



SEÇÃO TEMÁTICA

Thinking ethically about pandemics: a matter of public health and social ethics

Pensar eticamente sobre pandemias: uma questão de saúde pública e ética social

Patrick T. Smith*

Abstract: This essay argues that any ethical approach to mitigating the negative effects of pandemics must give detailed and sustained attention to those who are on the margins of society. This means tackling widespread racism and concentrated poverty in our body politics. The challenges resulting from pandemics are not merely ones of public health but are simultaneously matters of social ethics. The aim of this essay is to highlight important values from religious social ethics for responding ethically to pandemics. In this work, I do not undertake the task of formulating and prescribing national policies that egalitarian democratic societies should adopt in pandemic situations. Instead, the paper focuses on how religious social ethics can help reimagine social life and communal practices by focusing on the margins to mitigate some of the negative effects caused by public health disasters.

Keywords: Social ethics. Pandemic ethics. Health disparities. Racism. Poverty. Social justice.

Resumo: Este ensaio argumenta que qualquer abordagem ética para mitigar os efeitos negativos das pandemias deve dar atenção detalhada e continuada àqueles que estão à margem da sociedade. Isso significa combater o racismo generalizado e a pobreza concentrada em nossas políticas corporais. Os desafios que resultam das pandemias não são meramente de Saúde Pública, mas são simultaneamente questões de ética social. O objetivo deste ensaio é destacar valores importantes da ética social religiosa para responder eticamente às pandemias. Neste trabalho, não se assume a tarefa de formular e prescrever políticas nacionais que as sociedades democráticas igualitárias deveriam adotar em situações de pandemia. Em vez disso, o artigo evidencia o modo como a ética social religiosa pode ajudar a repensar a vida social e as práticas comunitárias, focalizando as margens para mitigar alguns dos efeitos negativos causados por desastres na saúde pública.

Palavras-chave: Ética social. Ética pandêmica. Disparidades em saúde. Racismo. Pobreza. Justiça social.

Introduction

This essay argues that any ethical approach to mitigating the negative effects of pandemics must give detailed and sustained attention to those who are on the margins of society. A central claim being made here is that challenges from pandemics are not merely ones of public health but are simultaneously matters of social ethics. As a work in bioethics, the aim of this essay is to identify how select values and dispositions that emerge from social ethics, namely, commitments to human dignity, the common good,

* Associate Research Professor of Theological Ethics and Bioethics, Associate Faculty at the Trent Center for Bioethics, Humanities, and History of Medicine, and Senior Fellow at the Kenan Institute for Ethics (Duke University, USA). PhD in Philosophy (Wayne State University, USA). ORCID: 0000-0002-4818-6946 – contact: psmith@div.duke.edu

solidarity, and justice, can inform national responses to pandemics both during them and certainly afterwards. These commitments necessarily resist social arrangements that facilitate racism and sustain situations of involuntary concentrated poverty. In this work, I do not undertake the task of prescribing or formulating national policies that egalitarian democratic societies should adopt in pandemic situations or after they subside. Instead, the claim advocated here is that religiously informed social ethics can help reimagine social life and communal practices in order to mitigate the negative effects of various types of widespread health disasters.

In order to unpack this claim, I first highlight the role of involuntary concentrated poverty and racism in countries like Brazil and the United States (notable differences notwithstanding) in shaping the social conditions for health disparities. From there in sketching a way forward, I emphasize how commitments to human dignity and the common good, so essential for political and spiritual life together, can explain why a focus on the margins is essential. Then, I explain the importance of the interrelationship of commitments to human solidarity and concrete expressions of justice. That is, in order to seek an ethical pathway for mitigating the negative effects of pandemics. A commitment to solidarity is an orientation of being steadfastly dedicated to work for the good of all people. Simply put, it is to be for others. It is an ongoing recognition that the flourishing of the “least of these” is important to the flourishing of society. A commitment to justice entails creative ways to implement a principle of redress that seeks to repair wrongs and create conditions needed to promote human flourishing for all with special attention to those on the margins. Justice goes beyond the allocation of potentially scarce resources in tragic pandemic situations. It extends its reach to address the fault lines of communal life that in too many cases produce and sustain health and health care disparities.

