press. 2nd Ed

The concept of conjoint solidarity builds upon existing theories such as Durkheim's *"community cohesion [which is] extended to all".* Yet whilst Durkheim's organic solidarity is founded upon an interdependence being individuals with specialised roles in society, conjoint solidarity is considered to be a descriptive norm. Such an inherent form of solidarity does, however, acknowledge bring together the value of the specialised role adopted by HCP with the epistemic value of patient knowledge, experience or input.[139] This is contrasts, to certain extent, with forms of solidarity which develop upon concepts of similarity.[140] Conjoint solidarity also closely aligns with Dawson and Jennings' solidarity of 'standing up beside' one another.[141] However, the foundation of their concept is based upon an act of positively identifying with others – such as through 'sympathy and understanding'. This applies in three main forms; the act of 'standing up for' (speaking on behalf of others), the act of 'standing up with' (mutuality and equality) and 'standing up as' (tolerance of difference or disagreement). Whilst this model is in the same vein as conjoint solidarity due to its inclusive and descriptive nature, it diverges upon the suggestion that there need be disadvantage or injustice to prompt such an act of standing alongside. By contrast conjoint solidarity does require sympathy or disadvantage – although it may exist – nor does it look to similarity or difference in order to forge bonds, but instead it looks positively ahead towards the shared interest that is improving healthcare outcomes. Such a shared goal instils a sense of unity and togetherness. Moreover, whilst Dawson and Jennings' model is - like conjoint solidarity - one of mutuality and bi-directionality it applies solely to *public* health, whereas conjoint solidarity applies at various healthcare decision-making levels. It focuses upon a *shared* 'self' interest - that of 'improved

[139] Durkheim E. (1984 [1893]). *The Division of Labour in Society*. London: Macmillan
[140] Prainsack (t
[141] Dawson A, Jennings B. (2012) The Place of Solidarity in Public Health Ethics. *Public Health Rev.* 34, 65-79.

healthcare outcomes' – and so it represents an *inclusive* form of solidarity which incorporates all stakeholders within the diverse healthcare system they subscribe to. Naturally this position raises questions pertaining to *epistemic* solidarity and *who* decides what *improved* healthcare outcomes are. Whilst general conceptualisations of solidarity concern collective *action*, *epistemic* solidarity concerns consolidation of information to ascertain the "*true interest*" of the collective. [142]

As a political concept, Goodin and Speikermann describe how masses – often disadvantaged by less information and incompetence – can 'pool information' to redress balance with the informed, competent elites. Taking the Condorcet Jury Theorem (CJT) as an example, they assert than in democratic voting systems, the majority of voters are more likely to come to the 'right' decision pertaining to collective best interests, than individual voters. Notably, the power of the collective depends upon the *"sufficiently independent and competent*" individuals. In this way, epistemic solidarity may be said to be *dependent* upon individual autonomy. However, epistemic solidarity with its focus upon 'elites' and 'masses' – which in healthcare may pertain to 'elite or specialised HCPs' and 'patient masses' – may represent an *exclusive* model of solidarity. Furthermore, competent elites may also pool *their* knowledge and resources to 'over-come' the masses to determine best interests which, in healthcare, could promote paternalism over autonomy.[143] The investigative findings of the Independent Medicines and Medical Devices Safety Review (IMMDR) offer a potential insight into how this could affect determination of collective interests. The review addressed, in part, the scandal

[142] Goodin B, Spierkermann K. (2015). Epistemic Solidarity as a political strategy. *Episteme*. 12, 4: 4239-457.
[143] Goodin B, Spierkermann K. (2015). Epistemic Solidarity as a political strategy. *Episteme*. 12, 4: 4239-457.

