VIRTUE ETHICS IN THE DEVELOPMENT OF A FRAMEWORK FOR PUBLIC HEALTH POLICYMAKING

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PROMOTER:
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DEC 2010

"DECLARATION
By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

This dissertation has two quite separate and rather different starting points. The first centres on the significant renaissance of virtue ethics as a moral theory that has occurred in the last 50 years. The second starting point is embedded in the recent discourse about the need for an ethical framework for public-health policymaking. (Up until now the ethical theories of deontology, manifested as either a 'principle-based' or 'human-rights' approach, and utilitarianism, have provided the theoretical background to this discourse.) When these two starting points fuse, the question arising – can character or virtue ethics contribute positively to the moral debates surrounding many vexing public-health issues? – seeks an answer.

Broadly speaking, the ethics of public-health policymaking deals with ethical issues that occur within the macro-environment and that arise out of relationships between entities other than individuals, for example, states, regions, institutions, etcetera, and the policies in terms of which these interactions are regulated. Public health ethics 'seeks to find a balance between the notions of 'common good' or 'public interest' and individual autonomy.

I plan to investigate whether a virtue-based ethics, -which is concerned with a notion of human flourishing that is not primarily atomistic but intricately linked to the mutual well being of others and to notions of what the 'good life for man' means within the context of a shared history and connectedness with fellow human beings,- could contribute positively to current 'public health ethics' discourse. I believe that an exploration of the ethical basis of public health decision-making, focusing particularly on virtue ethics, but also examining other approaches like utilitarianism, principle-based approaches and the human-rights approach, will make a positive and original contribution to this area of philosophical discourse.

Chapter one is an introduction which provides the rationale and motivation for the dissertation and briefly introduces the layout of each subsequent chapter. Chapter two is a concept analysis of 'public health' and justifies why I argue that the concept of public health *is* contingent, *and ought to be contingent on* an inextricably linked, and context appropriate concept of social justice. In this chapter I clarify the scope of

the concept of public health used for this dissertation. Chapter three is an in-depth literature review of virtue ethics and similarly the next chapter is a literature review of the current status of public health ethics.

Chapter five is entitled "Virtue Ethics, Social Justice and Public health". My overall aim in this dissertation is to consider if virtue ethics as a moral theory can contribute positively to the practice of public health and thus by inference to an underlying concept of social justice. This receives in-depth consideration in this chapter. In chapter six I explore virtue theory in relation to public health from various other perspectives. In particular I return to MacIntyre to consider his concept of a 'practice'[1] which I apply specifically to the domain of public health, exploring the concepts of "extrinsic goods" and "intrinsic goods", and how they translate to the practice of public health. Chapter VII is entitled "Theory and Practice: Critical Perspectives". In this chapter I explore the challenges of adapting philosophical theory to actual context. I focus particularly on the problems of public health policy within a Southern African context.

I conclude this dissertation by conceding that while virtue ethics can indeed make a positive contribution in some respects, its applicability is largely limited to public health problems that pertain to specific localised contexts. It has very limited applicability as an ethical theory or framework for trans-global public health issues, and public health issues influenced by global politics and economics.

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[1] MacIntyre uses the term 'practice' very specifically as a particular concept and this concept is introduced and explained in Chapter IV.

Opsomming

Hierdie verhandeling het twee heeltemal afsonderlike en taamlik uiteenlopende uitgangspunte. Die eerste handel oor die beduidende oplewing in deugde-etiek as 'n morele teorie oor die afgelope 50 jaar. Die tweede uitgangspunt is veranker in die onlangse diskoers oor die behoefte aan 'n etiese raamwerk vir die bepaling van openbaregesondheidsbeleid. (Tot dusver het die etiese teorieë van deontologie, hetsy in die vorm van 'n 'beginselgegronde' of 'menseregte'-benadering, en utilitarisme as teoretiese grondslag vir hierdie diskoers gedien.) Wanneer hierdie twee uitgangspunte egter byeenkom, ontstaan die vraag: Kan karakter- of deugde-etiek 'n positiewe bydrae tot die morele debatte oor talle netelige openbaregesondheidskwessies lewer?

Oor die algemeen handel etiek in die bepaling van openbaregesondheidsbeleid oor etiese kwessies in die makro-omgewing wat ontstaan vanuit die wisselwerking tussen entiteite anders as individue, soos state, streke en instellings, en die beleid wat hierdie wisselwerking reguleer. Openbaregesondheidsetiek is daarop uit om 'n balans te vind tussen die konsepte 'algemene welsyn' of 'openbare belang', en individuele outonomie.

Hierdie ondersoek beoog om vas te stel of 'n deugdegegronde etiek – wat gemoeid is met 'n konsep van menslike welstand wat nie grootliks atomisties is nie, maar ten nouste verband hou met die onderlinge welstand van ander, en 'n begrip van 'die goeie lewe' in die konteks van 'n gedeelde geskiedenis en verbondenheid met ander mense – positief tot die huidige diskoers oor 'openbaregesondheidsetiek' kan bydra. Die navorser argumenteer dat 'n ondersoek van die etiese grondslag van besluitneming oor openbare gesondheid, met 'n bepaalde klem op deugde-etiek, dog ook 'n nuwe bydrae tot ander benaderings soos 'n utilitaristiese benadering, beginselgegronde benaderings en die menseregtebenadering, 'n positiewe en oorspronklike bydrae tot hierdie filosofiese diskoers (kan) lewer.

Hoofstuk 1 bied 'n inleiding wat die beweegrede en motivering vir die verhandeling uiteensit, en verduidelik kortliks die uitleg van elke daaropvolgende hoofstuk. Hoofstuk 2 is 'n konseptuele ontleding van 'openbare gesondheid', en ondersteun die navorser se betoog dat die konsep van openbare gesondheid afhanklik *is* en

afhanklik *behoort te wees* van 'n kontekstoepaslike begrip van sosiale geregtigheid wat onlosmaaklik daarmee verbind is. In hierdie hoofstuk word die betekenis en omvang van die begrip 'openbare gesondheid' soos dit in hierdie verhandeling gebruik word, ook verduidelik. Hoofstuk 3 bevat 'n omvattende literatuuroorsig van deugde-etiek, terwyl die daaropvolgende hoofstuk eweneens 'n literatuuroorsig van die huidige stand van openbaregesondheidsetiek behels.

Hoofstuk 5 is getiteld "Deugde-etiek, sosiale geregtigheid en openbare gesondheid". Die oorkoepelende doelwit van hierdie verhandeling is om daaroor te besin of deugde-etiek as 'n morele teorie positief tot die praktyk van openbare gesondheid, en dus ook tot 'n onderliggende konsep van maatskaplike geregtigheid, kan bydra. Dít word omvattend in hierdie hoofstuk bespreek. In hoofstuk 6 ondersoek die navorser deugde-teorie met betrekking tot openbare gesondheid uit verskeie ander oogpunte. Die studie konsentreer in besonder op MacIntyre se konsep van 'n 'praktyk',[2] wat bepaald op die gebied van openbare gesondheid toegepas word om só die begrippe 'ekstrinsieke goedere' en 'intrinsieke goedere', en hoe dit in die praktyk van openbare gesondheid omgesit word, te bestudeer. Hoofstuk 7, getiteld "Teorie en praktyk: Kritiese perspektiewe", bevat 'n ondersoek van die uitdagings om filosofiese teorie by die werklike konteks aan te pas. Die navorser konsentreer veral op die probleme van openbaregesondheidsbeleid in Suider-Afrikaanse verband.

Die verhandeling sluit af deur toe te gee dat, hoewel deugde-etiek inderdaad in sommige opsigte 'n positiewe bydrae kan lewer, die toepaslikheid daarvan grootliks tot openbaregesondheidsprobleme in bepaalde gelokaliseerde kontekste beperk is. Dit het 'n uiters beperkte nut as 'n etiek-teorie of raamwerk vir globale openbaregesondheidskwessies, en openbaregesondheidskwessies wat deur die wêreldpolitiek en -ekonomie geraak word.

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[2] MacIntyre gebruik die term 'praktyk' op 'n heel besondere wyse, wat in hoofstuk 4 bekend gestel en verduidelik word.

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ACRONYMS

ART	Antiretroviral treatment
ARV	Antiretroviral
BIG	Basic Income Grant
CSO	Civil Society Organisation
DOH	The Department of Health
DOTS	Directly Observed Treatment Strategy
ELSI	Ethical, Legal and Social Issues
FDA	Federal Drug Agency (of America)
MDR	Multi Drug Resistance
NGO	Non Governmental Organization
NHS	National Health System
NIH	National Institute of Health (of America)
PHASA	The Public Health Association of South Africa
PMTCT	Prevention of the mother to child transmission of HIV
R&D	Research and Development
SAMRC	South African Medical Research Council
SARS	Sudden Acute Respiratory Syndrome
TAC	Treatment Action Campaign
TB	Tuberculosis
TDR	Research and Training in Tropical Diseases
UK	United Kingdom
US	United States (of America)
USA	United States of America
WFPHA	World Federation of Public Health Associations
WHO	World Health Organization
XDR	Extreme Drug Resistance

I. INTRODUCTION

This dissertation has two quite separate and rather different starting points. The first centres on the significant renaissance of virtue ethics as a moral theory that has occurred in the last 50 years. A large body of scholarly work now supports the view that virtue ethics is a complete moral theory, a rival to theories like deontology and utilitarianism, and as such able to inform the moral dimension of our modern-day lives. The second starting point is embedded in the recent discourse about the need for an ethical framework for public-health policymaking. (Up until now the ethical theories of deontology, manifested as either a 'principle-based' or 'human-rights' approach, and utilitarianism, have provided the theoretical background to this discourse.) When these two starting points fuse, the question arising – can character or virtue ethics contribute positively to the moral debates surrounding many vexing public-health issues? – seeks an answer. However, virtue ethics, an approach to moral decision making that focuses on the moral agent rather than on action or outcomes, does at first glance, seem somewhat unsuited to the domain of public health. Thus the rationale for a project that investigates such an application requires detailed explication.

The field of bioethics has developed exponentially in the last forty years. In particular, the fields of clinical ethics (that deals with the interaction between health-care worker and patient, and what occurs or can occur in that interaction) and research ethics have attracted a great deal of research and commentary. In contrast, the ethics of public-health policymaking and research was, up until fairly recently, a relatively unexplored field, with several authors asking for an increase in academic effort in this area (Roberts, Reich 2002) (Callahan, Jennings 2002) (Thomas et al. 2002). The response to this has been a great deal of scholarly activity in the field in the last five or so years, and these developments will be examined closely in this dissertation. Broadly speaking, the ethics of public-health policymaking deals with ethical issues that occur within the macro-environment and that arise out of relationships between entities other than individuals, for example, states, regions, institutions, etcetera, and the policies in terms of which these interactions are regulated. I think it is fair to state that the bioethics 'project' of western philosophers has largely, although not exclusively, been about advancing the notion of individual autonomy within the realm of medicine and research. In contrast, the public health ethics 'project' could be

summarised as one that seeks to find a balance between the notions of 'common good' or 'public interest' and individual autonomy. One of the core ethical issues in the domain of public health revolves around determining the scope, the justification and the implementation of limits to individual autonomy in the interests of public welfare (O'Neill 2002, Bayer, Fairchild 2004, Bayer, Fairchild 2002, Bayer 2007, Gostin et al. 2002). Other areas of fundamental concern within this context revolve around issues related to social justice and global justice (Gostin 2007)(Kass 2004)(Anand, Peter & Sen 2006; 2004, Marmot 2004).

In 2002 I completed a Master's dissertation entitled "*Theories of Justice and an HIV /AIDS Healthcare Policy for South Africa: A Comparative Analysis.*" In this dissertation for the M. Phil. degree in Applied Ethics, I examined three theories of distributive justice: Utilitarianism, Rawls's "Justice as Fairness" and Libertarianism, and their implications for HIV healthcare policy in South Africa. After completing this dissertation I was left with two insights. The first was that 'justice', defined and understood as *distributive* justice, may not give an adequate account of the full moral dimension of public health decision-making, particularly within the resource-limited contexts of the African HIV/AIDS and TB pandemics. Justice is, however, an undisputed fundamental component to any discussion that involves the ethical dimension of public health. Second, that distributive justice alone may constitute a narrow window through which to consider the scope and breadth of the problems of ethical public-health decision-making, particularly, but not exclusively, within a resource-poor setting. Thus, in this dissertation I plan to explore the concept of justice, more broadly conceived as 'social justice'. I shall explore the concepts of distributive justice and social justice and the relationship between social justice and distributive justice in some detail. In particular I shall examine the significance of justice, including global justice, in a discussion of the moral basis of public health.I shall then consider if virtue ethics as a moral theory can contribute positively in developing a particular concept of social justice, that could serve as a platform for public health policy making.

Discussing public health issues primarily within a scientific or economic context may not always capture or fully explore the moral dimension of public-health although South African authors such like Nattrass, Barnett and Whiteside have attempted to

sensitise policy makers to the dire socio-economic impact of epidemics such as HIV/AIDS (Nattrass 2004; Barnett, Whiteside 2002).

These insights have motivated me to look more closely at the moral basis of public-health decision-making. Jennings comments that public health ethics has shown itself to be

> "predominantly a child of liberalism. The language of policy justification that liberalism offers public health is primarily a language of rights, liberties, obligation and autonomy on the contractarian side and a language of interests, utilities, preferences and beneficence on the utilitarian or welfarist side" (Jennings 2007 p.31).

Furthermore he argues that while the liberal language of public health ethics is "useful up to a point" it fails to provide the depth of moral insight or adequate justification for the "kinds of social change public health must strive to bring about" (2007 p. 31). Jennings is referring to the fact that the moral justification of much public health policy is either rights-based or supported by some version of Mill's utilitarianism[3]. I would thus like to investigate whether a virtue-based ethics, -which is concerned with a notion of human flourishing that is not primarily atomistic but intricately linked to the mutual well being of others and to notions of what the 'good life for man' means within the context of a shared history and connectedness with fellow human beings,- could contribute positively to current 'public health ethics' discourse. I believe that an exploration of the ethical basis of public health decision-making, focusing particularly on virtue ethics, but also examining other approaches like utilitarianism, principle-based approaches and the human-rights approach, will make a positive and original contribution to this area of philosophical discourse.

Virtue ethics is a body of philosophical theory, originally developed by the ancient Greek philosophers, particularly Aristotle, but greatly expanded in the last 50 odd years, which maintains that good conduct springs from, and is guaranteed by the character traits ('virtues') of the moral agent, and not from one or more characteristics of the actions performed, neither from the consequences achieved by the actions, nor from the question as to whether the actions performed comply with certain 'moral

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[3] Current dominant approaches to public health ethics are explored in detail in chapter IV.

rules'. Nussbaum contends that 'virtue ethics' cannot be considered to be one unified theory as many contemporary philosophers who consider themselves to be virtue ethicists do in fact disagree on many aspects of virtue theory. However she concedes that there are common ground and common threads that run through all these discussions. Virtue ethics is concerned with the *moral agent* and not just with choice or action; it is concerned with "motive and intention" and with the way emotion and motive result in "settled patterns" of reasoning that result in that person being described as honest or courageous or just; it is concerned not just with single actions or moral choices, but rather with "the whole course of the agent's moral life, its patterns of commitment, conduct and also passion" (Nussbaum 1999 p. 170). Virtue ethics has undergone a renaissance in the last fifty years, since first brought back into focus and international philosophical discussion by G.E. M. Anscombe in 1958 (Anscombe 1997). This theory is now regarded by many philosophers such as MacIntyre, Husthouse, Slote and others as providing a serious challenge to the two prominent ethical theories of utilitarianism and deontology.

But why attempt to apply virtue ethics to the moral domain of public health, particularly as public health seems to involve populations and institutions rather than individuals? I have begun to answer this question above, but it does require a more detailed exploration. In the first paragraph of this introduction I noted that this dissertation has two starting points. Similarly, this question can be considered from two angles. The first, and perhaps simultaneously more obvious and less relevant answer, is as a sort of test of the virtue ethics theory itself. If virtue ethics is an approach to moral decision making that can rival deontology and utilitarianism then it should have some application or relevance to all moral domains, not just selected ones. This consideration does seem to be an intriguing one and one worth exploring. However viewed from the perspective of someone whose main concern is public health, it is hardly relevant and the question thus requires further exploration.

Virtue ethics is a theory that focuses primarily on moral agents, rather than on actions or rules or outcomes. It is important to emphasise at this point, that this dissertation is concerned with the possible application of virtue ethics to public health *policymaking* rather than 'public health' in its broadest sense. There is no doubt much that influences public health, at both a national and international level, that falls outside of the specific domain of public health policymaking and into the broader

sphere of international (and national) politics and economics. It does seem justifiable to make a prima-facie assumption that virtue ethics would have little to contribute in this arena. This assumption will be explored in more detail later.

For the purposes of this discussion moral agents could conceivably be divided into two categories. The first group of moral agents are those that we would consider to be public health professionals, those individuals who are developing and implementing public health policy. The second group of moral agents are those that make up 'the public', or those for which the public health policy or programme is designed to serve or target.

Jennings regards public health as a "civic profession" and comments that "we entrust these civil servants and professionals with a large measure of stewardship over the common good" It is these professionals that we rely on to:

> [E]ducate and enlighten us as to what the common good consists in and what social justice requires in a practical, programmatic sense. We look to these professionals to transform power into authority and to provide us with the good reasons that will persuade us to voluntarily comply with all manner of rules, regulations and recommendations that are conducive to life together and to our own best interests (Jennings 2007 p. 33).

It does seem that the some of the key concepts or ideas contained within an ethics of virtue such as "settled patterns" of virtuous reasoning and "patterns of commitment" to an ideal of holistic human flourishing, could indeed be relevant to the portrait of the profession of public health, as described above by Jennings and are thus worth exploring further (Nussbaum 1999 p.170). Jennings does in fact expand his discussion in this general direction and argues for a version of what he calls "civic republicanism", supported by "civic virtue". I shall thus return to Jennings later in chapter four.

Within a Southern African context the practice of public health is largely the responsibility of the state although Non-government Organisations (NGOs) are also significantly involved. Allegations of corruption, inefficiency, nepotism and

inappropriate spending are reported in the media on an almost daily basis. Just as frequently are reports of *individuals* being suspended or appearing in court on charges of mismanagement, or fraud involving public funds. This point is particularly relevant to the allegation that the practice of public health is institutional and thus a theory that focuses on the conduct, attitudes and motivational or character structure of individuals can have little relevance to this domain. While one corrupt or inefficient individual may not influence the conduct of the entire institution, in time several surely will. Likewise prominent leaders with well developed qualities of practical reasoning and other "civic virtues" may significantly influence institutional culture and practice. The course of the South African HIV/AIDS epidemic during the almost ten year presidency of Thabo Mbeki and his Minister of Health, Dr Manto Tsabala- Msimang, illustrates quite clearly that one or two individuals with significant power can also have a profound negative influence on public health policy and the public's health (Van Niekerk 2005). This period is also chronicled in detail by Justice Edwin Cameron in chapter four of his book *Witness to AIDS* (Cameron 2005).

The second group of 'moral agents' that I referred to above are those that make up 'the public', or those for which the public health policy or programme is designed to serve or target. Public health policy and programmes are aimed at the health of populations and at outcomes that will be measured at a population level. However these programmes or policies are often targeted at changing the patterns of behaviour of individuals. Many of the problems which are considered to fall within a broader concept of public health relate directly to the behavioural patterns, motivational structure and attitudes of individuals and to the choices that they make (Buchanan 2000). Examples include patterns of sexual behaviour and the HIV/AIDS epidemic, stigma and HIV/AIDS, alcohol abuse and its relationship to road accidents, child abuse and domestic violence, cigarette smoking and foetal alcohol syndrome. Public health policies aimed at addressing these problems may be paternalistic and regulatory, or confined to the fairly narrow language of individual rights. The arguably richer moral language of virtue ethics and particularly its focus on considering individual lives as always relational and existing within a detailed social fabric of community could possibly be used to bring about a paradigm shift in the way these problems are viewed and managed. Buchanan comments:

The source of most major health problems in industrialized nations today lies in the choices people make about how to live their lives, but human choices are inextricably linked to understandings about how people ought to live their lives......The question "How should one live?" is the classical starting point for all ethical inquiry. Yet, the scientific method is incapable of providing answers to normative questions about the validity of different human values, the significance of different visions of the good life for human beings, and the quality of different ideals about how we think we should live (Buchanan 2000 p.4)

This statement may only be partly true in developing world nations where the susceptibility to many infectious diseases, and other issues like poverty and its negative influence on health status, have very little to do with individual choices. However even in this context, individual choice may still significantly influence health outcomes for example with respect to both HIV/AIDS and TB, cigarette smoking, drug and alcohol abuse.

Virtue ethics can seemingly be applied fairly successfully to many areas of clinical ethics (Gardiner 2003; Van Zyl 2002; Hursthouse 1991). However, virtue ethics has not been fully explored within the context of public health ethics in the same way as it has been within that of clinical ethics, although elements of virtue ethics, particular the writings of Aristotle, have undoubtedly influenced some scholars in this field (Jennings 2007, Buchanan 2000, Pellegrino, Thomasma 2004, Sen 1993). The impact of its direct application to public health ethics thus remains less clear. Virtue ethics is concerned with the notion of *eudaimonia* -- complete human flourishing -- and therefore may well turn out to be of particular relevance to public health ethics.

The ethical challenges of clinical practice will continue for as long as doctors treat patients. While the decisions that have to be taken may, at times, be difficult ones, many texts, codes and guidelines have been developed to assist doctors and their patients to meet and adequately resolve most of the moral dilemmas arising. The moral challenges presented to sub-Saharan public health policymakers, especially in the time of AIDS and drug-resistant TB, seem to be significantly more difficult, partly because decisions taken may affect thousands of lives and not just one or two. This

dissertation is, in an important sense, a critical investigation of theoretical points of departure. Public policy, particularly in the sphere of healthcare, is often, morally speaking, based on either a utilitarian or a liberal-individualist (or rights-based) ethic (Gostin, Mann 1999)(Singh, Upshur & Padayatchi 2007). Alasdair MacIntyre, a contemporary philosopher whose writings on virtue ethics have been very influential, has provocatively described the "concept of rights and that of utility, [as] a matching pair of incommensurable fictions" (MacIntyre 1985 p. 71). Therefore, the exact purpose of this study is to explore whether virtue ethics provides a meaningful and applicable moral alternative to these more established approaches. If it does, this would indicate the potential to develop a new set of theoretical points of departure for the ethics of public policymaking in the field of healthcare. This study will be guided by the hypothesis that virtue ethics does indeed offer possibilities in this regard, and that the impact of the inclusion of a virtue ethics inspired perspective in the underlying moral foundation of public health ethics could have some beneficial consequences for public health policymaking. At the same time, I do not work with the hypothesis that virtue ethics will be able to *wholly* replace dimensions of the other approaches mentioned. My hypothesis is rather that virtue ethics can supplement other approaches when reflecting on the theoretical and moral bases of public policymaking in healthcare. The research questions can thus be restated as:

1. What potential exists, within a virtue ethics approach that can be developed to provide the moral basis for the formulation of public policymaking as regards healthcare?
2. How can the potential (if any) of virtue ethics in this regard be realised when we consider the requirements of a morally-based public health policy in a context (such as that of sub-Saharan Africa) where we are dealing with a developing-world economy and significant public health challenges such as HIV/AIDS, tuberculosis and alcohol abuse.

In Chapter two, I begin to address these questions by exploring the meaning of the concept of 'public health', and identifying the different definitions of this concept which are in use. I then discuss and compare a narrow conception of public health with a broader one, considering whether or not public health is a universal or a particular concept, and if the same concept is applicable to both first-world and developing-world nations. I reflect also on whether or not a nation's interpretation of

distributive or social justice, manifested in its broad health policies, plays a pivotal role in how the concept of public health is interpreted, and how consequently the scope of public-health policy is defined. I argue that the concept of public health both *is* contingent *and ought to be contingent on* an inextricably linked and context appropriate concept of social justice. Finally I clarify the scope of the concept of public health used within the context of this dissertation.

The nature of this dissertation demands an in-depth study of virtue ethics which is the subject of Chapter III. I begin by trying to ascertain why there has been such a huge rekindling of interest in virtue ethics in the last sixty years. Why should a moral theory, originally articulated about two thousand five hundred years ago, become the subject of so much recent attention? Anscombe's contribution to this renaissance is discussed. Classic virtue-ethic theory, as described by Aristotle in *The Nicomachean Ethics*, is critically explored, and the 'Christianising' of Aristotelian ethics by Thomas Aquinas is considered briefly, too.

MacIntyre must be regarded as one of the most vociferous contemporary virtue ethicists. His book *After Virtue*, first published in 1981, is now considered a seminal work in contemporary moral philosophy. MacIntyre has expanded his arguments in support of virtue ethics in later works and elements of these works are discussed in Chapter III, as well as arguments presented by some of his critics and detractors. MacIntyre's 'brand' of virtue ethics is Aristotelian, but other contemporary writers have expanded virtue theory in directions which are not typically Aristotelian. The key questions that must be answered, after a critical analysis of the arguments presented by writers such as Rosalind Hursthouse, Michael Stocker, Michael Slote, Sponte-Comville and others, are, what relevance, if any, does virtue ethics as a theory hold for the moral domain of public health, and, how can it best be applied? I conclude this chapter by introducing what I consider to be the key virtue-ethics 'take-home-messages' for public health that I explore in detail in later chapters .

Chapter IV begins with an account of the evolution of public health ethics that has occurred over the last decade. I introduce the three core themes that cut across most debates on ethical issues related to public health; the tension between individual autonomy and public interest or common good and issues related to both social justice and global justice. I continue by critically examining what I consider to be the

three dominant current frameworks for 'public health ethics' as reflected in the recent bioethics literature: a human rights approach; utilitarianism; and a principle-based approach adapted to the sphere of public health. I conclude the chapter by considering some of the alternative approaches that have appeared in the literature recently. These approaches are either 'communitarian' or appear, at least, to have been influenced by ethical frameworks that are neither utilitarian nor deontological.

Chapter V is entitled 'Virtue Ethics, Social Justice and Public health'. I have argued in Chapter II that some conception of social justice underlies a conception of public health, that is, a prevailing state or institutional concept of social justice will profoundly influence, if not dictate, the scope and reach of that state's or institution's 'practice'[4] of public health. My overall aim in this dissertation is to consider if virtue ethics as a moral theory can contribute positively to the practice of public health and thus by inference to an underlying concept of social justice. Thus in this chapter I explore the concept of social justice and its relationship to distributive justice in more depth, and particularly its significance for a discussion of the moral basis of public health. I briefly discuss current common theories of distributive justice and identify some of their deficiencies, including more recent theories of global and cosmopolitan justice. However, I do not attempt to engage in a thorough critical analysis and comparison of concepts of distributive justice which I see as a huge task and well beyond the scope of this dissertation. After considering justice as a virtue of individuals, I establish what elements of virtue ethics as a whole, could contribute to a concept of social justice that would be applicable to the 'practice' of public health. Additionally, I examine a theory of social justice (Powers, Faden 2006), first published in 2006 specifically as a "moral foundation of public health and health policy", which, to my mind, is very much a virtue-ethics-inspired theory of social justice. I conclude this chapter by considering virtue ethics within the context of public health and trans-border or global justice and by noting its limitations in this particular context.

In Chapter VI I explore, from various perspectives, virtue theory in relation to public health. I return to MacIntyre to consider his concept of a 'practice'[5] which I apply

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[4] The term 'practice' in this context implies a working or practical concept of public health that ultimately determines the scope of, and implementation of, public health policies and programs.
[5] MacIntyre uses the term 'practice' very specifically as a particular concept and this concept is introduced and explained in Chapter III, VI and VII.

specifically to the domain of public health, exploring the concepts of "extrinsic goods" and "intrinsic goods", and how they translate to the practice of public health. In an examination of "virtue ethics and professional roles" (Oakley, Cocking 2001), I identify the particular virtues that would be relevant to public-health practitioners. Aristotle's (particular) view on moral education is that virtues could be taught, and in this regard I explore virtue ethics as it could relate to, or influence, the education of public-health professionals. I continue with a focus on 'casuistry'[6] within the context(s) of virtue ethics and public health, to conclude the chapter with an examination of the relevance of virtue ethics and motive within a public-health context.

Chapter VII is entitled 'Theory and Practice: Critical Perspectives'. In this chapter I explore the challenges of adapting philosophical theory to actual context. I focus particularly on the problems of public health policy within a Southern African context. I critically explore virtue ethics within the realm of public health policy at a national and community level and at a macro level, identifying both the strengths and weaknesses of this approach. I use various examples to illustrate the discussion and attempt to demonstrate how additional insights into practical ethical problems are gained when these problems are viewed from an alternative ethical paradigm.

Finally I end this dissertation by reviewing the arguments and insights developed and determining whether or not I have achieved what I set out to illustrate, namely that virtue ethics can contribute constructively to a framework for public health ethics. I conclude by conceding that while virtue ethics can indeed make a positive contribution in some respects, its applicability is largely limited to public health problems that pertain to specific localised contexts. It has very limited applicability as an ethical theory or framework for trans-global public health issues, and public health issues influenced by global politics and economics. Many public health problems do fall into this latter category and are still best served by the more conventional ethical frame works such as international principles of human rights, even though these approaches also have both strengths and weaknesses. The domain of public health ethics does appear to require a good measure of ethical pluralism.

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[6] "Casuistry" is a term now used commonly in bioethics to denote a 'bottom up' rather that 'top down' form of moral reasoning. Similar 'cases' are compared and "rules of thumb" developed that can then be applied to other similar cases.

II. PUBLIC HEALTH: THE CONCEPT EXPLORED

INTRODUCTION

An investigation into the possible role virtue ethics may play within the domain of an ethical framework for public health automatically means that the concept of 'public health' needs to be explored and defined. However, a survey of the literature quickly reveals that the answer to the question 'What is public health?' is not a straightforward one and seems contingent on many factors, not least by the socio-political inclination of the writer. This is understandable as one of the key components of public health is the legitimate extent of the role and responsibility of the state or government in the health of its citizens. My intention in this dissertation is to situate the discussion firmly within a developing world context. Thus, I need to consider whether or not public health *is* an independent 'stand-alone' concept or whether it is contingent on other factors and whether it would be appropriate to apply the same concept of public health to both first world and developing-world nations. Inseparable from this is a need to reflect on whether a nation's interpretation of distributive or social justice, manifested in its broad health policies, plays a pivotal role in how the concept of public health is interpreted and how, consequently, the scope of public health policy is defined.

In this discussion I shall begin by examining some of the many commonly used or quoted definitions of public health. I shall then proceed to discuss and compare a 'narrow' conception of public health with a 'broader' one. I shall complete this discussion with a brief consideration of how virtue ethics and public health may come together.

COMMON DEFINITIONS OF PUBLIC HEALTH

There are many definitions of public health available, usually put forward by academic institutions or professional associations. I shall present a few of the most influential ones here, and then identify common themes and differences, pinpointing areas left open to debate by these definitions. It is important to note that the definitions articulated by institutions that identify themselves in some way with the enterprise of public health, are

generally fairly broad. One of the most often quoted and most detailed definitions comes from an article published in 1920 by CEA Winslow, then Professor of Public health at Yale. This definition is particularly useful because it lays down an initial platform for any discussion as to what is, and what is not, public health:

> Public health is the science and art of (1) preventing disease, (2) prolonging life and (3) organized community efforts for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical services for the early diagnosis and prevention of disease, and (e) the development of a social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright and longevity (Winslow 1920 p. 183).

A broader definition of public health is given by the Institute of Medicine (IOM) in its 1988 report entitled *The Future of Public health.* The IOM definition has 3 parts, namely mission, substance and organisational structure:

- The *mission* of public health as: the fulfillment of society's interest in assuring the conditions in which people can be healthy.
- The *substance* of public health as: organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology.
- *The organizational framework* of public health: to encompass both activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals (Institute of Medicine 1988).

The Royal College of Physicians, United Kingdom defines public health as: "The science and art of preventing disease, prolonging life and promoting health through organized efforts of society."[7] The Nuffield Council on Bioethics also uses the above

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[7] http:www.fphm.org.uk/about_faculty/what_public_health/default.asp accessed 18.10.2008

definition, but adds that two notions are of particular importance when trying to define the scope of public health, namely the importance of prevention and the notion that public health is achieved by "collective effort" (Nuffield Council on Bioethics 2007 p.6).

The World Health Organization (WHO) is regarded as the 'public health arm' of the United Nations and as such has articulated a 'utopian' definition of health, as an ideal state of mental and physical well being, which underpins its approach to public health (Gostin 2001a).The current director-general, Dr Margaret Chan, notes that the "boundaries of public health action have become broad" and describes the WHO overall agenda as one that promotes development, fosters health security, strengthens health systems, harnesses research information and evidence, enhances health partnerships and promotes the efficiency and effectiveness of existing health programs (Chan 2008).

PHASA, the Public health Association of South Africa, does not provide a specific definition for public health but is affiliated with the World Federation of Public health Associations (WFPHA) who also appears to aspire to a broad approach. Their mission is to "develop and promote effective global policies in order to improve the health of populations…. We hold that health is a fundamental human right and a public good." The broadness of the WFPHA agenda is confirmed by the very wide range of themes and topics for discussion at its triennial conference in April 2009.[8]

EXPLORING THE CONCEPT FURTHER: 'NARROW' OR 'BROAD'?

The definitions presented above all appear to be fairly neutral descriptive definitions although some do have normative elements. They all have common themes and by looking at their commonalities one can start to develop a better idea of "what is public health?" but also begin to understand why there is an undeniably normative and contentious aspect to the scope and practice of public health. The following are some of the themes or phrases that appear repeatedly: 'prevention of disease', 'promotion of health', 'organised effort of society', 'health of populations' or 'people', 'conditions under which people can be healthy'. Thus a minimum conception of public health could be

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[8] http://wfpha.confex.com/wfpha/2009/cfp.cgi accessed 20.10.2008

some form of organised effort undertaken to promote the health of a community or nation, particularly by preventing disease. Underlying the apparent neutrality and nobleness of the concept though, is in fact a stormy sea, the nature of which will become more apparent as this discussion unfolds. The main areas of contention are: Who is in fact responsible for this 'organised effort' of health promotion and disease prevention, and what is or should be the extent of that responsibility? Does it include ensuring that "conditions exist under which people can be healthy?" (Institute of Medicine 1988). And last, but by no means least, what should the extent and reach of the authority be, by those recognised as having this responsibility, to fulfil the goals of health promotion and disease prevention?

A useful discussion of the concept of public health is presented by Dawson and Verweij (Dawson, Verweij 2007). They note that Winslow's definition sets out the traditional field of public health as those activities such as water sanitation, disease surveillance, health education, etcetera, that can be undertaken to promote health and prevent disease. More recent definitions and discussions however, like those reflected above, do appear to be widening the field of public health to include a wide range of factors that may influence the conditions under which people can or cannot live healthy lives.