Health and health care inequities

Most societies, if not all, reflect some kind of social hierarchy within them. These societies also have corresponding hierarchies of health status and outcomes directly associated with those social arrangements. Countries like Brazil and the United States, for instance, are no exceptions and illustrate the point. Donald Barr has summarized the general findings of “a growing body of research suggests that the health of an individual will be affected both by their place in the social hierarchy of their own society as well as by the level of economic inequality that exists between the best-off and the worst-off within society” (Barr, 74). Not only is it the case that social arrangements reflect varying levels of socio-economic status. But they are also developed along racialized lines reflecting social hierarchies. The links between health inequalities, race, and socio-economic status are well established.

These social arrangements contribute to poorer health outcomes and higher mortality rates for those in these populations. “The suffering resulting from poverty prevents people from flourishing and causes many premature deaths” (Martins, 202, xii). A recent study examining the mortality rates according to skin color in the Brazilian urban context of

cities found the inequalities in this regard “reflect a set of structural disadvantages and aspects of social organization within cities” (De’Oliveira, Luiz, 2018). Related to this is the “burden of stroke mortality [being] higher among [Brazilian] blacks compared to brown and white” (Lotufo, Benenor, 2013, p. 1201). An example from the United States, is the deep disparities between blacks and whites in the area of infant mortality and black women’s reproductive health (Smith, 2019). Of course, those familiar with these discussions know that these examples could be multiplied in a myriad of ways. Moreover, in light of the challenges of racial classification and determining life expectancy (Chiavegatto Filho, Beltrán-Sánchez, Kawachi, 2014), these sorts of health disparities cannot simply be explained by appeal to biological features that people of a particular race share in distinct ways as opposed to other groups of people. Rather, as many have argued, there are broader social determinants that are directly contributing to many of these negative health outcomes that we see.

The problem is not solely that inequalities in health exist. The primary issue in view is when those differences become disparities, when those inequalities become inequities. Evaluations such as these are largely correlated with the amount of control a person has over the conditions that is causing the disparity. “Those [factors] that we have no control over but that are imposed on us by others represent the extreme forms of injustice” (Hebert, Sisk, and Howell, 2008, pp. 380-381). A socio-historical understanding of the formation of poorer suburbs, favelas, low-income towns, and ghettos reveals the role of systemic legal and financial exploitation in directly contributing to the creation of such conditions and the maintaining of unfair social hierarchies.

Moreover, beyond the economic aspect is the racial dynamic. The racial demographic of these spaces often is characterized by blacks, brown, mixed-race people, and other non-whites and those of lower socioeconomic status. These dynamics are part of a larger pattern of social life that unfortunately has characterized significant aspects of the western world including countries like Brazil and the United States. I refer to it as the works of a racialized imagination, which is discussed below.

The general direction of the evidence suggests that both racism and socioeconomic status often work together in mutually reinforcing ways to perpetuate disparities in health (Kawachi, Daniels, Robinson, 2005, 343-352). Nazroo and Williams suggest that social and economic inequalities as well as the effects of racism both can be viewed as fundamental causes of ethnic inequities in health (Nazroo, Williams, 2006, 238-266). And so they must be understood in tandem as potential co-determinants. Nevertheless, we must be careful not to collapse the issue of race into the category of socioeconomic status or “class” as if the latter do all the work in explaining disparities with which we are dealing. Race and socioeconomic status remain distinct categories with distinct issues and distinct outcomes even if they are connected to each other in important ways (Smith, 2019, p. 189). Donald A. Barr surveys a number of studies that look at the effect of race on health outcomes after accounting for socioeconomic status. The conclusion these studies draw is blacks still had more unhealthy outcomes than their white counterparts (Barr, 2019, 120-127).

These realities should capture our moral attention. They suggest that many of the health inequalities people experience are due to unjust social arrangements. As such, they

reflect genuine health disparities not just differences. The intermingling of skin color and economic exploitation has been linked to some of the most insidious social arrangements of our body politics – the legacy of slavery, colonialism, and ongoing tribalism. The concept of race developed alongside the transatlantic slave trade in an attempt to justify the accumulation of wealth and the political economy built upon the exploitation and dehumanizing treatment of people. Through creative forms of maneuvering financial tools and resources, much of the Western world was able profitably to invest into the vast expansion of the practice of slavery (Baptist, 2014, pp. 215-260). These sorts of creative financial practices “multiplied the incredible productivity and profitability of enslaved people’s labor and allowed enslavers to turn bodies into commodities with which they changed the financial history of the Western world” (Baptist, 2014, pp. xxvi).