surrounding implantable pelvic polypropylene mesh (pelvic mesh).[144] The prolonged use of mesh in the treatment of stress urinary incontinence (SUI) and pelvic organ prolapse (POP) was, for a considerable period of time, considered to be safe despite patient reports of harm suffered. Indeed, several patients asserted that their complications were often dismissed and not taken seriously. Instead, the 'knowledgeable healthcare elite' relied upon evidence-based practice – which was subsequently found to be subject to bias - to determine that this was a safe practice which could attain improved healthcare outcomes. Following decades of campaigning, 'masses' of independent, competent patient participants collectively pooled information through support groups such as 'Sling the Mesh' to campaign present a consensus of the significant morbidity and even mortality associated with the practice. [145] In doing so, the patient 'masses' successfully challenged the views of the 'elite'. This, perhaps, illustrates that exclusive forms of epistemic solidarity are not conducive to improved healthcare outcomes. It is to this end that conjoint solidarity applies *inclusive* epistemic solidarity so the *collective* healthcare entity 'pool information' to better determine best interests and improve healthcare outcomes.

In healthcare, decision-making occurs at the micro, meso, macro and meta levels.[146] The micro level concerns decision-making between patients and HCPs whilst the meso-level concerns the "*clinical decisions involved in the development of guidelines or protocols that*

[144] Independent Medicines and Medical Devices Safety Review [Internet]. Cumberledge J, CBE. 2018, November 20. [Updated 2020, July 31; cited 2021, February 8]. Evidence. Available from https://www.immdsreview.org.uk/Evidence.html . See also the final report: Cumberlege J CBE. First Do No Harm – The Report of the Independent Medicines and Medical Devices Safety Review. 2020 July 8 [cited 2021 February 8] United Kingdom. ISBN 978-1-5272-6567-7. Available at https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf Accessed 12 April 2021.
[145] *Ibid*
[146] Guler S, Hurton S, Winn MC, Molinar M. (2015). Levels in Decision Making and Techniques for Clinicians. *Int J Dig Dis.* 1(1) 2

can be used for the treatment of specific conditions…with the aim of [determining] optimal treatment policies".[147] Subsequent macro and metal level decision-making tends to pertain more to distributive justice which will be considered later with macro-level decisions concerning "*allocation and utilization of resources in a region, organization [or] hospital etc*"[148] with the meta-level concerning healthcare budget as determined at governmental level. It is anticipated that application of an inclusive epistemic gloss to conjoint solidarity would enable determination of 'improved healthcare outcomes'. At the micro level conjoint solidarity can promote a two-way dialogue between patient and HCP through the medium of shared decision-making which will facilitate the initial 'pooling of information'. Such information can subsequently contribute to determination of best interests and improved healthcare outcomes. Conjoint solidarity is likely to promote trust and, in turn, greater patient disclosure which can improve diagnosis and promote better clinical outcomes.[149] Similarly, the HCP offers their specialised knowledge, and the patient discloses key information for diagnosis. Following treatment, this model can also provide a valuable source of information pertaining to patient experiences and their perspectives on treatment outcomes which can help shape future practice. Such an approach at both meso and macro levels could also enrichen the evidence-base for policymakers. Currently in the UK, the evaluation of efficacy, safety and cost-effectiveness of treatments is undertaken by the National Institute for Clinical Excellence (NICE) – a macro level organisation - which subsequently provides evidence-based guidance on available treatments and how to improve

[147] Guler S, Hurton S, Winn MC, Molinar M. (2015). Levels in Decision Making and Techniques for Clinicians. *Int J Dig Dis.* 1(1) 2
[148] Guler S, Hurton S, Winn MC, Molinar M. (2015). Levels in Decision Making and Techniques for Clinicians. *Int J Dig Dis.* 1(1) 2
[149] Guler S, Hurton S, Winn MC, Molinar M. (2015). Levels in Decision Making and Techniques for Clinicians. *Int J Dig Dis.* 1(1) 2