> …All these factors are held to be legitimate concerns for public health activity because they all impact on people's health in the broadest sense….. In principle, such a conception of public health could be limitless, as almost all human activities (and many inactivities) may affect health……If we employ such an approach, any intervention aiming at improving well-being is likely to count as a matter relevant to public health. The concept of 'public health' essentially just collapses into that of generating well-being or welfare: as a result such a concept arguably loses any useful purpose (Dawson, Verweij 2007 p. 17).

They thus caution against defining the concept of public health too broadly and go on to illuminate the concept by focusing on the two senses of 'public' in 'public, health', namely: public as meaning health of populations or communities of people; and 'public'

as meaning a 'collective', as in organisational group responsible for health prevention and promotion. Thus, the "practice of public health (roughly) consists of collective interventions that aim to promote and protect the health of the public" (2007 p.21). These interventions are aimed at the population as a whole, rather than at individuals and the effect of such interventions or outcome measures should be apparent at population level. However the distribution of health within a population is as important as the overall aggregation of health improvement, as are "the underlying social and environmental conditions that might affect the health of each member of the public" (This last qualification resulting in the concept perhaps becoming much broader than initially claimed) (Dawson, Verweij 2007 p. 25).

The second sense of "public" discussed by Dawson and Verweij is the notion of a "collective intervention" i.e. that public health does not involve the actions of individuals but rather collective actions in the form of policies or programs. Unlike authors proposing a particularly narrow view of public health, they concede that these collective efforts may involve both government and other organisations like Non Governmental Organisations (NGOs) and to be successful, also often involve the cooperation and participation of members of the public themselves.

Lawrence Gostin who has written extensively in this field, states that "the problem with an expansive view, is that public health becomes limitless, as almost everything human beings undertake affects public health" (Gostin 2001a p.123). Gostin's concerns are mainly pragmatic as by adopting such a wide approach the "field lacks precision" and "lacks a discrete expertise". He also notes that "by espousing controversial issues of economic redistribution and social restructuring the field becomes highly political" (p.123)

 Mark Rothstein argues against a broad agenda for public health and proposes a diametrically opposite view i.e. a particularly narrow one (Rothstein 2002). He discusses three different approaches to public health, namely, "Human Rights as public health"; "Population health as public health", and "Government intervention as public health", rigorously supporting the last one (2002 pp.144-147). The human rights approach to public health will be discussed in more detail in the next chapter, but it is a broad

approach and Rothstein's objections to it are in accordance with Gostin's argument above. Rothstein states:

> …labelling so many activities as public health does little if anything to eliminate the problem of poor health…..Individuals trained in public health should not give up the noble struggle to ensure that every person has a minimum standard of living to support a healthy life. But this battle must be fought together with people from all disciplines and all walks of life and without using the self-defeating strategy of annexing human rights into the public health domain" (Rothstein 2002 pp. 144-145).

The goal of the second approach Rothstein discusses ("Population health as public health") is to reduce disease at a population level, and thus any effort to do this, by any role player, would be considered a public health intervention. Included, for example, would be a campaign by a professional association of dermatologists to increase the use of sunscreen to decrease skin cancer, or the campaign by a beer company to reduce under-age drinking. He describes three important features of this approach and believes that each raises concerns. First, government, NGOs and the private sector may all be involved to some degree in public health initiatives. "With such a broad approach, there is a risk that the urgency of public health will become diluted, and the public will have an increasingly difficult time in distinguishing public health from public relations"(Rothstein 2002 p. 145). Second, this approach fails to distinguish clearly the domains of individual health and public health. His main concern with this issue is that it is unclear when responsibility for the introduction of new health measures or interventions "shifts from the individual health-care provider to a public health official" (2002 p.146). His last objection is that if the public health agenda is broadened beyond issues that do not directly affect others or put others at risk, then there are "too many actors, pursuing widely divergent strategies" in a largely uncoordinated manner (2002 p. 146). "It is ill-advised to adopt a definition of public health that mixes government with non-government initiatives, coercive with non-coercive measures and harms that affect individual health with those that affect the health of the public" (2002 p.146).

Rothstein thus proposes and supports the third conception of public health, namely, 'government intervention as public health'. This approach to public health "involves public officials taking appropriate measures, pursuant to specific legal authority, after balancing private rights and public interests, to protect the health of the public" (Rothstein 2002 p.146). At least one of three conditions (listed below) must be in existence for a problem to fall into the domain of public health. The three areas are weighted in importance, as listed:

1. The health of the population is threatened e.g. by an infectious disease or some other environmental hazard.
2. Government has the specific ability or expertise to deal with a particular health issue. Thus disease surveillance measures would be included in this category.
3. Government action is more resourceful or more likely to result in a successful intervention. The example given is that of newborn screening programs.

Interventions in category three would most likely require more motivation than those in category one, to be included as part of such a public health program. I shall critically discuss Rothstein's narrow conception of public health, including his reasons for supporting it, a little later in this chapter. At this point in my discussion, I think it is fair to say that this conception is a contested one and is contrary to the broader conceptions discussed earlier and favoured by organisations such as WHO and WFPHA. However, it is important to consider why Rothstein is proposing such a conception and to what extent the current American libertarian conception of distributive justice, particularly as it relates to the United States of America (USA) health system, has influenced such a conception.

The Nuffield Council on Bioethics published an extensive report in December 2007 entitled *Public Health: Ethical Issues* and devoted the first chapter largely to attempting to define the scope of public health (Nuffield Council on Bioethics 2007). This discussion contrasts significantly with Rothstein's view and is situated within the context of the United Kingdom's (UK's) National Health System (NHS), which in turn appears to be underpinned by a very different philosophical conception of healthcare, than that of the

USA. The authors note that the NHS is an important part of the UK's public health system and that the main reason for this is that it is:

> …considered too important to be left to private suppliers alone…..Focusing on equity and fairness considerations, there is a risk that a fully privatised approach would increase inequalities……The reduction of health inequalities must be one of the principal aims of public health policy. The provision of some form of public healthcare system....is therefore a public service of exceptional value, complementing other forms of public health initiatives, such as provision of clean water, (Nuffield Council on Bioethics 2007 pp. 7-8).

This egalitarian approach to healthcare in general, seems to result in a broader approach to public health, in which the boundaries between individual healthcare service provision, measures aimed primarily at socio-economic factors such as housing, and other public health initiatives, are blurred. The central obligation for public health is placed clearly at government level but other role players are not excluded. "The role of government is to provide certain key services that should not be left to the market alone, and to establish the rules under which different agents operate in a way that is compatible with promoting health and reducing inequalities" (Nuffield Council on Bioethics 2007 pp. 7-8).

Most organisations and people, who consider themselves involved in the business of public health, do seem to interpret the concept of public health in broad rather than narrow terms. The contrast between Rothstein's discussion of the issue and that of the Nuffield Council for Bioethics illustrates that the interpretation of this concept seems to be fundamentally linked to a broader notion of healthcare and a nation-state's perceived obligation (or lack thereof) as a provider of healthcare. The US healthcare system, although often under fire from various sources, is currently not based on a view that at least some basic level of healthcare services are a universal right, irrespective of one's ability to pay for them. Rather, healthcare is regarded as a commodity and is subject to the principles applicable to a free market economy, that is, you can have healthcare if you can pay for it, or pay for the insurance cover that will provide it.

Barry S Levy, Professor of Community Health at Tufts University, in an address to the American Public health Association in 1997 commented that a recent Harris opinion poll had indicated that only three percent of a random sample of one thousand Americans responded correctly to the question "What is public health?" with answers like "health education", "health promotion", etcetera (Levy 1998 p. 189). Ninety seven percent did not have any understanding of the concept of public health.

The US is generally considered to be a liberal democracy with a libertarian outlook, and one of the central tenets of libertarianism is the idea that coercion may only be used to prevent physical harm, theft and fraud, to punish those guilty of such, and to enforce contracts (Buchanan 1981). Rothstein's narrow approach to public health seems primarily to be an attempt to continue to limit government involvement in most aspects of health and healthcare and ensure that healthcare remains largely in the 'private' domain and thus a matter of individual choice and preference. His assertion that it is "ill-advised to adopt a definition of public health that mixes government with non-government initiatives, coercive with non-coercive measures and harms that affect individual health with those that affect the health of the public" is unsupported (Rothstein 2002 p. 146). It is also worth noting that there are those in the US, both in the past and present who do not agree with this perspective. Gostin quotes from a 1932 speech by then USA president Franklin D Roosevelt and asks whether a modern politician would express these ideas today: "The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people" (Gostin 2001b p.139).

A UNIVERSAL OR PARTICULAR CONCEPT?

In the introduction I stated that my intention in this dissertation is to situate the discussion firmly within a developing world context. I commented that I needed to consider whether or not public health *is* an independent concept and whether the same concept is applicable to both first world and developing world nations. Let me state now that I believe that in reality, at a grassroots level, 'public health' is not a universal independent

or 'value- neutral' concept at all, but entirely contingent on a prevailing, usually politically-mandated concept of social justice. In this I am in full agreement with Powers and Faden who see social justice as the essential moral foundation of public health policy and practice (Powers, Faden 2006). This is not to say that 'public health' should not be a universal and independent concept. However, I believe this will only be possible if one is prepared to accept a particular conception of social justice as *the* conception. A state or government that upholds a libertarian concept of justice where the protection of rights to property, liberty and privacy are paramount, and does not see the provision of a basic level of healthcare to all its citizens as its duty or obligation, will support a very different concept of 'public health' to that of a government who adheres to a more egalitarian concept of social justice.

South Africa, a country that has undergone a dramatic political transition, illustrates this point well. The apartheid government's interpretation of social justice (1948-1994) significantly influenced the biased implementation of both health-service provision and the scope of public health practice. The post-apartheid era has seen a considerable widening of the scope of health services that now are delivered by the state. Even so, the scope of these services has been highly contentious and a matter of great controversy in the recent past. The court action by the Treatment Action Campaign (TAC)[9] regarding the very slow implementation of Prevention of Mother to Child Transmission (PMTCT) of HIV and the reluctance by government to roll out an antiretroviral treatment programme for those suffering from AIDS is a case in point. Should such a programme be considered 'public health'? Not if you are in accordance with scholars such as Rothstein who, as we have seen, advocate a narrow concept of public health. The answer to this question though, is, I believe, entirely contingent on the speaker's interpretation of the concept of social justice. I shall explore the link between public health and social justice in depth in Chapter V and shall attempt to show that a conception of justice that is compatible with virtue ethics, and which has the notion of

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[9] The Treatment Action Campaign (TAC) is a South African HIV/AIDS advocacy group that has taken the South African government to court on several occasion in the last decade in order to try and improve access to HIV health services, in particular to Antiretroviral drugs for those affected by HIV/AIDS. http://www.tac.org.za/community/

optimal human flourishing at its heart, would be a suitable conception to serve as a foundation to public health in a developing world context.

CONCLUSION

What is 'public health' then? I think it is fairly easy to accept that public health is about the health of 'societies' and 'communities' rather than the health of individuals. To my mind, it involves all those spheres of health, where collective action by governments and other organizations can make a positive impact. I thus disagree with authors such as Dawson and Verweij who would regard interventions to address domestic violence as outside of the scope of public health (Dawson, Verweij 2007 p. 18). The exact scope or range of programmes and interventions, however, that will fall under the umbrella of public health is intricately interwoven with, and contingent on, some prevailing concept of social justice. Powers and Faden describe the "standard view" of the moral foundation of public health as resting on "general obligations in beneficence to promote good or welfare" (Powers, Faden 2006). Furthermore, the "standard view" is usually understood to:

> H]ave utilitarian commitments to bring about as much health as possible. Concerns about justice, like concerns about respect for individual liberties, are understood as ethical considerations external to the moral purpose of public health that serve to balance public health's single-minded function to produce the good of health with other right making concerns. In these discussions, justice is almost entirely presented as a distributional principle" (2006 p. 81).

Powers and Faden disagree with this "standard view" and I am in agreement with their position, which will be explored in Chapter V. They state:

> What the standard view of public health gets wrong is that it frames public health as if the enterprise is solely concerned with outcomes. Unlike either beneficence based or utilitarian justifications for public health, by situating the focus on well being within a theory of social

justice, we capture what we believe are the twin moral impulses that animate public health: to improve human well-being by improving health and to do so in particular by focusing on the needs of those who are the most disadvantaged. A commitment to social justice, as we explicate it, attaches a special moral urgency to remediating the conditions of those whose life prospects are poor across multiple dimensions of well-being. Placing a priority on those so situated is a hallmark of public health" (Powers, Faden 2006 p. 82).

Dawson and Verweij have commented that "it would be ironic and dangerous if the public's health were threatened by the term 'public health' coming to be seen as presupposing a particular ideological perspective" (Dawson, Verweij 2007 p. 19). While I understand their cautionary stance, as I have emphasized and illustrated above, I believe that 'public health' is not a value-neutral concept, but is always influenced by some conception of distributive justice, whatever that conception may be. In addition, I believe that the moral foundation of public health ought to be closely linked to a broader concept of social justice.

III. VIRTUE ETHICS

INTRODUCTION

What is virtue ethics? The short answer -- a theory that prescribes that we should live or act virtuously or, put another way, a theory that defines the right action as the action which a virtuous agent would choose in a given circumstance -- could easily be dismissed with a cynical and incredulous response. One of the problems with virtue ethics is that it seems far more difficult to really get to grips with the depth and breadth of the theory than it is to sum up its rivals. Contemporary writers have debated and expanded virtue ethics from so many angles that it is quite challenging to obtain a really clear and coherent picture of what 'virtue ethics' actually is. Nussbaum argues that the term 'virtue ethics' is misleading. She points out that although it is customary to teach 'virtue ethics' as a unified theory that is a rival to Kantian ethics or utilitarianism, both Kant and Mill in fact had incorporated notions of virtue in their theories and in fact Kant's theory of virtue is well developed. She goes on to assert that although there is a common thread of unity between contemporary virtue-ethicists, it is quite thin. However she identifies three common claims: Moral philosophy should be concerned with the moral agent, not only with actions; it must focus on motive and intention and the character of moral agents; it should be concerned with an agent's moral life as a whole and not just on isolated choices or action (Nussbaum 1999).

Despite Nussbaum's words of caution I shall use the term 'virtue ethics' throughout this dissertation, acknowledging that there is quite a lot of difference between contemporary virtue ethicists, some keeping close to Aristotle, some seeming to combine Aristotle with Kant, and yet others relying mainly on Hume. The issue of pinning down 'virtue ethics', becomes more pertinent when trying to apply virtue ethics to modern day moral problems, such as those identified in the preceding case discussion. One of the biggest criticisms of virtue ethics, and one that I will attempt to address, is that virtue ethics cannot easily be used to guide actions. My central undertaking in this chapter is threefold: to develop a broad understanding of what 'virtue ethics' is; to demonstrate that there are at least some significant aspects of virtue theory that are intelligible; and

finally to begin to consider these aspects within the moral context of public health. This last aim will be developed in detail in subsequent chapters.

Virtue ethics has two notable elements. One element is that it provides an account of moral reasoning that relies on a notion of the "rationality of virtue itself, and is therefore somehow more basic than the concepts that define utilitarian and Kantian moral theory (Crisp, Slote 1997). Thus the reason I will not tell a lie is not because it is contrary to some moral law, nor because I have an obligation to tell the truth, or because by telling a lie I will not maximize utility, but because it is *dishonest* and as a rational human being I can recognize it as such. The other notable element is that virtue ethics focuses on moral agents and their lives rather than on actions or outcomes (Crisp, Slote 1997 p. 3). A very simplistic way of starting to think about virtue ethics is by comparing moral life to a game of cricket. Virtue ethics considers the player first and foremost, and the qualities and virtues that go into making a 'good' player. A good player will play the game 'well', not just to win. A 'good' player is one who has a lot more than just skill at cricket, but also qualities ('arête' or excellences or virtues) such as good sportsmanship, perseverance, fidelity and courage.

The revival or renaissance of virtue ethics is generally attributed to G. E.M. Anscombe and an essay entitled *Modern Moral Philosophy*, first published in 1958 (Anscombe 1997).[10] I shall begin this chapter by considering the main points discussed in her essay: Anscombe's criticism of modern moral philosophy, and her reasons for suggesting that moral philosophers should look to an ethics of virtue as an alternative. I shall continue this discussion by returning to the roots of virtue ethics, as presented by Aristotle, primarily in the *Nichomachean Ethics* or "*Ethics*" as it is usually referred to, and exploring Aristotle's conception of ethics (Aristotle 2004).[11] Alasdair MacIntyre is arguably the most influential contemporary philosopher working in the field of virtue

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[10] This essay was first published in 1958, but has been republished subsequently in various books and collections. Anscombe, G.E.M. "Modern Moral Philosophy" in *Philosophy* 1958 Vol. 33.

[11] Aristotle. *The Nicomachean Ethics.* Translated by J.A.K. Thompson with revised notes and appendices by Hugh Trednik; first published by Penguin Classics in 1955. Please note that I shall use the accepted conventional numbering system in brackets directly in the text e.g. V (Book) ii (part) 1094a1-5 (line reference) whenever I quote directly from Aristotle's *Nichomachean Ethics*, rather than using a full citation each time. Also, all references to Aristotle in this dissertation refer to the *Nichomachean Ethics,* not the *Eudemian Ethics*

ethics. His book, *After Virtue*, which appeared in 1981, is recognised as one of the most significant, albeit controversial philosophical works of the 20th century (MacIntyre 1981). I thus devote a large section of this chapter to MacIntyre, including discussing the perspectives of some of his critics. After considering MacIntyre in some detail, I explore additional or alternative aspects of virtue ethics that have been highlighted by a number of contemporary scholars, working in this field. In particular I highlight among others the views presented by Rosalind Hurthouse, Michael Stocker and Michael Slote. Finally I discuss some criticisms of virtue ethics and briefly introduce what I consider to be the aspects of virtue ethics that hold some promise for my project.

G.E.M ANSCOMBE: "*MODERN MORAL PHILOSOPHY*"

Anscombe's essay is not so much about Aristotelian ethics, as it is a scathing criticism of modern moral philosophy, particularly that of modern British philosophers, although Kant also comes under the spotlight. Aristotle's ethics is certainly mentioned favourably, with an indication that the way forward may well be to travel backwards, and reconsider virtue ethics. However, the main thrust of her essay is a harsh criticism of consequentialism and rule-based morality (as opposed to a discussion of virtue ethics). She describes Kant's notion of "self- legislation" as "absurd", and goes on to state that the problem with a "law conception of ethics" is that in order for this to make sense, an acceptance of divine law is necessary.

> Naturally it is not possible to have such a conception unless you believe in God as a lawgiver; like Jews, Stoics and Christians. But if such a conception is dominant for many centuries and then given up, it is a natural result that the concepts of 'obligation', of being bound or required by law should remain though they had lost their root…..It is as if the notion 'criminal' were to remain when criminal law and criminal courts have been forgotten (Anscombe 1997 p. 31).

Consequentialist philosophers such as Hume, Mill, Bentham and others, are also given short shrift, primarily because all actions, even murder and theft, can theoretically be

acceptable if they fall within the limits of the principle of utility. Anscombe concludes her essay by suggesting that what is needed is a return to the ethical language of Aristotle and Plato where actions are simply 'just' or 'unjust', 'honest' or 'dishonest' as the case may be. However, she does note that much philosophical work needs to be done in order to progress in this direction. "Philosophically there is a huge gap, at present, unfillable as far as we are concerned, which needs to be filled by an account of human nature, human action, the type of characteristic a virtue is, and above all human flourishing" (Anscombe 1997 pp. 43-44).

Anscombe may justifiably deserve to take the credit for starting a renaissance in virtue ethics, but it has been other authors, especially Alasdair MacIntyre, who have really attempted to "fill the gap" she describes. Virtue ethics has now been re-explored and arguably placed on equal footing as a moral theory to the deontological and consequentialist theories that Anscombe decries (Baron, Pettit & Slote 1997; MacIntyre 1990).

ARISTOTLE'S ETHICS

In returning the focus to what is generally considered the roots of 'virtue ethics', that is, ethics as encountered in Aristotle's *Nichomachean Ethics*, it is important to note that other Greek philosophers of that time, including Plato, also advanced a similar conception of morality. The sentiments expressed in my introduction, that virtue ethics seems somehow more complicated than the modern ethical theories, are echoed by Jonathon Barnes in the introduction to this edition of the *Nichomachean Ethics* "Yet any but the most shallow reading of the *Ethics* soon strikes on hidden reefs; and the deeper the reading the more frequent become the dangers and the more testing the steerage" (Aristotle 2004 p. ix). However, I think it is essential to consider at least the core elements of Aristotle's ethics because much of what is written later about this, by more contemporary philosophers, is based at least in part on Aristotle's original concepts. Thus it is important to understand how they all fit together - man as a functional concept; *eudaimonia* as the supreme good toward which man must aim in order to achieve his

purpose or *telos*[12]*,* and the virtues as essential character traits that enable man to do this; the doctrine of the mean and the notion of *phronēsis* or practical wisdom. I shall first attempt to present the core components of Aristotle's ethics, and then discuss some criticisms.

Perhaps the central difference between Aristotle's ethics and other ethical theories is that the focus of the investigation is "How should I live?" rather than "How should I act?" (Crisp 1996 p. 1). Aristotle's aim in writing both the *Nichomachean Ethics* and the *Politics* is to provide a description of how the good person should live and of how a society should be organized in order to facilitate a fulfilled or "good" life (Hughes 2001 p. 13). Thus before determining how I should act, I need to first have a clear idea of the answers to the more important question - how should I live? Virtue ethics is in essence about "the big picture" as an essential background to individual morality. However, Aristotle's *Nichomachean Ethics* is not just about moral theory, but also about becoming good. He writes:

> Since the branch of Philosophy on which we are at present engaged
> is not, like the others, theoretical in its aim - because we are studying
> not to know what goodness is about, but how to become good men,
> since otherwise it would be useless - we must apply our minds as to
> how our actions should be performed (II, ii, 1103b26-31).

Aristotle begins "Every art and every investigation, and similarly every action and pursuit, is considered to aim at some good. Hence the good has been rightly defined as 'that at which all things aim'" (I, i, 1094a1-2). It is important to note that Aristotle makes this blunt assertion and provides no argument for it (Norman 1998 p. 30). He goes on to explain that there are many "actions, arts and sciences" and many ends to which things aim, for example, the end of medical science is health. Ends of actions can also be the activities themselves or something separate and can be chosen to achieve other ends. However ultimately there must be some end that is chosen for its own sake.

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[12] *Telos* translated as aim, objective, end.

> - If then we do not choose everything for the sake of something else
> (for this will involve an endless progression, so that our aim will be
> pointless and ineffectual) - it is clear that this must be the good, that
> is, the supreme good (I, i, 1094a 18-22).

Somewhat surprisingly he digresses at this point to identify politics as the science that studies the supreme good for man. Aristotle's perspective on politics, perhaps better translated as 'statecraft' is notably different to ours, and involves an understanding of how communities should be structured in order to "enable man to live the good life" (Broadie 1991 p. 17). He takes up the discussion again a little later and identifies the supreme good as *eudaimonia,* usually translated somewhat unsuccessfully as "happiness".

> Well, happiness more than anything else is thought to be just such an
> end, because we always choose it for itself and never for any other
> reason. It is different with honor, pleasure, intelligence and good
> qualities generally. We do choose them partly for themselves
> (because we should choose each one of them irrespectively of any
> consequences); but we choose them also for the sake of our
> happiness, in the belief that they will be instrumental in promoting it.
> On the other hand nobody chooses happiness for *their* sake, or in
> general for any other reason (I, vii, 1097a 35-1097b1-7).

Hughes prefers the terms "a fulfilled life" or "fulfillment" to happiness and points out that Aristotle does not have notions of contentment or pleasure in mind, but rather that happiness amounts to achieving full potential (Hughes 2001 p. 22). "If happiness is an activity in accordance with virtue, it is reasonable to assume that it is in accordance with the highest virtue, and this will be the virtue of the best part of us" (X, vii, 1177a11-14). Although happiness is not the only good we may aim for as an end in itself, it is hierarchically at the top of all ends. "Happiness then is found to be something perfect and self sufficient, being the end to which our actions are directed" (I, vii, 1097b 20).

What follows now, is generally referred to as the 'Function Argument' and is at the heart of Aristotle's ethical scheme. Classes of men, such as flautists or sculptors, have a specific function and their goodness or proficiency lies in the performance of that function. A good flautist plays the flute well. The same will be true of man, presuming that man has a function. Aristotle asserts that man, like all beings does indeed have a proper function that sets him apart from other living beings such as plants or sentient animals. That function is living a life according to the "rational principle."

> …and if we assume that the function of man is a kind of life, namely, an activity or a series of actions of the soul, implying a rational principle; and if the function of a good man is to perform these well and rightly; and if every function is performed well when performed in accordance with its proper excellence: if all this is so, the conclusion is that the good for man is an activity of the soul in accordance with virtue, or if there are more kinds of virtue than one, in accordance with the best and most perfect kind (I, vii, 1098a13-18).

In order to fully understand his argument one needs to have an understanding of Aristotle's view of the soul or *psychē* which is based on his metaphysical biology. The soul is the essence of living things. Souls are "the capabilities which correspond to the different ways in which the bodies of different organisms are organised" (Hughes 2001 p. 35). From Aristotle's perspective, the well-being of any organism consists in the "integrated exercise of these capabilities." This is what constitutes its *telos.* And man like any other organism has a *telos* (Hughes 2001 p. 35). He completes the argument by stating, "There is a further qualification: in a complete lifetime. One swallow does not make a summer; neither does one day. Similarly neither can one day, or a brief space of time, make a man blessed (*makarios*) and happy" (I, vii 1098a19-21). What Aristotle is saying here is that exercising the virtues needs to be done habitually, not just as a once off, or now and then. Telling the truth once does not make a man honest.

In summary, Aristotle's argument up until this point has the following steps:

- Actions or activities are performed for some end, and that end aims at some good.
- Some actions are performed as means to some other end and others are performed as ends in themselves.
- The supreme good, or highest end, is that which is always performed for itself alone and that is *eudaimonia,* translated as 'happiness' or 'well-being' or 'fulfillment'.
- Achieving this highest good is contingent on fulfilling our overall *telos* or function as a human being and that can only be achieved by living in accordance with virtue or as Norman has stated, "the rational use of emotions" (Norman 1998 p. 27)

This must become habitual, exercised throughout life*. Eudaimonia* is not achieved instantly. Also it is not related to the turn of a man's fortunes or success and failures. "It is virtuous activity that determines our happiness and the opposite kind that produces the opposite effect" (I, x, 1100b10).

After setting out his argument, Aristotle proceeds in Book II of the *Nichomachean Ethics* to discuss moral virtues. He asserts that there are two kinds of virtue, intellectual and moral. Intellectual virtues are of two types: *Sophia* is the ability to think clearly and competently about scientific or theoretical matters and *phronēsis,* the ability to think effectively about practical matters. The intellectual virtues are closely integrated with the moral virtues, are mainly taught, need time and experience to become fully developed, and are discussed by Aristotle later in Book VI. Moral virtues, on the other hand, are the result of conscious habit. Almost like 'practice makes perfect'. We become just by repeatedly choosing to do just acts. We become temperate by performing temperate acts, etcetera. There are a couple of core issues introduced in Book II. The first is the link between action and disposition or character:

> …we should apply our minds to the problem of how our actions should be performed, because….. it is these that determine our dispositions" (II, ii, 11035b29-31), and

But virtuous acts are not done in a just and temperate way merely because *they* have a certain quality, but only if the agent also acts in a certain state, that is (1) if he knows what he is doing, (2) if he chooses it, and chooses it for its own sake and (3) if he does it from a fixed and permanent disposition (II, iv, 1105a27-31).

These statements at first glance may appear circular, but what Aristotle appears to be emphasising is the importance of correct motive and attitude with respect to actions. The role of motive in the moral scheme of things is a critical component of virtue ethics, largely missing from modern ethical, particularly deontological, theories. Motive has been explored in depth by contemporary virtue ethics authors like Michael Slote and I shall discuss this particular aspect a little later in this section.

The second key issue Aristotle introduces is the 'Doctrine of the Mean'. Aristotle asserts that the right moral virtue is always a mean between two extremes:

By virtue I mean moral virtue, since it is this that is concerned with feelings and actions, and these involve excess, deficiency and a mean. It is possible, for example, to feel fear, confidence, desire, anger, pity, and pleasure and pain generally, too much or too little; and both are wrong. But to have these feelings at the right times, on the right grounds, towards the right people, for the right motive and in the right way, is to feel them to an intermediate, that is to the best degree and this is the mark of virtue. Similarly there are excess and deficiency and a mean in the case of actions. But it is in the fields of actions and feelings that virtue operates; and in them excess and deficiency are failings, whereas the mean is praised and recognised as a success: and these are both the mark of virtue. Virtue then is a mean condition, inasmuch as it aims at hitting the mean (II, vi 1106b16-27).

Aristotle's 'Doctrine of the Mean' is probably one of the aspects of the *Nichomachean Ethics* that is most at risk of being misinterpreted or misunderstood. What Aristotle means by this becomes clearer when he uses a table to illustrate his point, even though some of his examples seem a little odd today, more than 2000 years later. (See below) For example, in the sphere of "fear and confidence", the excess would be rashness, the deficiency cowardice, but the mean is the virtue of courage. Likewise in the sphere of "pleasure and pain", excess is licentiousness, deficiency insensibility, and the mean is the virtue of temperance. Thus a moral virtue is that rational disposition or character that enables us to use our feelings to govern our actions in such a way that we will hit the mean between two extremes of conduct. Such virtue is not something inherent to our nature, but is cultivated by habitually choosing to act in such a way. I discuss the 'Doctrine of the Mean' in more detail later within the context of emotions and motive.

Table of Virtue and Vices (Aristotle 2004 pp. 284-285)

SPHERE OF ACTION OR FEELING	EXCESS	MEAN	DEFICIENCY
fear and confidence	rashness	**Courage** *andreia*	cowardice
pleasure and pain	licentiousness	**Temperance** *sōphrosmē*	insensibility
getting and spending (minor)	prodigality	**Liberality** *eleutheriotēs*	illiberality
getting and spending (major)	vulgarity	**Magnificence** *megaloprepeia*	pettiness
Honour and dishonour (minor)	vanity	**Magnanimity** *megalopsuchia*	pusillanimity
Honour and dishonour (major)	ambition *philotimia*	**Proper ambition**	unambitiousness
anger	irascibility	**Patience** *praotēs*	lack of spirit
self-expression	boastfulness	**Truthfulness** *alētheia*	understatement
conversation	buffoonery	**Wittiness** *eutrapelia*	boorishness
social conduct	obsequiousness	**Friendliness** *philia(?)*	cantankerousness
shame	shyness	**Modesty** *aidōs*	shamelessness
indignation	envy	**Righteous indignation** *nemesis*	malicious enjoyment

The intellectual virtues are discussed in Book VI of the *Nichomachean Ethics* and the discussion focuses on the concept of *phronēsis* or 'practical wisdom'. The whole concept of practical wisdom is crucial to Aristotle's moral scheme, because practical wisdom is

that virtue or excellence that allows one to choose the right action at the right time. Getting to grips with Aristotle's commentary on practical wisdom is challenging. Sarah Broadie, a renowned scholar in this field, writes, "This more than most, is rough terrain for commentators, being densely thicketed with controversy. Some of the difficulties spring from the obscurity of Aristotle's exposition, while some flourish through our own confusing preconceptions" (Broadie 1991 p. 179). Hughes echoes similar sentiments (Hughes 2001 p. 84). Forewarned therefore, I shall merely attempt to convey the main points of Book VI as simply and as clearly as possible, using the translated original text and Hughes' commentary (primarily) as a guide.[13]

In Book VI Aristotle often refers to the 'soul'. However, as mentioned earlier, his concept of a 'soul' is quite different to the concept in current use today, or to Plato's concept (Plato 1987 p. 382). It is not something that is separate from the body or that can leave the body after death. It is rather the essence of a thing or animal, the way one is internally organised. For humans, 'soul' is closely related to 'mind' and 'thought' or 'intellect'. According to Aristotle the rational 'soul' has two parts, each adapted to cognition of two different kinds: the scientific soul comprehends things whose "first principles are invariable" (VI, i, 1139 a6-7). This kind of thinking he calls *sophia*; usually translated as 'wisdom'. The other part of the rational soul is concerned with deliberation and calculation of the variable - *phronēsis* or 'practical wisdom' (VI, i, 1139a15). It is this 'calculative soul' that we are concerned with here.

> We are here speaking of intellect and truth in a practical sense: in the case of contemplative (as distinct from practical and productive) intellect, right and wrong are truth and falsehood. To arrive at the truth is indeed the function of intellect in any aspect, but the function of practical intellect is to arrive at the truth that corresponds to the right appetition. Now the origin of action is choice and the origin of choice is appetition and purposive reasoning. Hence choice necessarily

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[13] This approach is adequate for my purposes here. However there are many detailed commentaries available. E.g. See Sarah Broadie's excellent in-depth commentary, *Ethics with Aristotle*. 1991 Oxford University Press.

involves not only intellect and thought, but a certain moral state (VI, I, 1139a26-35).

Phronēsis or 'practical wisdom' is thus the virtue or ability to make the right choice, for the right reason, in circumstance where a deliberative choice is required. This virtue has been translated as "prudence" in the translation that I am using. So to quote Aristotle again:

> Well, it is thought to be the mark of a prudent man to be able to deliberate rightly about what is good and advantageous for himself; not in particular respects, e.g. what is good for health or physical strength, but what is conducive to the good life generally (VI, v 1140a 26-29).

The aim of theoretical or "scientific" thinking is to understand the way things are; practical thinking is reasoning about choices that will change things, or lead to an action of some sort (Hughes 2001 p.87). Hughes has clearly summarised some of Aristotle's main points with respect to the key elements of practical wisdom as follows:

- Practical wisdom involves a combination of understanding and experiences and results in the ability to read individual situations accurately.
- One's previous experience enables one to develop insight into the "demands of truthfulness, kindness, courage etc".
- Every time one is faced with a new situation that requires moral deliberation and choice, the virtue of practical wisdom is strengthened.
- "We come to understand the end- what a fulfilled life involves- better precisely by deliberating about what to do, situation by situation. Where the moral life is concerned, to deliberate about particular actions is also to deliberate about what a fulfilled and worthwhile life involves. It is therefore to become the kind of person who sees life in a particular way, and sees one's decisions as fitting into that vision of a life" (Hughes 2001 pp. 102-106).

Bernstein adds further insights into the notion of *phronēsis,* which he regards as involving a dialectic interaction between universal norms and practical knowledge and understanding.

> For *phronesis* is a form of reasoning and knowledge that involves a distinctive mediation between the universal and the particular. This mediation is not accompanied by any appeal to technical rules or [m]ethod,…or by the subsumption of a pre-given determinate universal to a particular case*…..[P]hronesis* is a form of reasoning, yielding a type of "ethical-know-how" in which both what is universal and what is particular are co-determined. Furthermore, *phronesis* involves a "peculiar interlacing of being and knowledge, determination through one's own becoming. It is not to be identified with or confused with the type of "objective knowledge" that is detached from one's own being and becoming (Bernstein 1982 p. 828).