Of course, one has to be able to tell a story as to how these sorts of socio-economic arrangements can be morally justified. What is needed is a set of ideas that can be so embedded in every aspect of public, private, and civic life that it appears to be beyond question. Judy Root Aulette summarizes the content of such a rationalization as needing to: (i) identify people who have been enslaved as not being fully or “really” human, (ii) establish “the superiority of slave owners (and others who were of the same ‘race’) over those who have been enslaved”, and (iii) defend “the harsh treatment and the enslavement itself as part of the natural orderly system of humans caring for/ managing their fellow creatures” (Aulette, 2017, p. 47). All of this would need to be enmeshed fully in social institutions, practices, and policies in order for it to be firmly entrenched in human imagination and the corresponding collective agency needed to maintain such social relations.

Thus, in order to appreciate how this connects to questions of health, pandemic ethics, and a focus on the margins, it is important to understand the notion of ‘race’ as denoting a social construct. A social construct is an idea developed around a social imagination and set of practices that appear to be natural but are actually the creation of a given society. Race, then, is an invented social category that divides human beings into hierarchical groups based on differences in physical appearance, geographical origin, and ethnic backgrounds (Barr, 2019, p. 91). Historically speaking, as philosopher Alyssa Ney points out, “the system of racial classification is designed to enforce a social hierarchy, with [those who are considered] white people at the top” (Ney, 2014, p. 265). To be racialized, then, is “to be systematically subordinated or privileged, in virtue of being perceived as ‘appropriately occupying certain kinds of social position’” (Ney, 2014, p. 265). In this sense, all people in a given context are actually racialized whether or not it is acknowledged. Race as a social construct produces a racialized imagination with respect to how people view, encounter, embrace, include and exclude one another, and configure social arrangements. It is this framing of the issue that makes sense out of the claim by Dorothy Roberts when she writes, “race is the product of racism; racism is not the product of race” (Roberts, 2012, p. 25). Martin Luther King, Jr. was correct, “Racism is no mere American phenomenon. Its vicious grasp knows no geographical boundaries. In fact, racism and its perennial ally—economic exploitation—provide the key to understanding most of the international complications” of our generation (King, 2010, p. 183).

Yet, these racialized social arrangements can look differently depending on the particular socio-historical and geographical context. As researchers have duly noted in their work, there are distinct differences in the way Brazilians think about and experience race relative to those in the United States (Telles, 2004). “Color lines exist in Brazil. But Brazil does not have the binary of black and white that has been so prominent in the [United States] race relations. Rather, Brazil has many color lines” (Aulette, 2017, p. 167). Even so, what seems to remain a common feature of the experience of race and racism between the two countries is the social exclusion that results as a result of skin color albeit in different ways. Social exclusion, as Edward Telles’s groundbreaking work has pointed out, “refers to the ‘lack of social integration which is manifested in rules constraining the access of particular groups or persons to resources or limiting their access to citizenship rights’” (Telles, 2004, 4).

Understanding race as a social construct rejects a notion that it somehow refers to or “picks out” objective categories inherent to the biological nature of distinct human communities. This distinction is crucial to keep in mind. For “if race is a natural division, it is easy to dismiss the glaring differences in people’s welfare as fair and even insurmountable...which leaves huge gaps between white and nonwhite wellbeing” (Roberts, 2012, p. 5). Therefore, the observed health disparities in places like Brazil and the United States cannot be explained by appeal to some kind of inferior biological status of entire groups of human beings. The racialized imagination continues to inform our ways of relating to one another despite the abolishing of slavery and other forms of racial oppression. When the racialized imagination is still at work, forms of racism in the body politic simply evolve (e.g., Black Codes, peonage, share cropping, Jim and Jane Crow laws in the United States, mass incarceration, racially motivated police brutality, discriminatory housing practices even if not stated in housing policies, etc.). Racism has always stifled health and human well-being. The effects of which are still being felt on health outcomes and the ability to provide adequate health care and access to it for particular communities of people.

Thinking about a way forward

Clearly, those working in medical health care spaces must deal with the immediate physical health challenges of people needing care who present before them. And so there needs to be attention to the allocation of scarce resources, a commitment that health professionals will have the equipment they need, people will have good symptom management, and be treated as well as they can at the bedside. These are non-negotiable and essential aspects to managing care in a pandemic. To be sure, this is not easy. It is understood, even though unfortunate, that crises as the ones described here present particular challenges which prohibit optimal care being provided in every instance. There is a sense of the tragic that attends to such states of affairs. The term “tragic” is being invoked “to mean the inescapable ways in which in trying to do good we either cause or cannot alleviate suffering. Tragic situations often occur when a moral conflict arises that cannot be resolved or bypassed so that

whatever choice is made, even a choice to do nothing, results in suffering for someone” (Bretherton, 2020).