outcomes. Such 'evidence-based practice' involves assimilation of the best research evidence.[150] However, the evidential hierarchy which currently favours quantitative data tends to disregard input such as patient-based qualitative evidence.[151] Patient-based evidence pertains to that which is collaboratively generated from patients and has been shown to improve healthcare outcomes.[152] Arguably the disregard for patient-based evidence may, inadvertently, promote a paternalistic approach to determining best interests and good healthcare outcomes. Recent studies also discuss how conflict of interest can bias clinical studies, unduly influence the medical literature and therefore impair healthcare outcomes[153]. This was the case in the aforementioned IMMDR, whereby mesh studies unduly influenced by conflict of interest dominated the literature and eclipsed smaller studies - and even NICE recommendations.[154] Indeed there was such a reliance upon quantitative data in the medical literature, that patient experiences were often discounted. Arguably the *lack* of epistemic conjoint solidarity could have contributed to the use of mesh for far longer than need have been the case. If the epistemic value of all stakeholders *had* been considered, better healthcare outcomes could have been achieved and increased morbidity avoided. In the USA, the regulatory body the 'Foods and Drug Administration (FDA)' has outlined ways in which patients can be engaged during *their* decision-making to contribute qualitative input,

[150] Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS.(1996). Evidence based medicine: what it is and what it isn't. *BMJ*. 312(7023),71.
[151] Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS.(1996). Evidence based medicine: what it is and what it isn't. *BMJ*. 312(7023),71.
[152] Staniszewska S. Werko S. (2017) P*atient-Based Evidence in HTA.* In: Facey K. Ploug Hansen H. Single A. (Eds) Patient Involvement in Health Technology Assessment. Adis, Singapore.
[153] Elder K, Turner KA, Cosgrove L, Lexchin J, Shnier A, Moore A, Straus S, Thombs BD. (2020) Reporting of financial conflicts of interest by Canadian clinical practice guideline producers: a descriptive study. *CMAJ*, 192(23) e617-625 https://doi.org/10.1503/cmaj.191737
[154] See Rowland, D. (2020) Some financial conflicts of interest in medicine cannot be managed and should be prohibited. *BMJ Opinion. Available at* https://blogs.bmj.com/bmj/2020/07/21/david-rowland-some-financial-conflicts-of-interest-in-medicine-cannot-be-managed-and-should-be-prohibited/ Last Accessed 11 March 2021 and also National Institute for Clinical Excellence (2003). Final appraisal determination. Tension-free vaginal tape (Gynecare TVT) for stress incontinence. Available at https://www.nice.org.uk/guidance/ta56/documents/final-appraisal-determination-tension-free-vaginal-tape-gynecare-tvt-for-stress-incontinence2 Last Accessed 11 March 2021

stating "*…if our ultimate goal is…to improve patient outcomes, we must take a whole-system approach*".[155] The Advancing Quality Alliance (AQUA) found that where patients were empowered, through shared decision making, to make decisions about their own health, there were "more favourable health outcomes"[156] In the UK, NICE will look to patient-based evidence only if there is a corresponding *lack* of quantitative evidence. Whilst greater patient engagement may be considered burdensome, studies have shown that *overall* healthcare system burden is lowered, which in turn results in better outcomes[157]. It is not suggested that such patient-based evidence in any way *replace* existing evidence, but instead that it should, instead, support it. An epistemic interpretation of conjoint solidarity would call for collective pooling of information from *all* stakeholders to determine and then improve healthcare outcomes. In a manner similar to Goodin and Speikermann's example of CJT, the majority are more likely to reach the right outcome than individuals.[158] The determination of outcomes and what constitutes a 'good healthcare outcome' is complex as it must reflect public interest, societal preference and cost-benefit analyses. These further considerations tie into the principle of justice.

BRIDGING THE GAP BETWEEN SOLIDARITY AND JUSTICE?