Aristotle's perspective on ethics is the subject of much scholarly work and much controversy. His *Nichomachean Ethics* has also been extensively criticised by proponents of alternate moral theories. One of the main criticisms is the notion of man having a *telos;* in fact, the 'function argument' in its entirety is questioned and as already stated this argument starts off with an assertion that is simply asserted, never justified. (MacIntyre has, as we shall see, largely dismissed Aristotle's account of the telos of man for the very reason that it relies on his "metaphysical biology".)[14] Another problem with Aristotle's ethics revolves around *phronēsis* and how this virtue or ability is in fact obtained. Aristotle is quite clear on this - by habit and by "moral training" - but the details of how this is actually achieved are never fully explained. Another major criticism of Aristotle's ethics and virtue ethics in general, is the fact that it is not 'action guiding': it cannot easily be applied to specific situations or moral dilemmas; it does not provide a ready solution. Many of these issues have been addressed by contemporary writers and

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[14] In *After Virtue* MacIntyre considers Aristotle's concept of telos as reliant on his "metaphysical biology" and thus not entirely plausible in current times. MacIntyre thus develops an alternative account of man's *telos*. However as shall become clear in my discussion, MacIntyre does seem to reconsider this position in later works, particularly *Dependent Rational Animals* published in 1999 almost 20 years after *After Virtue*.

I shall thus not consider them now, but rather discuss the strengths and weaknesses of virtue ethics as a whole at the end of this section, after the perspectives of more recent authors have been considered.

THOMAS AQUINAS

A discussion of virtue ethics would be incomplete historically, without at least mentioning Thomas Aquinas who is generally credited for 'Christianising' Aristotle's ethics. Thomas Aquinas (1224-74) is arguably the greatest medieval philosopher-theologian. His moral philosophy was elaborated in the *Suma Theologiae*, which was unfinished at his death (Honderich 1995 p. 43). His philosophy is usually discussed within the context of theology or Christian ethics because, obviously, the presence of a 'divine law giver' is an essential component of Aquinas' moral scheme. I thus do not attempt to discuss or analyse Aquinas's contribution to virtue ethics, other than to acknowledge it and to note that MacIntyre draws quite extensively from Aquinas and generally purports to be in accordance with Aquinas's perspective (MacIntyre 1990). Like Aristotle, Aquinas was concerned with looking at one's life as a whole, and at choosing the kind of life and actions which would lead to ultimate human fulfilment, not after death, but within the context of one's life on earth. He is concerned with 'practical reason' as it applies both to the individual and to 'politics' or how people should live together in communities. Finnis comments that "it is a fundamentally practical philosophy of principles which direct us towards human *fulfilment* so far as that happier state of affairs is both constituted and achievable by way of the actions that both manifest and build up the excellences of character traditionally called *virtues*. If one must use a post-Kantian jargon, it is both 'teleological' and 'deontic', and not more the one than the other (Finnis 2005).

ALASDAIR MACINTYRE AND *AFTER VIRTUE*

Justification

MacIntyre's seminal work *After Virtue*, first published in 1981 and now in its 3rd Edition, probably stands beside Rawls's *Theory of Justice* as a twentieth century philosophical work to have made the most impact on the modern-day political and moral philosophy.

In a way, MacIntyre continued where Anscombe left off; but, to represent his work as merely a completion of her project would be a grave mistake. *After Virtue* is primarily a deconstruction of the "Enlightenment project" of finding a secular and rational basis for morality. However it is also very much a reconstruction of an alternative moral philosophy, based primarily on the works of Aristotle. (Knight 1998) This reconstruction project is begun in *After Virtue,* and continues in later works: *Three Rival Versions of Moral Enquiry*, based on the 1988 "Gifford Lectures"; *Whose Justice? Which Rationality?* (1988) written as a sequel to *After Virtue,* and *Dependent Rational Animals* (1999) (MacIntyre 1990, MacIntyre 2007, MacIntyre 1988; MacIntyre 1999)

The dramatic impact *After Virtue* had on modern-day political and moral philosophy is probably due more to its criticisms of that genre of philosophy, than to its presentation of an alternative. As mentioned, *After Virtue* initially made an impact probably as much, if not more, with respect to its criticisms of modern moral philosophy, as opposed to its presentation of an alternative. MacIntyre begins with a parable. He asks to imagine that the natural sciences have suffered a catastrophe of such huge proportions that everything is destroyed: laboratories, books, instruments etcetera. Even the scientists themselves are all "lynched". All that is left are fragments that hinted at a time gone past, and knowledge that existed but has now been lost. Enlightened people try and resurrect science and they start using phrases and expressions such as 'specific gravity', 'atomic mass' but the real intelligible meaning of these concepts has been lost. After relating this scenario, MacIntyre presents a provocative central thesis:

> The hypothesis which I wish to advance is that in the actual world that we inhabit the language of morality is in the same state of grave disorder as the language of natural science in the imaginary world that I described. What we possess if this view is true, are the fragments of a conceptual scheme, parts which now lack those contexts from which their significance derived. We possess indeed simulacra of morality; we continue to use many of the key expressions. But we have very largely, if not entirely- lost our

comprehension, both theoretical and practical, of morality (MacIntyre 1985 p. 2.).

He then goes even further with the catastrophe analogy: "For the catastrophe will have to have been of such a kind that it was not and has not been -- except perhaps by a very few -- recognised as a catastrophe" (MacIntyre 1985 p. 3). In other words, the philosophers of recent times have failed to realise just what a real mess modern moral philosophy is actually in!

Why has MacIntyre made such an astounding assertion? The first eight Chapters of *After Virtue* are devoted to explaining the rationale behind this assertion. Chapter 9 represents the turning point of the discussion and is titled, quite dramatically, "Nietzsche or Aristotle?" MacIntyre himself summarised the main points of his argument in the "Claims of *After Virtue*" and so I shall lean on him in trying to develop a clear précis of these chapters (MacIntyre 1998 pp. 69-71). According to MacIntyre, one of the distinctive features of our current social order is that we disagree over moral issues without any prospect of ever finding a resolution. Examples given are debates about the value of human life, abortion, and euthanasia; which "degenerate into assertions and counter assertions, because the protagonists of rival positions invoke incommensurable forms of moral assertion against each other." (MacIntyre 1998 p. 69). These arguments employ completely different normative concepts, for example, an appeal to utility versus an appeal to obligation, and thus we posses no rational way of balancing and comparing the claims of one against that of another (MacIntyre 1985 p. 8). MacIntyre's diagnosis for our current moral malaise is "emotivism":

> Emotivism is the doctrine that all evaluative judgements and more specifically all moral judgements are nothing but expressions of preference, expressions of attitude or feelings….Factual judgements are true or false; and in the realm of fact there are rational criteria by means of which we may secure agreement as to what is true and what is false. But moral judgements, being expressions of attitude or feeling, are neither true nor false; and agreement in moral judgement

is not to be secured by any rational method because there are none. It is to be secured, if at all, by producing certain non-rational effects on the emotions or attitudes of those who disagree with one. We use moral judgements not only to express our own feelings and attitudes, but also precisely to produce such effects in others (MacIntyre 1985 p. 12).

Of course MacIntyre does not believe that "emotivism" as a doctrine is correct. But why has it been adopted as the main moral currency of our time? The reason for this is what he describes as the failure of the Enlightenment Project, laid out in Chapters five and six of *After Virtue*. The writers of the Enlightenment period all share a common project of developing valid arguments "which will move from premises concerning human nature as they understand it to be, to conclusions about the authority of moral rules and precepts" (MacIntyre 1985 p. 52). This project was bound to fail because of an "ineradicable discrepancy" between their shared understanding of moral rules and principles on the one hand and their notion of human nature on the other (1985 p.52). The crucial point is that both of these conceptions have a history and their relationship can only be understood within the context and understanding of that history. But that preceding history has been lost (as illustrated by the parable discussed earlier). The "historical ancestor" of these conceptions is a moral scheme that dominated the European Middle Ages from about the twelfth century onwards and was based on a combination of the teleological moral scheme laid out by Aristotle in the *Nichomachean Ethics*, discussed earlier, and developed further by Aquinas who combined an Aristotelian view of morality with the "theistic" dogma of Catholicism. The following paragraph is the crux of MacIntyre's argument and I shall thus quote it directly from the text:

Within that teleological scheme there is a fundamental contrast between man-as-he-happens-to-be and man-as-he-could-be-if-he-realised-his-essential-nature. Ethics is the science which is to enable men to understand how they make the transition from the former state to the latter. Ethics therefore in this view presupposes some account

of potentiality and act, some account of the essence of man as a rational animal and above all some account of the human *telos*. The precepts which enjoin the various virtues and prohibit the various vices which are their counterparts instruct us how to move from potentiality to act, how to realize our true nature and our true end. To defy them will be to be frustrated and incomplete, to fail to achieve that good of rational happiness which it is peculiarly ours as a species to pursue. The desires and emotions which we possess are to be put in order and educated by the use of such precepts and by the cultivation of those habits of action which the study of ethics prescribes; reason instructs us both as to what our true end is and as to how to reach it (MacIntyre 1985 pp. 52-53).

The above scheme becomes complicated and added to when placed within the context of a belief in God, which has in fact been accomplished by scholars in all three of the monotheistic religions[15], but still remains essentially unchanged. However, now these "precepts" must be understood not only as teleological directives, but also as a manifestation of divine law. Hence the ultimate *telos* of man will only be attained in the next world, not in this one. This scheme still remains a three step scheme:

1. Untrained "raw" human nature.
2. Application of rational moral precepts and habits which enable the transition to…
3. ….Human nature as it can be, having accomplished its *telos* i.e attained a state of *eudaimonia.*.

The problem and the reason why the philosophers of the Enlightenment period have failed, is because the scheme has lost the third step. The notion of *telos* (as well as the notion of a divine law giver; but this is incidental to the argument) has been lost and thus the scheme is no longer intelligible. The Enlightenment project sought to find an objective neutral universalisable truth. However the quest for a universal rational truth has failed and has delivered up a large number of moral theories, each incommensurable, hence the interminable debates around moral issues so characteristic

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[15] Aquinas for Christianity; Maimoides for Judaism and Ibn Roschd for Islam.

of our society. That these philosophers sought universal truth outside of the historical and traditional social and cultural contexts that determine the *telo*s of man, that is, regarding a cultural tradition as merely contingent, is at the source of the Enlightenment project's failure. MacIntyre believes that tradition and culture are crucial components of man and his *telos*. Different traditions can come to different outcomes regarding moral truths. However, as we shall see, MacIntyre is *not* a cultural relativist. Hence the pivotal question - Aristotle or Nietzsche?

Nietzsche or 'Genealogy' takes the above argument one step further; that because different cultural rationalities can come up with different moral truths, this means that there is no moral truth at all. All truth is relative and man actually picks his own morality to suit his own ends. No 'morality' is any better than the next. MacIntyre disagrees with this. Just because different traditions or rationalities may come up with different moral truths or views on what is right or wrong, good or bad, that is no reason to believe that, viewed from a specific social and cultural context and point in history, there is no 'moral truth'. The fact that there may be no objective neutral moral truth does not mean that there is no correct truth for me in my social and traditional context, at a specific point in time and with my narrative quest.

MacIntyre argues that ultimately we must choose between a tradition of the virtues, as outlined by Aristotle, where we focus on answering the question how should I live my life, or what sort of person should I become, *or* we must take Nietzsche's very bleak view, which he clearly does not support, that all morality is relative and we choose our morality, as a mask, to suit our own manipulative ends.

There is a crucial paragraph in Chapter 9, the "Nietzche or Aristotle?" chapter, which emphasises how strongly MacIntyre feels about this choice. It is not merely that one is right or the other wrong, but rather that they are actually matched against each other. This section is of such importance to the overall discussion, and to what follows, that I will quote the entire paragraph:

For as I argued earlier, it was because a moral tradition of which Aristotle's thought was the intellectual core was repudiated during the transitions of the fifteenth to seventeenth centuries that the Enlightenment project of discovering new rational secular foundations for morality had to be undertaken. And it was because that project failed, because the views advanced by its most intellectually powerful protagonists, and more especially by Kant, could not be sustained in the face of rational criticism that Nietzsche and all his existentialist and emotivist successors were able to mount their apparently successful critique of all previous morality. Hence the defensibility of the Nietzschean position turns *in the end* on the answer to the question: was it right in the first place to reject Aristotle? For if Aristotle's position in ethics and politics -- or something very like it -- could be sustained the whole Nietzchean enterprise would be pointless. This is because the power of Nietzsche's position depends upon the truth of one central thesis: that all rational vindications of morality manifestly fail and that therefore belief in the tenets of morality needs to be explained in terms of a set of rationalizations which conceal the fundamentally non-rational phenomena of the will. My own argument obliges me to agree with Nietzsche that the philosophers of the Enlightenment never succeeded in providing grounds for doubting his central thesis; his epigrams are even deadlier than his extended arguments. But if my earlier argument is correct, that failure itself was nothing other than an historical sequel to the rejection of the Aristotelian tradition. And thus the key question does indeed become: can Aristotle's ethics, or something very like it, after all be vindicated? (MacIntyre 1985 p. 119.)

The remainder of *After Virtue* and much of MacIntyre's subsequent writings have been about answering this key question, that is, justifying "why human beings need the virtues" (MacIntyre 1999). I think the mere fact that I have undertaken this dissertation indicates that I am at least partly convinced by MacIntyre's arguments and wish to

explore them further within the context of practical every-day reality; none better or more challenging than the moral sphere of public health. I have attempted to outline the overall thrust of MacIntyre's argument leading up to the point of why Aristotle's ethics is credible and thus needs to be reconsidered. I now present MacIntyre's own conception of virtue ethics in more detail, and then consider the view points of some of his critics.

MacIntyre's conception of Aristotle's ethics

The remaining chapters of *After Virtue* represent a re-formulation of Aristotle's ethics, a project which MacIntyre has continued and developed in more detail and depth in his later works. One of the reasons for this re-formulation is because Aristotle's *Ethics* was based on Aristotle's 'metaphysical biology' which MacIntyre felt (in *After Virtue*) is no longer tenable in the modern world. It is worth noting that he seems to have retracted this idea in part, in his last work where he concludes that a complete account of virtue must also contain an account of human flourishing (MacIntyre 1999 p. 77; Porter 2003 p. 43).

MacIntyre begins, in Chapter ten of *After Virtue,* by considering the virtues in ancient Greek heroic societies and concludes that we can learn two key points from these societies. First, that morality is always tied to the "socially local and particular" and second, that "there is no way to possess the virtues except as part of a tradition in which we inherit them and our understanding of them from a series of predecessors" (MacIntyre 1985 p. 126-127). The notions of the importance of 'tradition' and the social embeddedness of morality are of fundamental importance to his conception of virtue ethics. According to MacIntyre, the core concept of a virtue has to be understood or developed in three stages.

> The first stage requires a background account of what I will call **a practice**, the second an account of what have already characterised as the **narrative order of a single human life** and the third account a good deal fuller than I have given up to now of what constitutes a **moral tradition** (MacIntyre 1985 p. 187).[16]

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[16] **Bold** is my addition.

The first stage in the development of the concept of a virtue is understanding what MacIntyre means by 'practice'. He notes that he uses the term specifically; in a way which does not completely coincide with its conventional use. Furthermore, he points out that his argument does not imply that virtues are only used within the context of a 'practice'. The concept of a 'practice' is also used, on occasion, by Aristotle. MacIntyre defines a practice as:

> …any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (MacIntyre 1985 p. 187).

Some examples of a practice are architecture, playing chess, farming, scientific enquiry, and painting (as in art), music as performed by a musician. Brick-laying or planting turnips are not examples of a 'practice'. What is characteristic about a practice is that the goods achieved by a practice are of two kinds: external and internal. It is the internal goods that characterise something as a 'practice'. External goods attached to practices are money, prestige or a prize of some sort. There are usually other ways of achieving these external goods; they are not 'practice' specific. However, goods internal to practices can only be understood and achieved by taking part in that particular practice. MacIntyre uses the example of chess and portrait painting to illustrate his point. An accomplished chess player may do so for monetary reward or status, but more often he will play chess because there are "internal goods" to be gained by honing one's skill as a good chess player, for example, analytical skill and strategic imagination (MacIntyre 1985 p. 188). A child may learn to play chess well because of a reward of sweets for every game played and won. At this point the child is playing merely for the 'external goods' attached to the game. However one would hope that in time, this child will learn to understand the 'internal goods' associated with chess, and want to play chess for no

other reason. Internal goods may well be the outcome of competition to excel but what is "characteristic of them is that their achievement is good for the whole community who participate in the practice" (MacIntyre 1985 p.190). A portrait painter may well earn a living and achieve status by painting portraits but it is the internal goods, the satisfaction of being able to capture a mood and likeness accurately, that make the whole practice of painting portraits worthwhile. After this explanation MacIntyre presents us with his first definition of a virtue, which he acknowledges will need amplification at a later stage:

> A virtue is an acquired human quality the possession and exercise of
> which tends to enable us to achieve those goods which are internal to
> practices and the lack of which effectively prevents us from achieving
> any such goods (MacIntyre 1985 p. 191).

He also states quite categorically that in order for a virtue to be effective in producing the internal goods that are sought, it must be exercised regardless of consequences. This, is in direct contrast to the principle of utility. "We cannot be genuinely courageous or truthful and be so only on occasion" (MacIntyre 1985 p. 198). There will also be times when exercising a virtue may in fact result in the loss of external goods, but as MacIntyre puts it, "the road to success in Philadelphia and the road to heaven may not coincide at all" (1985 p.198).

Another aspect of 'practices' which is quite important to understand is their relationship with institutions. Practices are not institutions but are associated with them and usually sustained by them. Medicine is a practice; a 'Faculty of Health Sciences' is an institution. Institutions are concerned appropriately with external goods; the accumulation of material goods, power, status etc. However the close association between practice and institution means that practices are vulnerable to corruption:

> Indeed so intimate is the relationship of practices to institutions -- and
> consequently of the goods external to the goods internal to the
> practices in question -- that institutions and practices characteristically
> form a single casual order in which the ideals and the creativity of the

practice are always vulnerable to the acquisitiveness of the institution, in which the cooperative care for the common goods of the practice is always vulnerable to the competitiveness of the institution. In this context the essential function of the virtues is clear. Without them, without justice, courage and truthfulness, practices could not resist the corrupting power of institutions (MacIntyre 1985 p. 194).

The relationship between virtues, practices and institutions is particularly important to the topic of this dissertation as the 'practice' of public health is closely interwoven with various institutions including those of state, and even international institutions such as the World Health Organisation. According to MacIntyre, the exercise of the virtues itself requires a "highly determinate attitude to social and political issues" and we learn, or fail to learn, to develop and exercise the virtues within a particular community, with its own specific forms of institution and some form of cohesive vision as to what constitutes 'the good life for man' (MacIntyre 1985 p. 194). He goes on to emphasise the difference between the relationships of 'moral character' to 'political community' within the context of modern liberalism and that of the tradition of virtue ethics that he is developing and that originates from a prior medieval and earlier tradition. This difference is particularly relevant within the context of the discussion in my next chapter on current approaches to 'public health ethics', where I illustrate that most current approaches originate from a tradition of liberalism. "For liberal individualism a community is simply an arena in which individuals each pursue their own self-chosen conception of the good life, and political institutions exist to provide that degree of order which make such self-determined activity possible" (MacIntyre 1985 p. 195).

The second step in MacIntyre's three stage conception of a virtue is to consider the **narrative order of a single human life**. He asserts, in line with Aristotle, that there needs to be a *telos* which goes beyond the restricted goods of practices and determines the good of a human life, conceived as a whole. If not, the result will be that a "subversive arbitrariness will invade the moral life *and* we shall be unable to specify the content of certain virtues adequately" (MacIntyre 1985 p. 203). The notion of a narrative unity of a human life is developed in *After Virtue* Chapter 16, pp 206-218.There are

several key points that need to be identified. The first is that action becomes intelligible when placed in a context of a narrative.

> …in successfully identifying and understanding what someone else is doing we always move towards placing a particular episode in the context of a set of narrative histories, histories both of the individuals concerned and of the settings in which they act and suffer. It is now becoming clear that we render actions of others intelligible in this way because action itself has a basically historical character. It is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others (MacIntyre 1985 p. 211-212).

The second key point in this discussion is the notion of accountability. "The difference between imaginary characters and real ones is not in the narrative form of what they do; it is in the degree of their authorship of that form and of their own deeds" (MacIntyre 1985 p. 215). The third key point is that each narrative is constrained in part by the narrative of others and influenced by the social context in which it is embedded. No man is an island and if we play the main part in our own narrative, then we play many other smaller and sometimes not so small roles in the narratives of others. The final, and most important key point, is that lived narratives have a teleological character.

> We live out our lives, both individually and in our relationships with each other, in the light of certain conceptions of a possible shared future, a future in which certain possibilities beckon us forward and others repel us, some seem already foreclosed and others perhaps inevitable. There is no present which is not informed by some image of some future and the image of the future which always presents itself in the form of a *telos* -- or of a variety of ends or goals towards which we are either moving or failing to move in the present (MacIntyre 1985 pp. 215-216)

One issue that to my mind MacIntyre does not emphasis or clarify well enough at this point, is that the *telos* or narrative quest must be informed by 'internal goods' rather than 'external' ones; a point integral to Aristotle's conception of the fulfilled life. He does however make the point a little later, perhaps slightly obtusely, when he redefines a virtue (bearing in mind that at this point we have not yet got to the final stage in the three stage development process).

> The virtues therefore are to be understood as those dispositions which will not only sustain practices and enable us to achieve the goods internal to practices, but will also sustain us in the relevant kind of quest for the good by enabling us to overcome the harms, dangers, temptations and distractions which we encounter, (perhaps in the form of "external" goods)[17] and which will furnish us with increasing self knowledge and increasing knowledge of the good. The catalogue of virtues will therefore include the virtues required to sustain the kind of households and the kind of political communities in which men and women can seek for the good together and the virtues necessary for philosophical enquiry about the character of the good. We have then arrived at a provisional conclusion about the good life for man: the good life for man is the life spent in seeking for the good life for man, and the virtues necessary for the seeking are those which will enable us to understand what more and what else the good life for man is (MacIntyre 1985 p. 219).

The third and final stage in the development of this complete theory of virtue is to place the narrative quest of an individual life within the context of a **'tradition'**. For MacIntyre, we are all part of some social and cultural context and that critically influences what equates to 'the good life for me'. We are all part of a family, involved in a profession that has been shaped by a history, part of a city or country with a particular social context and set of cultural traditions. These circumstances constitute "the given of my life; its moral starting point." This view of 'self' stands in contrast to the view of liberal

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[17] My addition in brackets.

individualism which says: "I am what I choose to be" (MacIntyre 1985 p. 220). MacIntyre defines a tradition thus:

> A living tradition then is a historically extended, socially embodied argument, an argument precisely in part about the goods which constitute that tradition. Within a tradition the pursuit of goods extends through generations. Hence the individual's search for his or her good by those traditions of which the individual's life is a part, and this is true both of those goods that are internal to practices and of the goods of a single life (MacIntyre 1985 p. 222).

This scheme can be represented visually by the illustration below. It is the virtues that unify the picture and make it coherent. MacIntyre points out two essential differences between his scheme and that of Aristotle's. Firstly, both are teleological, but MacIntyre's account does not rely on what he has described as Aristotle's 'metaphysical biology', because he states that this notion is not really tenable today. I.e. the idea that 'man' has a 'function' and it is that predetermined intrinsic function which ultimately will determine his overall purpose in life, or his quest. The function of a knife is to be sharp and to cut well; that function is intrinsic to its very nature. A good knife cuts well and a 'bad' knife is blunt and cannot perform its function. The function of 'man', in Aristotle's scheme, is to live a life according to a rational principle that aims at *eudaimonia* or 'well-being'; fulfilment; ultimate human flourishing.

The second difference is that MacIntyre acknowledges that there are now so many goods and practices and that at times goods will be "contingently incompatible" and result in conflict. This conflict will thus not simply be due to flaws in individual character. (MacIntyre 1985 pp. 196-197) However his account is otherwise very similar to Aristotle particularly with respect to the importance of tradition and practical reasoning. Personally I do not find Aristotle's teleological concept of man that problematic. In fact the notion that man exists without some form of predetermined ultimate function or purpose is quite disquieting. As stated earlier, MacIntyre appears to have reconsidered this perspective in later works and defended a teleological idea of "human flourishing". I

shall consider the sequel to *After Virtue*, *Whose justice? Which rationality?* in more detail in Chapter V, when I discuss "Virtue Ethics, Public health and Social Justice".

Of course MacIntyre's *After Virtue,* and to a lesser extent the works that have followed, have become themselves subjects of intense discussion and philosophical debate, and have spawned many commentaries and lengthy critiques.[18] Covering these in detail is beyond the scope of this discussion. Much of the criticism is aimed at Macintyre's critique of modern philosophy, rather than his portrayal of an ethics of virtue. I will consider some weaknesses of virtue ethics as a whole a little later. However I do think that it is important to briefly consider at this point, some potential problems with MacIntyre's scheme in particular, without losing focus of my essential task in this chapter, that is: to develop a broad understanding of what virtue ethics is all about, to demonstrate that there are at least some significant aspects of virtue theory that are intelligible and to test these aspects within the moral context of public health.

One of the problems that critics have identified in *After Virtue* is Macintyre's insistence that he needed to develop an account of the role of virtue within the moral sphere of life that did not rely on Aristotle's "metaphysical biology" but was embedded in the notion of 'tradition'. This aspect is problematic for the following reasons. First, it does seem to weaken the account considerably, as noted somewhat caustically by Bernstein: "I suspect that both Aristotle and Nietzsche would agree that *if* one calls into question what MacIntyre labels Aristotle's "metaphysical biology", then the entire traditional moral scheme of the virtues falls apart and Nietzsche wins." (Bernstein 1986 p.128) However, as I have stated earlier, I do not really think it is necessary to discount Aristotle's view on this point, and MacIntyre also, has reconsidered this aspect. What is for me more problematic, is what happens to the whole scheme if the 'moral tradition' in which ones narrative quest is embedded is "morally wrong", such as Nazi Germany or apartheid South Africa. Would this 'tradition' be able to give rise to individuals in which the virtues are sufficiently well developed so as to enable them to criticise the 'tradition' from the view point of 'insiders'? Aristotle is himself a 'case-in-point', as he did not appear to

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[18] In the "Guide to Further Reading" section of *The MacIntyre Reader* edited by Kelvin Knight, 1998, Polity Press, there are almost 20 pages of references listing the various articles, papers and books devoted to 'MacIntyre' commentary and critique.

have any problems with a society that excluded large sections of its population from 'moral consideration' at all e.g. slaves and women. As an aside however, it is also worth noting that Nussbaum and Sen have looked to Aristotle to provide insight on the very issue of internal criticism of cultural values (Nussbaum, Sen 1989)[19]. Seeing virtues as qualities that enable us to aim at, and eventually attain, an almost pre-ordained or independently defined *telos,* even if that telos was shaped in some significant way by the culture and tradition that indisputably forms a background to our lives, seems to me more promising than relying solely on that tradition for the bedrock of our *telos*.

A third criticism levelled not just at MacIntyre, but at virtue ethics as a whole, is that the criterion for right action is vague. It is not all that easy to say, especially from a position of hindsight, that such-and-such a deed or decision or action was definitely and indisputably wrong, because the criterion for right action seems to be based, somewhat obscurely, on that action which a virtuous person would choose to do in the circumstances. Rosalind Hursthouse (1996) has discounted this argument and I shall consider her perspective shortly. Bernstein has levelled a fourth criticism against MacIntyre though, for his justification for needing to return to Aristotle at a far more fundamental level. He accuses MacIntyre of actually building much of his argument on one of the core 'universalisable' principles thrashed out during the Enlightenment, namely the principle of 'universal respect for persons', and failing even to recognise this fact.

> To oppose the failures of the "moderns" with the wisdom of the "ancients," is to violate MacIntyre's own insistence that we cannot escape our historicity, our social identities, nor the traditions which inform our lives --including the tradition of the Enlightenment itself. It is to fail to recognize how much MacIntyre himself appropriates from this tradition in his critical reconstruction of the virtues: his implicit appeal to a concrete determinate universality; his defence of the principle of freedom where every participant can share in the type of communal life required for living a good life; his emphasis on the

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[19] I return to a discussion of Nussbaum and Sen's interpretation of Aristotle and internal criticism of cultural values in more depth in later chapters, particularly chapter V.

shared vision of a moral life by the participants in such communities; his demand that we treat all human beings with respect and recognize every agent's capacity to act rationally (Bernstein 1986 pp. 139-140).

I think Bernstein has a point. However this criticism still does not render virtue ethics unintelligible as a theory. I also think that virtue ethics, and Macintyre's version of it, is not an ethical theory that disputes the existence of universal moral truths. Rather, it asserts, quite intelligibly from my perspective that many moral truths (even if not all of them) are embedded in a particular context or reality and can only be discovered within the context of that reality.

It may be helpful at this point to consider an instance in recent medical moral and public health history that I believe illustrates MacIntyre's argument for historical and socially embedded truth rather well. I am referring to the furore created by the clinical trials that took part in Africa, in the 1990's, investigating an affordable alternative to the clinically proven gold standard treatment for the prevention of mother-to-child transmission of HIV. The controversy was created because Zidovudine, commonly known as AZT, was already widely used, with proven efficacy in this clinical context, in the Western world. The regimen was very costly and also involved the use of AZT intravenously during pregnancy. It had not been implemented in any sub-Saharan African countries, where the HIV epidemic was at its worst, because of prohibitive cost and the lack of healthcare infrastructure needed to support such a programme. Therefore the standard of care for HIV positive women in this social, historical and geographical context was no treatment at all. Researchers in these countries conducted a clinical trial comparing a vastly simplified and affordable oral treatment regimen with no treatment i.e. a placebo arm. They justified this because 'no treatment' was standard of care in Africa. Comparing their 'new' affordable regimen to the gold standard, would simply have shown that the gold standard was better. But this fact was already accepted. However there was no prospect that this gold standard would ever be available to the masses of HIV positive pregnant women in Africa. Therefore in their view, this clinical trial was completely justifiable because it may well open the door to a new dawn of ART prevention for HIV

positive pregnant women in Africa and other poor developing world nations (Van Niekerk 2005 b).

The trial was condemned by Marcia Angell in an editorial in the *New England Journal of Medicine* and dealt the worst ethical blow that can be dealt to clinical research -- it was compared with the infamous Tuskegee syphilis study (Angell 1997). A furious debate ensued in the bioethical literature, spearheaded by ethicists like Benatar and others who viewed the issue from a sub-Saharan reality and who argued strongly that in fact this study was entirely justifiable (Nash et al. 1999). Viewed now from the standpoint of history, there are very few who would still argue otherwise. This research did indeed open the door to the roll out across much of Africa, and the rest of the developing world, of effective mother-to-child HIV prevention therapy. However at the time, viewed from a first-world western standpoint of universal standards, these clinical trials were morally wrong.

I shall now turn to discussion of this topic by other contemporary writers, highlighting additional perspectives or points of difference that have not been addressed in the above discussion.

CONTEMPORARY VIRTUE ETHICS: ADDITIONAL PERSPECTIVES.

I have chosen to rely firstly on Aristotle and then MacIntyre to present what I hope is a fairly comprehensive picture of what constitutes 'virtue ethics'. However, there are many other contemporary scholars who are producing important work in the field of virtue ethics. Although impossible to represent them all here, there are additional perspectives within the wide discussion of virtue ethics that have not been fully captured in the above account, and which I feel will inform further discussion on the possible role virtue ethics may have in developing an ethical framework for public health. These perspectives are incorporated below.

'Normative' Virtue Ethics (Hursthouse 1996)

Rosalind Hursthouse has written extensively on virtue ethics and has applied virtue ethic theory quite successfully in the context of bioethics, particularly with respect to abortion[20] (Hursthouse 1991). She forthrightly addresses the criticism that virtue ethics does not clearly guide action and hence cannot "figure as a normative rival to utilitarian and deontological ethics" (Hursthouse 1996 p. 19). The criterion of right action is that which "a virtuous agent would characteristically (i.e. acting in character) do in the circumstances" (1996 p. 22). But how can we know what that action should or would be? According to Hursthouse virtues do in fact generate rules which are prescriptive, such as 'act honestly' or charitably, as the case may be. She refers to these as "v-rules" (1996 p. 25). These rules contain evaluative concepts, as do deontological rules such as "Do not kill the innocent" or "Do not kill unjustly" (an example, in fact, of a v-rule). V-rules and the deontological rules we learn "at our mother's knee" are in fact very similar. However a virtuous agent is not simply someone that is inclined to act according to moral rules, despite the obvious connection for example between the virtue of honesty and not telling a lie.

> Virtue ethicists want to emphasise the fact that if children are taught to be honest, they must be taught to prize the truth and that merely teaching them not to lie will not achieve this end. But they need not deny that to achieve this end teaching them not to lie is useful, even indispensable. So we can see that virtue ethics not only comes up with rules (the v-rules, couched in terms derived from virtues and vices) but further, does not exclude the more familiar deontological rules. The theoretical distinction between the two is that the familiar

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[20] Husthouse's application of virtue theory to the abortion debate cannot be summed up or even explained in a footnote. Like MacIntyre, she believes the arguments used to defend the opposing positions in the abortion debate are 'incommensurable'. She asserts that "virtue theory quite transforms the discussions of abortion by dismissing the two familiar dominating considerations [right to life of the foetus versus the woman's 'right to choose'] as, in a way, fundamentally irrelevant" (Hursthouse 1991 p. 227) The decision to terminate a pregnancy is one that is at the very heart of the question How should one live? rather than How should I act? As such, it is an issue of such importance that it cannot ever be taken lightly. However judging whether a woman who takes such a decision, has acted "viciously" does not depend on whether or not she has disobeyed a deontological or 'divine' rule, but rather depends on an entire range of considerations that are an integral part of that woman's particular life story.

rules and their application in particular cases are given entirely
different backings (Hursthouse 1996 p. 29).

Beauchamp and Childress have also demonstrated the link between virtues and
principles and provide a list of "principles of obligation" and corresponding virtues. For
instance "respectfulness" corresponds to "respect for autonomy" (Beauchamp, Childress
2001 p. 39). Of note is the fact that they list principles in the left hand column and the
virtues on the right, which could be interpreted to imply that the principle comes first and
the virtue is developed in order to enable us to adhere to the principle. This is of course
contrary to Hurthouse's interpretation -- the virtue generates the principle, not visa-versa.