When pandemics strike it exacerbates existing health and health care disparities. Public health crises, such as COVID-19, expose and expand the fault lines of communal life that have produced such deleterious effects. Human well-being or flourishing requires a kind of holism. The World Health Organization (WHO) has provided a definition of health that is quite comprehensive. It suggests that health should be seen as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2007, p. 1). Many have criticized the WHO definition by claiming that it includes too much. Here I do not undertake an evaluation of these sorts of arguments and claims. Notwithstanding these concerns, I raise this description of health because there is a sense in which the WHO definition is identifying important features of the collective life of people and what it means for humans to flourish. Promoting health includes attention to the fact that people are complex biopsychosocial entities. There is a deep interconnection between people, health, and how we arrange our political life. Moreover, the kind of environment in which people live, move, and have their being and how they existentially make sense out of all this does impact overall health outcomes.

A holistic approach to health will require more than just the practice of medicine to achieve. There needs to be a simultaneous devotion to addressing the larger social conditions that make it much more difficult for people to withstand public health disasters. Addressing these issues is arduous and long such that patience and perseverance are needed. Nevertheless, responsiveness to these matters cannot be held in abeyance until such crises have dissipated. This is why the insights and commitments of religious social ethics become essential in thinking about a way forward. If the WHO’s holistic vision of health is right headed, it requires commitments to human dignity, working for the common good, human solidarity, and a vision of justice – all hallmarks of social ethics, in general, which require a focus on those at the margins.

Commitments to human dignity and the common good

An appeal to dignity has frequently provided a basis for human rights. As ethicist Dónal O’Mathuna observes, “Dignity is an underpinning idea that has been incorporated into various conventions of human rights that seek to practically improve the lives of all human beings” (O’Mathuna, 2013, p. 99). The term appears five times in both the *1948 Universal Declaration of Human Rights of the United Nations* and the *European Convention on Human Rights and Biomedicine* (Sulmasy, 2006, p. 71). The term also plays an important role in the *2005 Universal Declaration on Bioethics and Human Rights* where the “member states endorsed universal principles governing human subject research in ‘medicine life sciences and associated technologies’ to promote respect for human dignity, human rights and fundamental freedoms” (Jotterand, 2010, p. 45).

Despite its widespread appeal, the concept of dignity is often maligned due to its ambiguity (Macklin, 2003, pp. 1419-1420; Rosin, 2012). Steven Pinker criticizes the

contributors of an edited volume on the subject by highlighting the ambiguity in how the authors use the term. He claims that employing the idea of dignity is unhelpful since that leads to outright contradictions. Pinker writes, “We read that slavery and degradation are morally wrong because they take someone’s dignity away. But we also read that nothing you can do to a person, including enslaving or degrading him, can take his dignity away” (Pinker, 2008). Given the idea of dignity does in fact, rightly or wrongly, ground much moral discourse regarding how people should be treated—and reflects the idea that they have a significant kind of worth—the vagueness surrounding the term “dignity” needs attention.

Pinker’s and many others’ criticisms of human dignity raises the need to highlight an important distinction in any discussion of the concept of dignity. It is the distinction between invariable and variable senses of the term. The invariable sense of dignity refers to something about humans in virtue of their humanity. It can be said to refer to the status held by humans entitling them to respect throughout the duration of their lifespan (Matz, p. 158). Whereas the variable sense is contingent or fluctuates depending on some perceived status or ability or even on the context in view. We can refer to this latter sense of dignity as circumstantial dignity. An example of it would be giving higher regard or more honor to some people based on their accomplishments or social status (e.g., an Olympic gold medal winner over against a groundskeeper) (O’Mathuna, 2013, pp. 101-103). The invariable sense of the term, though, I claim is more ethically robust. It refers to why all people, simply because they are people, matter. The invariable sense of dignity proffered in this essay is central for appreciating the spiritual, political, and ethical importance of focusing on the margins in times of public health crises and beyond.

Regardless of the controversy that surrounds its use, many political theorists recognize the ethical importance that attends to the idea of dignity. Ronald Dworkin highlights the moral significance of the term “dignity” when discussing political rights, despite its lack of clear meaning.