Conjoint Solidarity and Justice

[155] Finnegan G. (2018). Patient Collaboration and Patient-Based Evidence – Closing the Infinite Loop to Connect the Dots. Patient Focused Medicines Development. Available at https://patientfocusedmedicine.org/patient-collaboration-and-patient-based-evidence-closing-the-infinite-loop-to-connect-the-dots/ Accessed on 12 April 2021

[156] NHS. Shared Decision Making to Improve Health Outcomes. https://www.england.nhs.uk/shared-decision-making/why-is-shared-decision-making-important/shared-decision-making-to-improve-health-outcomes/ Accessed on 12 April 2021

[157] Finnegan G. (2018). Patient Collaboration and Patient-Based Evidence – Closing the Infinite Loop to Connect the Dots. Patient Focused Medicines Development. Available at https://patientfocusedmedicine.org/patient-collaboration-and-patient-based-evidence-closing-the-infinite-loop-to-connect-the-dots/ Accessed on 12 April 2021

[158] Goodin B, Spierkermann K. (2015). Epistemic Solidarity as a political strategy. *Episteme*. 12, 4: 4239-457.

Justice has been described as a *virtue* associated with the intrinsic moral character of the individual, a prescriptive *norm* aimed at guiding conduct and a *moral practice* through which an externalised form of virtue may be attained. Modern theories of *distributive* justice in particular seek to ascertain which societal frameworks (such as laws and policies) should be implemented to determine the distribution of resources amongst a collective. It was the influence of Roman Jurisprudence upon Thomas Aquinas which saw the shift from the classical position of *virtuous* justice towards an approach whereby rights and obligations approach were incumbent upon individuals under frameworks of moral guidance.[159] This apparent focus on 'the individual' may lead to the assumption that justice is a liberal construct which opposes the commonality of solidarity (Moralitat) however, just as there are liberal and social interpretations of both autonomy and solidarity, so too there are also liberal and social interpretations of justice.

One of the most rudimentary approaches to the matter of *distributive* justice is to apply a framework of strict equality amongst individuals in society. Such *egalitarianism* considers that individuals are morally equal and so there should be equal distribution of goods. Aristotle and John Stuart Mill both considered equality to be the foundation-stone of justice[160]. Indeed, Mill's philosophy was one of 'the greatest good for the greatest number', of the utilitarian kind. However, egalitarianism often does not take into account that, in the simplest of terms, there may not be equal contribution or *need* amongst the collective. So, somewhat paradoxically, equal allocation could result in actual or perceived inequality.

[159] St. Aquinas T. (1947). Summa Theologica of St Thomas Aquinas, 'Of Justice' [translated by Rathers of the English Dominican Province]. New York: Benziger Brothers Inc.
[160] Agnol D D. (2005). Dworkin's Liberal Egalitarianism. *Kriterion* [online]. 46(111), 55-59 Translated by Tonette MC.

Marxian views sought to eliminate inequality by distributing goods, first according to contribution and then - upon the subsequent establishment of a communist society - according to need (Marx 1978). By contrast, *liberal* theories of justice mirror liberal conceptualisations of autonomy in that they consider whether the act of a free individual to be just [161]. Liberal theory, developed from philosophers such as John Locke, hold that every individual has equal basic moral or natural rights which relate to their claims on societal resources.[162] Philosophers such as Kant prioritised liberty as the basis of justice, so that the state would redistribute very little in order to facilitate the greatest individual autonomy.

Philosphers such as Rawl[163] and Dworkin[164], however, sought to bridge the gap between liberal and egalitarian theories of justice. Their theories of *liberal egalitarianism* combine equality with personal liberty and responsibility. Dworkin's liberal egalitarianism aimed to bridge a gap by considering liberalism and equality as complementary to one another. Equality - such as equal respect and equal opportunity amongst individuals – would provide foundation upon which liberty would be established. Inequality is acceptable, according to Dworkin, if it derives from voluntary choice, rather than disadvantage. [165] [166] In this way, he seeks to make people responsible for their choices, but not matters beyond their control. Rawl's publication '*A Theory of Justice'* presents the one of most influential theories of liberal egalitarian justice.[167] Justice according to Rawl, should not "*adopt for society as a whole the*