Another set of criticisms of virtue ethics involves the resolution of genuine moral
dilemmas when virtues seem to conflict, or, in the case of a moral dilemma, when
Virtuous Agent A does X but Virtuous Agent B does Y. The problem of conflict is of
course not unique to virtue ethics, but equally relevant to a rule-based morality. The
virtues often point in different directions and thus lead to conflict: honesty should lead us
to tell the truth even if that truth causes pain, while the virtues of compassion and
kindness dictate that we should remain silent. Hursthouse makes a number of salient
points in this regard. First, both deontologists and virtue ethicists accept that often what
appears to be a conflict at first glance is revealed not to be one when explored or
examined in more depth. In other words 'honesty' indicates that I should tell a recently
widowed elderly aunt that she is getting fat, because she is using food to comfort
herself, but 'kindness and compassion' tell me to keep quiet. The apparent conflict is
not really a conflict at all, because I am doing her no favours by not addressing an issue
that will ultimately be detrimental to her health. The second point is that there is a
difference between whether a 'normative ethics' has the ability to solve a moral dilemma
correctly and whether an individual manages to do so in a given circumstance. A lack of
moral wisdom (*phronēsis)* may mean that an individual does not fully grasp what is
involved in acting kindly or unkindly or charitably or uncharitably (Hursthouse 1996 p.
29). Hursthouse is in complete accordance with Aristotle on the next point -- the issue of
acquiring moral wisdom. (This point in itself is a common criticism of Aristotle's ethics
but one that Hursthouse seemingly has no problem with). Moral knowledge unlike

mathematical knowledge is not easily attainable by clever adolescents. There are no moral whiz-kids, as there are mathematical whiz-kids, because the acquisition of this kind of knowledge requires experience of life (including no doubt making mistakes and having to take responsibility for the consequences)[21], moral training and habitual exercise of the virtues (1996, pp. 29-30). Earlier, Hurthouse comments that one of the resources we have as moral agents, when unsure what to do in a particular circumstances, is to seek out guidance from someone that we admire and respect and acknowledge as "kinder, more honest, more just" (Hursthouse 1996 p. 24). By so doing, we grow in moral wisdom.

Finally she addresses the criticism identified above. How can a credible moral theory that defines right action as that which a virtuous agent would do in a given circumstance, explain the very conceivable situation whereby in identical circumstances Virtuous Agent A does X, but Virtuous Agent B does Y? One possible conclusion would be that one of the agents was lacking in practical moral wisdom and did indeed choose to do the wrong thing. Another alternative, and one Hursthouse defends in some detail, is the possibility that there are irresolvable moral dilemmas or, alternatively, moral dilemmas where more than one right action exists.

> The acceptance of this should not be taken as counsel for despair, nor an excuse for moral irresponsibility. It does not licence coin-tossing when one is faced with a putative dilemma, for the moral choices we find most difficult to not come to us conveniently labelled as 'resolvable' or 'irresolvable'. I was careful to specify that the two candidates for being virtuous agents acted only 'after much thought'. It will always be necessary to think very hard before accepting the idea that a particular moral decision does not have one right issue, and even on the rare occasions on which she eventually reached the conclusion that this is such a case, would the virtuous agent toss a coin? Of course not (Hursthouse 1991 p. 34-35).

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[21] My comment in brackets.

Why not? Hursthouse's reply to this is that the question is an *ad hominen* one. If one's understanding of virtue ethics and the virtue agent is such that one can conceive of a virtuous agent as someone who tosses coins to decide important moral dilemmas, then one must think that there is nothing morally wrong with coin tossing as a method of resolving such issues. Such a person should therefore not look to virtue ethics to explain 'why not?' If, however, one's understanding of a virtuous agent is that of someone who would not dream of coin tossing in the first place, then there is no reason to ask 'Why Not?'

Hurthouse has provided valuable additional insight into an ethics of virtue as well as responding to some of the criticisms levelled against virtue ethics. Her notion of 'v- rules' is a useful one, even if the rules themselves still have a significant evaluative component that critics may yet find problematic. Her discussion of the importance of moral education and guidance is enlightening, as is her suggestion that sometimes the possibility may exist that there is no absolute 'right' way out of a moral dilemma.

Partiality and Friendship

Utilitarianism and Kantianism are prized for their impartiality on the one hand, but on the other are criticised, particularly by proponents of an ethics of care and by virtue ethicists, for distorting the real moral world that we live in, where bonds of family, love and friendship play a decisive role in our moral lives (Baier 1999).

> Many ethical writers, whether working at an abstract level or on concrete problems are officially subscribing to accounts of rightness and goodness which simply do not impinge on or make contact with, the partialistic commitments and preferential ties that deeply and pervasively inform their own lives. Such a schism between word and deed generates a problem not merely about the application of philosophical ethics but about its very coherence; for there is a serious instability in a moral theory which urges on us attitudes that we could not in honesty conceive of incorporating into our ordinary blueprint for daily living (Cottingham 1996 p. 58).

Cottingham argues that virtue ethics as laid out by Aristotle, is an 'inside-out' theory that presupposes a "pre-existing network of preferences and partialities" which gives virtue theory a "rootedness in the real world" and hence "a decisive edge over its competitors" (1996 p. 58). He uses Aristotle's detailed discussion of friendship and certain other virtues to defend his position, (that virtue ethics is not an impartial theory) which I think is a fairly widely accepted position (even by non-subscribers). What is disputed is the advantage of partiality in an ethical theory. Supporters of Mill as well as Kant would argue to the contrary. Within the context of a discussion of public health, which is health at a population level, not at an individual level, it may seem that the notion of partiality might well have been ignored or glossed over. However I do believe it is relevant to this discussion and will explore the 'partiality' of virtue ethics again in chapter VI.

Motive and Emotion

One aspect of virtue ethics that has not been adequately highlighted or explored in the previous discussion is the role that motive plays in this moral theory. At a purely 'gut-feeling' level it does seem to me that my underlying deep motive for doing something contributes significantly to whether, finally, and despite the consequences of my action, what I have done can be judged to be noble or ignoble, good or bad. It was this aspect of morality which I, as a practising clinician, grappling with moral issues such as abortion, assisted-suicide and 'mercy' killing, identified as being an integral part of virtue ethics but largely missing from other moral theories. According to Michael Stocker, modern ethical theories fail as theories for the very reason that they "fail to examine motives and the motivational structures and constraints of ethical life" (Stocker 1976 p. 453).

Aristotle's 'Doctrine of the Mean' is essentially about having the right or appropriate emotion in a particular instance and which would result in right action. Anger is a good example of an emotion that can be both appropriate and inappropriate and as such give rise to very different kinds of actions, for example, a brawl at a bar in one instance, and a furious defence of someone accused of something they did not do in the other. Right action is thus triggered by right emotion. As Aristotle explains:

So it is not easy to define by rule how, and how far, a person may go wrong before he incurs blame; because this depends upon particular circumstances, and the decision lies with our perception. However this much is clear: that the mean state, which makes us angry with the right people for the right reasons in the right way is commendable, while the excesses and deficiencies are to be censured -- gently or more strongly or very strongly according to the degree of the error. Clearly, then, we must keep closely to the mean (IV, v,1126b3-9).

There is thus a harmony between the reason for doing something and the motive or emotion guiding the action. Aristotle regarded the right emotion as being the embodiment of reason. That is, reasons don't just control emotion but rather emotions can themselves be the incarnation of reason (Norman 1998 p. 38).

It is important to highlight that when explaining the "Doctrine of the Mean" and the sliding scale of emotion, Aristotle does point out that not every emotion or feeling has a mean and that some emotions, such as malice and envy (and their correlative actions) are simply wrong, no matter to what degree they are experienced. "In their case then, it is impossible to act rightly; one is always wrong. Nor does acting rightly or wrongly in such cases depend on circumstances -- whether a man commits adultery with the right women or in the right way- because to do anything of that kind is simply wrong" (II,VI, 1107a15-18). Thus for Aristotle there do seem to be some universal truths that will hold good, no matter what the circumstances. I think this point is particularly relevant for those critics that are concerned that Aristotle, MacIntyre, and others of their ilk come dangerously close to a position of moral relativism. Deontologists would of course interpret this point differently, by asserting that it is proof after all that there are *a priori* universal moral rules! Aristotle would retort that well developed virtues enable rational man to recognise a set of universal moral truths[22].

Virtue ethics and motive have also been explored in detail by Michael Slote in *Morals from Motives* (Slote 2001). He has developed what he calls an "agent- based ethics" of

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[22] See related discussion of this point on page 154-156.

virtue which he describes as being more extreme or "purer" than other forms of virtue ethics, including Aristotle's ethics. "An agent-based approach to virtue ethics treats the moral or ethical status of acts as entirely derivative from independent and fundamental aretaic (as opposed to deontic) ethical characterisations of motives, character traits or individuals"[23] (Slote 2001 p. 5). For Slote, the underlying motive for an action is what determines whether or not the action is right or wrong and he recognises that this approach is "more radical" than Aristotle's. Commenting on Aristotle, Slote writes:

> Such language clearly implies that the virtuous individual does what is noble or virtuous because it is the noble-for example, courageous-thing to do,-rather than its being the case that what is noble-or courageous-to do has this status simply because the virtuous individual actually will choose or has chosen it. Even if right or fine actions cannot be defined in terms of rules what makes them right or fine for Aristotle, is not that they have been chosen in a certain way by a certain individual. So their status as right or fine or noble is treated as in some measure independent of agent evaluations, and that would appear to lead us away from agent-basing as defined above (Slote 2001 p. 5).

Slote develops his agent-based version of virtue ethics further, drawing on the "British Sentimentalists" particularly James Martineau and Hume and focusing for the most part on benevolence and an "ethic of care" similar to that proposed by some feminist ethicists. His specific version of virtue ethics has been criticised as too 'fundamental' and not being able to draw "such fundamental and intuitive distinctions as that between acting rightly and acting for the right reasons" (Jacobson 2002 p. 57). However for the purposes of this discussion Slote's emphasis on the importance of underlying motive in any moral scheme is what is most relevant. His writings confirm what is to my mind common sense that considerations of motive are of central relevance to morality.

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[23] "*Deontic*" from the Greek word 'necessity' and used to describe a rule based morality, with ethical tags such as 'obligation', 'duty'. "*Aretaic*", derived from the Greek word for 'excellence' or 'virtue' and associated with ethical tags such as 'virtuous', 'just', 'honest' etc.

Community

The philosophy of Aristotle and MacIntyre has been labelled 'communitarian' and there is something about this term that now seems to have attracted slightly negative connotations within current political philosophy. According to Kraut, modern communitarianism came to the fore in the years following the publishing of Rawls's *Theory of Justice,* largely as a challenge to this landmark work of liberal political philosophy. Rawls presents his concept of justice as a universal one, conceptualised and chosen by rational human beings behind a veil of ignorance i.e. all 'particulars' are concealed from view (Rawls 1999). "Communitarians argued that the standards of justice must be found in forms of life and traditions of particular societies and hence can vary from context to context" (Bell 2009). Bell also notes that the '1980's communitarians' (Alasdair MacIntyre, Charles Taylor, Michael Sandel and Michael Walzer are the main contenders for this title) have little success in presenting attractive and viable visions of communitarian societies, particularly because of the examples that they choose to use. Bell comments further:

> Communitarians could score some theoretical points by urging liberal thinkers to be cautious about developing universal arguments founded exclusively on the moral argumentation and political experience of Western liberal societies, but few thinkers would really contemplate the possibility of non-liberal practices appropriate for the modern world so long as the alternatives to liberalism consisted of Golden Ages, caste societies, fascism, or actually-existing communism. For the communitarian critique of liberal universalism to have any lasting credibility, thinkers need to provide compelling counter-examples to modern-day liberal-democratic regimes and 1980's communitarians came up short (Bell 2009).

I think there is some merit in the above fairly harsh criticism, as well as a warning that the real world of public policy-making, especially within the context of semi-industrialised and multi-cultural societies is a very different one to that which is described in text books of philosophy. However, that said, I still believe that many of the

ideas put forward by MacIntyre regarding the importance of forming moral judgements within the contexts of history, tradition and culture are very important for this particular discussion. We are considering the moral foundation for an ethics of public health, an ethics which to my mind will often need to be simultaneously universal and particular if it is to make sense. In today's world, the 'science' and the 'policy' so often still originate in a 'removed' first world context which may be very different from the developing world 'on-the-ground' context in which that 'science' and 'policy' need to be implemented.

The 'Virtues' Expanded

One of the most refreshing perspectives on virtue ethics is that of the French academic and philosopher, André Comte-Sponville. He does not bother at all with providing any explanation or justification of virtue ethics theory but rather concentrates on providing us with a present-day "treatise" of the "great virtues" in his book *A Small Treatise on the Great Virtues* (Comte-Sponville 2001)[24]. Aquinas added faith, hope and charity to Aristotle's list. Comte-Sponville has a list of 18 virtues and a chapter devoted to each one, which justifies its position historically and philosophically, and discusses its present-day relevance and application in detail. Many of the virtues discussed are also common to Aristotle, but the list is an updated or modernised one: Politeness, fidelity, prudence, temperance, courage, justice, generosity, compassion, mercy, gratitude, humility, simplicity, tolerance, purity, gentleness, good faith, humour and love. I shall discuss some of these virtues in more detail in chapter VI.

CRITICISMS OF VIRTUE ETHICS

There are as many critics and criticisms of virtue ethics as there are proponents. I have covered most aspects of substantive criticism in the preceding discussion. Some of the counter arguments to criticisms raised are explanatory and satisfactory; others, I acknowledge, leave one feeling not quite satisfied. I shall now provide a brief synopsis of the main points of this discussion.

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[24] *A Small Treatise on the Great Virtues* by Andre Comte-Sponville, a professor of classical philosophy at the Sorbonne, was first published in French in 1996 but has subsequently been translated into 19 different languages. Perhaps it sits on the fence between academic philosophy and popular writing, but this book would definitely be my 'desert island' virtue ethics book, if I had to choose one.

- The first and perhaps most fundamental criticism of virtue ethics is the fact that it rests on one central notion, that is, that of man having a function or *telos* which is either an essential essence of what it means to be a human being (Aristotle), or derived from a particular historical and social background (MacIntyre). I have already discussed this in some detail and stated that I do find MacIntyre and in fact Aristotle's conception of a human *telos* plausible. However I shall let Iris Murdoch have the last (contrary) word on this matter: "I assume that….human life has no external point or τέλος….That human life has no external point or τέλος is a view as difficult to argue as its opposite, and I shall simply assert it"! (Murdoch 1997) In other words I think this issue is on a par with discussions on the evidence that God exists or not. Ultimately you have to take a leap of faith one way or the other.

- The second serious criticism of virtue ethics is that it does not clearly define 'right action' or, put another way, it does not provide any clear decision- making guidance or prescription for action. This criticism was discussed in some detail in 'Normative virtue ethics'. I again acknowledge that the outcome of the defence offered was not completely satisfying. Perhaps the one thing that can be added here is that the two main rivals to virtue ethics also provide guidelines (to actions) that are not fully satisfying. Deontological norms and principles often conflict with each other and utilitarian calculations are subject to much subjectivity and sometimes produce outcomes that although clear, are nevertheless morally disquieting. However, for the reason of its seemingly inadequate prescription for action, some critics like James Rachels regard virtue ethics as an "incomplete theory"; one that can possibly supplement deontological or consequentialist theories, but that cannot stand up on its own (Rachels 1999 pp. 189-193).

- The third serious criticism of virtue ethics is that it equates to 'moral relativisim'. This issues has been discussed previously (Pages 46, 52-53) and will be addressed again later in chapter V.

- Virtue ethics can be criticised for its 'partiality', just as much as deontology and utilitarianism are criticised for the opposite reason. This was discussed in the section entitled 'Partiality and friendship (Page 69).

- The communitarian aspects of virtue theory have also come under fire as was illustrated in the section entitled 'Community".

- Kantians and utilitarians alike have difficulties with the intrinsic or intricate role that emotions and feelings play within a virtue-inspired moral scheme.

- Some feminist ethicists take exception to the fact that virtue theory, especially Aristotle's and MacIntyre's version of it, appears to be male-orientated and dismissive of the critical role women play within the moral life of any society (Moller Okin 1996). Conversely, other feminist ethicists find positive aspects in a virtue-centred ethics, with its acceptance of partiality and emphasis on the importance of emotions and close relationships within the realm of moral judgement (Baier 1997).

In the first paragraph of this chapter I noted that my central undertaking in this chapter would be firstly to develop a broad understanding of what 'virtue ethics' *is*, and secondly to demonstrate that there are at least some significant aspects of virtue theory that are intelligible. Despite the above fairly lengthy list of purported criticisms and weaknesses, I do believe that I have achieved both these aims and demonstrated that there is much about virtue ethics that *is* intelligible and is worth thinking about seriously. My third task is to begin to consider what aspects of virtue ethics may be applicable to an ethical framework for public health policy making. These initial thoughts will be expanded upon in following chapters.

VIRTUE ETHICS AND PUBLIC HEALTH: INITIAL PERSPECTIVES.

In my research proposal for this dissertation and in my introduction I made the following statement:

> The purpose of this study is to explore whether virtue ethics provides a meaningful and applicable moral alternative to these more established approaches. In that sense, this is the (possible) development of a new set of "theoretical points of departure" for the ethics of public policymaking in the field of healthcare. The study will, by and large, be guided by the hypothesis that virtue ethics does indeed offer possibilities in this regard that make it worth exploring. At

the same time, I do not work with the hypothesis that virtue ethics will be able to *wholly* replace dimensions of the other approaches mentioned above. My hypothesis is rather that virtue ethics can supplement other approaches when reflecting on the theoretical and moral bases of public policymaking in healthcare.

I think it is important for me to reassert this position at this point in my discussion. As shall become apparent in the following chapter, current approaches to public health ethics may have some deficiencies, but they also most certainly do have strengths. For instance, I think I would be most foolish if I tried to establish an argument that the language of human rights, which has achieved so much globally within the broader context of health and human development, could be done away with and replaced exclusively by virtue ethics. Philosophical purists would probably deplore what seems like a capitulation to ethical pluralism at such an early stage of this discussion. However the field of applied ethics must retain a fair chunk of pragmatism if it is to serve a useful purpose.

My intention now is to briefly extract from the above rather lengthy discussion the key 'virtue ethics take-home-messages for public health' that I plan to explore in detail at a later stage. For the sake of clarity and brevity I shall use bullet points:

- In Chapter II, I explored the concept of public health and argued that I believe that some conception of social justice underlies a conception of public health. I shall thus devote an entire chapter to exploring what a 'virtue ethics inspired' concept of social justice would consist of, and what implications it would have for the ethical dominion of public health.
- One of the key elements of virtue ethics identified above is the view that 'context' and 'circumstance' are an integral part of practical wisdom and hence moral judgements and action. Virtue ethics is thus essentially casuistical. This aspect may well be the area in which virtue ethics has the most to contribute within the sphere of public health, and will be explored in some detail.

- MacIntyre's exposition of virtues relied on the development of the concept of a practice and a discussion of goods internal to practices. Therefore I plan to explore the notion of public health as a 'practice'. What are the goods 'internal' to the practice of public health? How can they be obtained and what virtues would be needed to obtain these goods and sustain this 'practice'. I have up to this point said very little about individual virtues and propose considering some pertinent individual virtues in more detail.

- Virtue ethics places great emphasis on the character of the moral agent. Thus, following on from the above discussion, I would like to consider in more detail: the role of the public health practitioner particularly within the light of work done by other scholars who have examined the connection between virtue ethics and professional roles (Oakley, Cocking 2001). What could virtue ethics mean for the public health practitioner or policy maker rather than for a 'public health programme'?

- Notions of practical reasoning, rational use of emotion and motive have been shown to be essential components of virtue ethics. How can these elements be used positively within a broader framework of public health ethics?

- One of the points of controversy, particularly in Aristotle's ethics, is his emphasis on the need for moral education. Hursthouse has also taken up this point positively. I think it is worth exploring in more depth: what are the implications of this notion for present-day schools of public health?

- Of what relevance is 'partiality' within the context of public health, when impartiality would at first glance seem to be preferable?

The above are some initial perspectives on the role that virtue ethics could play within a broader ethical framework of public health policy making. This will be explored in more depth especially in chapters V, VI and VII. In the next chapter I shall digress from virtue ethics and investigate the current common approaches to public health ethics, an understanding of which is essential for this dissertation.

IV. 'PUBLIC HEALTH ETHICS'

INTRODUCTION

The notion of public health ethics as a specific entity, warranting separate attention and a conceptual space of its own, is one which is quite new and largely of the 21st Century. A decade ago, discussions surrounding the need for a separate framework for an ethics of public health were only just beginning. This discourse arose out of a growing realisation that the autonomy-based focus of late twentieth century bioethics was often problematic when trying to find pragmatic solutions to many of the epidemics sweeping our world, most notably HIV/AIDS. In the last few years, the discussion has gained considerable momentum with several books now published on the topic and the launch, in 2008 by Oxford University Press of the journal *Public Health Ethics.*[25] Public health ethics curricula are now in the process of being developed and launched at several high-profile universities and public health ethics is increasingly recognised as an important discipline within the academic fields of both public health and bioethics. The dilemma facing governments and non-governmental organizations, of how best to tackle the myriad health problems facing populations and communities right across the world, is profound and more often than not, the moral dimensions of these health problems are as complicated and vexing as the practical ones.

I begin this chapter by discussing the evolution of public health ethics as a specific field, and outline the contributions that various authors have made to "Mapping the Terrain" of public health ethics (Childress et al. 2002). I then identify and discuss in some detail what I believe are the three dominant approaches to public health ethics, all arising from a liberal tradition, namely: a rights-based approach in a neo-Kantian tradition; a utilitarian approach based specifically on Mill's Harm principle; and specified principlism arising out of, or at least influenced by, the 'Four Principles' approach to Bioethics (Beauchamp, Childress 2001). Finally I introduce some of the more community oriented influences which are present in the current literature and which challenge the pre-eminence of liberalism within this context. As shall be seen, these perspectives are

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[25] Editors: Angus Dawson and Marcel Verweij

more closely associated with the virtue ethics theme of this dissertation. The critical role that various conceptions of social justice play within this discussion will be considered in chapter VI.

THE EVOLUTION OF PUBLIC HEALTH ETHICS

The discipline of Bioethics, as currently understood and practised, developed in the 1960's and 70's and was prompted largely by the rapid growth in medical technology, and the subsequent need, often, to limit the availability of new technologies and therapies because of limited resources. A detailed discussion of the history of bioethics is not needed here other than to note that the most influential text and theory of Bioethics is the *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress, first published in 1979. This text identifies four fundamental principles: autonomy, beneficence, non-maleficence and justice as providing the foundations for bioethics. I think few scholars in this field would dispute that although these four principles are given equal weight in the original and subsequent editions of this scholarly work, the principle of autonomy seems to have somehow taken first place in the minds of many students and teachers of bioethics and in the wealth of bioethical literature that has been published in the last two to three decades. The influence of the concept of personal or individual autonomy is a critical one within the field of health policy and practice, and will come under scrutiny in the pages that follow.

Nancy Kass divides the development of public health ethics into three phases (Kass 2004). The first phase she describes is situated within the language of bioethics and ranges from the 1970's to the late 1990's. Several subjects caused much discussion and debate during this period and could arguably be considered to fall within the realm of public health. These topics include: the ethics of health education and health promotion; the allocation of health resources and issues relating to distributive justice; and most notably, the moral issues surrounding the HIV/AIDS epidemic. It is important to note that the 'human rights' approach to public health arose largely out of the ethical challenges presented by the HIV/AIDS epidemic.

The second phase Kass identifies is the period of 2001 and 2002 where, for the first time, several scholars discuss 'public health ethics' as a defined entity. The first attempts to articulate a framework for public health ethics were made during this period and the American Association of Public Health published a code of ethics for public health (Thomas et al. 2002). Writing in 2004, Kass believed the development of public health ethics had moved into a new, third, phase where public health issues relating to globalisation and global justice were increasingly taking centre-stage.

Speaking and writing on the subject from 1994, the late Jonathan Mann was one of the earliest scholars to specifically link the concept of ethics and public health. Mann primarily explored the link between human rights and public health and questioned the "usefulness and structure of the language of ethics" within a public health context (Mann et al. 1994, Mann 1995, Mann 1996). He notes that "it seems evident that a framework which expresses fundamental values in societal terms and a vocabulary of values which links directly with societal structure and function may be better adapted to the work of public health than a more individually orientated ethical framework" (Mann 1997 p.9). (The 'rights-based' approach to public health will be critically examined in some detail a little later in the discussion). Other authors, most notably Lawrence Gostin, have expanded on Mann's discussion of the applicability of human rights to the terrain of public health (Gostin 2001a; Gostin 2006).

Gostin also suggested that public health ethics has three distinct spheres of application. These are outlined in the table below. I am not sure that his distinctions are helpful in delineating the field of public health ethics though, particularly within the context of advancing discussion as to the moral foundations of this field. Those who develop public health policy, 'the professionals', are also often closely involved in developing and implementing policy 'on the ground' in response to real situations, and thus it does not seem helpful to separate an ethics *of* public health from an ethics *in* public health, as the two are intricately interwoven. The third category (tabled) does seem to stand apart and does, indeed, seem well suited to the language of human rights.

Table 4. (Gostin 2001a p. 124)**.**

Public health ethics	
Ethics *of p*ublic health	• Ethical dimension of professionalism • Moral trust society bestows on professional to act for the common good
Ethics *in p*ublic health. (Applied ethics; situation or case orientated)	• Ethical dimension of public health enterprise • Moral standing of the population's health • Tradeoffs between the collective good and individual interests • Social Justice: equitable allocation of benefits and burdens
Ethics *for* public health. Advocacy Ethics: Goal orientated, populist ethics	• Overriding value of healthy communities • Serves interests of populations, particularly powerless and oppressed • Methods: pragmatic and political

In a paper (2001) that precedes the one mentioned above, Kass proposes a six step ethics framework for public health (Kass 2001). In her introduction, she states that the field of bioethics emerged from within the context of medical care and research, and that these contexts are "orientated towards a different set of concerns than those typically arising in public health….Codes of medical and research ethics generally give high priority to individual autonomy, a priority that cannot be assumed to be appropriate for public health practice" (Kass 2001 pp. 1776). The main reason for this is that public health programmes often override individual preference or choice in the name of the 'common good'[26]. She points out that although these codes do sometimes discuss traditional public health functions, for example, breaching patient confidentiality to prevent the transmission of infectious diseases, or allowing certain forms of

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[26] A good example of such programmes are fluoridation of water supply or iodination of salt, both which occur in South Africa. One could not choose not to drink fluorinated water (at least from a tap) or ingest iodine-free salt even if one wanted to.

epidemiological research, they present the action as an allowable exemption to established ethical rules.

> At best this leaves public health professionals needing to muddle through most situations on their own; at worst, it could leave them or even the public to assume that public health is the branch of healthcare sanctioned by bioethics to make exceptions to existing ethics rules at will, in the name of public health and safety. Indeed it is in great part because such power is vested in public health by law, that a code or framework of ethics designed specifically for public health is so very important (Kass 2001 p. 1777).

Kass goes on to describe a six step ethical framework (See Table 5) that she depicts as an analytical tool to assist public health professionals evaluate the ethical significance of planned public health interventions or programmes. Although this framework is useful and practical to a certain extent, it is not a theory of public health ethics, nor does it claim to be one. It is thus limited in scope and neither identifies any fundamental principles of public health ethics, nor provides a moral justification for state paternalism, the 'linchpin' of many public health programmes. It is unhelpful in marking out the precise moral terrain of public health and the respective roles and responsibilities of various stakeholders.

Table 5. An Ethics Framework for public health (Kass 2001)**.**

1.	What are the public health goals of the proposed program?
2.	How effective is the program in achieving its stated goals?
3.	What are the known or potential burdens of the program?
4.	Can burdens be minimized? Are there alternative approaches?
5.	Is the program implemented fairly?
6.	How can the benefits and burdens of a program be fairly balanced?

The above approach was expanded upon, or re-articulated, in an article published a year later and co-authored by Kass and nine other prominent scholars in this field. The approach taken can be considered to be a form of specified principlism, combined in part with a casuistical approach. This approach, which I discuss in detail in point 2 of the next section, is based on recognising a collection of "general moral considerations that do not entail a commitment to any particular theory or method" (Childress et al. 2002). These general moral considerations are underpinned by three elements described by the authors as essential to an ethics of public health, namely; casuistical reasoning, a universalisability, and "a substantive requirement of attention to human welfare" (Childress et al. 2002 p. 171).

The British moral and political philosopher Onora O'Neill, in a paper published in 2002 identified two themes which have become central to current debates surrounding an ethics for public health (O'Neill 2002). She opens her discussion by stating that she will explore "two sources of contemporary neglect" of public health ethics. The first source of neglect is that medical ethics has been "damagingly preoccupied with the autonomy of individual patients" (O'Neill 2002 p. 35). According to O'Neill, individual autonomy cannot be a guiding principle for public health interventions, as many of these must be "uniform and compulsory if they are to be effective." The second neglect that she identifies is that political philosophy is preoccupied with expounding theories of justice which are bound to within states or societies and have neglected to explore concepts of justice that cross borders. She notes that public health problems often cross borders, and that accounts of justice within the context of health "must cover more than the just distribution of clinical care within health systems" (O'Neill 2002 p. 35).

The role, or rather the problem of the pre-eminence of individual autonomy within healthcare ethics, has now become a common theme within the context of public health ethics debates. O'Neill clearly sets out why this is so. Ethically acceptable clinical practice rules out compulsion or coercion, except in very specific and limited circumstances. However, many, if not most, measures traditionally seen as the domain of public health need to be collectively applied to be effective, and are thus often obligatory. As soon as something is compulsory, negative consequences or penalties

must be in place, to be effected if individuals do not comply with the requirement. This runs completely contrary to an autonomy-based ethic for healthcare, and thus casts public health in a poor light. She uses the UK and Germany as illustrations of societies that have allowed individual autonomy to override public-health concerns, and sectors of these societies are now facing the very real risks of measles epidemics. She concludes her discussion in this section by stating:

> "During recent decades a concentration on autonomy in medical ethics, combined with the assumption that public health can properly be separated from provision of clinical care, has distracted us from thinking as broadly or as well as we might about health ethics, and in particular about the ethics of public health" (O'Neill 2002 p. 38).

O'Neill's second theme is that of "Health, Justice and Boundaries." Again this theme is now very prominent within the context of debates on ethical frameworks for public health (Daniels 2008; Kass 2004, Benatar, Daar & Singer 2005, Benatar 2003). She comments that discourse about justice within a health context is so often confined to a discussion of the distribution of, and access to, therapeutic clinical care and hence public health is reduced to a level of insignificance.

> The huge health problems of poorer parts of the world, for which public health interventions are often of decisive importance, are then seen as matters for developmental programs and developmental studies rather than as part and parcel either of main stream theories of justice or of mainstream medical ethics (O'Neill 2002 p. 39).

This sentiment is echoed by Powers and Faden who comment that in discussions about public health "justice is almost entirely presented as a distributional principle (Powers, Faden 2006 p. 81).

The two prominent themes identified by O'Neill as central to the debate surrounding an ethics for public health have been expanded on by subsequent authors, some of whose

comments are represented here. An article by Bayer and Fairchild explores O'Neill's first theme: the role of individual autonomy within a public health context. The authors begin by proclaiming dramatically, "In the beginning there was Bioethics" and end by stating "As we commence the process of shaping an ethics for public health, it is clear that bioethics is the wrong place to start" (Bayer, Fairchild 2004 pp. 473,492). The twenty odd pages in between these two statements are devoted to examining the influence bioethics has had on establishing individual autonomy as the pre-eminent principle within the practice of healthcare, and examining how inappropriate this principle is as the linchpin of an ethics of public health. Herman Biggs, an influential public health government official in New York at the turn of the last century, is effective in framing the issue:

> The government of the United States is democratic, but the sanitary measures adopted are sometimes autocratic, and the functions performed by sanitary officials paternal in character. We are prepared, when necessary to introduce and enforce, and the people are ready to accept, measures which might seem radical and arbitrary, if they were not plainly designed for the public good and evidently beneficent in their effect (Bayer, Fairchild 2004 p.474).[27]

Bayer and Fairchild proceed by examining a series of debates that involve the concepts of "privacy, liberty and paternalism." These are framed as case studies and each highlights the clash between principles of liberal individualism and those that may need to be invoked in the name of public health, namely paternalism, compulsion and coercion. The first example discussed is the clash between the aims of epidemiological research, which often involves the unauthorised (on an individual basis) access to personal medical records and the rights to privacy and confidentiality of the 'owners' of those records. Epidemiologists argue that essential research relating to disease surveillance and management of problems, such as TB and HIV/AIDS, would be logistically impossible and economically unaffordable if they were morally obliged to obtain individual consent from each health record 'owner' and that public interest

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[27] Herman M Biggs.1987. Preventive Medicine in the City of New York. New York, NY Health Department:28, note 2. as quoted by Bayer and Fairchild in this article.

justifiably outweighs individual rights in this instance. Other case studies presented are: routine disease surveillance involving compulsory notification, including identity, of individuals diagnosed with certain diseases such as tuberculosis; isolation and quarantine in epidemics such as SARS (Severe Acute Respiratory Syndrome); and the paternalism involved in government-initiated attempts to curtail smoking.

The in-depth discussion of these case studies serves as a platform from which to launch the main point of this discussion:

> Those involved in the practice of public health embrace a set of values that are often, if not always, in conflict with the autonomy-centred values of those who take an individualistic and anti-paternalistic stance…….In the context of public health, the question that needs to be addressed is whether paternalism and subordination of the individual for the good of the commonwealth should serve as the foundation for an ethics of public health or whether the perspective derived from the dominant autonomy-focused and anti-paternalistic currents in bioethics should serve as a point of departure for a thoroughgoing challenge to the fundamental values and practices of public health (Bayer, Fairchild 2004 p. 488).

It is clear from what follows that these authors strongly believe that the dominant status of individual autonomy within the context of bioethics means that "bioethics cannot serve as a basis for thinking about the balances required in the defence of the public's health" (2004 p. 492). The tension between individual rights and preferences and the right of state authority, enacted through public health policy to override individual rights and preferences, in the name of the 'common good', is one of the most fundamental issues at the core of discussion relating to ethical frameworks for public health.

O'Neill's second core theme is the relationship between public health and social justice. Many scholars are now taking up the challenge to debate and explore this topic and new papers are appearing on a regular basis. Kass states the problem clearly:

Social justice is highly correlated with better health outcomes and social justice is a recurring theme of public health. Indeed, public health practitioners rarely go far in an epidemiological investigation without finding correlations relating to social class and social position. To what extent, then, do public health professionals have an affirmative obligation to better *social* rather than narrowly health-related conditions in the name of public health? (Kass 2004 p. 236).

In his presidential address at the sixth International Association of Bioethics (IAB) World Congress, the theme of which was "Bioethics: Power and Injustice", Benatar focused on social justice within a rapidly globalising world (Benatar 2003). He noted that the focus on bioethics at an individual or interpersonal level "has undoubtedly eclipsed ethical issues that need to be addressed in dealing with public health issues." He concluded that "achieving improved health at population level will be less dependent on new discoveries or on technological advances than on achieving greater social justice through moral progress" (Benatar 2003 pp. 389, 397).

CURRENT DOMINANT APPROACHES TO PUBLIC HEALTH ETHICS.