Anyone who professes to take rights seriously, and who praises our government for respecting them [...] must accept at a minimum, one or both of two important ideas. The first is the vague but powerful idea of human dignity. This idea [...] supposes that there are ways of treating [humans] that are inconsistent with recognizing [them] as a full member[s] of the human community, and holds that such treatment is profoundly unjust. The second is the more familiar idea of political equality. This supposes that the weaker members of a political community are entitled to the same concern and respect of their government as the more powerful members have secured for themselves (Dworkin, 1977, pp. 198-199)

Building on Dworkin’s insights, I would urge consideration of the invariable sense of dignity as the more suitable for egalitarian societies. It would seem that it establishes better the principle of equal regard in ethics and social political philosophy. Even political equality, according to Dworkin, is ultimately based on something more fundamental and foundational, namely, “the powerful idea of human dignity.” It creates not only negative rights, the right to be left alone, but positive rights, obligations on the part of others to positively treat people in particular ways. Of course, there is much debate as to what constitutes legitimate examples of positive rights. Nevertheless, this notion flows directly from a deep sense of human dignity.

Further, it is the invariable sense that serves as the basis for making moral deliberations about circumstantial dignity meaningful. As one ethicist has recognized: “[W]hen we see people being treated in undignified ways, or who are unable to achieve their full potential, or who live in abject poverty, and we say their dignity is diminished, we do not thereby claim that they have less inherent dignity” (O’Mathúna, p. 103). This way of speaking, even if not philosophically precise enough for some contexts, points to something more fundamentally significant about people and the respect that is due them. When the arrangements of our communal life generate circumstances that prohibit people from flourishing, society is failing to treat people in ways compatible with the sense of dignity they possess in virtue of their humanity. It is because of the inherent dignity of humans that there remains, especially to those on the margins of society, “an ethical responsibility to address the reasons for their diminished circumstantial dignity” (O’Mathúna, 2013, p. 103).

This widely-held idea that people have some sort of invariable dignity signifies that humans are to be valued for who they are as they are. This is why racism is such an affront to human dignity. The notion of dignity strongly affirms that people matter morally despite their skin color, socioeconomic status, limitations, and vulnerabilities that come along with being finite and embodied beings. In fact, how people are viewed and treated precisely in the face of their human limitations, difficult circumstances, and vulnerabilities is one of the most powerful means of affirming the value or dignity of all people.

A commitment to human dignity provides the impetus for a corresponding commitment to the common good. If human dignity “concerns itself with the status of individual persons in society, the principle of the common good widens our focus to the status of the whole society” (Matz, 2017, p. 170). Social arrangements shaped by policies, laws, and practices matter with respect to promoting or stifling human flourishing. The common good, then, reflects the degree to which the social conditions enable individual members of a given society to flourish. Working for the common good, then, means working against poverty. “Poverty is an undeniable reality that prevents billions of people from enjoying social conditions that promote health” (Martins, 2020, p. xii). As with the case with racism, involuntary poverty too is an affront to human dignity and detrimental to the common good.

Moreover, the invariable sense of dignity intimates the importance of and an attendance to notions of human spirituality. In other words, people are more than political animals. Dignity denotes that humans are the kinds of entities that have a special moral status among the rich biological diversity of the biosphere (which the latter nevertheless has its own form of intrinsic value). Much debate surrounds what exactly about people grounds this exalted moral status, their dignity. As political scientist Francis Fukuyama puts it:

If what gives us dignity and a moral status higher than that of other living creatures is related to the fact that we are complex wholes rather than the sum of simple parts, then it is clear that there is no simple answer to the question, What is Factor X? That is, Factor X cannot be reduced to the possession of moral choice, or reason, or language, or sociability, or sentience, or emotions, or consciousness, or any other quality that has been put forth as a ground for human dignity. It is all of these qualities coming

together in a human whole that make up Factor X. Every member of the human species possesses a genetic endowment that allows him or her to become a whole human being, an endowment that distinguishes a human in essence from other types of creatures (Fukuyama, 2002, pp. 171).

As Rolston Holmes III notes “Humans are a paradox on Earth, both part of nature and apart from nature” (Holmes, 2011, p. 52). Modern biology has certainly taught us that humans are part of nature. To be sure, nature can do without humans, humans cannot do without nature. Nevertheless, “there is cause for wonder” (Holmes, 2011, p. 52). A certain mysteriousness joins the idea of human dignity and the exalted moral status associated with it. Part of this mysteriousness that Fukuyama and Holmes are describing can be expressed by the unique penchant for people to engage in meaning making of various sorts which can be referred to as spirituality. An often-neglected part of these conversations is the consideration of spiritual concerns.