[161] Ter Mulen R. (2016). Solidarity, Justice and Recognition of the other. *Theor. Med. Bioeth*. 37, 517-529.
[162] Locke J. (1978) [1698]). *Two Treatises of Government*. New York: EP Dutton
[163] Rawls J. (1971). A *Theory of Justice*. Oxford: Oxford University Press.
[164] Dworkin R. (2000). *Sovereign virtue: The theory and Practice of Equality*. Cambridge. MA: Harvard University Press
[165] Agnol D D. (2005). Dworkin's Liberal Egalitarianism. *Kriterion* [online]. 46(111), 55-59 Translated by Tonette MC.
[166] Dworkin R. (2000). *Sovereign virtue: The theory and Practice of Equality*. Cambridge. MA: Harvard University Press
[167] Rawls J. (1971). A *Theory of Justice*, Oxford: Oxford University Press.

principle of choice for one man" as the utilitarian approach proposes, as this places broad limitations upon the rights and liberties of individuals. Rawl acknowledges limitation in another way by way of his 'thin theory' which proposes an index of primary goods should be developed to identify the necessities individuals require to then go on and achieve their various *individual* goals. It is this primary index which can be used to determine whether inequality is justified or not.[168] An example of a primary good could be that of 'opportunity', which is explored in more depth through the theory of opportunity egalitarianism whereby rights take the form of opportunity. The degree to which individuals then take advantage of such opportunities determines their degree of distribution. In this way, individual justice can be derived from social justice, as the individual is seen to effectively comply with societal principles of justice[169]. There are problems with such opportunity egalitarianism, described by Ter Meulen as a cold form justice as not everyone will be able to take advantage of opportunities in the same way.[170] For example, some individuals may be less *able* to adopt a healthy lifestyle due to sedentary forms of employment. Yet under such opportunity egalitarianism they may be denied healthcare access or have it restricted. According to Ter Meulen, this is a form of humiliation, whereby those who do not take the opportunities afforded to them are be considered, by society, to be 'underserving' of collective resources.[171] Such humiliation may lead to *"rejection, exclusion, paternalism and denial of rights*".[172] Schmidtz and Thrasher suggest that justice should *bridge* the gap between individual virtue

[168] Rawls J. (1971). A *Theory of Justice*, Oxford: Oxford University Press.
[169] Ter Meulen R (2017). *Solidarity and Justice in Health and Social Care*. Cambridge: Cambridge Books. Ch 3, 12.
[170] Ter Meulen R (2017). *Solidarity and Justice in Health and Social Care*. Cambridge: Cambridge Books. Ch 3, 12.
[171] Ter Meulen R (2017). *Solidarity and Justice in Health and Social Care*. Cambridge: Cambridge Books. Ch 3, 12.
[172] Ter Meulen R (2017). *Solidarity and Justice in Health and Social Care*. Cambridge: Cambridge Books. Ch 3, 12.

and the virtue of the *polis* or society.[173] They recognise that as relational entities we rely upon community, therefore where justice promotes harmony in a community, compliance with justice will promote individual virtue. In a similar vein, Ter Meulen argues that *solidarity* should be applied *in addition* to theories of distributive justice to support relational aspects of personhood – as this can contribute to reciprocity, support and so ultimately perpetuate solidarity.

Conjoint Solidarity to Support Relational Distributive Justice

According to Ter Meulen, justice as a theory of rights and obligations, lacks a normative framework for its practical application which exists in the practical application of solidarity. Therefore, the incorporation of relational elements such as communication and "*reciprocal recognition of individuals"* amongst those who act in solidarity can *supplement* justice. In delivering healthcare, this would facilitate a relational approach to distributive justice which would allow participants to appreciate their "*identities and responsibilities*".[174] Relational justice may be defined as *"justice produced through cooperative behaviour, agreement, negotiation or dialogue amongst actors in a post-conflict situation"*[175]. It has also been described by Raines as a *"connectedness of persons and groups in community and [the] basic obligations to look out for the relational good of others".*[176] [177] Whilst Raines' definition

[173] Schmidtz D, Thrasher J. (2014). *"The Virtues of Justice,"* in K. Timpe and C. Boyd (eds.), *Virtues and Their Vices*, Oxford: Oxford University Press

[174] Ter Meulen R (2017). *Solidarity and Justice in Health and Social Care*. Cambridge: Cambridge Books. Ch 3, 12.