The new field of 'public health ethics' is one which is growing and developing rapidly. I have identified three mainstream approaches that are dominant in this field, each of which I shall critically discuss here. The first of these is the 'human rights approach' which was shaped predominantly by the HIV/AIDS epidemic in the 1980's and 90's. The second is a modified version of 'principlism', while the third approaches public health ethics from a 'utilitarian' perspective. The connection between social justice and public health could arguably be discussed in this chapter as well. However I have chosen to discuss social justice and public health in a separate chapter as I believe it requires in-depth exploration and is pivotal to the arguments presented in this dissertation. Also, up until fairly recently, I do not think that public health has been commonly viewed from a 'social justice' perspective. Finally I shall briefly introduce some of the more community-orientated perspectives on this topic, which challenge the 'liberalism' of the three dominant perspectives.

Human Rights Approach

The public health practitioner and scholar, Jonathan Mann, has been fairly accredited as the main architect and most influential proponent of the human rights approach to public health (Mann et al. 1994, Mann 1995, Mann 1998). Lawrence Gostin, a colleague of Mann's, has also played a very prominent role in the public health and human rights discourse of the last decade or so. The AIDS epidemic gathered momentum in the 1980's at a time when bioethics was in its ascendancy and challenging paternalistic approaches to healthcare. It was thus to be expected that the influence of bioethics, and the pre-eminence of individual autonomy, would play an important role in shaping the public health approach to HIV and AIDS. The activism and civil rights campaign, shaped by members of the gay community who were initially most affected by the AIDS epidemic in the US, ensured that the AIDS epidemic would be treated differently to epidemics in the past and, indeed, in the future as well.

> Focused on the centrality of education for mass behavioural change, the protection of the rights and privacy of people infected with HIV, and a rejection of coercive measures, the approach to AIDS was voluntarism to the core. A simple dictum emerged: no public health policy that violated the rights of individuals could be effective in controlling the spread of HIV (Bayer, Fairchild 2004 p. 478).

Now in the 21st century, the HIV-AIDS epidemic has been almost eclipsed in Sub-Saharan Africa and other developing-world nations by a closely-associated TB epidemic, the control of which is challenging these suppositions. The advent of multi-drug resistant TB has added to the moral complexities of controlling a disease that is air-borne and particularly contagious in conditions of poverty, poor nutrition and overcrowding.

Jonathan Mann was arguably the first and most vocal early proponent of a human rights approach to public health problems. He asserted that a human rights analysis of health equated to a "societal analysis" of health, and if taken seriously this would require

"uncovering the rights violations, failures of rights realization and burdens on dignity which constitute the societal roots of health problems" (Mann 2006 p. 115).[28] He believed that the future of public health and the future of human rights are "mutually interdependent" and that progress in the arena of health at a community or population level would only occur if this interdependence was widely acknowledged and accepted, and formed the bed-rock of public health interventions. The language of medical ethics is appropriate for identifying and resolving moral problems relating to the healthcare needs of individual patients and the physician-patient relationship that is at the core of such healthcare. However, the population focus of public health and the widely accepted fact that the major determinants of health at this level are societal in nature, mean that a moral framework that "expresses fundamental values in societal terms, and a vocabulary of values which links directly with societal structure and function may be better adapted to the work of public health than a more individually orientated ethical framework" (Mann 1997 p. 9). Modern human rights is a universal language developed outside of the sphere of health in order to express the conditions in any given society that need to be present to allow for human flourishing. It is thus, according to Mann, the ideal moral framework for public health.

Mann described three central associations between public health and human rights:

1. Public health practices and policies place a potential burden on human rights, particularly as many of these practices are inadvertently discriminatory.
2. Human rights violations impact negatively on health and well being.
3. The promotion and protection of human rights is "inextricably linked" to the promotion and protection of health because human rights "offers a societal level framework for identifying and responding to the underlying societal determinants of health (Mann 1997 pp. 9-11).

The second and third of these are in essence the same concept, first phrased negatively, then positively. Most would agree that these associations are real and

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[28] This address was re-published almost a decade later in the American Journal of Public health. See Jonathan Mann. "Health and Human Rights: If not Now, When?" 1997. *Health and Human Rights* Vol. 2, No 3. 2nd International Congress on Health and Human Rights. Harvard School of Public health/ Francois-Xavier Bagnoud Center for Health. http://www.jstor.org/stable/4065162 Accessed 14.02.2009. p. 115

immediately apparent. What is more debatable, though, is whether or not the language of human rights *is* the most suitable "language" to articulate or define the appropriate moral dimension of public health, and whether it is comprehensive enough to act as a guide for the full scope and breadth of the moral complexities of public health issues.

Gostin has also written extensively on this topic. However, he noted in a 2001 article that there is substantial ambiguity in the use of human rights concepts and language. "Some use human rights language to mean a set of entitlements under international law, others use human rights to mean a set of ethical standards that stress the paramount importance of individual interests and still others use human rights for its aspiration, or rhetorical qualities" (Gostin 2001a p. 126). Although international human rights law is a set of universally adopted and accepted rules, it does not often provide ready solutions to problems, but instead "struggles to define and enforce human rights in the contexts of legitimate powers of governments and the needs of communities" (Gostin 2001a p. 126).

According to Gostin, international human rights is a field quite distinct from that of ethics, and when ethicists invoke the language of human rights there is often a lack of clarity into exactly what is meant. Although both fields are concerned with rights and interests of individuals, there is a considerable difference in the way the concept of human rights is articulated. Human rights scholars usually have a legal background and rely largely on the body of international human rights laws and treaties, as well as the constitutions of governments, to provide justification for policy and action. Ethicists are philosophers and rely on philosophical reasoning and argument to provide justification for standpoints on policy. They seldom invoke human rights law to support arguments. Thus, Gostin claims that when ethicists "adopt the language of international human rights there is bound to be a certain amount of confusion. If an ethicist claims that healthcare is a "human right," does she mean that a definable and enforceable right exists, or simply that philosophical principles such as justice support this claim?" (Gostin 2001a p. 128) One of the problems of thinking of health as a "human right" and not just as a "moral claim" implies that "states possess binding moral obligations to respect, defend, and promote that entitlement" (2001a p. 128). A great deal of dissension exists at all levels of academic and political debate as to the exact extent of a state's legal obligation to provide first, the

conditions under which people can be healthy and second, to provide 'healthcare', whatever that is interpreted to mean.

Hessler has criticised some proponents of the human rights approach to public health, including Gostin, for not being willing to explore fully the philosophical moral justification of human rights, and but for rather regarding human rights as "constructs of international human rights law" (Hessler 2008 p. 33). She acknowledges, however, that Mann's conception of human rights and public health was indeed grounded in the far broader good of overall human well being. "Grounding the human rights approach to public health ethics in international human rights law and shunning a philosophical account of human rights sells short the potential moral significance of this approach" (Hessler 2008 p. 35). Hessler continues by considering "interest-based" and "agency" accounts of human rights and concludes by stating that:

> If we understand human rights to mean legal human rights alone, then what we can learn from public health about the complex good of human well-being will be truncated, for this approach to understand what human rights are we only need to look at the documents of international law. If we understand human rights in the moral sense, however, we need to think more deeply about the value and functions of rights, as well as whether international human rights law actually got the lists of recognised rights correct (Hessler 2008 p. 41).

There are more generic criticisms to a 'rights–based' approach to moral reasoning which are also relevant to this discussion, such as, whether or not 'human rights' is the best moral framework for resolving the ethical dilemmas so prevalent within the context of public health, given the liberal and individualistic essence of the human rights movement. Within the context of liberal individualism, the protection of individual interests and liberties is paramount. Communal goods, institutions and practices, like public health, are largely ignored. Furthermore, the language of rights is often quite confrontational, sometimes even aggressive, and if used in the first instance, may not always be the means to the best solution. Another criticism is that rights-based ethical

theories present a limited view of morality. A large section of the moral landscape remains hidden. The moral significance or relevance of duties, obligations, virtues and motivating factors like compassion and empathy are omitted from an ethical language of rights. Annette Baier, a proponent of an Ethics of Care states the following:

> The main complaint about the Kantian version of society, with its first value justice, construed as respect for equal rights to formal goods, such as having contracts kept, due process, equal opportunity, basic liberties of speech, assembly and religious worship, is that none of these goods do much to ensure that the people who have and mutually respect such rights, will have any other relationship with each other, other than the relationship needed to keep such a civil society going. They may well be lonely, driven to suicide, apathetic about their work…. Find their lives meaningless…. Their rights, and respect for rights are quite compatible with very great misery and misery whose causes are not just individual misfortune, but social and moral impoverishment (Baier 1999 p. 43).

However one cannot lose sight of the fact that many victories against social, racial and gender injustice have been won, using the language of rights. This language likewise forms the basis of international organisations, treaties and laws seeking to protect citizens from various forms of abuse. "Being a rights bearer in a society that enforces rights, is both a source of personal protection and a source of dignity and self respect" (Beauchamp, Childress 1994 p. 77).

A 'Principle-based Approach

The most influential text within the field of bioethics is arguably the *Principles of Biomedical Ethics*[29]*,* (Beauchamp, Childress 2001). Beauchamp's approach, which describes four principles of bioethics, namely beneficence, non-maleficence, autonomy and justice, underpinned by a theory of "common morality", has shaped the field of bioethics over the last 30 years. It is thus not unexpected that when scholars in the field

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[29] Tom L Beauchamp, James F Childress. Principles of Biomedical Ethics. Oxford University Press. First published in 1979 and now in its sixth edition. 2008

of bioethics started to discuss the need to articulate the need for an ethical framework for public health, that a similar approach may well be thought to be appropriate. Such an approach, as mentioned earlier, has been described by Childress and colleagues in *Public Health Ethics: Mapping the Terrain*:

> The terrain of public health ethics includes a loose set of general moral considerations -- clusters of moral concepts and norms that are variously called values, principles or rules -- that are arguably relevant to public health. Public health ethics in part, involves ongoing efforts to specify and to assign weights to these general moral considerations in the context of particular policies, practices and actions, in order to provide concrete moral guidance (Childress et al. 2002 p. 171).

The authors further go on to state that this approach does not entail a commitment to a particular moral theory but is in fact compatible with several theoretical approaches, in particular that of casuistical reasoning, which they feel should be an integral part of public health ethics.[30] The following set of general moral considerations is proposed as being fundamental to public health ethics:

- Producing benefits;
- Avoiding, preventing and removing harm;

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[30] Casuistical reasoning is a 'bottom up' approach to applied ethics, where the examination of similar "cases" or case studies can give rise to principles which could guide in the resolution of other cases in the future. It involves comparing similar cases and thereby reaching a moral conclusion and principles which can be used as guidance to similar cases -- similar to the development of common law within the legal profession. Casuistry was a prominent method of reaching moral conclusions in medieval times particularly within the Catholic Church. It has been revived and adapted for use in bioethics particularly by Albert Jonsen and Stephen Toulmin. (Jonsen, Toulmin 1988). Beachamp and Childress classify casuistry, along with virtue ethics and feminist ethics, as an 'inductive' approach to moral reasoning, rather than deductive which is 'top down' or principle-based. They acknowledge the usefulness of casuistry, but do not believe it can be regarded as a comprehensive 'stand-alone' approach to moral reasoning. It can however be usefully combined with a deductive approach as part of a process of 'reflective equilibrium' where principles are used in combination with specific situations or 'cases' in order to reach a final moral conclusion (Beauchamp, Childress 2001 p. 392-401). As we have seen, virtue ethics could be considered to be closely aligned to casuistry as it involves moral reasoning within particular and specific contexts. This aspect of virtue ethics will be considered in Chapter VI and VII.

- Producing a maximum balance of benefits over harms and other costs (often called utility);
- Distributing benefits and burdens fairly (distributive justice) and ensuring public participation including the participation of affected parties (procedural justice);
- Respecting autonomous choices and actions, including liberty of action;
- Protecting privacy and confidentiality;
- Keeping promises and commitments;
- Disclosing information as well as speaking honestly and truthfully (often grouped under transparency); and
- Building and maintaining trust (Childress et al. 2002 pp. 171-172).

At first glance, three things are immediately apparent in the above list. First, this is an amplified version of the "Four Principles" with a public health 'twist' or flavour. The first three bullets roughly equate to 'beneficence' and non-maleficence. The fourth bullet concerns 'justice' and bullets five to nine could be collectively considered under the principle of 'autonomy'. Secondly, as in medical ethics, inevitably these principles will conflict with each other and there will be a need to find a means of resolving this conflict. For instance, the principle of "respecting autonomous choices" may conflict with the principle of "avoiding and removing harm" in an influenza or SARS pandemic. Third, even individual principles will be subject to the need for a great deal of interpretation and justification, for example, what exactly will be the scope and reach of "protecting privacy and confidentiality" when a school teacher is diagnosed with MDR-TB.

Thus, in order to move moral decision-making forward with the above list, the authors acknowledge that these general moral considerations need 'specifying' and 'weighting.' The specification of a principle or norm involves adding content to it and if done coherently can assist with the resolution of conflict (Childress 1998). General moral considerations have two dimensions, namely "scope or range and meaning" and "weight or strength". Specifying the first dimension of a principle, that is its scope and range, or reach, according to Childress et al "provides increasingly concrete guidance in public health ethics" (Childress et al. 2002 p. 172). But, they proceed with a note of caution:

However it would be a mistake to suppose that respect for autonomy requires consent in all contexts of public health or to assume that consent alone sufficiently specifies the duty to respect autonomy in public health settings. Indeed specifying the meaning and scope of general moral considerations entails difficult moral work. Nowhere is this more evident in public health ethics than with regard to considerations of justice. Explicating the demands of justice in allocating public health resources and in setting priorities for public health policies, or in determining who they should target, remains among the most daunting challenges in public health ethics (Childress et al. 2002 p. 173).

The above paragraph illustrates, fairly succinctly I think, the challenges faced by this approach. The list of general moral considerations provided has, as yet, not really advanced discussion on some of the core and most vexing concerns in the moral domain of public health: the conflict between individual autonomy and the "common good"; issues relating to the role and concept of social and distributive justice within the public health context; and, the use and possible abuse of the principle of utility. In order to get moral clarity on these issues 'difficult moral work' still needs to be done.

In the *Principles of Biomedical Ethics,* Beauchamp and Childress favour a process of "reflective equilibrium" similar to that proposed by Rawls, as part of an "integrated model" of moral reasoning (Rawls 1999 pp. 18-19). Both "inductive" and "deductive" approaches do not have "sufficient power to generate conclusions with the needed reliability. Principles need to be made specific for cases and case analysis needs illumination from general principles" (Beauchamp, Childress 2001 p.398). This process begins with "considered moral judgements", those in which our "moral capacities are most likely to be displayed without distortion". Examples of "general moral considerations" are judgements about racial prejudice and political and religious intolerance. The authors go on to describe the process of reflective equilibrium in more detail:

Whenever some feature in a moral theory conflicts with one or more of our considered judgements, we must modify one or the other in order to achieve equilibrium…….. The goal of reflective equilibrium is to match, prune and adjust considered judgements in order to render them coherent with the premises of our most general moral commitments. We start with paradigm judgements of moral rightness and wrongness, and then construct a more general and more specific account that is consistent with these paradigm judgements, rendering them as coherent as possible. We then test the resultant action-guides to see if they yield coherent results. If not, we readjust these guides or give them up and then renew the process. We can never assume a completely stable equilibrium. The pruning and adjusting occur continually in view of the perpetual goal of reflective equilibrium (Beauchamp, Childress 2001 p. 398).

This discussion occurs within a bioethical context and the example used to illustrate it is that of the rule of 'giving priority to patients' interests'.

We seek in biomedical ethics to make this rule as coherent as possible with other considered judgements about clinical teaching responsibilities, responsibilities to subjects in the conduct of research, responsibilities to patients' families, legitimate forms of financial investment in medical facilities, responsibilities to corporate sponsors of clinical trials, and so forth" Childress, J.F. 2002 p.398).

The article under discussion above- "Public health ethics: Mapping the Terrain"- is an attempt to adapt the approach of "reflective equilibrium" described by Beauchamp and Childress and outlined above, to the ethical dimension of public health. In order to assist with the process of moving from "general moral considerations" to more specific moral judgements, a framework for resolving conflicts between principles is proposed. Five conditions, summarised in the table below, are proposed as yardsticks for determining whether "promoting public health warrants overriding such values as individual liberty or

justice in particular cases" (Childress et al. 2002 p. 173). If all of these conditions are fulfilled in a particular circumstance, this could warrant overriding a "general moral consideration" such as "protecting confidentiality and privacy". However, if the proposed policy does not comply with one or more of these benchmarks (its effectiveness is not completely established) then the policy would need to be carefully reconsidered and adjusted, before being implemented, or abandoned altogether.

Table 6 Preconditions for Ethical Public health Interventions (Childress et al. 2002 p. 173)

Effectiveness	If a policy infringes one or more general moral considerations (GMC) then it must be demonstrable that the policy will advance public health and achieve its goals.
Proportionality	Probable public health benefits outweigh the infringed GMC
Necessity	A policy that is effective and produces benefits that outweigh burdens may still not be necessary to achieve a specific set of public health outcomes.
Least infringement	Even if a policy fulfils the effectiveness, proportionality and necessity criteria, it should ensure that it results in the "least infringement" possible to the GMCs described earlier
Public justification	If a policy does result in a infringement of a GMC then public health professionals have an obligation to publicly explain and justify the policy.

The public health policy benchmarks described above, together with the list of general moral considerations that should be considered when public health policy is being developed, definitely do represent a very useful and practical approach or tool for public health policy makers. The approach is also fairly compatible with a human rights perspective. In fact Gostin, and later Gostin and Mann, described a fairly similar list of principles in 1994 as "A framework for analysing the rights impacts of public health policies" (Gostin, Mann 1994). Questions about the more fundamental moral justification of this approach do still remain, though. The process of "reflective equilibrium" begins

with "paradigm judgements of moral rightness and wrongness". The justification for these "paradigm judgements" remains unclear other than that they are part of a "common-morality theory" on which the *Principles of Biomedical Ethics* is based.[31] A more fundamental moral justification for the resolution of some of the more complex moral problems within this field does seem to be required.

Many of the broader arguments that have been levelled at the 'four principles approach' to bioethics are equally applicable here. One of the most stridently negative critiques of 'principlism' was written by Clouser and Gert in 1990[32]:

> Our bottom line, starkly put, is that "principle" as conceived by the proponents of principlism, is a misnomer and that "principles" so conceived cannot function as they are in fact claimed to be functioning by those who purport to employ them. At best "principles" operate as checklists, naming issues worth remembering when considering a biomedical moral issue. At worst principles obscure and confuse moral reasoning by their eclectic and unsystematic use of moral theory (Clouser, Gert 1990 p. 220).

The core of their argument is that *this* use of principles bears no similarity to principles such as those articulated by Mills and Rawls, which in fact embody an entire moral theory. It is the theory that provides the justification for the principle. The principles used in "principlism" are free-floating and not underpinned or unified in any meaningful way. Thus when they conflict, as they often do, there is no real guidance as to how the conflict should be resolved. However, Beauchamp and Childress have discounted this criticism as largely irrelevant. They assert that their approach does provide a method for the resolution of conflict and as they also point out, they have not attempted to formulate a general ethical theory but have rather sought to "eliminate what is unacceptable in

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[31] A detailed defense of the strategy of using a theory of common morality as the foundation for the *Principles of Biomedical Ethics* has been vigorously defended by Beauchamp and Childress.(Childress 1998 pp. 401-408)
[32] The term principlism was first used or 'coined' by Clouser and Gert in 1990 to describe Beauchamp and Childress's 'Four Principles' approach to bioethics. Current usage of the term is now associated with slightly negative connotations.

each type of theory and appropriate what is relevant and acceptable" (Beauchamp, Childress 2001 p. 337).

One other problem with their approach is that it does seem easy to arbitrarily add and remove principles as circumstances or contexts require. Despite Beauchamp and Childress's expressed "scepticism with foundationalism"[33] I believe that there is some merit in Clouser and Gert's argument that 'principles' need to be supported by something more morally fundamental. This search for moral foundation within the specific context of public health is the primary concern of this dissertation. Conversely, a 'principle-based approach' to the moral dilemmas that are encountered within the field of public health is attractive because it provides guidelines for action that are immediately apparent, even if they do involve a process of specification and balancing. This approach is also readily amenable to being taught to public health officials, who have little or no background in ethics or human rights at a more theoretical level.

A Utilitarian Approach

Most public health practitioners and policy makers are very familiar with 'Mill's Harm Principle' which is often invoked in discussions relating to contentious public health issues, and related as an example of a utilitarian approach. However there is far more to utilitarianism within the context of public health than the Harm Principle, and it would be insufficient to confine this discussion of utilitarianism only to this one aspect. In this section I will briefly identify the key elements of utilitarianism that are of particular relevance to public health. I will then introduce Mill's Harm Principle and the interpretation of this principle reflected in the Nuffield Council on Bioethics report entitled *Public health: ethical issues.* (Nuffield Council on Bioethics 2007) Lastly, I shall consider some of the criticisms levelled against utilitarianism as a moral theory, and how these inadequacies impact on the suitability of utilitarianism as the ideal moral framework for a theory of public health ethics.

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[33] The term 'foundationalism', used in this particular context, refers to the belief that a collection of moral principles need to be supported by a more fundamental or 'foundational' moral theory, such as that of Immanuel Kant, or John Stuart Mill.

Utilitarianism as a moral theory was first articulated by David Hume (1711-1776) but later fully developed by Jeremy Bentham (1780-1832) and John Stuart Mill (1806-1873). This moral theory is based on one principle only -- the principle of utility. The principle of utility dictates that the morally right act is the one that maximizes value over "disvalue"[34] (Beauchamp, Childress 1994 p. 4). In other words-what makes an action right, are its consequences:

> The creed which accepts as the foundation of morals, Utility, or The Greatest Happiness Principle, holds that actions are right in proportion, as they tend to produce happiness, wrong as they tend to produce the reverse of happiness. By happiness, are intended pleasure and the absence of pain, by unhappiness pain and the privation of pleasure (Mill 1871 p. 91).

Within the context of public health, this principle can essentially be interpreted to mean that the right policy or practice is that which produces the most benefit for the greatest number. The theory is entirely *outcomes focused* and it is easy to see that on first accounts, it seems to be ideally suited to the domain of public health because the aim is to maximise benefit for as many as possible and this does seem to be what public health is generally all about – improving health outcomes at a community or population level rather that at an individual level.

A second important component of utilitarianism from a public health perspective is impartiality, or as Jeremy Bentham supposedly stated: "Everybody to count for one, nobody for more than one" (Hare 1998 p. 82). When the balance of value and disvalue is being calculated, all parties affected must be considered from a disinterested impartial point of view. Public health is concerned with health at a population level, not at an individual level, thus a theory that is impartial and regards everyone's interests as equal, no matter where one stands in the social order of things, would be particularly suitable within this context.

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[34] "Disvalue" is a term used by these authors to mean anything that would be considered the opposite of anything "of value"

An aspect of Mill's philosophy, perhaps not central to the theory of utilitarianism, but particularly relevant to the field of public health is what is known as Mill's Harm Principle, first presented in his essay entitled *On Liberty* in 1859:

> The object of this essay is to assert one very simple principle, entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties or the moral coercion of public opinion. That principle is that the sole end for which mankind are warranted individually or collectively in interfering with liberty of action of any of their number is self protection. That the only purpose for which power can be rightly exercised over any member of a civilised community against his will is to prevent harm to others. His own good either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinions of others to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or entreating with him, but not for compelling him, or visiting him with any evil, in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. Over himself, over his own body and mind, the individual is sovereign (Mill 1989 p. 13).[35]

And restated in *Utilitarianism* some 12 years later (1871):

> "The moral rules which forbid mankind to hurt one another (in which we must never forget to include wrongful interference with each other's freedoms) are more vital to human well-being than any other maxims" (Mill 1897).

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[35] This extract from Mill's essay was also quoted in the Nuffield Council Report, *Public health: Ethical Issues*, on Page 16.

In summary, Mill is stating two things -- the only justifiable reason to interfere in someone's personal autonomy or freedom is to prevent him from harming others; beneficence alone in not a good enough reason to override individual autonomy. The authors of the Nuffield Council Report point out that "even in an approach that seeks to ensure the greatest possible degree of individual liberty and the least possible degree of state interference, there is a core principle according to which coercive, liberty infringing state interference is acceptable: where the purpose is to prevent harm to others" (Nuffield Council on Bioethics 2007). This report attempts to find a midway between Mill's liberalism and a more communitarian approach to public health that they call the "Stewardship Model", which will be discussed in the next section as it is only minimally utilitarian.

The aim (or stated aim) of most governments is to maximize the overall well-being of society. This seems a noble and just cause and within the context of public health appears to be easily compatible, at first glance, with a utilitarian approach. Many bio-ethicists believe that utilitarianism has a "legitimate role to play, if not an exclusive role, in the formation of health policy" (Beauchamp, Childress 1994). However, this somewhat wry comment by Max Charlesworth is worth noting:-

> At a time when in mainstream theoretical ethics utilitarianism has been stringently criticized and is now in considerable disarray as an ethical theory, it has become the darling of the healthcare resource allocation experts. The late Cambridge philosopher C.D. Broad once remarked that all good philosophical heresies go to America when they die, but whether or not that is true, utilitarianism has certainly found a home among healthcare economists, planners and bureaucrats, even if it has fallen out of favour with many professional moral philosophers (Charlesworth 1993 p. 112).

Utilitarianism is a teleological moral theory. This means the 'good' is defined independently from the 'right' and the 'right' is defined as that which maximizes the 'good'. The 'good' is defined as pleasure, happiness, absence of pain, satisfaction, and

all collectively labelled 'utility' (Buchanan 1995). Thus, the right decisions at an institutional or policy level is that which, when everybody involved is taken into consideration, will maximize the overall or aggregate well-being. This of course implies that it is possible to calculate or add up different 'satisfactions' where 'satisfaction' may mean any of an extensive number of things; food security and a roof over one's head; a safe and easily accessible water supply, or effective treatment programs for diseases such as TB and AIDS. The difficulties encountered with these sorts of calculations and comparisons, which involve value judgements as often as empirical information, is one of the main problems encountered with this moral theory, particularly when applied within a public health context.

Historically, Utilitarianism has been severely criticized by several prominent moral philosophers. Many of the criticisms levelled at the theory in general are also relevant to the theory when applied to a public health context. W.D. Ross, in *The Right and the Good*, states that utilitarianism "seems to simplify unduly, our relations to our fellows." He goes on to elaborate:

> It says in effect, that the only morally significant relation that my neighbour stands to me, is that of being possible beneficiaries of my action. They do stand in this relation to me, and this relation is morally significant. But they may also stand to me in the relation of promise to promiser, of creditor to debtor, of wife to husband, of child to parent, of friend to friend, of fellow countryman to fellow countryman and the like, and each of these relations is the foundation of a prima-facie duty, which is more or less incumbent on me, according to the circumstances of the case (Ross 1977 p. 89).

Ross discusses a list of duties, each resting on morally significant circumstances, for example, duties of fidelity, duties of reparation, duties of gratitude, duties of beneficence, duties of self-improvement and duties of non-malificence. Utilitarianism ignores, or does not do justice to the concept of duty (Ross 1977).

Another critic of utilitarianism is John Rawls. In *A Theory of Justice*, which stands in direct opposition to utilitarianism, he states that a "principle that may require lesser life prospects for some, simply for the sake of greater life prospects for others", is unlikely to be adopted by any rational man, concerned with his own interests, as a principle on which to base a system of social justice.

> In the absence of strong and lasting benevolent impulses, a rational man would not accept a basic structure, merely because it maximizes the algebraic sum of advantages, irrespective of the permanent effects it has on his own basic rights and interest (Rawls 1999).

A utilitarian system of social justice requires that the good in society as a whole, be maximized, even if this ultimately means that a few are disadvantaged in order to benefit the majority, and even if that few are the already disadvantaged poor. Beauchamp and Childress illustrate this feature of utilitarianism with an example of public health practice.[36] Researchers, seeking the most cost-effective way of controlling hypertension in an American population, came to the conclusion that in a community with limited resources, it would be more cost effective to concentrate on improving compliance and treatment of the hypertensive sufferers already diagnosed, rather than to extend the programme to the poorer, undiagnosed sectors of the population. The investigators were bothered by the apparent injustice of their findings, but nevertheless recommended what they described as a utilitarian allocation of resources (Beauchamp, Childress 1994 p. 55).

Robin Barrow, a proponent of utilitarianism responds to this concern by actually questioning whether it is correct to interpret utilitarianism as wanting the greatest happiness for the greatest number. He says ideally everybody's happiness should be maximized equally and prefers a formula that builds in the "assumption that nobody's claim to happiness can simply be ignored, though in an imperfect world a policy may have to be adopted that brings little happiness to particular individuals" (Barrow 1982

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[36] Weinstein, M and Stason, W.B Hypertention (Cambridge, MA: Harvard University Press, 1977) and their articles in *New England Journal of Medicine* 296(1977):716-721, and *Hastings Center Report* 7 (October 1977):24-29

12). He goes on to suggest that this could be done by adapting the wording to approximate John Rawls's principle of justice. Thus in practice, one should aim at the greatest happiness for the greatest number, provided that no policy is adopted that ignores the claims to happiness of any individual, or would make some happier at the expense of others. Barrow seems quite happy that this qualification "is sufficient to dispose of the charge that utilitarianism would sanction the sacrifice of some in the interests of others" (Barrow 1982 p. 20). However, by needing to add a 'side constraint', he is in fact emphasizing what many find problematic with the principle of utility in general and utilitarian justice in particular, that the communal greater good can on occasion be to the detriment of individual or minority good.

Despite the problems with utilitarianism as a moral theory, I think there can be no doubt that the principle of utility does have some role to play in the development of public policy. Utilitarianism calls for an objective, impartial evaluation of everyone's interests and decision-making that will ultimately increase the goods received by all parties.   It is also important to acknowledge that utilitarianism is both a consequence and a beneficence-based theory (Beauchamp, Childress 1994 p.55).

PUBLIC HEALTH ETHICS AND 'COMMUNITY'

The three broad approaches to public health ethics discussed above all have one thing in common: they all are products of a liberal philosophico-political tradition where central importance is attached to the rights and liberties of individuals (Honderich 1995 p. 483)[37]. Liberalism, which has its foundation in the writings of moral philosophers such as Locke, Kant, Mill, Berlin, Rawls and others, is without doubt the dominant political philosophy of the modern western world. It is thus not unexpected that an ethics of public health, which by its very nature is in part political, would be strongly influenced by this tradition. But it is also true that the moral dilemmas that are so often a central part of the sphere of public health are in fact becoming a means for philosophers and scholars to challenge the dominance of liberalism within this sphere of our moral and political world. The ethical

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[37] Utilitarinism may seem to not quite fit into this description because rights are secondary to the principle of utility and the preference of individuals may be overridden in order to maximize utility. However Mill's essay on Liberty no doubt qualifies him to be regarded as part of a liberalist tradition.

dilemmas that were illustrated in the earlier discussion of the South African TB and HIV epidemic and that are ever-present within many public health contexts, so often have at their centre the tension between the "good of the individual" and the "good of the community". As the field of public health ethics grows, it is to be expected that alternatives to purely liberal perspectives will play an increasingly prominent role in this discussion, both in the form of a re-look at the applicability of "old" philosophical traditions such as virtue ethics (the focus of this dissertation) and an exploration of newer ones such as an "ethics of care".

One of the earlier papers that considered public health from a community perspective was written in 1985 by Dan Beauchamp. Beauchamp explored the meaning of the "common good' by tracing the history of the commonwealth doctrine that influenced the regulatory power of the state of Massachusetts in the eighteenth century, and subsequently the US as a whole:

> In the republican vision of society, the individual has a dual status. On the one hand, individuals have private interests and private rights; political association serves to protect these rights. On the other hand, individuals are members of a political community -- a body politic. This common citizenship, despite diversity and divergent interests presumes an underlying shared set of loyalties and obligations to support the ends of political community, among which public health and safety are central….Strengthening the public health includes not only …improving aggregate welfare; it involves the task of reacquainting the American public with its republican and communitarian heritage and encouraging citizens…… to promote a wider welfare, of which their own welfare is only a part (Beauchamp 1985 pp. 46).

This view, and other examples in more recent literature that I shall briefly review here, challenge either directly or indirectly the dominant liberal approaches discussed above.

Elements of this discussion that have bearing on virtue ethics will be explored in more detail in the next section.

The Nuffield Council Report suggests that an ethical framework for public health should not be too individualistic, but needs to acknowledge the value of community and should be based more on social contract theory than on other liberal traditions (Nuffield Council on Bioethics 2007). This ethic needs to be underpinned by a value that expresses the way we each benefit from being part of a society in which the health needs of that society are addressed. This value may be referred to as "fraternity" or solidarity" or "community". They propose a "revised liberal framework" for an ethics of public health that the authors call the "Stewardship model":

> The concept of stewardship means that the liberal states have responsibilities to look after important needs of people both individually and collectively. Therefore they are stewards both to individual people, taking account of different needs arising from factors such as age, gender, ethnic background or socio-economic status, and to the population as a whole, including both citizens of the state, and those that do not have citizen status but fall under its jurisdiction….the notion of stewardship gives expression to the obligation on states to seek to provide conditions that allow people to be healthy, especially in relation to reducing health inequalities (Nuffield Council on Bioethics 2007 p. 25).

The above proposal is an attempt to chart a middle course between liberal individualism and authoritarianism for the purpose of public health policy, and at face value is appealing, and possibly quite readily acceptable. However, the report seems to assert a particular perspective without providing an in-depth moral justification as to why the state should act in this way. Perhaps such a discussion is beyond the scope of a report of this nature, and a primarily Rawlsian justification *is* presented in the preamble to the stewardship proposal. (Rawls 1999) My discussion in Chapter II, which proposes that the concept of public health adopted by a particular government or institution is intimately

linked and inseparable from an underlying concept of social justice, is of particular relevance here.

Edmund Pellegrino and David Thomasma have written extensively on the ethics of clinical medicine which has its foundation in a "philosophy of medicine", in which the duties and virtues of the health professional are determined by the 'good' of the patient (Pellegrino, Thomasma 1981). More recently they have extended this discussion to include "an authentic ethic of social medicine which has its roots in a "philosophy of society" in which the common good determines the obligations and virtues of the (public) health professional" (Pellegrino, Thomasma 2004 p. 17). The 'philosophy of society' that is being proposed in their essay lies between that of a libertarian society, where individual choice and preference are paramount on the one hand, and a communitarian society, in which "the individual is defined by the group", on the other. This philosophy is, according to Pellegrino and Thomasma, rooted in the…

> "..social philosophies of Aristotle and Thomas Aquinas… which holds
> to a reciprocal view of the relations of the good society and the good
> person. Neither has sovereignty over the other. It avoids
> totalitarianism, which exalts the common good above the individual,
> as it avoids the anarchism of exalting the good of the individual over
> the good of the whole" (Pellegrino, Thomasma 2004 p. 19).

After a brief discussion of "ends" and "telos", so important to any philosophical perspective based on Aristotle and Aquinas, they go on to develop what they describe a "quadripartite notion of the ends and good of social medicine". Particularly noteworthy is a comment which clearly distinguishes their approach from most of what has been discussed previously in this chapter.