Nations can also experience a pandemic of grief. The sudden and enormous loss of life, income, normal routine, opportunities, rites of passages, among other things can become existentially disorienting. In times of pandemics and with such significant loss, there may not be adequate time nor space to process all that is happening. Hence, possibly creating mental health challenges for many people. Attention to the spiritual dimension of our humanity remind us of the need for a kind of collective lament in order to process deeply felt grief and to cope with various kinds of suffering.

Following the work of Mary Rute Esperandio, I take an approach often found in religious studies and health care ethics by distinguishing notions of spirituality from religiosity. On this framing, the former concept is broader than the latter. Spirituality is “used to refer to the dimension of the human being that involves the search for meaning and purpose in life, search for self-integration and self-realization; search for relationships satisfactory human beings and a sense of connection with themselves and with others, with the universe and with transcendence (which can be a Higher Being or force in which the person believes)” (Esperandio, 2014, p. 808). Esperandio goes on to note that religiosity is “an expression of an individual’s involvement with religious practices that can be identified with institutionalized religions and can therefore be an aspect of spirituality of the subject” (Esperandio, 2014, p. 808).

This dimension of human life should not be minimized. Nor should the particular expressions of human religiosity that are based upon spirituality be disregarded when thinking about mitigating the negative effects of pandemics and the ongoing social conditions beyond the crises. Commitments to human dignity and the common good involve acknowledging this complex feature of human being. This is especially so when these resources might provide symbols, themes, and tropes to help communities reimagine notions of political justice for all (Carvalho, 2018). In addition, many in marginalized communities who disproportionately bear the burden of these disparities often rely on such resources in order to persevere and make sense out of the suffering they are experiencing.

In the United States, for example, prophetic expressions of Christianity have historically played a vital role in helping African-Americans to be resolute in their attempts to cope with and challenge the fundamental dehumanizing depths of racism and its

connections to negative psychosomatic health effects on their bodies and communities. It is difficult to conceive of the Civil Rights Movements of the 1960's in the United States, other black freedom movements that predates it, and its global impact without particular expressions of human religiosity as a form of spirituality in the service of a kind of justice (Harris, 1999; Savage, 2008; Baldwin, 1995). An exemplar of this tradition, Martin Luther King, Jr. explicitly rooted his larger social vision of the Beloved Community in the idea of human dignity and the common good in order to firm up one's sense of 'Somebodyness'. His particular expression of religiosity in the form of African-American prophetic Christianity served as inspiration and a counter perspective "in the wake of questionable sociological and biological analyses" of the plight of black Americans in the United States (Willis, 2009, p. 116).

For decades, intellectually rigorous projects of praxis addressing the cries of the poor and marginalized with respect to health care have developed from religious scholars in South America. A Brazilian theologian and bioethicist, Alexandre A. Martins, has recently developed a religiously informed, ethically robust human rights approach that focuses on those who are impoverished, listening to them, and identifying their needs in order to have justice in health care (Martins, 2020). The most intriguing factors about these types of endeavors is that by focusing on the margins it in the end affirms human dignity and promotes the flourishing and well-being of all.

Commitments to human solidarity and particular forms of justice

Pandemics have a way of reminding people of a deep sort of interconnectivity people have with each other and a kind of vulnerability they all share. During the COVID-19 pandemic there is the oft repeated expression, "We are all in this together." Politicians, pundits and media outlets repeat this phrase as the reach of the COVID-19 pandemic spreads. Politicians, journalists, athletes, actors, doctors and academic elites suffer alongside those without that same social standing, health security, and financial stability: small business owners, artists, service industry workers, the unemployed and underemployed, those who are homeless, those who are incarcerated and those who are employed to work in these spaces with them. And there is a whole range of people in between. The problem, however, is the suggestion that COVID-19 made this true. It perhaps naively suggests that all of a sudden people will now act in ways that reflect human solidarity when deep social fragmentation mar important aspects of our collective life together. Human tribalism, unfortunately, is not so easily set aside.

The challenges resulting from COVID-19 is a reminder of something that has always been true ethically and sociologically. People are deeply interconnected and yet our societies are often structured so that we lose sight of this reality. Those who are marginalized or part of vulnerable communities disproportionately suffer even when – and perhaps especially when – we say that "we're all in this together." COVID-19 is a reminder that we cannot easily nor without consequence separate our particular community's well-being from that of others. Responding ethically to pandemics requires a commitment to a robust notion of human solidarity, a notion which is a hallmark of

social ethics. Solidarity is a unity among people within a social organization to have a firm commitment to the common good of all people, especially to those on the margins (Matz, 2017, p. 194). It is a realization that all inhabitants of this great “world house” are now, and will continue to be, neighbors “brought into being largely as a result of the modern scientific and technological revolutions” (King, 2010, p. 177). Thus, people have obligations to work on behalf of one another. Solidarity is the realization that Martin Luther King, Jr. admonished a half century ago that “together we must learn to live as [neighbors] or together we will be forced to perish as fools” (King, 2010, p. 181).