[175] Casanovas P, Poblet M. (2008). *Concepts and Fields of Relational Justice. In: Casanovas P, Sartor G, Casellas N, Rubino R (Eds). Computable Models of the Law. Lecture Notes in Computer Science.* Vol 4884. Berlin: Springer. 323-339.

[176] Pillsbury SH. (2019). What Is Relational Justice? Loyola Law School, Los Angeles Legal Studies Research Paper No. 2019-09. doi:10.2139/ssrn.3338052

[177] Pillsbury SH. (2019). What Is Relational Justice? Loyola Law School, Los Angeles Legal Studies Research Paper No. 2019-09. doi:10.2139/ssrn.3338052

relates to *restorative* justice, such reciprocal recognition amongst individuals is also pertinent to distributive justice as means of addressing the deficiencies in equality identified in liberal, liberal egalitarian and opportunity egalitarian views of justice.[178] To attain this goal, relational justice also requires "*attentiveness and appropriateness of response…trust and loyalty*" as well as reciprocity. As with relational autonomy and conjoint solidarity, relational justice recognises that individuals are inextricably linked. It holds that where the individual is denied their voice, there is subsequent inequality and *lack* of justice. In this way relational justice addresses the social collaboration which is often missing in alternate constructs of distributive justice. Conjoint solidarity could also support relational distributive justice as both concepts share the goal of improving healthcare outcomes. The collaborative nature of conjoint solidarity, founded upon the shared decision making of relational constructs of autonomy, can support distributive justice by involving patients in the matters of healthcare utilisation and allocation which currently do not include them. A collaborative approach could promote the responsible utilisation of healthcare resources which could - in turn - allow more efficient future allocation of resources to attain the goal of improved healthcare outcomes. It is not anticipated that patients would be able to participate in *all forms or levels* of distributive justice, however even at the micro level of care, collaboration and involvement could have a substantial impact. Consider, for example, that in 2017 the National Health Service (NHS) spent £70 million on paracetamol prescriptions alone. On prescription, paracetamol may cost £34 for 32 tablets,[179] whilst some retailers sell it "for pennies".[180] It is predicted that the NHS

[178] Raines JC. (1989). Toward a Relational Theory of justice. *Cross Currents* 39(2), 129-141, 160.
[179] NHS England. (2017). Prescription Curbs to Free up Hundreds of Millions of Pounds for Frontline Care. News. Available at https://www.england.nhs.uk/2017/11/prescription-curbs-to-free-up-hundreds-of-millions-of-pounds-for-frontline-care/ Accessed on 12 April 2021.
[180] Buchan L. (2017). Providing paracetamol to Patients in England Cost over £70m last year, official figures show. *The Independent.* 2 July. Available at https://www.independent.co.uk/news/uk/politics/nhs-70-million-paracetamol-last-year-figures-department-health-painkillers-prescriptions-a7819661.html

could save £190 million a year by reducing prescriptions for short term, or minor conditions which are alternatively available over-the-counter. [181] In UK law, the issue of distributive justice recently came to the fore in the legal case of *Bayer Plc v NHS Darlington CCG and Others* [2018] which considered the use of "off-label" and "off-licenced" medicines in National Health Service (NHS). The case explored where the NHS could use cancer drug Avastin "off-label" – beyond its licenced indication – in the treatment of ophthalmic condition macular degeneration.[182] Avastin cost £28 per dose whilst Bayer's EYLEA drug with specific marketing authorisation for the treatment of macular degeneration cost £816 per dose. The court, in establishing a legal precedent whereby the NHS could use 'off-label' medications to reduce cost, determined that Avastin was a safe and cost-effective treatment for macular degeneration.[183] The case also created a new legal duty for doctors to consider the wider issues of distributive justice and resource allocation when prescribing medical treatment. Justice Whipple said that "*having regard to resources is an enduring requirement, which touches on every decision which a clinician makes*"[184] and that it was a "*.. a matter of professional conduct…[that doctors] be free to choose whichever medicine he or she considers to be most suitable, taking account of his obligations to the patient, and to patients more generally*".[185] Therefore, whilst doctors have legal obligations to act in the best interests of individual patients they also have an obligation to consider the best interests of *all* patients when prescribing. Sutherland 2015 suggests that healthcare will face increasing difficulties in