> "Today, discussion of ends has been replaced by discussion of values
> and choices. The right to choose and to value have become the warp
> and woof of bioethics, rather than a search for the good of individuals
> and society…….The shift from consideration of ends to consideration

of "value" choices lies at the root of confusion about social medicine and its philosophy as well."(Pellegrino, Thomasma 2004 p. 23).

Another scholar who has challenged the pre-eminence of liberalism within the domain of public health is Bruce Jennings. According to Jennings, the placement of public health ethics within a liberal context is valuable to a degree, but is "ultimately too narrow to provide normative justification for -- or adequate moral insight about -- the kinds of social change public health must strive to bring about" (Jennings 2007 p.31). He believes that a major paradigm shift in ethical thinking is needed to develop an adequate foundation for an ethic for public health as a 'civic profession'. Liberal ethical language that focuses on 'individual rights, liberties, interests and utilities' is inadequate for public health as a service profession that adequately and authoritatively addresses all the issues involved in the 'public's health'. The terms of engagement involved in this discussion will need to be "much richer than the language of interests" and rights and involve "grassroots discussions" as to what human flourishing actually means.

> The language of liberalism forces public health professionals to appeal to 'interests' when the issue really does not have to do fundamentally with individual needs and desires. It leads one to argue in terms of the promotion of restraint of autonomy when the issue isn't one of choice, but one of comparing an entire form of life with other possible ways of living. It leads one to talk of preference when the question is one of discernment and judgement. It leads one to talk of utility and welfare when the question is one of distinguishing between those relationships that are merely instrumental to the human good and those that are constitutive of it (Jennings 2007 p. 34-35).

Jennings develops this discourse further by exploring the concepts of "civic republicanism" and "civic virtue". Much of this thought is based on European and North American political philosophy of the 16th to the mid 19th century, but has its origins in the political writings of ancient scholars such as Aristotle. Similar themes will be developed and explored in Chapter VI and VII.

CONCLUSION

In this chapter I have discussed the evolution of public health ethics, as a discipline, within the last ten to fifteen years. I have demonstrated how several core themes have emerged within the domain of public health ethics. In particular, the tension between the interests of individuals and those of the so-called 'common' or 'public good', competing notions of 'social justice', and differing conceptions and understanding of 'global justice', is at the forefront of this debate. I then proceeded to identify what to my mind are the three dominant approaches to public health ethics, namely a human-rights approach, a utilitarian approach and modified principlism. I explored the weaknesses and strengths of each of these and established that they all have a liberal philosophico-political tradition as their back bone. The discussion revealed that this tradition is essentially individualistic and thus may not always be fully compatible with the resolution of moral dilemmas within the context of public health. Finally I explored some of the challenges to liberalism that are present in the literature and have demonstrated that these discussions are a very useful platform from which to proceed to the next and central part of this dissertation -- an in-depth exploration of the role that virtue ethics as an ethical theory could possibly play within an ethic of public health.

V VIRTUE ETHICS, SOCIAL JUSTICE AND PUBLIC HEALTH

INTRODUCTION

I have argued earlier that the relationship between justice and public health is both an 'is' and an 'ought'. The "is" of the argument claims that some conception of social and distributive justice underlies a conception of public health. That is, a prevailing nation-state or institutional concept of social justice will profoundly influence, if not dictate, the scope and reach of *that* nation-state or institution's 'practice' of public health. Furthermore, a 'good' and appropriate theory of social and distributive justice 'ought' to form the platform for public health policymaking. In this chapter, I explore the concept of social justice and its relationship to distributive justice in more depth. In particular I investigate why this relationship is so important to a discussion of the moral basis of public health. I then briefly consider justice as a virtue of individuals, before discussing prevailing theories of distributive justice and newer theories of global justice identifying some of their strengths and deficiencies.

My overall purpose in this dissertation is to consider if virtue ethics as a moral theory could contribute positively to the ethical domain of public health and thus by inference to an underlying concept of social justice. My purpose is not to attempt to engage in a thorough critical analysis and comparison of theories of distributive justice. That would be a huge task, best left to scholars of political philosophy and completely beyond the scope of this discussion[38]. Furthermore, I do not intend to try and develop my own 'virtue ethics inspired' theory of distributive justice. Rather, I continue this discussion by attempting to establish what elements of virtue ethics as a whole could contribute to a conception of social justice that would be applicable to the 'practice' of public health. This, in effect, amounts to an attempt at an indirect application of virtue ethics to the moral sphere of public health policy making. In order to accomplish this, I critically

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[38] The title of my M Phil thesis, completed in 2002 was *Theories of Justice and an HIV/AIDS Healthcare Policy for South Africa: A comparative analysis.* In this thesis I compared three theories of justice: Mill's utilitarianism, Nozick's libertarianism and Rawls' 'Justice as fairness' and considered their applicability to HIV/AIDS healthcare policy in South Africa. I concluded that Rawls' egalitarian theory of justice was the most promising.

explore a theory of social justice, first published in 2006 specifically as a "moral foundation of public health and health policy", which to my mind is a theory of justice for public health that is closely aligned with most of the common threads that run through the various conceptions of virtue ethic theory discussed previously in chapter three (Powers, Faden 2006). Finally I consider virtue ethics, social justice and public health within a global or trans-border context, noting that this particular conception of social justice does appear to have limitations when applied to a global context.

SOCIAL JUSTICE AND PUBLIC HEALTH

In this chapter I am using the term 'justice' in three distinct ways, even though the concepts are all inter-related. First, I will be considering 'justice as a virtue' usually understood as a character trait of individuals. However, Aristotle did not clearly distinguish between the moral virtues of individuals, as discussed in the *Nichomachean Ethics* and the nature of a just or good society as discussed in his *Politics*, because just individuals are a prerequisite component of just societies (Aristotle. 1998). Rawls also named justice as the "first virtue of social institutions" thereby in a way echoing Aristotle's perspective (Rawls 1999 p. 3).

Next I shall discuss the concept of 'distributive justice' as that concept aligned with the various 'theories of justice' that have been articulated by scholars such as Mill, Rawls, Nozick and Sen. 'Distributive justice' refers to the equitable societal distribution of goods or benefits and burdens. Theories of distributive justice identify the norms and principles which should be used to determine such distributions.

'Social justice' on the other hand, is a concept which seems to somehow incorporate both 'justice as a virtue of individuals' and 'distributive justice' and possibly even something more. Social justice is concerned with the just distribution of 'goods' such as wealth or income, housing, access to sanitation healthcare and education, but it is also goes further than just the distribution of 'external' goods. There are other 'goods', often expressed in the language of human rights, which are also an important component of the concept of 'social justice'. These include the range of rights identified under the

Universal Declaration of Human Rights such as the right to dignity and respect, civil and political rights which enable self-determination, rights to security of person and property, to freedom of religion and speech and rights to fair treatment and equality of opportunity (United Nations 1948). 'Goods' such as dignity, self respect and self-determination are more in line with MacIntyre's notion of "internal" goods.

Social justice is thus very much an ethical and normative concept. An alternative way of looking at social justice is to consider social injustice. According to Levy et al, people in communities affected by social injustice may have "poorer nutrition; poor sanitation; crowded and substandard housing; greater exposure to unsafe water; increased contact with infectious disease agents; increased exposure to occupational and environmental hazards; increased alcohol, tobacco and drug abuse; decreased social support," poor or reduced education, increased unemployment, increased risk of gender related violence etcetera- the list goes on and on (Levy, Sidel 2006 p. 5). The end result of all of this is that "social justice is inextricably linked to public health. It is the philosophy behind public health….The goal of public health to minimize preventable death and disability, is a dream of social justice" (Levy, Sidel 2006 pp. 5-9).

 Levy's sentiments are echoed by many other authors in this field. For example, Powers and Faden "view social justice as the foundational moral justification for public health" (Powers, Faden 2006). An entire section of *Public health, Ethics and Equity* is devoted to the topic of "Health, Society and Justice" (Anand, Peter & Sen 2006; 2004 pp.35-106). Marmot notes that for economists, health can be an indicator or marker of "how well a society is doing in delivering well being" (Marmot 2004 p. 33).

JUSTICE AS A VIRTUE OF INDIVIDUALS

Social justice, as I have said, seems to incorporate a concept of distributive justice, as well as a broader notion or sense of justice. My overall discussion of virtue ethics, public health and social justice would be incomplete without at least some discussion of the 'virtue' of justice. Justice, conceived as a virtue or an individual character trait is important at the level of individual relations, but even more important to individuals and

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groups of individuals who are in positions of power and authority and who make policy and law that affects the lives of countless usually 'nameless' and 'faceless' individuals. A true 'virtue-ethical' conception of justice "ties justice (acting justly) to an internal state of the person rather than to (adherence to) social norms or good consequences" (Slote 2008). In other words "justice does not make just people; just people make justice" (Comte-Sponville 2001 p. 66). Being a 'just' individual is an internal virtue or character trait, developed over time and used in conjunction with *phronēsis* or practical wisdom.

Aristotle regards the virtue of justice as the "sovereign" virtue. As Comte- Sponville neatly puts it, "justice encompasses all other virtues though it substitutes for none" (Comte-Sponville 2001 p. 60). Aristotle says:

> Justice in this sense then, is complete virtue; virtue however not unqualified but in relation to somebody else. Hence it is often regarded as the sovereign virtue and neither 'evening nor morning star is such a wonder'. …It is complete virtue in the fullest sense, because it is the active exercise of complete virtue; and it is complete because its possessor can exercise it in relation to another person, and not only by himself. I say this because there are plenty of people who can behave uprightly in their own affairs, but are incapable of doing so in relation to somebody else (V,I,1129b26-34).

Justice could be considered the first or minimum virtue of human relations. It particularly governs relationships between strangers rather than friends, because "between friends there is no need for justice" (VIII,I,1155a26). There may be other virtues which override justice in close relationships, such as compassion, humility and generosity. Justice often involves compliance with the law, but laws can be unjust. Therefore justice does not equate to the law. Justice always incorporates the notion of equality. It is the virtue "of order and exchange - equitable order and honest exchange" (Comte-Sponville 2001 p. 69). The true essence of justice is an equality of rights which means that any transaction can only be considered just if it is one that people of equal knowledge, understanding, power and freedom would have been willing to enter into, or agree to. In circumstances

where the two sides in a transaction or agreement are unequal, those on whose side power and knowledge rests can be considered to have acted justly only if they take steps to avoid any exploitation or gain that may have accrued as a direct result of this inequality (2001 pp. 69-70).

A discussion of the virtue of justice could go on and on, as almost all the modern philosophers from Hume to Kant and Mill and many contemporary ones have had much to say on this subject. It is however, unnecessary for the purposes of this discussion, to explore justice as an individual virtue any further and I conclude with a quotation from Comte-Sponville:

> To be just in the moral sense is to refuse to place oneself above the law or above one's fellowman. In other words justice is the virtue that leads each person to try to overcome the temptation to place himself above everything and consequently to sacrifice everything to his own desires and interests (Comte-Sponville 2001 p. 74).

DISTRIBUTIVE JUSTICE

Conceptions of distributive justice have been a matter of in-depth philosophical debate and enquiry for several centuries. This debate has intensified and proliferated in the 20th Century, especially after the publication of John Rawls's landmark *A Theory of Justice* in 1971 which has been used extensively as a platform for discussion of healthcare equity and reform.[39] At least a superficial understanding of some rival concepts of distributive justice is important to this discussion because, as mentioned above, these competing concepts of distributive justice impact significantly on concepts of social justice. However, as noted, there has been a huge amount of work in the field of distributive justice especially within a healthcare context in the last thirty years and a great deal of cross pollination has occurred between the fields of economics and political philosophy.

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[39] I am referring in particular to the work done by Norman Daniels, James Sabin, Alan Buchanan and Bruce Jennings among others in adapting Rawls's *Theory of Justice* to the domain of health, particularly resources allocation and access to healthcare.

In particular, the extensive work in the field of development economics by Amartya Sen, Nobel Prize winner for Economic Sciences in 1998, in collaboration with philosophers like Martha Nussbaum, has contributed significantly to the mingling of the economics of social welfare with political philosophy.

What follows is thus a fairly superficial overview of the current most influential theories of 'distributive justice' as well as the "capabilities approach" primarily articulated by Sen (Sen 1993). I shall discuss an alternative theory of 'social justice' for public health later. For the purpose of this discussion, I shall focus mainly on briefly highlighting deficiencies in each theory. I shall assume that the strengths of each theory are more or less implicit in the theory itself. Each theory of justice bases it decision making criteria on certain information or, as Sen puts it, an "informational basis". When comparing theories of justice it is important to be aware that the information excluded from the decisional basis is often as important as the information included (Sen 2001; 1999 pp.56-57).

Aristotle speaks specifically about distributive justice in Book V of the *Nichomachean Ethics*. He divides the concept of justice into two: the 'universal' (which is the overall understanding of the virtue of justice) and the 'particular'. Particular justice is further divided into 'distributive' justice and 'rectificatory' justice, which is involved in rectifying injustices. His account of distributive justice is not typically 'virtue ethical' in that it is rooted in the idea of merit and desert. Justice involves an equal distribution to those that are equal. Implicit in his discussion is the notion that not all are equal and those that are not equal do not need to be given an equal share. "…for if the persons are not equal, they will not have equal shares; and it is when equals have or are assigned unequal shares or people who are not equal, equal shares, that quarrels and complaints break out" (V,iii,1131a22-24) This statement is a bit of an 'Aristotelian minefield'. Aristotle is certainly not a strict egalitarian. He admits as well that when it comes to settling on the correct distributive principles there is much controversy. "Everyone agrees that justice in distribution must be in accordance with merit in some sense but they do not all mean the same kind of merit: the democratic view is that the criterion is free birth; the oligarchic that it is wealth or good family; the aristocratic that it is excellence" (V, iii, 1131a25-29).

What counts as the right principles of distributive justice, is still, two thousand years later, a subject of much dispute.

A Utilitarian Theory of Justice

I have already discussed utilitarianism in Chapter IV. A utilitarian theory of justice is based entirely on maximising outcomes- the 'greatest good/happiness/utility for the greatest number'. The 'right' distribution will be that which achieves this. There are now many versions of utilitarianism based primarily on interpretations of what counts as 'utility' or 'good.' For example 'preference utilitarianism' aims at the satisfaction of preferences or choices, 'average utilitarianism' aims at a per capita optimal average utility rather than an overall aggregate utility.

Utilitarianism, as a theory of distributive justice has some significant weaknesses which have been clearly identified and summarised by Amartya Sen in *Development as Freedom* (Sen 1999). First, utilitarian calculations are aggregate. It is the overall sum of total satisfaction that is important. Significant uneven distribution of 'happiness' can occur within this aggregation. This uneven distribution can be seen as completely justifiable and in accordance with the principle of utility. Second, other 'goods' such as those that we discussed above like rights and freedoms can be neglected or overridden, as they are valued only in as much as they may or may not affect overall utility. "It is sensible enough to take note of happiness, but we do not want to be happy slaves or delirious vassals" (Sen 1999 p. 62). The third criticism is one that has been specifically identified by Sen as "Adaptation and mental conditioning." Placing an emphasis on "mental" or cognitive characteristics such as pleasure, happiness or preferences can be particularly limiting when one is making "interpersonal comparisons of well being and deprivation". The problem with this is that our aspirations and concept of pleasure changes, or contracts, to accommodate circumstances of hardship and deprivation. Life becomes about survival and notions of pleasure; well being and happiness can become severely distorted.

> The utility calculus can be deeply unfair to those who are persistently deprived……Deprived people tend to come to terms with their deprivation because of the sheer necessity of survival, and they may

even adjust their desires and expectations to what they unambitiously see as feasible. The mental metric of pleasure or desire is just too malleable (Sen 1999 pp. 62-63).

Sen concludes his discussion of the deficiencies of a utilitarian theory of justice by reasserting a previous point and one I referred to above: often what is left out of a theory of justice is as important as what is considered essential to the theory. A broader 'informational base' is needed in order to get the full picture.

A Libertarian Theory of Justice

A libertarian theory of justice is essentially the basis of capitalism and a free market economy. The central idea of libertarian justice is that the rights of personal liberty and property must be protected by the state. Any state intervention in the free market, or individual wealth and property, for redistribution purposes is unjust. Robert Nozick is the proponent of a fairly radical form of libertarian justice, the "Entitlement Theory of Justice", which he expounded in *Anarchy, State and Utopia* in 1974, partly in response to Rawls's *Justice as Fairness*. Nozick believes the term distributive justice is a misnomer, because it implies a central agent who has the authority to distribute or redistribute goods and there is, or should be according to him, no such thing (Nozick 1974). One is only entitled to what one can earn, or pay for, or gain by ones own initiative. In this extreme form of libertarianism even taxation is suspect and only justifiable in as much as it supports those structures needed by the state to protect individual liberty and property. Circumstances of poverty may be unfortunate, but they are not unfair. The essence of Nozick's theory consists of two central ideas. First, individuals have rights of liberty and property. "No one ought to harm another in his life, health, liberty or possessions" (Nozick 1974 p. 10, in a footnote quoting Locke). Second, the only legitimate role the state has to play is to protect individual rights of property and personal freedom, ensuring that others do not interfere in those rights and punishing those who do. Libertarians fully support the notion of philanthropy on the condition that contributing to alleviate the plight of the less privileged is an entirely voluntary exercise.

I think the considerable deficiencies and limitations of this theory, particularly within the context of this dissertation -- that of an adequate concept of social justice as a moral foundation for public health in developing world contexts -- are quite obvious. Taken in its extreme or 'pure' form, a libertarian theory of justice is an 'every-man-for-himself' theory. Past unjust distributions or removal of property, such as occurred in South Africa during apartheid, are largely ignored. Similarly left out of the 'informational basis' are inequalities of opportunities, which will result in further inequalities of property distribution. Furthermore, libertarianism is fundamentally individualistic and this as has been shown, is potentially problematic within the realm of public health. It is the experience of individuals that have intrinsic value.

> There are no objective state of affairs that can be understood or appraised independently of the effect that they have on individual attitudes, feelings and emotions. A common culture, an artistic tradition or a traditional way of life, have no intrinsic value, though each may have considerable instrumental value in promoting that which is of intrinsic value, individual experiences (Barry 1989 p. 11).

Rawls: "Justice as Fairness" (Rawls 1999)**.**

John Rawls's major work, *A Theory of Justice* (1971) has, since its publication, become the platform from which any discussion or debate regarding distributive justice is launched (Campbell 1988 p. 66). It has been the subject of countless reviews and commentaries. His ideas have influenced several spheres beyond his original stated intentions, healthcare reform being one such example. Rawls's theory is a social contract theory.[40] In order to determine what basic principles of justice should be chosen, Rawls invites us the readers to enter a hypothetical "original position", the purpose of which is to institute a fair procedure so that any principles agreed upon, will be just. The idea is that the hypothetical members of society will get together under a "veil of ignorance" and agree upon a set of principles that will be used to establish the basic functioning and

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[40] Social contract theory was first developed and proposed in the 17th century. Examples are Thomas Hobbes, *Leviathan* 1690 John Locke *Two Treatises of Government* 1690 and Jean-Jacques Rousseau, *The Social Contract* 1762.

mutual cooperation of their society. It is assumed that those involved in this process, do not know their "own place in society, class, position or social status, fortune in the distribution of natural assets and abilities, intelligence and strength, own conception of good, or even special features of psychology, such as aversion to risk, or liability to optimism or pessimism" (Rawls 1999 p. 118). They also do not know the particular circumstances of their own society, that is its economic, or political structure, level of wealth or type of civilization or culture. They do not even know to which generation they belong. Behind the "veil of ignorance" they are unable to use their own social position or talents to influence the choosing of principles, because when the veil is lifted they may either be among societies most fortunate or least fortunate. In addition, the parties involved in the original position are described as rational and mutually disinterested, or not taking an interest (in support of or opposed to) another's interest. The concept of rationality is used by Rawls in the sense used "in standard economic theory" as meaning "taking the most effective means to a given end" (1999 p.12).

After defining the "original position" that will be used to identify principles of justice, Rawls proceeds to state what those principles of justice would be.

> The first statement of the two principles reads as follows:-
> First: Each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others.
> Second: Social and economic inequalities are to be arranged so that they are both:
> - Reasonably expected to be to everyone's advantage and
> - Attached to positions and offices equally open to all. (Rawls 1999 p. 53).

Rawls reiterates that these principles apply to the basic institutions of society that is those institutions "that govern the assignment of rights and duties" (Principle one) and those institutions "that regulate the distribution of social and economic advantages". (Principle two) Basic liberties are specifically documented by Rawls and include political

liberty, freedom of speech and assembly, "liberty of conscience and freedom of thought", freedom of the person, which he defines as freedom from psychological oppression or physical assault, freedom to own personal property and freedom from "arbitrary arrest and seizure" (1999 p. 53). These liberties are to be regarded as equal and are covered by the first principle.

The second principle applies to the way income or wealth is distributed in society and to the manner in which organizations or institutions are structured to allow for differences in positions of authority and responsibility and of course remuneration. Rawls further stipulates that these two principles are ordered, that is, the first takes priority over the second. This means that they cannot justify an infringement of basic liberties by a position of increased economic social advantage (1999 p. 54). Rawls summarises the essential conception of "Justice as Fairness" as follows:

> All social values including liberty and opportunity, income and wealth,
> and the social bases of self respect, are to be distributed equally,
> unless an unequal distribution of any, or all of these values is to every
> one's advantage (1999 p. 54).

Rawls's first principle is fairly self-explanatory and I shall not elaborate further. However, the second principle contains two phrases "to every one's advantage" and "equally open to all", that are acknowledged by Rawls as ambiguous and require further explication. This is in fact undertaken by Rawls in great detail, using fairly complicated mathematical models and takes up much of the rest of the book. I shall briefly discuss what has become widely and famously known as the 'Difference Principle' and 'Rule of Fair Opportunity' because this aspect of Rawls's theory has been applied specifically to the context of health and healthcare.

"Equally open" can, according to Rawls, be interpreted as "Equality, as careers open to talents" or "Equality, as equality of fair opportunity". Rawls assumes a background of equal liberty, as determined by the first principle and a free-market economy. "Equality as careers open to talents" means that everyone has the same legal right of access to all

advantaged social positions. However, the initial distribution of talents and abilities, income or class position, is determined by social circumstances and contingencies that may negatively influence one's ability to attain such a position. So, although a particular position is open to all, one's chance of accessing that position may well be much higher for someone born into a higher social class and afforded a private education, than someone not so advantaged by life's natural or social lottery. Rawls's second interpretation of 'equally open', adds to the "requirement of careers open to talents, the further condition of the principle of "fair equality of opportunity" (1999 p. 63). This means that positions must not only be open to everyone in a non-discriminatory manner but that everyone should have a fair opportunity at actually being appointed to such a position. In other words those who have a specific level of talent and ability and have an equal willingness to use or develop their talents should have identical prospects of success *regardless of their initial place in the social system*. However, as Rawls points out, this concept or principle still seems to be lacking. Although compensation has been made for differences in social class, what about the natural distribution of talents, abilities, or even disabilities; the outcome of "life's natural lottery"? One's family circumstances can also be considered part of the natural lottery. He says:

> Furthermore the principle of fair opportunity can be only imperfectly carried out, at least as long as some form of family exists. The extent to which natural capacities develop and reach fruition is affected by the kinds of social conditions and class attitudes existing. Even the willingness to make an effort, to try, and so to deserve in the ordinary sense, is itself dependent upon happy family and social conditions (1999. p. 64).

Intuitively, a principle of justice must recognize this fact and attempt to compensate for the arbitrary allotment of life's natural lottery. Rawls's 'Difference Principle' is his answer to the above problem. The principle of 'fair equality of opportunity' must be combined with the 'Difference principle'. The basic structure of society means that individuals' life prospects are influenced by factors beyond their control such as the social position or class they are born into, gender, natural ability or disability. A system of distributive

justice must address these differences in life prospects. 'The Difference Principle' holds that:

> These differences are just, if and only if, the greater expectations of the more advantaged, when playing a part in the working of the whole social system, improve the expectation of the least advantaged. The basic structure is just throughout when the advantages of the more fortunate promote the well-being of the least fortunate, that is, when a decrease in their advantages would make the least fortunate even worse off than they are. The basic structure is perfectly just when the prospects of the least fortunate are as great as they can be (1999 p. 81).

Any society consists of members occupying different positions of wealth, income and status. 'The Difference Principle' says that these inequalities are just, only if, in the greater scheme of things, those at the bottom of the social scale would be in an even worse position if those higher up had less; for example less power, innovation, entrepreneurial skills, etcetera. The difference principle is in fact an agreement to share the benefits of the arbitrary distribution of social position and talent, as well as the arbitrary handicaps, physical, mental or circumstantial that are largely beyond our control. Those on whom the 'gods have smiled' may justly benefit from their good fortune, only if they improve the lot of those less fortunate. Rawls believes that the parties in the 'original position' as described, behind their veil of ignorance, in a position of complete fairness, would choose these two principles of justice because they would be seen to be in their best interests to do so.

In the remainder of *A Theory of Justice*, (a 500 page book) Rawls elaborates further on these two basic principles, including their justification. He also provides a fairly detailed framework for the institutions of society needed to fulfil or comply with his 'Theory of Justice'. "Justice as Fairness" has been widely proclaimed as a landmark moral theory that provides a plausible and instinctively acceptable alternative to the deficiencies of utilitarianism and libertarianism. In fact, Rawls uses the notion that his principles comply

with our commonsense intuitions of justice and would be reached by a process of 'reflective equilibrium', to partly justify his choice of principles (Campbell 1988 p. 73). A concept of social justice must be closely linked to the idea of addressing the needs of the least fortunate members of society. Any adequate conception of justice must consider or account for the interests of the poverty stricken, the weak and the disabled or exploited members of the society, and one that does not, seems intuitively, to be deficient.

One of the strengths of Rawls's theory is that it appears to combine the concept of moral agency, autonomy and freedom of choice with a sincere concern for less fortunate members of society. It is this feature that makes it immediately compelling when considering theories of justice for a society such as post-apartheid South Africa, struggling with the effects of a devastating HIV and TB epidemic. As I mentioned previously Rawls's theory has been widely and successfully adapted to the healthcare environment and in my comparative analysis of utilitarian, libertarian and 'Justice as Fairness' for my Masters degree I had no doubt at that time, that 'Justice as Fairness' was eminently suitable to serve as the moral basis for the just distribution of healthcare in South Africa particularly within the context of HIV/AIDS. However when I wrote the proposal for this doctoral thesis in 2005 I noted that:

> Justice as a concept is too often quite narrowly defined and understood and does not give an adequate account of the moral dimension of public health decision-making, within the context of the HIV/AIDS pandemic. Similarly, discussing this problematic primarily within an economic context may also not capture or fully explore this moral dimension".

My intention here is to explore the concept of justice more broadly, while still accepting that Rawls has contributed hugely to our understanding of distributive justice and has laid the foundation for further discussion.

Of course Rawls's theory has been extensively criticized by many authors who have attempted to show that its application may not in fact relieve the plight of the less fortunate, as it appears to promise on first inspection. Many of the criticisms deal with

details of his theory and its complex application to government and economy. I shall discuss some of the weaknesses of Rawls's theory of justice in the final section of this chapter as part of my discussion of the "Justice and Well-being" theory of social justice proposed by Powers and Faden (Powers, Faden 2006). However, I shall now briefly highlight some pertinent criticisms.

Churchill states that while Rawls and his "health-policy interpreter", Norman Daniels, have been very influential among bioethicists and academics, this influence has not translated (until very recently) into any form of public or healthcare reform (referring to the USA). One of the main reasons he gives for this is that the 'original position' is too remote, "the price of becoming unbiased is too high and relevance is sacrificed in the bargain". He goes on to state his point quite clearly:

> Few of us are prone to think of the ideal setting of moral choice as one in which all the social and historical aspects of our lives are stripped away. Choosing as if we were disinterested, rational contractors, or as angelic beings, seems not only remote from our real concerns, but deprives us of those very tools and resources for choosing, that make our choices morally coherent (Churchill 1999 p. 356).

Churchill is writing within the context of a discussion about just distribution of healthcare resources and believes that the "motivational remoteness" of the Rawls's contract position tends towards utopianism, which he says, quoting Thomas Nagel, is a view that ordinary people cannot be motivated to take seriously. In addition, he believes Rawls's aim to remove bias by the "veil of ignorance" may have the opposite effect of subverting bias and making it too difficult to examine critically. "Even when our motives are benign or admirable, the high altitude theorizing of the Rawlsian program, tends to make us blind to our motives, rather than engage them in the light of day" (Churchill 1999 p. 357).

Apart from criticizing the 'original position' per se others have suggested that persons in the original position would in fact adopt the principle of 'average utility' rather than Rawls's two principles. Rawls defines the principle of average utility as directing society

to maximize not the total satisfaction or utility but the average utility per capita. Campbell believes it is "desperately ad hoc" of Rawls to rule out the adoption of this principle by insisting that rational, self-interested individuals would not be prepared to take the possible personal risks involved in accepting the principle of average utility as the basis for social choice in preference to the principles posed by Rawls (Campbell 1988 p. 83). Another important criticism, articulated by Campbell is that the difference principle is not actually directed at the most needy and unfortunate, in society. Rawls persistently refers to the 'lowest represented man' as the one earning the lowest wage and does not refer to the unemployed, destitute or homeless, or the mentally or physically disabled. Likewise, the members in the original position are all autonomous moral agents capable of mutual cooperation. There seems to be no voice representing those who cannot be independent moral agents for reasons of mental disability and the like. Rawls's model is designed to deal with the distribution of the benefits of society to which all members contribute. If non-contributors are represented in the original position, then the basis for a bargained agreement is compromised, but to exclude them seems to run contrary to our entire common sense notion of justice.

Sen has also similarly challenged the priority of liberty over all else. He asks why the status of intense economic needs, which can sometimes be "matters of life and death", be lower in Rawls's ranking of primary goods.

> If the 'priority of liberty' is to be made plausible even in the context of
> countries that are intensely poor, the content of that priority would
> have to be considerably qualified. This does not however amount to
> saying that liberty should not have priority but rather that the form of
> that demand should not have the effect of making economic needs be
> easily overlooked (Sen 1999 p.64).

Robert Veatch criticizes Rawls's theory for not being truly egalitarian. He says that, according to Rawls, if a practice can only improve the lot of the least well off by increasing inequality, it is not only permitted but also required (Veatch 1998 p. 45). Veatch uses an example of direct donation of transplant organs as a basis of his

argument to demonstrate that Rawls's system can require inequalities that would be offensive to most people's intuitive notion of justice. The family of a Ku Klux Klan member donates his organs to be used by a white patient only. If this condition is not fulfilled, the organs are not available. Should the direct donation be accepted within the limits set by the family, or should it be rejected on principles of equality and non-discrimination and the organs lost? If it is accepted, no one is worse off. All those in the queue for the next organ donation, move up a position, and are therefore better off. On the surface the dispute appears to be between utilitarians who tolerate directed donation and egalitarians that are committed to the principle of equality and would rather sacrifice the organs than contravene this principle of justice. However, according to Veatch the Rawlsian 'difference principle' also provides a support for directed donation because those below the recipient are better off and those above are in exactly the same position as they were. Thus it appears that tolerating discrimination on the base of race or religion is to the advantage of everyone worse off and to the disadvantage of no one. Consequently Veatch believes the difference principle of justice leads to a significantly different conclusion from a true egalitarian account of justice and therefore must be called into question. "What is missing from the Rawlsian sense of justice is any notion of community solidarity. Some have such empathy for their fellow humans, that they have a moral sense of revulsion at a lack of opportunities for equality regardless of whether they are among the best or worst off" (Veatch 1998 p. 47).

The "Capabilities" Approach

The three theories discussed above are generally recognised as the three 'main' theories of justice. However I would also like to discuss the "capabilities" or "functionings" approach because, as its name reveals, it is particularly relevant to this discussion. This theory (or perhaps method would be a better term) has been articulated initially by Sen, in a Tanner lecture entitled "Equality of What?" and delivered at Stanford University in May 1979. The Aristotelian connections of the theory were identified and elaborated later by Martha Nussbaum (Nussbaum 1988). Sen, as mentioned, is an economist not primarily a philosopher. He, together with philosophers like Martha Nussbaum, has done

extensive and ground breaking work in the combined field of distributive justice and economics (Nussbaum, Sen 1993).[41]

Sen argues that when making evaluations as to what counts as a just distribution within a society the element that should be used is not 'utility', or Rawls's list of primary goods, but rather the "capabilities" to choose the sort of life that one would value (Sen 1999, Sen 1982). It is not just 'primary goods' that are important but the circumstances or "functioning capability" that enable or disable each person to make full use of those primary goods, and the freedom to choose whether to use them or not. There is a big difference between choosing to fast and starving!

> A person's "capability" refers to the alternative combinations of functionings that are feasible for her to achieve. Capability is thus a kind of freedom: the substantive freedom to achieve alternative functioning combinations (or less formally put, the freedom to achieve various lifestyles) (Sen 1999 p. 75).

Or as MacIntyre would say, to choose one's own "narrative quest"[42]. Obviously deciding and ranking "capabilities" is evaluative and subject to dispute. However this process is inevitable and should be made explicit rather than hidden in "some implicit framework" (1999. p.75). This work has been done by Sen using the language and perspective of an economist rather than a philosopher and I shall not go into any detail here. However individual functionings, either actual or possible, can be compared more easily then calculations of utility. Also the 'non-mental capabilities' are easily separated from the 'mental', a criticism that Sen had of utilitarian calculations.[43]

Sen acknowledges that this approach is "inescapably pluralistic" but sees this as an advantage rather than a problem. There are three specific features of the "capabilities

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[41] A bibliography of their separate and combined contributions to this field would run into many pages.
[42] This association between Sen and MacIntyre is mine. Sen does not refer to MacIntyre (at least not in the books and articles that I have referred to in this thesis) but he does make a direct connection with the 'functionings' perspective and Aristotle. "The concept of "functionings", which has distinctly Aristotelian roots, reflects the various things a person may value doing or being" (Sen 1999 p. 75).
[43] Discussed above on Page 118.

approach" to distributive justice that need to be noted in this regard. First, some of the different functionings are more important than others. Ranking and comparing is evaluative and technically fairly complicated. Second, there is the issue as to what weight to place on the "substantive freedom or 'capability set' vis-a-vis the actual achievement (the chosen functioning vector)" (1999. p.76). Third, Sen does not claim that this perspective excludes other relevant issues that need to be taken into consideration:

> Finally, since it is not claimed that the capability perspective exhausts all relevant concerns for evaluative purposes (we might for example, attach importance to rules and procedures and not just to freedoms and outcomes) there is the underlying issue as to how much weight should be placed on the capabilities compared to other relevant considerations……..Is this plurality an embarrassment for advocacy of the capability perspective for evaluative purposes? Quite the contrary. To insist that there should be only one homogenous magnitude that we value is to reduce drastically the range of our evaluative reasoning (Sen 1999 p. 77).