What does solidarity require in mitigating the negative effects of pandemics? In seeking to navigate the murky waters of a global pandemic, there must be clear and careful thinking about how decisions impact those on the margins of our society – those who may be part of, as Howard Thurman said, the disinherited, the disenfranchised, or those whose backs are already against the wall (Thurman, 1996, p. 1). It is crucial to ask: How might we address this pandemic while working hard to minimize the widening of existing disparities in our society? Any responses to such a question must take into consideration how policy decisions and implementation, at all levels, will impact the most vulnerable, including the sometimes overlooked first responders in our healthcare institutions and other frontline services who have an intensified occupational risk. We must frame ways forward with due attention and even preference for the most vulnerable amongst us. Take for example, the location of testing centers for, say, COVID-19? Are those centers located in more affluent, less densely populated parts of the cities? Is there an overabundance of available tests in those locations and a scarcity in more densely populated residential areas? Has there been any thought as to how transportation concerns should impact the location of testing centers?

Whether thinking about allocating of scarce resources, safeguarding workers or other vulnerable populations, flattening of the curve of the pandemic, allocating money from the Federal government to a nation’s citizens, or supporting various industries, I would suggest this attention to the margins must be the case, not only for government, but also for health care institutions and local civic community groups engaged in mitigation efforts. It is problematic for public health professionals to encourage people not to go to work when for some people if they do not work, they literally do not eat. What does it practically look like for those who are asked to shelter in place who do not have adequate housing? Or live in densely populated favelas? Or if they do have adequate housing, they are also victims spousal abuse in their homes? How are we to discriminate the financial needs of citizens who need immediate cash from those of us who do not given current employment options available? Of course, many of these issues are being discussed and some are being addressed. But there needs to be, ethically speaking, concerted attention given to these matters and a fully coordinated federal response that has in its scope “the least of these.”

A commitment to solidarity requires both individual and communal introspection and action. Individually, “solidarity also invites us to consider whether our own behaviors and mentalities demonstrate a concern with those on society’s margins” (Matz, 2017, p. 193). Communally, “solidarity challenges us to ask whether the social organizations of which we are a part strengthen the bonds of human friendship, especially the bonds

between those with and those without sufficient resources” (Matz, 2017, p. 193). If our societies are not doing this well – like, for examples, Brazil and the United States given the data on their health disparities along racialized and socio-economic lines – then we must seek systemic changes as to how they might be improved in order to enable such relationships.

The kind of solidarity called for here which requires introspection leading to action is not merely about technique. Religious social ethics keeps before our collective work the spiritual dynamics of our existential predicament. Martin Luther King, Jr. articulated this well. He is worth quoting at length.

Every [person] lives in two realms, the internal and the external. The internal is that realm of spiritual ends expressed in art, literature, morals and religion. The external is that complex of devices, techniques, mechanisms and instrumentalities by means of which we live. Our problem today is that we have allowed the internal to become lost in the external. We have allowed the means by which we live to outdistance the ends for which we live...Enlarged material powers spell enlarged peril if there is not proportionate growth of the soul. Our hope for creative living in this world house that we have inherited lies in our ability to reestablish the moral ends of our lives in personal character and social justice. Without this spiritual and moral reawakening we shall destroy ourselves in the misuse of our own instruments (King, 2010, pp. 181-183).

This deep work of character formation, or as King expressed, of the soul, is important for the work of social justice that is informed by religious social ethics.

Widespread public health crises exacerbate problems of disparities between groups of people thus undermining a notion of genuine solidarity. Pandemics, like COVID-19, signify challenges to health and human well-being both in our physical bodies as well as in our body politic. In other words, they display the effects of an underlying socio-political pathology just as much as diseases like COVID-19 present pathologically in people’s bodies. Pandemic ethics then must attend to both of these categories simultaneously while recognizing that each one is multifaceted. This dual emphasis is especially important to keep in mind. It is especially so given that many of the mental, spiritual, and physical vulnerabilities faced by people in such times are due not only to pre-existing co-morbidities they may have, but also, as indicated above, because of existing social and economic inequalities that are the result of various forms of injustice.