[181] NHS England. (2017). Prescription Curbs to Free up Hundreds of Millions of Pounds for Frontline Care. News. Available at https://www.england.nhs.uk/2017/11/prescription-curbs-to-free-up-hundreds-of-millions-of-pounds-for-frontline-care/ Accessed on 12 April 2021.
[182] *Bayer Plc v NHS Darlington CCG and Others* [2018] EWHC 2465 (Admin)
[183] Wolgast E. (1987). *Wrong Rights, The Grammar of Justice*. Ithaca: Cornell University Press, 30
[184] *Bayer Plc v NHS Darlington CCG and Others* [2018] EWHC 2465 (Admin)
[185] *Bayer Plc v NHS Darlington CCG and Others* [2018] EWHC 2465 (Admin)

trying to satisfy both issues of patient autonomy and distributive justice in years to come.[186] However, Davies and Savulescu 2016 propose that in order to enjoy the right to free healthcare, patients should be obliged to "play their part" in terms of healthcare solidarity[187] Relational justice in healthcare - whereby individuals acknowledge their "*identities and responsibilities*" as inextricably linked entities – could facilitate a form of collective collaboration which is often missing constructs of distributive justice. Conjoint solidarity, which requires collaboration and collating of information, could also provide a means of supporting distributive justice by allowing patients to 'play their part' – although to a degree. As relational autonomy and conjoint, epistemic forms of solidarity all involve sharing and pooling information, then it is likely that healthcare literacy will be improved. Subsequently, through greater collaboration, a form of collective responsibility could be adopted which would facilitate more conscientious use of the NHS and more efficient healthcare utilisation. The UK healthcare system is based upon universal access at the point of need with distributive justice is used to address such questions of 'need'. This proposal does not intend to provide a single solution to these issues, but instead to serve as a reference point for future debate.

CONCLUSION

Solidarity in the field of healthcare ethics has been somewhat neglected, perhaps due to the assumption that it opposes concepts of individuality and autonomy. Yet where autonomy is interpreted as a *relational* concept, these principles can develop an inter-dependency –

[186] Sutherland A. (2015). It is time to review how unlicensed medicines are used? *S. Eur J Clin Pharmacol.*71,1029 doi.org/10.1007/s00228-015-1886-z
[187] Davies B, Savulescu J. (2019). Solidarity and Responsibility in Health Care. *Public Health Ethics.*12(2):133-144

founded, in part, upon the process of shared decision-making - so that both individual and collective may benefit. In seeking to complement existing scholarship, conjoint solidarity proposes a new model which is inclusive of *all healthcare* stakeholders in diverse healthcare communities. In this way, with the focus upon the mutually held goal of improved healthcare outcomes, exclusion and othering can be avoided in our diverse healthcare communities. It is anticipated that such desirable healthcare outcomes can be determined by adopting an *epistemic* approach, which involves collective pooling of information. Furthermore, this may also help address some of the current problems in healthcare - such as exclusion, paternalism and conflict of interest - so that they be mitigated. Such a conjoint and epistemic approach can also provide an opportunity to rethink distributive justice. As a *relational* concept it may afford patients the opportunity to 'play their part' in a small way – such as through responsible healthcare usage. This may help ensure efficient use of healthcare resources and more appropriate resource allocations - which can, in turn, improve healthcare outcomes.