Sen's approach to distributive justice, while perhaps not a complete theory of justice, does seem to be both very relevant and eminently applicable to act at least as a foundation for social justice within a public health context. Faden and Powers have criticised what they describe as ambiguity in the language of "capabilities and functionings" that could be misleading. "We think it is better to simply note that there are distinct dimensions of well being and that for each dimension, a part of its value lies in what states are achieved and another part often consists in our active role in bringing the states about" (Powers, Faden 2006 p. 38). However they acknowledge that their theory of justice (which will be elaborated shortly) has many similarities and "owes considerable debt to capabilities theories as developed by Sen and Nussbaum" (2006. p.37)

Theories of Global Justice

I have discussed four theories of justice, focusing mainly on Rawls's *Theory of Justice* as this theory has arguably been the most influential in recent times . Discussions of distributive justice do seem to be based on the assumption that the principles expounded belong in a "bounded society" and that their application is "a primary task of states" (O'Neill 2000 p. 45). That is, obligations determined by principles of distributive justice are confined to the borders of states, and do not apply globally (Caney 2005). However there has been a great deal of argument and debate over the last two decades or so, that counteracts this assumption and argues that there are indeed cosmopolitan principles of justice that apply globally and place cross-border obligations and duties on states (Caney 2005)(Pogge 2002). Some of these discussions do in fact use Rawls's *Theory of Justice* as a starting point and attempt to adapt aspects of this theory, to the global sphere (Beitz 1999, Moellendorf 2002, Brock 2004).

Caney notes that there are, in his view, four broad approaches to global political theory which he identifies as "cosmopolitanism, realism, the 'society of states' tradition and nationalism" (Caney 2005 p. 3). The last three can be grouped together as variations of communitarianism and thus display varying degrees of opposition to cosmopolitanism. Beitz largely concurs with Caney and also groups global political theory into two broad camps, cosmopolitan theories on the one hand and "morality of states" theories, which include Rawls's later work *The Law of Peoples,* originally published as a lecture, on the other (Beitz 2005 p.16)(Rawls 1999). According to both these authors, Rawls's *Law of Peoples* fits into a "society of states idea" and is not a cosmopolitan theory of justice. One core difference between these two broad approaches is that in the former, "the principal bearer of rights and duties are states and not persons" (Beitz 2005 p.16). Caney notes that in the *Law of Peoples*, "Rawls defends what he terms a 'society of peoples'. He makes clear his rejection of realism and cosmopolitanism and calls for a world constituted by decent well-ordered peoples" (Caney 2005 p. 5). Rawls's *Law of Peoples* has been extensively criticized by many scholars who believe, among other problems, that his focus on 'peoples' rather than 'persons' is fundamentally flawed (Moellendorf 2002)(Brock 2004, Beitz 2000)(Nussbaum 2006).

The term cosmopolitanism can be applied to many things such as "schemes of world political order and conceptions of individual cultural identity", hence Beitz refers specifically to "moral cosmopolitanism" when using the term in the context of a discussion of global justice (Beitz 2005 p.17). Moral Cosmopolitanism is an approach to issues of global justice that has many different versions and continues to be the focus and subject of much current debate. There is now a general acceptance of the fact that the world faces numerous urgent global problems that involve matters related to justice (Beitz 2005). There are three key principles common to most cosmopolitan approaches:

- the value of individuals
- equality of individuals
- obligations of duty that apply to everyone (Caney 2005 p.4).

Caney quotes Thomas Pogge in this regard:

> Three elements are shared by all cosmopolitan positions. First, individualism: the ultimate units of concern are human beings, or persons- rather than, say, family lines, tribes, ethnic, cultural, or religious communities, nations or states. The latter may be units of concern only indirectly, in virtue of their individual members or citizens. Second, universality: the status of ultimate unit of concern attaches to every living human being equally – not merely to some sub-set, such as men, aristocrats, Aryans, whites or Muslims. Third, generality: this special status has global force. Persons are ultimate units of concern for everyone- not only for their compatriots, fellow religionists, or such like (Pogge 1994 p. 89).

Beitz also notes that there are two principle dimensions of global justice, economic and political (Beitz 2005). These two dimensions are in many ways closely intertwined and not fully separable. Cosmopolitan approaches to global justice do have common principles, as described above, but "cosmopolitan justice" cannot to be considered to be one unified moral theory. There are many different theories and approaches that fall under this umbrella, some very theoretical and others suggesting specific practical

solutions. A detailed exploration of this subject is beyond the scope of this dissertation and unnecessary for my purposes. I shall thus very briefly mention a few of these proposals.

One of the first major contributors to the development of a concept of cosmopolitan justice was Beitz's *Political Theory and International Relations,* initially published in 1979 and republished twenty years later in 1999. His argument in this work has two central themes. The first is a critique of Rawls that aims to establish that, converse to Rawls's own standpoint, his "state-centric theoretical framework yields a global principle of distributive justice" (Caney 2005 p.109). The second aim of this work is to illustrate that, rather than a domestic social contract that yields a domestic 'difference principle', there should be a global contract, where representatives in the 'original position' behind a 'veil of ignorance' do not know to which society they belong, nor what the distribution of talents and abilities is. Under such conditions individuals will always chose a global version of the 'difference principle'. (The 'Difference Principle' states that inequalities are just, only if, in the greater scheme of things, those that are most disadvantaged would be in an even worse position if those higher up had less). Similar arguments have been developed by Moellendorf who also, in addition, develops a global version of Rawl's "equality of opportunity principle". Brock, in turn criticizes these approaches and argues that Rawls's thought experiment, if undertook at a global rather than a domestic level, would not in fact give rise to a global difference principle, but rather to a "minimum floor principle" where representatives of states would choose to ensure that any distribution provides a minimum safety net or "floor constraint" rather than a global version of the difference principle. She uses evidence from a body of empirical research to support this claim (Brock, G. 2004 171).

Pogge argues against both Sen and Rawls, who appear to claim that the primary reasons behind developing world poverty, relate to domestic factors such as poor governance, and unfortunate geography (Pogge 2002)(Pogge 2005). The real truth is that "we, the more advantaged citizens of the affluent countries, are actively responsible for most of the life threatening poverty in the world" (2005 p.30). Pogge proposes a "small change in international property rights" as the solution to the problem of world

poverty (2005. p. 50). This global tax he calls a GRD or Global Resource Dividend. The details of this proposal are discussed in chapter 8 of his book *World Poverty and Human Rights* (Pogge 2008). The basis for his idea is that states or governments do not have "full libertarian property rights" to all the natural resources in their country, but should be obligated to share a small proportion of the value of resources that they use or sell towards eradicating global poverty.(Pogge 2008 pp. 202-203) The "global poor" do in fact own a share in all limited natural resources. (2008. P 202) This shareholding does not mean that they have a right to exercise any decisions as to how these resources are used but it does mean that they have a claim to a share of the economic value of these resources. This shareholding is represented by the Global Resource Dividend. "Proceeds from the GRD are to be used toward ensuring that all human beings can meet their own basic needs with dignity. The goal is not merely to improve nutrition, medical care and sanitary conditions of the poor, but also to make it possible that they can themselves effectively defend and realize their basic interests.

This philosophical discourse is likely to continue to expand and develop. What is important for the purpose of my discussion is not so much the individual standpoints, but the collective perspective that the issue of global justice matters greatly and impacts significantly on the sphere of public health. I shall return to the subject of virtue ethics and global justice at the end of this chapter and consider whether or not a theory of justice that is purportedly inspired or influenced by the core elements of virtue ethics, has any applicability to this discourse.

VIRTUE ETHICS AND SOCIAL JUSTICE

In this section I propose six conditions that I consider essential to a virtue ethics inspired conception of social justice. I return to Alasdair MacIntyre to illuminate discussion of the first condition. I continue by exploring my six conditions within the context of a theory of social justice proposed by Faden and Powers which although is not specifically presented as a virtue ethics inspired theory of justice, has unmistakable and acknowledged Aristotelian roots. Their theory is developed around six criteria of well-being: health, personal security, reasoning, respect, attachment and self-determination. I

draw the conclusion that the six conditions I have proposed are accommodated by this theory. I then discuss global justice and public health and consider the role that virtue ethics may have in this particular sphere. I also reassess whether or not I have managed to successfully answer my original question: Can virtue ethics contribute positively to the domain of social justice and public health?

A virtue ethics- inspired Conception of Social Justice

The preceding discourse in this chapter serves as a rather lengthy overture to the crux of this discussion. Can virtue ethics contribute positively to a concept of social justice that would be useful as a moral foundation to the field of public health? Before I embark on this section I must admit to taking great comfort from a comment by Sen: "Euclid is supposed to have told Ptolemy 'There is no 'royal road' to geometry'. It is not clear that there is any royal road to evaluation of economic or social policies either" (Sen 1999 p.85)

In Chapter III I attempted to provide a broad but fairly detailed overview of virtue ethics as a moral theory incorporating the perspectives of many scholars but particularly Aristotle and Alasdair Macintyre. So, with this detail as the informational background, I think it is fair to propose that a theory of social justice which incorporated all the components identified below could be considered to be a virtue ethics inspired notion of social justice, or at least a theory of social justice that was aligned with the central elements of virtue ethics. (For ease of reference and for clarity I shall refer to each of my numbered points or conditions listed above, as VEC1, VEC2 etcetera)

Six Conditions for a virtue ethics inspired conception of social justice for public health:

This conception:

1. Must be embedded at least to some degree in a particular and specific social reality and set of circumstances, even though its foundation is underpinned by a common and universal understanding of the human good. I.e. it would incorporate Bernstein's concept of phronēsis – a dialectic interaction between universal norms and practical knowledge and understanding (VEC1).

2. Must have human well-being or flourishing as its end point (VEC2).

3. Must not be cross-sectional[44] but acknowledge the importance of an individual life seen as a whole or as MacIntyre would have it has as a 'narrative quest' (VEC3).

4. Must acknowledge the importance of the ability to choose one's "narrative quest" and the variety of 'goods' required to optimally complete that narrative quest and particularly that 'internal goods' such as self worth or self respect are as important as 'external goods' (VEC4).

5. Must accommodate the notion of 'partiality' and the essential role that close human relationships have within the broader notion of well being (VEC5).

6. Must place some emphasis on the role and significance of underlying motive when developing or settling on policy (VEC6).

I believe that a concept or model of social justice serving as a moral foundation for public health that could somehow accommodate the above points would be well on its way to being a concept that I would see as a 'good' one. I think the value and advantage of incorporating the above points into such a model, especially conditions two to five, is largely self evident. However I will, examine each of these points in more detail and hopefully in the process provide any necessary explanation or justification needed. I plan to consider my six points within the context of a theory of social justice that has been proposed by Ruth Faden and Madison Powers (Powers, Faden 2006). They describe their theory as a "non-ideal theory" based on six criteria or dimensions of well being. These dimensions do not correlate in any direct way with my six conditions, but I will argue that my conditions are accommodated within their theory and that the presence of these conditions, particularly the first three, are sufficient to claim that this theory is compatible with the essentials of virtue ethics[45].

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[44] I am borrowing this term from the field of clinical epidemiology where a research study is cross sectional, if information is collected and evaluated at one point in time only and conclusions are drawn based on this cross-sectional evaluation.
[45] This theory did not appear to be specifically named in their book. However 'justice as well-being' seems suitable and is the term that I shall use to describe it in the remainder of this discussion.

<u>Social Context and Social Justice</u>

Before exploring this theory in more detail I would like to digress slightly and discuss the relevance of social context with respect to social justice. The first of my six conditions (VEC1) states that virtues ethics would require a theory of social justice to be embedded at least to some degree in a particular and specific social reality and set of circumstances, even though its foundation may be underpinned by universal principles. Nussbaum states in the introduction to *Frontiers of Justice* (2006) that theories of justice do need to be abstract in order to have a "generality and theoretical power" that enables them to transcend local political conflicts and remain stable over a period of time.

> On the other hand, theories of social justice must also be responsive to the world and its most urgent problems, and must be open to changes in their formulations and even in their structures in response to a new problem or an old one that has been culpably ignored (Nussbaum 2006 p. 1).

(I discuss again the notion that theoretical frameworks, need to be sensitive to specific context, in the following chapter under the heading "Context, Cases and Rules")**.** Virtue ethics is a theory about practical reasoning and having the internal qualities which enable one to choose to act 'justly' or 'honestly' or 'with courage' depending on a *prevailing set of circumstances and contexts*. It refutes the idea that a set of norms and principles is universally applicable to every situation and context, in a 'top-down' manner.

In Chapter I of *Whose Justice? Which Rationality?,* aptly titled "Rival justices, competing rationalities", MacIntyre continues to build on the arguments presented in *After Virtue* and discussed in Chapter III, but this time focusing on different concepts of justice that have arisen from different traditions (MacIntyre 1988). Similar to the parable used to begin *After Virtue*, he starts with a whole range of semi-rhetorical questions aimed at demonstrating the "incommensurability" of conflicting notions of justice. Most of this book is devoted to a very detailed analysis of four historically, socially and intellectually different traditions (Aristotelian, Augustinian, Scottish Calvinism and liberalism). This

analysis is aimed at demonstrating that these traditions are largely "incommensurable" with each other. This does not mean that such traditions will not have points of agreement and similarity, but rather that there will be disagreement across traditions that "cannot be resolved by appeals to mutually agreeable standards of reasonableness and excellence because the agreements have to do at least in part with those very standards themselves" (Porter 2003 p. 45). Hence because we cannot escape from arguing from within one or other tradition we must look to that tradition to provide a framework for "speculative as well as practical reasoning" (2003 p.45). MacIntyre also provides very complex arguments against allegations of 'relativism' and 'perspectivism' (similar to in *After Virtue*). In addition he discusses how the rationality of traditions evolves and copes with "epistemological crises" as well as at times adopting perspectives from other traditions to resolve "irresolvable" problems. He describes a three stage process of internal criticism and re-evaluation that can and often does result in an epistemological shift (MacIntyre 1988 pp. 356-357). This account includes the ability as it were, to stand with a foot in each tradition and assess each from that particular vantage point. Porter concludes her critique of this book, with this comment:

> "What are we to make of the account of tradition developed in *Whose justice? Which Rationality?* This is clearly a more developed account than we find in *After Virtue*, and it offers an advance in many respects. It provides a way of thinking about epistemic functioning and rational status of traditions that is interesting and (at least for this reader) persuasive. On this account, genuine conversation and even intellectual conversion between proponents of rival traditions are possible, even though there is no point at which the interlocutors stand outside any tradition whatever. We might say that on MacIntyre's view the necessity for standing outside of any tradition whatever is obviated by the possibility of standing within two traditions at once in order to move between them in a comparative assessment of their claims. At the same time, this account of traditions offers a plausible resolution of key questions in contemporary philosophical discussions of truth and rationality, one that preserves a strong

meaning for both terms without resorting to a widely discredited foundationalism (Porter 2003 p. 53).

What though does all of this mean to social justice and public health in the real world of here and now? Let us compare two societies: Society A, a quasi-utopian society where the Universal Declaration of Human Rights is generally upheld, everyone lives in a formal dwelling, has access to clean water, sanitation and electricity, is employed and earns an income that can, at minimum, provide adequately for basic needs with a certain amount available for a modest degree of discretionary spending; and Society B (representing many in sub Saharan Africa) where 40 to 50 percent of the population are unemployed, living in informal shelter with no access to sanitation, clean water or electricity and earning a per capita income which does not cover basic needs and thus there is no remaining income available for any form of discretionary spending. A 'just' conception of 'social justice for public health' (at a domestic level) for Society A may in fact be very different to a 'just' conception of 'social justice for public health' for Society B. Very simply stated: a 'one-size-fits-all' approach does not work. The real-world situation needs to inform and shape a 'just' concept of social justice that can be implemented in such a way that it will act as the foundation for public health policy.

Another important consideration, not directly related to the point currently under discussion, is the relationship between Society A and Society B and the possible role or obligation that Society A may or may not have to contribute in some way to Society B. I shall return to this matter towards the end of this chapter.

<u>'Justice as well-being'</u>
The task of a non-ideal theory of justice, according to Faden and Powers is to offer a "basis for assessing social institutions and practices" and to "provide guidance on questions of which inequalities matter most" when prevailing background conditions are often far from ideal (Powers, Faden 2006 p. 30). For example are inequalities in the distribution of heath resources more important than inequalities in education. Thus the central questions posed by Faden and Powers are:

- "Which Inequalities matter most?" and

- "What is the job of justice?"

The first point they make is that unlike Rawls's theory of justice, theirs is not an 'ideal' theory because it does not start off with an ideal set of principles. "We start with an assumption that the best justified set of distributive principles are not readily ascertainable apart from a more detailed account of the ends of human action underlying them" (Powers, Faden 2006 p. 4). This immediately places this theory "within the tradition of theories that start with some conception of human well-being as a basis for evaluation of proposed distributive principles. Aristotelian theories, some natural law theories and now capability theories such as those proposed by Amartya Sen and Martha Nussbaum are examples" (2006. p. 4). Theories in this tradition do begin with ideals, but ideals that are related to the "specific ends of human activity informing an account of justice" rather than ideals in the form of distributive principles (2006.p.5). This teleological theory starts off by identifying six essential components or dimensions to human well being, which would be needed to constitute 'human flourishing' (VEC2). Very importantly, distributive principles which may arise in order to achieve these six dimensions are therefore secondary.

A critical point of difference between this theory and the 'Rawlsian tradition' is that pragmatic judgments about the effect or interplay of different inequalities evaluated in existing circumstances are regarded as "in eliminable moral data" (2006. p.5).

> In a non-ideal world questions of justice emerge from the operation of the totality of social institutions, practices and policies and both independently and in combination have the potential for profound and pervasive impact on human well-being in all of its essential aspects. In our account questions about which inequalities matter most are comprehensible only by examining all the social determinants having cumulative and interactive effects on human well-being. "Which inequalities matter most?", is thus a question appropriate to a concrete empirical context……..Justice, then, is not a matter of conforming society to an antecedently identifiable set of distributive

principles, but rather it is a task requiring vigilance and attentiveness to changing impediments to the achieving of enduring dimensions of well-being that are essential guides to the aspiration of justice (Powers, Faden 2006 p. 5).(VEC1)

A third difference these authors identify between their approach and others, particularly that of Rawls, is that justice involves a lot more than just distributive principles and hence a requirement of a theory of justice should be the need to acknowledge and integrate the distributive and non-distributive aspects of justice. "[M]uch of what justice comprehends lies beyond an assessment of each person's distributive shares and includes equally concerns about the nature of relations between persons" (Powers, Faden 2006 p. 6). Issues related to "social subordination and stigma, lack of respect, lack of institutions, and social practices that adequately support capacities for attachment and self-determination are also matters for justice for both individuals and groups" (2006 p.6).(VEC 4 and 5)

As mentioned earlier, Powers and Faden's theory is built around six essential and irreducible "determinants of well-being" each representing an essential component that is morally indispensable or irreplaceable. These six determinants are of particular moral significance because they "matter centrally to everyone, whatever the particular life plans and aims each has" (2006. p.15). However, the authors point out that although these six criteria are useful for classifying the moral domain of social justice, it is important to note that each determinant is itself an umbrella for many other "more finally grained" moral aspects (2006. p.18).

- **Health**: The concept of health used here is that which is generally understood as physical and mental health by the average man in the street. Although this concept usually entails a notion of normal biological functioning it also includes aspects which may not prevent normal biological functioning in a narrow sense, but do contribute to lack of well-being, such as chronic pain or infertility. What is of particular note is that although this dimension is the main dimension offered as the moral

foundation for public health, not all public-health issues are exclusively confined to "health". Thus for example the consequences of the cultural practice of female genital mutilation or ritual male circumcision, when seen as a public health issue, incorporate far more than just the well-being dimension of health but also that of "personal security", "respect" and "self-determination" (2006 pp.17-18).

- **Personal Security**: A constant fear of physical or emotional abuse from a partner may not directly result in tangible ill health but will certainly detract from well-being. Other issues that may be present within a particular social reality, such as frequent human rights abuses in the context of political unrest or instability, risk of torture, urban terrorism, civil war or rampant crime also fall within this dimension.

- **Reasoning:** Aristotle divided reasoning skills into two: theoretical reasoning is the ability that allows us to make sense of the *is* of the world around us, whereas practical reasoning enables us to determine the *ought* of how we should live our lives. Theoretical reasoning also includes the intellectual virtues that enable us to understand certain 'truths' about the world including the ability to question established convictions or practices and the willingness to consider alternatives. There are obviously many factors that influence these cognitive capacities either positively or negatively and they range from issues directly related to healthcare availability (e.g antenatal and peri-natal care) to nutrition and education. There are other "epistemic authorities" which include religious and state leaders, musicians, writers etc who regularly "pronounce" on matters of moral and public importance and play a huge, even if unacknowledged role, in "transmitting moral beliefs" (Powers, Faden 2006 p. 19). These authorities are often not deserving of the moral status with which they are accorded, especially when their beliefs reinforce notions of inequality with respect to race or gender or "exaggerate the epistemic credibility of those in dominant institutions and

positions of cultural authority" (2006 p. 22). It is essential that we have well developed capacities of practical and theoretical reasoning in order to be able to identify the flaws in messages communicated by those in authority. Such capacities are also essential to enable us to choose and direct out own particular 'narrative quest' (VEC3).[46]

- **Respect:** The notion of 'respect' as an essential component of human flourishing and an important component of justice has been noted by several authors (Rawls 1999) (Nussbaum, Sen 1993). This includes self respect, respect of others and respect for others, the concepts all being closely interwoven and interdependent. Lack of respect is associated with conditions of discrimination or judgments based on notions of inferior social class or status for whatever reason. "A lack of respect from others and an awareness of one's own exclusion from the reciprocal system of mutual respect that others in one's society enjoy, are profound injustices in their own right" (Powers, Faden 2006 p. 23).

- **Attachment:** This dimension of well-being acknowledges that the formation of "bonds of attachment" is essential for human flourishing. This view is echoed by authors such as Nussbaum and Baier. (Baier 1999) (Nussbaum 2001; 2000) 'Attachment' is as important to justice as 'respect'. Respect and attachment reinforce each other but are separate moral concerns of justice.

The level of emotional engagement and sympathetic identification with others is what in our view distinguishes attachment as an essential, irreducible element of what is necessary for the processes of forging bonds of mutual forbearance and mutual aid and for participation in the responsibilities of caring for one another. A theory of justice that does not require that its basic social institutions conform to and reproduce capacities for human attachment leaves out something of crucial moral

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[46] I have obviously borrowed this phrase from MacIntyre. It is not used by Faden and Powers.

significance (Powers, Faden 2006 p. 25) (This dimension relates directly to VEC 5.)

- **Self-determination:** (VEC3) Self-determination is the cornerstone of liberal democracy and it is a "broad and encompassing category of human good" (2006 p. 26) The importance of the value of personal autonomy has been emphasised by many modern philosophers. Isaiah Berlin expresses this very clearly in his now famous treatise on the subject (Berlin 1958). Self-determination needs far more than political freedom.

  Unless legal systems and cultural norms are structured in ways that provide social room for meaningful choices and their implementation, then leading a self-determined life is unlikely. More to the point, without the proper economic, legal and social structures, one's chances for being self determining are thwarted" (Powers, Faden 2006 p.27).

According to Faden and Powers each of the above dimensions is distinct and a theory of justice that does not adequately consider each dimension is deficient, because a life that is significantly lacking in one or more of the above dimensions is a life lacking in well-being. Each of these can be considered to be an "indicator of a decent life which it is the job of justice to facilitate" (2006 p. 29). This theory is an egalitarian theory of justice, described as a version of a sufficiency approach, which requires a sufficiency of each of the dimensions of well being, unlike other sufficiency theories which frame the concept of sufficiency in economic terms. Thus the distributive principles are derivative of an assessment of what is required for sufficiency of each of the six dimensions. This assessment is not 'ideal', but specific and informed by a particular social context and reality. (VEC1) Furthermore, justice is regarded as an essentially "remedial" process, requiring constant attention and monitoring of actual 'on the ground' circumstances so that distributive principles can be adjusted appropriately to continually respond to the question: Which inequalities matter most in this particular context? Powers and Faden

note that there is often a good deal of agreement and understanding of what constitutes a level of sufficiency of well-being.

> Fortunately for many aspects of well-being there is frequently substantial agreement about the general range of normal functioning, permitting widely shared judgments that below some defined threshold, someone is malnourished, inadequately sheltered or burdened by preventable disease and a shortened lifespan. Thus while absolute measures of sufficiency of the essential dimensions of well-being may be controversial at crucial points, there are many uncontroversial instances in which we know that the minimal level is not met (Powers, Faden 2006 p. 58).

Sufficiency of each dimension of well-being is influenced and determined by many social determinants, not only by economic determinants, as is the main focus of consideration in most theories of justice. Culture, "social practices and norms" and political structures and dispensations, including those that influence the structure and scope of health services, can profoundly influence each dimension of well-being. These social determinants may produce deficiencies in a dimension, such as 'self-determination' which in turn result in deficiencies in other dimensions, and negatively influence the social determinants themselves, such as economic stability, in a circular fashion. In the real world it is often the case that "overlapping social determinants" have a "profound and pervasive effects on a cluster of well-being dimensions" (2006 p. 65). The inequalities that need to be addressed most urgently are the ones that are a result of "systematically related overlapping social determinants affecting multiple dimensions of well-being". Justice requires action to address these inequalities as they exist in current actual circumstances, as well as an obligation to "design social institutions and structures to prevent such patterns of disadvantage from arising" (2006 p.72).

These authors conclude the explication of their theory by noting that it is simultaneously a "more encompassing" theory then other accounts of justice and is also "less guided by fixed guideposts" (2006 p. 78) This non-ideal theory of justice has both a "positive aim"

and a "remedial aim". The positive aim requires that justice be regarded as a sufficiency of well being for each of the six dimensions discussed above and that sufficiency of these dimensions can only be ascertained within a particular set of concrete and real circumstances. The remedial aim requires an ongoing dialectic between the determined distributive principles and the changing "patterns of disadvantage" that are present in the given social reality, so that appropriate changes can be made to the derivative principles, as needed (2006 p.79)

I have identified six conditions of virtue ethics that I believe could positively contribute to the development of a conception of social justice for public health[47]. Conditions one and two relate respectively to the need for social justice to be context embedded and to have a notion of human well being or flourishing as its end point. These first two conditions are clearly well accounted for in the above discussion. Similarly condition five, the need to consider the importance of human relationships, relates directly to the dimension of well-being described as "attachment", Conditions three, four, and six still need to be considered more closely.

VEC 3 and 4 are interwoven in many respects. VEC 3 states that a virtue ethics inspired concept of social justice *would not be cross-sectional but acknowledge the importance of an individual life seen as a whole, or as MacIntyre would have it, has as a 'narrative quest*. The notion that one's life is a 'narrative whole' and that chosen action is not considered in isolation, but must fit in to that narrative whole is an integral part of virtue ethics. This is expressed in the question-'How should I live?', rather than 'How should I

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[47]**Six conditions associated with a virtue ethics inspired notion of social justice for public health:**

1. Must be embedded at least to some degree in a particular and specific social reality and set of circumstances, even though its foundation is underpinned by a common and universal understanding of the human good. I.e. it would incorporate Bernstein's concept of phronesis – a dialectic interaction between universal norms and practical knowledge and understanding (VEC1).
2. Must have human well-being or flourishing as its end point (VEC2).
3. Must not be cross-sectional but acknowledge the importance of an individual life seen as a whole or as MacIntyre would have it has as a 'narrative quest' (VEC3).
4. Must acknowledge the importance of the ability to choose one's "narrative quest" and the variety of 'goods' required to optimally complete that narrative quest and particularly that 'internal goods' such as self worth or self respect are as important as 'external goods' (VEC4).
5. Must accommodate the notion of 'partiality' and the essential role that close human relationships have within the broader notion of well being (VEC5).
6. Must place some emphasis on the role and significance of underlying motive when developing or settling on policy (VEC6).

act?' A virtue ethics-inspired 'just' concept of social justice, particularly within the context of public health needs to ensure that it views lives as a whole; as a continuum with well-being as the end point. Such a theory of social justice must not just accommodate or focus on one cross-sectional time point in a life, such as productive or working adult life, to the exclusion or detriment of childhood or old age. It also needs to consider well-being as a complex concept that is not just confined to a narrow concept of health or to economic sufficiency. Being able to experience 'well-being' in old age and death, even if this is primarily in the form of inner peace and comfort from "bonds of close attachment", respect (both self-respect and dignity that come from respect from others) rather than complete health, is as important as experiencing 'well-being' in the prime of life.

VEC 4 has three distinct parts. It is concerned with (1) 'choosing a life', (2) 'internal goods' and (3) 'external goods' and states that a *virtue ethics inspired notion of social justice would "acknowledge the importance of the ability to choose one's 'narrative quest' and the variety of 'goods' required to optimally complete that narrative quest and particularly that 'internal goods' such as self worth or self respect are as important as 'external goods'*. The ability to choose one's narrative quest is accommodated in the dimension of "Self-determination" discussed above. However I think it is important to note that the liberal individualistic conception of self-determination is not necessarily the same as a life chosen and lived within the parameters of a *telos*. Fulfilling our overall *telos,* or function as a human being can only be achieved by living in accordance with virtue. Self-determination as conceived by Isaiah Berlin or Ayn Rand may be at odds with an Aristotelian version of the concept[48]. (Rand 2004). 'External goods' are the central subject of theories of distributive justice and require no further discussion at this point. 'Internal goods' as we have seen are not tangibles, but rather intangibles such as self worth, dignity, a sense of achievement etcetera. Certain theories of distributive justice certainly do accommodate 'internal goods' as well. Rawls has a list of "primary social goods" which includes characteristics such as dignity and self-respect and Sen and Nussbaum's 'capabilities approach' also places primacy on the importance of internal goods.

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[48] Ayn Rand (1905-1982) was best known as a novelist. She was the proponent of an extreme form of individualism which she called "objectivism" and which centred on the" virtue of selfishness". See *The Fountainhead* (1943) and *Atlas Shrugged* (1957)

The well-being dimensions of 'personal security', 'respect' and 'self-determination', incorporated in this expanded concept of well-being accommodate many of the goods that would be considered 'internal' goods. They also mean that this concept of justice is prepared to tackle and assess many of the issues, such as racial, ethnic or gender domination or oppression, group stigmatization, inadequate access to basic education and its effect on cognitive and reasoning capacities, etcetera, that profoundly affect one's ability to independently choose a life that is a 'good' life. It is a concept of justice that is not just confined to matters of economic sufficiency or equality, or to the question of access to adequate health care, but is far more holistic. In Chapter III I discussed the concept of a practice and the importance of practical reasoning *or phronēsis* in attaining goods internal to practices. The notion and importance of practical reasoning as a dimension of well-being is incorporated in Faden and Powers' third dimension, 'Reasoning', which was discussed above. It is also very much in evident as an integral and essential component of the way this theory works on the ground i.e. the "ongoing dialectic" between distributive principles and real-life context.

My last point states that a virtue ethics inspired theory of justice "would place some emphasis on the role and significance of underlying motive when developing or settling on policy". (Again, this is discussed in more detail in the following chapter). Motive is in effect the emotion guiding the action. The underlying reason for choosing a particular course of action is, according to proponents of virtue ethics, an essential part of one's moral life and cannot be discounted when evaluating whether or not such action would count as 'good' or 'just' or courageous etcetera. The real or deep motive, particularly in a highly politicised environment, may be different from the apparent motive or reasons given for why a specific public policy or programme is implemented. In some instances, theories of distributive justice can result in a split between motive and reason or justification, for example the distributive principle of utility may override motives which may incorporate notions of community solidarity or compassion[49].However, a theory of

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[49] The South African government policy on the prevention of the mother to child transmission of HIV (PMTCT) and the role out of anti-retroviral treatment programmes is a good example of disharmony between motive and reason. The apparent reasons given for the delay in developing and implementing policy were numerous and usually centered around lack of financial resources and questions related to utility and cost-effectiveness. The real motives behind the policy, or rather lack of one, appeared to be far

social justice for public health that incorporated Faden and Powers' six dimensions of well-being would be unlikely to result in a split between reason and motive, particularly if integrated into a MacIntyre model for public health, as illustrated in the next chapter. Underlying motive and reasons for action would amount to the same thing. To paraphrase Stocker: One mark of a good life (or theory of justice!),[50] is a harmony between one's motives and reasons, values and justification (Stocker 1976 p. 66).

My task in this section was to explore whether or not virtue ethics could contribute positively to a concept of social justice for public health. I think the above discussion clearly demonstrates that the theory of social justice published by Faden and Powers is closely aligned with the central elements of virtue ethics. Thus the answer to at least part of my question is in the affirmative. The preceding discussion has demonstrated that this contribution is a *positive* one and that a theory of justice that accommodates the virtue ethics elements identified, will be well on its way to being a 'just' or 'good' theory. However while it is fairly easy to imagine how this theory could be applied in local and particular contexts, as a means to evaluate institutions and social practices, it is more difficult to conceive of its application or influence at global level where the spheres of social justice and international politics collide and hence this issue now needs to be critically examined.

Virtue Ethics and Global Justice

Earlier I introduced the idea of cosmopolitan justice and reflected that a substantial body of scholarship argues that principles of both economic and political justice are applicable to the global realm. Three elements, or principles, are identified as essential components to this cosmopolitan approach to justice. Individual human beings, no matter where in the world they are situated, are units of moral concern. Moreover, each individual human being matters equally and they are matters of concern to everyone, not just to members of their own state or cultural or ethnic group. Does a virtue ethics conception of social justice, as described above, accommodate this conception of global justice?

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more complex and were probably related to political expediency and the relationship between the then Minister of Health and the State President, more than anything else.
[50] My addition.

We now live in a globalised world in which economies are interwoven and interdependent even if cultures, political systems and social practices remain at least partially circumscribed. In a paper on "International Health Inequalities and Global Justice", Daniels comments, contrary to cosmopolitan claims, that "[w]e remain unclear just what kinds of obligation states and international institutions and rulemaking bodies have regarding health inequalities across counties". He continues by stating that in order to clarify this issue we must engage in the task of "explaining the substance of international obligations for the various kinds of cooperative schemes, international agencies and international rule making bodies" (Daniels 2008 p. 109). These statements seem to associate Daniels with the "morality-of-states" group of theories, aligned more closely with Rawls's *Law of Peoples,* rather than with a cosmopolitan outlook.

Daniels divides international health inequalities into three categories (Daniels 2008 pp. 116-117):

1. Those that result from domestic injustice in the distribution of societal goods because such injustice incorporates practices that are discriminatory. The failure to adequately fund basic healthcare for indigent populations is also included here.
2. Inequalities in conditions that effect health. These include natural conditions such as living in a country susceptible to drought or malaria as well as inequalities in per capita income
3. Those that result from international practices that can impact negatively even if indirectly, on the health of communities such as trade agreements or contributing to a health brain drain. Such practices may well also create the conditions identified in category two.

First world or developed nations are certainly able to have some impact on category two and three health inequalities. The extent to which they choose to do so is no doubt influenced by various interpretations of the 'international moral obligations' referred to by Daniels. Daniels also notes that even though most people acknowledge some degree of "humanitarian obligation" there is significant disagreement even among "egalitarian liberals" with respect to international obligations of "*justice* to reduce these inequalities

and to better protect the rights to health of those whose societies fail to protect them as much as they might" (Daniels 2008 p.111).