So one can give a qualified affirmation to the widespread mantra surrounding the COVID-19 pandemic that “we are all in this together.” It must be remembered, however, though it is not the case “we are all in this together” in the same way. When crises emerge, the long-term health and economic impact for those who survive is often felt hardest by those who already experience disparities in wealth, overall health outcomes and in access to and benefits of health care. All of this suggests that any pathway forward requires and must be attentive to concrete material forms of justice. Thus, beyond a dignity-based principle of equal regard referred to above, an invariable sense of dignity with its associated commitment to the common good and solidarity would require a principle of redress. This is a central feature of any approach addressing situations of communal life where injustice persists. It will be necessarily political, even if not exclusively so. This is crucial to appreciate given the “distinction between the two meanings of race-as a biological versus a political grouping” noted above (Roberts,

2012, p. 5). It is an aspect of a kind of socio-political justice being advocated here that seeks a pathway to minimize the disproportionate negative impact experienced by those on the margins. Thus, “if race is a political system, then we must use political means to end its harmful impact on our society [...] Paying attention to race as a political system-which is what it really is-is essential to fighting racism” (Roberts, 2012, p. 5).

A principle of redress “postulates that inequalities in the conditions necessary to achieve the standard of well-being be corrected to approximate equality” (Mott, 2011, p. 56). Of course, one must tread very carefully on this point given the complexities of the concept of equality in political philosophy. Too easily, this sort of language and questions about redress can lead to “misunderstandings and stereotyped ideological assumptions.” It is not being suggested that “approximate equality” means “a mathematical division of all property and power or a leveling of all social goods” (Mott, 1993, p. 82). The priority or emphasis is that the basic needs for human flourishing or well-being of every member of the community be met before vast amounts of wealth be accumulated for a few. A religious social ethicist working in the Christian tradition, Stephen Mott, has emphasized that justice requires “special attention is given to the weak so that they can realize along with all other members the minimum requirements of participation in the community” (Mott, 1993, p. 82).

It is a principle that claims that undeserved inequalities must be redressed or otherwise compensated for (Rawls, 1971, p. 100). Clearly, one does not have to embrace the complete theoretical apparatus, say, of John Rawls’s ideal theory of justice to appreciate the importance of the idea of redress for social political philosophy (Rawls, 1971, p. 100-101) – especially since the idea predates Rawls’ significant work in this area (Mott, 2011, pp. 57-59). In many respects, the claims of this part of the essay are of different sort than a kind of Rawlsian account that, in part, is seeking to address questions of the unequal distribution of natural talents in a more ideal theory of justice (i.e. the difference principle, Rawls, 1971, pp. 101-105). The emphasis here is on the concrete particular conditions of people who have been largely, even if not exclusively, shaped by unjust policies, laws, and social arrangements that remain through some sort of collective intentionally agency.

Focusing on the margins takes into full consideration that many – even if not all – cases of existing health and economic inequalities are not just unfortunate but are actually unjust. Moreover, such conditions stifle human flourishing and well-being. Hence, ethically speaking they require redress. A principle of redress entails that social organizations seek to remedy those situations where members of the community do not have access to and possession of basic resources – food, clothing, shelter, health care – necessary for a reasonable level of subsistence. Beyond this, a focus on the margins requires forms of justice that facilitate people in these circumstances can possess and have some amount of “control of the resources that are preconditions for meeting those needs: land, due process of law, independence from subjugation either as a nation or as individuals, and participation legal decisions” (Mott, 2011, p. 56). It is important that national and local centers gather data and keep records of the negative impact of diseases of communities along the lines of race and socioeconomic status. Such data enables public health officials to identify the areas where a greater concentration of

resources may be needed. This, in turn, benefits the entire community since diseases like COVID-19 know no boundaries with respect to race and class.

Conclusion

What is needed in times of pandemics are large scale coordinated responses at various levels of civic, public, and private life. Though the principles and values highlighted in this brief essay were in the context of thinking about pandemic ethics, it should be clear that work in this area certainly extends beyond times of crises. The negative consequences of pandemics for all people in a society can be mitigated more effectively when people work for more justice in their social arrangements by focusing on the margins during non-pandemic times. The title of King's last book is *Where Do We Go From Here? Community or Chaos?* In some ways, this is our question. Where do we go from here? Will we have the political and spiritual will necessary to move forward? Whatever direction we take, may we be committed to the dignity of those who are on the margins, stand in solidarity with them, work for their common good by advocating for material forms of concrete justice as we think ethically about mitigating the negative impact of public health crises.

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