Authors such as Pogge and Benatar have no qualms in laying the blame for a large proportion of the social injustice and poverty experienced by poor nations fairly and squarely at the door of wealthy nations (Pogge 2002, 2008)(Benatar 2005b). Despite the fact that all western nations now generally purport to accept that all human beings have equal moral status, this conviction has not translated into the kind of action that seeks to take effective steps to alleviate world poverty. (Pogge 2008. p. 98) Thus from the perspective of the cosmopolitan theorists mentioned earlier, and in disagreement with Daniels, wealthy nations *and* the individuals living within their borders, all have both a clear individual and collective moral responsibility to take remedial action against social and distributive injustice that affects individuals living in other countries.

Is the virtue ethics aligned concept of social justice that I have described above a cosmopolitan theory of justice, or does it fit more readily into the "morality-of-states" category? I would like to argue that there is no component of this theory that specifically precludes it from being categorized as a cosmopolitan theory of justice and nothing that suggests that it is a theory whose applicability is confined to national borders, or is limited to the sorts of "obligations of international institutions and rule making bodies" described by Daniels. The three criteria identified by 'cosmopolitans' like Caney and Pogge as essential to this category are accommodated quite adequately, or certainly not excluded in any way, by both by my 'six conditions' and by Powers and Faden's theory. This is certainly a theory that is concerned with the moral worth of individuals and incorporates elements, such as 'personal security', 'self-determination', and 'respect' that are specifically designed to ensure that individuals are all treated with equal moral consideration, within the sphere of justice.

 The answer to the related questions "How should I choose to live?" and "What constitutes the good life for man?" has to be considered in the twenty first century, within the broad context of the world as I now know it to be. That is, I can no longer, morally speaking, choose to limit my deliberations of these two questions to my knowledge of

the world outside my back door. If the world outside my back door *is really* the only world that I know, then I am probably most likely to be either mentally disabled or significantly disadvantaged myself, if I do live in a first world nation, or living in an underdeveloped third world nation. In that case my individual moral responsibility to address matters of global justice is arguably limited.

It is important to note, that by their own admission, Powers and Faden, have drawn extensively on the work of Nussbaum and Sen to develop their theory. The major difference is the use of the more traditional language of well-being, rather than capabilities and the fact that they do not support the primacy that Nussbaum and Sen give to "protecting functional capabilities, over actual functioning" (Powers, Faden 2006 p. 192). Nussbaum has been 'categorised' by Caney as a cosmopolitan theorist and she certainly categorizes herself as a virtue ethicist (Caney 2005 p.4)(Nussbaum 1999 p.169). Nussbaum comments:

> Any theory of justice that aims to provide a basis for decent life
> chances and opportunities for all human beings must take cognizance
> both of inequalities internal to each nation and of inequalities between
> nations, and must be prepared to address the complex intersections
> of these inequalities in a world of increased and increasing global
> interconnection (Nussbaum 2006 p. 225).

Nussbaum is critical of social contract based theories of justice because all versions of these theories rely on the notion of 'mutual advantage' which cannot act as an impetus for global justice. "We live in a world where it is simply not true that cooperating with others will be advantageous to all. Giving all human beings the basic opportunities…..will surely require sacrifice from richer individuals and nations" (2006. p.273) She goes on to develop an account of global justice, adapting the 'capabilities approach', (which differs slightly but not extensively from the well-being approach of Powers and Faden) to the global sphere. This account returns to a pre-social contract era and draws on a "richer and more inclusive idea of human cooperation" and ethical reasoning, originating with Aristotle and further developed by other ancient and early

renaissance scholars such as Circero, the Roman Stoics and Hugo Grotius. (2006. p.273) The following excerpt illustrates the close proximity of this perspective, to what was identified earlier as the essential components of moral cosmopolitanism.

> The three central facts about human beings that moral intelligence apprehends are the dignity of the human being as an ethical being, a dignity that is fully equal no matter where human beings are placed; human sociability, which means that part of a life with human dignity, is a common life with others organised so as to respect that equal dignity; and the multiple facets of human need, which suggest that this common life must do something for us all, fulfilling needs up to a point at which human dignity is not undermined by hunger, or violent assault, or unequal treatment in the political realm. Combining the fact of sociability with the other two facts, we arrive at the idea that a central part of our own good, each and every one of us-insofar as we agree that we want to live on decent and respectful terms with others, is to produce and live in a world that is morally decent, a world in which all human beings have what they need to live a life worthy of human dignity (Nussbaum 2006 p. 274).

The above discussion supports the notion that, at least at a theoretical level, a theory of justice that is closely aligned with the core elements of virtue ethics can also be considered to fall within the broad umbrella of cosmopolitanism. Powers and Faden can be criticized for not explicitly discussing the issue of global justice and the direct application, or otherwise, of their theory to this domain in any detail. They do discuss the application of their theory to several specific areas of concern namely 'disadvantaged social groups', 'poverty and disadvantage' and children and use many international examples such as the oppression of women by the Taliban, differences in life-expectancy in first and third world countries, childhood mortality rates etcetera to illustrate the discussion, thus implying that their theory has global scope. They concede, however, that much of what needs to be achieved at a global level falls outside of the sphere of public health.

> In much of the developing world, governments are impoverished, corrupt or otherwise unable or unwilling to provide for their citizens the conditions necessary for health and thus the means to narrow these disparities. It is the duty of the global community to ensure that the needs of the people living under such governments are met. Once again, collective action is required but the best strategies for eliminating the injustice involve much more than what global public health institutions, both public and private, can provide (Powers, Faden 2006 p. 85).

This comment appears to lay the blame of developing world ills mainly at their own doorsteps and the ensuing brief discussion does not attempt to explore the issue of first world complicity and accountability in relation to developing world poverty. Further chapters in this book do also tend to explore issues that are particularly pertinent to North America such as "Medical Care and Insurance Markets" and "Setting Priorities" and the locus of discussion is very much 'at home' rather than 'abroad'.

One important aspect which has as yet not been discussed, and is of particular relevance to the global domain, is the relationship between justice-as-well-being and human rights. It is through the language of human rights that Powers and Faden do in fact see a method of application of their theory to the global domain of public health and justice. The language of human rights is used frequently as a succinct articulation of moral issues that are fundamental to justice. Human rights are often discussed as legal rights and basic human rights. Legal rights are relational in that they arise out of a contractual arrangement and are set down in statutes. Basic human rights, particularly positive rights, require some form of moral justification, as the claims are based on "one's universal humanity" rather than a relationship with a institution or state. Powers and Faden argue that the six dimensions of well-being proposed in their theory can be used to justify a positive account of basic human rights that has international moral force.

Public health has correctly understood that rights are claims of particular moral urgency and thus the recognition of a universal moral right to health is of considerable strategic importance. As we have noted, our theory is one way of justifying a "protected interests" account of basic human rights that arguably underlies the United Nations Declaration. Health along with the other five dimensions of well-being, are weighty interests of special enough importance to be given protection as basic human rights, assuming we are correct in our claim that it is rational for everyone to want these six dimensions no matter what else we want (Powers, Faden 2006 p.85).[51]

Before concluding this discussion it is important to briefly return and consider the first category of international health inequality identified by Daniels and Powers and Faden. There are undoubtedly certain health inequalities that do occur largely as a result of practices that are internal to nations or in other words, brought on by their own misdemeanors. We have seen there is much dissension as to how much blame can be justifiably accorded to impoverished nations in this regard. However even authors such as Pogge do concede that at least some proportion can be. This category thus involves the problem of adjudicating between differing standards of justice as it relates to health, between nations, or of criticizing another nation-state's standard of justice. And this brings us back to Daniel's assertion that there remains no clarity with respect to international obligation on this matter. As has been noted previously in discussion with respect to both Aristotle's "function argument" and MacIntyre, virtue ethics does not equate to cultural or moral relativism. The rationality of the virtues does mean that "it is possible to discover standards by which to assess any moral culture, including one's own" (Hughes 2001 p.214). Nussbaum has also defended Aristotelian virtue ethics against charges of relativism.

This is an odd result, as far as Aristotle is concerned. For it is obvious that he was not only the defender of an ethical theory based on the virtues, but also the defender of a single objective account of the

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[51] See Chapter 2 pp 45-49 for details of this argument. (Powers, Faden 2006)

human good, or human flourishing. This account is supposed to be objective in the sense that it is justifiable by reference to reasons that do not derive merely from local tradition and practices, but rather from features of humanness that lie beneath all local traditions and are there to be seen whether or not they are in fact recognised in local traditions (Nussbaum 1993 243).

Justice, as a virtue of individuals, dictates that just individuals, in a position to criticize and be heard, must speak out and criticize standards of social justice that are viewed as problematic, even if governments fail to do so. "Justice, whose primary consideration is the weak, can never under any circumstances exclude the weak from its sphere of influence" (Comte-Sponville 2001 p. 83).

In conclusion, a virtue ethics aligned theory of justice, such as Power's and Faden's justice-as-well-being, (a theory specifically developed for the realm of public health), is compatible with the essential components of a cosmopolitan conception of justice. It can also be called on to justify an extension of basic human rights that includes a broader range of positive rights. The main purpose of this account of justice it to provide a foundation for assessing the justice of social institutions and of practices, particularly as they relate to public health. It is far easier to imagine this theory applied in a real life situation at a local level, to address a fairly well circumscribed public health issue, than it is to envisage its implications in a global public health context, profoundly influenced by matters related to global politics and economics that arguably fall outside of the direct domain of public health. Never-the-less this theory of social justice can be a useful method of evaluation of real world contexts, by both domestic and international public health agencies to assess patterns of 'systematic disadvantage', identify those that are of particular moral urgency, as well as the remedial action required to address these patterns, and also as a tool to develop inspirational programs that seek to provide sufficiency of well being across all six dimensions, not just 'health'.

VI VIRTUE ETHICS AND PUBLIC HEALTH: ADDITIONAL CONSIDERATIONS.

INTRODUCTION

My discussion of virtue ethics has revealed, as Nussbaum cautioned, that unlike Kantian ethics or utilitarianism, virtue ethics is a theory that has been developed and shaped by many authors over a long period of time. Within the umbrella of virtue theory are contributions from scholars ranging from Plato and Aristotle to Aquinas, MacIntyre, Foot, Slote, Stocker, Hurtshouse and many others, who share some commonality but also differ in certain respects, and who sometimes focus on particular aspects of virtue theory only. I have chosen to present a predominantly Aristotelian picture of virtue ethics because, to my mind, he is the 'father' of virtue ethics. I have relied quite heavily on Alasdair MacIntyre, but also included the perspectives of other contemporary authors.

In Chapter V, I demonstrated that virtue ethics could play a role in constructing a theory of social justice that would be appropriate as a moral foundation for public health. In this chapter I investigate a more direct application of virtue theory in relation to public health. After returning to MacIntyre and considering public health as a 'practice', I explore virtue ethics within the context of both the "extrinsic goods" and "intrinsic goods" of this practice. In an examination of "virtue ethics and professional roles" (Oakley, Cocking 2001), I identify the particular virtues that would be relevant to public-health practitioners. As a continuation of this I explore virtue ethics as it could relate to, or influence, the education of public health professionals, followed by a consideration of 'casuistry' within the contexts of virtue ethics and public health. Finally, I briefly consider the relevance of 'motive' within a public health context.

PUBLIC HEALTH AS A 'PRACTICE'

In Chapter III I discussed the concept of a 'practice' as developed by MacIntyre, based on what he sees as a similar concept within both Homeric and Aristotelian accounts of virtues and human action (MacIntyre 1985 p. 187). I now attempt to apply this concept,

including the notion of 'internal goods' and the virtues required for achieving them, to the domain of public health. My purpose is to establish whether or not this notion could be helpful in developing a moral framework for the enterprise which is 'public health'. A reminder of MacIntyre's definition of a practice, which I have segmented for clarity, is helpful here.

By 'practice' I am going to mean:

- any **coherent and complex form of socially established cooperative human activity,**
- through which **goods internal** to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity,
- with the result that **human powers to achieve excellence** (virtue), and **human conceptions of the ends and goods involved**, **are systematically extended** (MacIntyre 1985 p. 187).

'Public health' arguably fits the first bullet of this definition readily. Many if not most public health activities such as prevention programmes, for example vaccination programmes, or health promotion programmes require coherent and integrated "cooperative human activity" The second and third bullets require more explication. What are the 'internal goods' of public health? What are the standards of excellence of public health that will act as benchmarks for achieving those internal goods? What human excellences or virtues need to be developed to achieve these internal goods? How will this process extend the conception of the ends and goods involved? These are tough questions to answer. Before attempting to answer them, I briefly recap some of the other important points that MacIntyre has made about "practices" (MacIntyre 1985 pp. 187-196):

- Internal goods are defined by each particular practice and recognised by the experience of participating in the practice in question.
- A practice involves "standards of excellence and obedience to rules" (1985 p. 190)

- Entering into a practice means that I accept the authority of these internal standards and I allow my own attitudes, choices and preferences to be guided by these standards.

- I also accept that my own performance may be judged inadequate, as compared to the standards of excellence established by the practice, especially when first entering into the practice. The practice therefore will shape my development of particular virtues.

- A virtue is an acquired human quality, that when exercised by a member of a practice enables that member to achieve the goods internal to the practice or to contribute towards the collective achievement of internal goods.

- A virtue does not equate to a skill. It is rather a character trait or quality that enables me to use my skills to obtain internal goods not just external goods.

- External goods are usually some form of 'property' attached to individuals. They are competitively acquired and often the more one person has of them the less there is for others.

- Internal goods are also the outcome of "competition to excel" but a defining characteristic of internal goods is that "their achievement is a good for the whole community who participate in the practice" (1985 pp.190-191).

- The virtues of justice, courage and honesty are fundamental to any practice with internal goods and standards of excellence.[52]

- Practices are historical i.e. they have a history and evolve over time. Sometimes they may even rise and fall.

- Institutions may be needed to sustain a practice but they do not equate to a practice. Institutions are concerned primarily with the competitive acquisition of external goods rather that internal goods[53]. Practices are thus always susceptible to being corrupted

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[52] Bernstein has strongly criticized this assertion by MacIntyre (Bernstein 1986 pp. 124-126). He argues that MacIntyre has not provided an adequate argument to support this claim and that there are practices such as chess or farming that do not require these virtues. I do not see this as a particularly problematic issue. Those practices that can be undertaken in relative isolation, such as chess or painting or writing a book, may be able to be done without one or more of these particular virtues, although it seems to me they would nevertheless be the poorer. My task is to focus on public health as a practice and I shall discuss specific virtues shortly.

[53] For example, an architectural firm or practice (in the conventional or legal sense) is the institution that sustains the *practice* of architecture by the architects that work for the firm. The firm is concerned with external goods such as good reputation and a large clientele base that will pay for the skills provided by the architects. The internal goods that the architects strive for are those that come with the satisfaction of

by institutions. "For the ability of a practice to retain its integrity will depend on the way in which the virtues can be and are exercised in sustaining the institutional forms which are the social bearers of the practice. The integrity of a practice casually requires the exercise of the virtues by at least some of the individuals who embody it in their activities; and conversely the corruption of institutions is always in part at least an effect of the vices" (MacIntyre 1985 p. 195).

- A practice without virtues, particularly those of justice, truth and courage would be only concerned with external goods. The internal goods would not be evident. Such a practice would be at risk of corruption or of self destructing.

- Possession of certain virtues may prevent us from achieving external goods. "Thus although we may hope that we can not only achieve the standards of excellence and the internal goods of certain practices by possessing the virtues *and* become rich, famous and powerful, the virtues are always a potential stumbling block to this comfortable ambition" (MacIntyre 1985 p. 196).

- Finally, we should not lose sight of the fact that practices are part of a broader scheme or narrative quest that constitutes the good of a whole life. They do not exist in isolation but must interact and complement each other at least most of the time.

As discussed above and illustrated in the diagram on page 167 MacIntyre's concept of a practice comprises several core elements of which the first, a **"coherent and complex form of socially established cooperative human activity"**, readily accommodates the enterprise of public health. However, I have identified three points which need further clarification:

1. What are the standards of excellence of public health that will act as benchmarks for achieving those internal goods?
2. What are the internal goods (and external goods) of public health?

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designing buildings which are either 'beautiful' or 'unique' or 'green', and which completely satisfy the requirements and expectations of their clients. Arguably, without the internal goods, the job of being an architect loses its meaning and becomes tedious. The same can be said with respect to the *practice* of medicine. If a medical practice becomes exclusively concerned with the external goods (consultation fees, medical insurance recovery rates etc) and those involved lose sight of the internal goods, then as Pellegrino has eloquently argued, medicine as a *practice* has lost its soul (Pellegrino 1999).

3. What human excellences or virtues need to be developed to achieve these internal goods and how will the development of these virtues extend the vision and meaning of the practice of public health for those involved?

The answer to the first question has in fact been dealt with already in the previous chapter. I have argued that the standards of excellence of public health that will act as benchmarks for achieving the internal goods of public health are those defined by a just concept of 'social justice for public health'. A virtue ethics aligned concept of social justice would regard human well-being as its most fundamental and overarching goal. A sufficiency of the six dimensions of human well-being identified by Powers and Faden could thus serve as the "standards of excellence" that MacIntyre requires.[54] However these authors note that each dimension can give rise to multiple sub-dimensions or standards. Thus, for example, the dimension of 'respect' can and must be interpreted on many different levels. It requires the conditions needed for self-respect and self-worth, mutual respect and respect for the equal moral worth of different groups of people irrespective of race, sex or age.

Point two requires that the external and internal goods of public health be defined. What are the external and internal goods to be achieved by the practice of public health? The external goods of public health can be considered to be the measurable outcomes that are listed as part of any specific public health programme. They often are expressed in statistics or percentages: number of deaths prevented; percentage of population covered by vaccination program *x* or educational program *y*; cure rate for TB; percentage DOTS coverage; adherence rates; programme cost-effectiveness evaluations etcetera. Internal goods, by contrast, are not that easy to define or list, because essentially they are those intangibles that come with knowing that a job has been well done or that goals have been successfully accomplished. Thus, within the domain of public health, internal goods would be achieved by successfully developing programmes and policies that contribute to the various dimensions of well-being previously identified, in as holistic a way as possible. Implementing a policy that targets one dimension only to the possible detriment of other dimensions is to *not* achieve the

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[54] The six dimensions of well being - health, personal security, reasoning, respect, attachment and self-determination- are discussed on pages 141-144.

'standards of excellence of public health' that have been identified as benchmarks. Under such circumstances, the internal goods of deep satisfaction and a real sense of achievement would remain elusive. Internal goods are also, I believe, those aspects of a public health programmes which are arguably as important as the measurable outcomes, but are often also fairly intangible and difficult to measure, such as increased levels of tolerance and decreased levels of stigmatisation within a particular community, or the empowerment and increased self- worth of women in a community that historically disempowered women. Hence the six dimensions of well being are the "bench marks of excellence" that remain constant for different types of public health programmes or interventions although each benchmark gives rise to programme specific internal and external goods. This is further explained and illustrated with examples in chapter VII.

Buchanan has discussed MacIntyre's notion of 'internal goods' within the context of heath promotion and public health and from the perspective of 'the public' as moral agents, rather than public health professionals as moral agents. He comments that the concept of virtue, "once one can get past its slightly archaic ring and prudish connotations", aligned with MacIntyre's concept of internal goods "offers an innovative framework for reconceptualising the work of health promotion" (Buchanan 2000 p.108). MacIntyre's notion of goods that are 'internal' to practices is really about the relationship between "means and ends". The ultimate end of health promotion should be to enable us to live a life of well-being in its fullest sense and a life of integrity. "[L]osing weight through diet pills does not enable us to realize the internal goods of self-knowledge, self discipline, dignity and integrity" (2000 p.109). Public health programmes that use coercive tactics, unrelated incentives or regulations to achieve their ends may be appropriate in certain circumstances, but by focusing exclusively on 'external goods' such programmes ignore the power and value of utilizing the successful achievement of internal goods as a tool to achieve success.

Achieving the external goods listed above is arguably what public health is all about, and it seems logical to claim that any programme that can successfully produce a list of positive statistics has achieved its goals. However, the problem with this is that it may foster fragmentation and a piecemeal approach. For example, a policy of involuntary

hospitalisation of MDR-TB patients that focuses entirely on the well-being dimension of 'health' and achieving a reduction in a set of measurable incidence or prevalence outcomes, but does not consider other dimensions of well-being, such as respect or attachment, is bound to succeed only partly, or fail altogether, on both accounts (that is, with respect to attaining external and internal goods). The "external" goods, equating to the goals of the policy are unlikely to be achieved. Scenes displayed on South African national television in 2007, of hospital 'in-mates' rattling security gates while guards looked on, and distraught and angry family members protested outside, when such a programme was implemented, is a good illustration of this point. The prospect of such a policy achieving 'internal goods' for those involved with implementing it is unlikely. It seems more likely that it may ultimately impact negatively on both the public-health professionals tasked with implementing the policy and, of course, the members of civil society affected by it.

In considering the third point, the following requires clarification: What virtues need to be developed so that public-health practitioners or professionals can obtain the internal goods of public health and by so doing, expand their vision of the standards of excellence that comprise the practice of public health? I have, up until now, said very little about the specific virtues required by public-health professionals or about the notion of *phronēsis* or practical wisdom.

Illustration1. MacIntyre's model of a practice, adapted for public health.
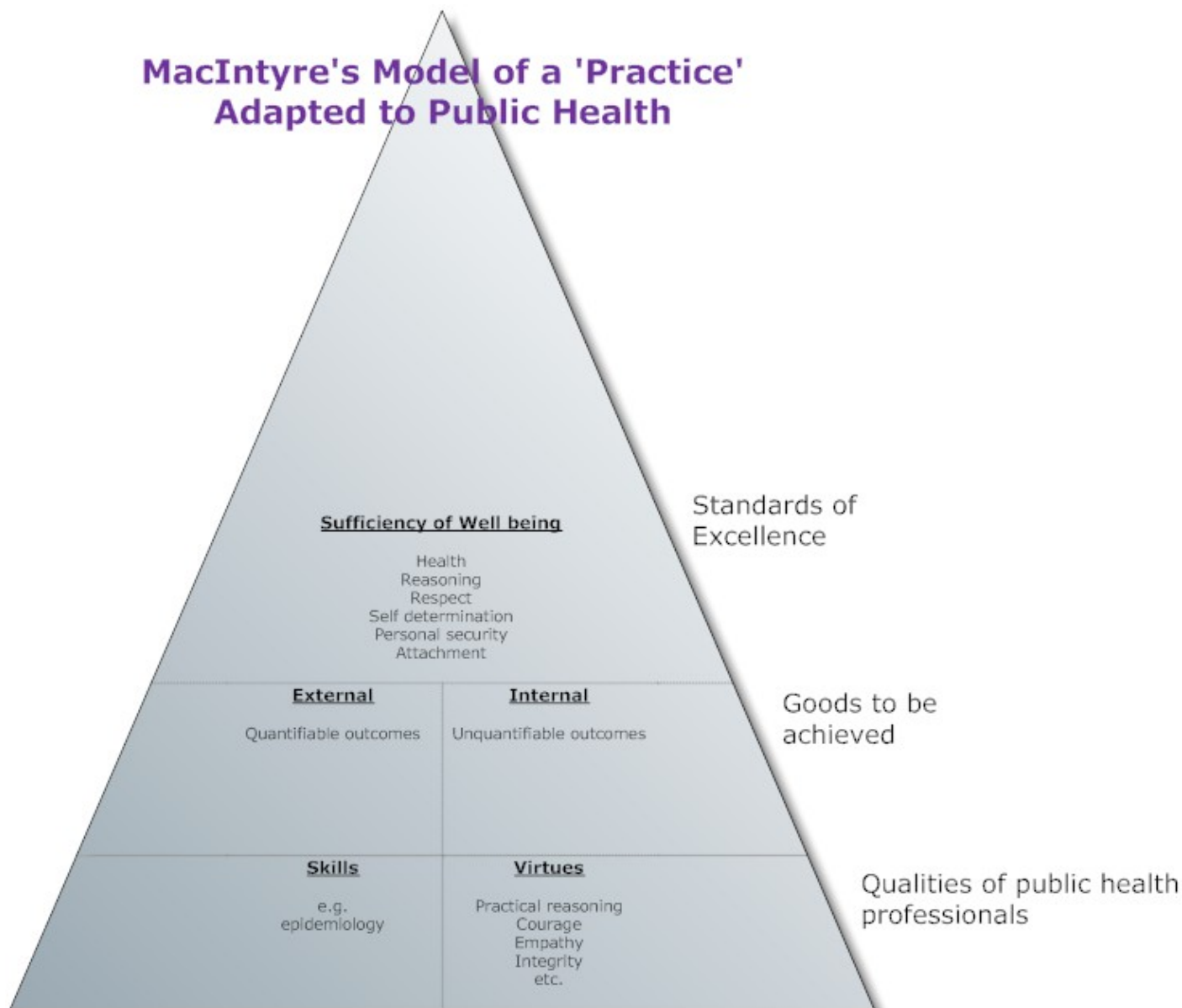
In this discussion I will focus predominantly on the decision- and policymakers, but those that are responsible for the implementation of policy are also public-health practitioners or professionals. Oakley and Cocking have discussed, in detail, a virtue-ethics approach to professional roles, concentrating primarily on the professions of clinical medicine and law (Oakley, Cocking 2001). However, much of their discourse is directly relevant to this discussion and echoes, in many respects, what has been said by MacIntyre about practices. They comment:

> Broadly speaking, what counts as acting well in the context of a professional role is in our view importantly determined by how well that role functions in serving the goals [ends] of the profession and by how those goals are connected with characteristic human activities. That is, good professional roles must be part of a good profession, and a good profession, in our virtue ethics approach, is one which involves a commitment to a key human good, a good which plays a crucial role in enabling us to live a humanly flourishing life (Oakley, Cocking 2001 p. 74) .

These authors also clearly distinguish between a 'profession' and an 'occupation', in much the same way as MacIntyre distinguishes between 'practices' on the one hand and 'skills' and 'institutions' on the other.

One of the strengths of an approach to professional roles which takes their moral status to depend importantly on their links with key human goods is that this sort of approach fits naturally with a central feature of any occupation's claim to be a profession in the first place. That is, it is widely agreed that for an occupation justifiably to claim to be a profession, its practitioners must deal not simply with the goods that many of us *desire* to have; rather its practitioners must be able to help us attain goods that play a crucial strategic role in our living a flourishing life for a human being (Oakley, Cocking 2001 p. 79). Oakley and Cocking have explored virtue ethics within the context of professional roles and have argued strongly for a virtue ethics inspired model for professionals. Their model is centred on what they describe as a "regulative ideal"; an idea that is derived

from Aristotle's notion of *phronēsis.* To say that I, as a public-health practitioner, have a "regulative ideal" of a 'good' public-health professional means that I have "internalised a certain conception of correctness or excellence, in such a way " that I am able to "adjust my motivation and conduct" to conform to that internalised standard (Oakley, Cocking 2001 p. 26). A regulative ideal is an "internalised normative disposition" which influences motivation and guides action. "Regulative ideals" can be general or quite specific and "because they operate as guiding background conditions on our motivation, they can direct us to act appropriately or rightly even when we do not consciously formulate them or aim at them". Also a regulative ideal can guide actions without becoming the purpose of action and can influence behaviour without being the motive for action. They embody both "standards of correctness" which may be codified in various rules or regulations, as well as standards of excellence that cannot be codified. (2001 pp.26-27) A professional "regulative ideal" must be based on the final "ends" of the profession.

Oakley and Cocking define regulative ideals as follows:

- They are 'internalised normative dispositions' which influence motivation and guide action
- They can be general or quite specific and "because they operate as guiding background conditions for our motivation, they can direct us to act appropriately or rightly even when we do not consciously formulate them or aim at them
- They can guide actions without becoming the purpose of action, and can influence behaviour without being the motive for action;
- They embody both "standards of correctness" which may be codified in various rules or regulations, as well as standards of excellence that cannot be codified;
- Finally, a professional "regulative ideal" must be based on the final "ends" of the profession (Oakley, Cocking 2001 pp. 26-27).

 In our case we have defined the ends of public health as comprising various dimensions of well-being. This regulative ideal also needs to become internalised to such a degree that it becomes part of the professional agent's character and influences motive and action in a consistent fashion.

Virtues are those character traits or human qualities that allow such a "regulative ideal" to be developed and to be fully operative. There seems to be something almost naïve or idealistic about expounding a list of the virtues required by good public-health professionals. Such a discussion seems somehow ridiculous in our modern world. A list of rules and regulations or a code of ethical conduct would be fine, but a list of virtues seems to be something that should be part of a Sunday school lesson, not part of a serious discussion of public-health ethics. My proposal is that this is where we have at least in part gone wrong, and that such a list is a critical component of this discourse. MacIntyre has stated that the virtues of justice, courage and honesty are integral to all practices. I certainly agree with him when it comes to public health. Beauchamp and Childress have identified five focal virtues for the practice of medicine, namely trust, compassion, discernment, integrity and conscientiousness (Beauchamp, Childress 2001 pp.34-35). I have adapted and modified their list to propose what I believe are core virtues or rather character traits of a good public-health professional. The list could no doubt be extended.

- **Justice:** The virtue of justice has been discussed previously. It seems intuitive that a deeply ingrained sense of justice or fairness is an essential character trait of a good public-health professional. Without it, public health programmes that do not address health disparities perpetuated largely as a result of race, ethnic differences, gender or poverty will continue to be developed and implemented.

- **Generosity:** Justice and generosity are both virtues that are about our relationship with others. Justice is about giving what is owed, but generosity is about just giving, even though an act of generosity can also be an act of justice.

  ….generosity is more subjective, more individual, more affective, and more spontaneous, while justice, even in its specific applications, is always somewhat more objective, more universal, more intellectual, and more considered. Generosity seems to owe more to the heart or

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temperament, justice to the mind or reason. A declaration of human rights makes sense, whereas a declaration of generosity sounds fairly non-sensical: generosity does not mean acting in accordance with that document or law; it means doing more than what the law requires (Comte-Sponville 2001 p. 87).

Generosity is an unlikely virtue to include in this list and arguably even inappropriate within this particular professional environment. Do we really want generous public health professionals who may be prone to allow sentiment to influence their use of scarce public resources by implementing public health policy or programmes that go beyond what is required or necessary? Justice is perhaps the first virtue of public-health practitioners, but I believe justice tempered with a spirit of generosity may be that much better, especially with the context of public health problems that fall into the ethical domain of global or trans-border justice. It is in this particular context (discussed previously at the end of Chapter VI) that, what may be viewed by some as a 'supererogatory action' is so urgently needed. Beauchamp and Childress describe supererogatory action as having four defining conditions: Optional and beyond what is "demanded by the common morality, intentionally undertaken for the welfare of others" and "morally good and praise worthy" (Beauchamp, Childress 1994 483) Thus it seems fair to say that supererogatory acts are ones conducted in a spirit of generosity and hence would not be out of place in a setting where first world decision makers are making decisions and determining policy that will ultimately influence public health in poor nations. However, within the context of public health, generosity without a well developed sense of justice may be as problematic as justice without generosity. It does seem that a finely-tuned balance of these two virtues is what is required.

- **Integrity:** Integrity is defined as "Strict adherence to a code of moral values, artistic principles or other standards; complete sincerity or honest" (Dictionary Editors 1987 p. 799). Integrity implies habitual honesty. Being honest or telling

the truth now and again does not amount to integrity. Integrity is a virtue that seems an obvious fit within the context of most professions but particularly public health. Rawls described truth as the first virtue of systems of thought (Rawls 1999 p. 3). Not much really needs to be said about the value of integrity as an essential part of the practice of public health. It needs to operate at all levels from transparency of information on the ground to fiscal management of public funds at a high institutional level. Some may argue that there may well be instances when the full truth is undesirable, or not in the public interest. However these instances should be very rare. A public health practitioner would need to be sure that the other virtues on this list are 'firing on all cylinders' before taking a decision or developing a policy that was less than truthful.

- **Courage:** Courage is one of Aristotle's cardinal virtues, midway between rashness and cowardice or "a mean state in relation to feelings of fear and confidence" (Aristotle 2004 III,vi,1115a8) He discusses it at length, mainly in the context of a military or statesmanship milieu. For Aristotle the greatest example of courage is to have no fear in the face of an honourable death. Hopefully this won't apply to a public-health practitioner! However, there is no doubt that courage, not impulsiveness or cowardice, manifested as willingness to engage tough issues, is needed by public-health policy- makers. Those at the coal-face will surely also need it from time to time. Courage is needed by policymakers at the WHO when implementing measures to control an influenza pandemic just as it is needed by doctors implementing the policy on the ground. An example of such courage in action was demonstrated by doctors working at Manguzi hospital in Northern Kwa-Zulu Natal who, daring to go against the provincial minister of health, changed the PMTCT policy in their area to one that was scientifically proven to be superior, and which had already been implemented in other parts of South Africa. Their act of courage resulted in suspension and disciplinary action[55].

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[55] See TAC website: http://www.tac.org.za/community/node/26 (accessed 11.06.09) This URL contains both a TAC "Statement on disciplinary action against Dr Collin Pfaff" dated 18 February 2008 as well as

- **Empathy:** According to Kopelman, "empathy or "einfuhlung" (feeling into) was invented by the German philosopher Robert Vischer [in order] to distinguish [the concept] from sympathy (feeling with)" (Kopelman 1995). She notes that empathy now has burgeoning meanings, but that in philosophical literature it is used in two different senses, the second of which she terms a "philosophical disposition":

> In the first use, empathy means we project our own attitudes, values, beliefs, perspectives, feelings, emotions, or passions onto another whether we do so justifiably or not. The second sense of empathy focuses upon our reasons for supposing our judgements have merits. Empathy in this second sense is a philosophical disposition because it presupposes we can give or defend reasons justifying our projections. This often involves showing that we understand the other person's situation, point of view, emotions, feelings, needs, expectations and relationships (Kopelman 1995 p. 800).

It is this philosophical disposition, often stated in common parlance as the ability to 'walk in someone else's shoes', which makes empathy an essential virtue for public health practitioners. Empathy means that I will actually try and understand what it must be like to have MDR-TB and be isolated or unable to support my family, or to be the victim of domestic violence or even to be a drug addict. Within the context of public health, empathy means doing your homework properly and really understanding what a prevailing set of circumstances truly means for those living within that context. Having sympathy or feeling sorry for certain groups of people is not good enough. It will not result in the kind of real insight into what is necessary to develop public-health interventions that will result in good overall outcomes. Spinoza

has said that "a man who lives according to the dictates of reason, strives as far as he can not to be touched by pity," because it is other virtues such as love or generosity that should motivate us to want to help our fellow man.[56]

'Solidarity' is another term that is sometimes used to describe a desirable value, principle or perhaps virtue, particularly within a public-health human-rights context. Is solidarity a virtue? The concept seems closely associated with empathy. However, somehow *my own* personal interests do seem to be incorporated into the notion of solidarity, even if not openly declared. Comte-Sponville is quite critical of the term solidarity. He notes that in socio-political vernacular it has become a substitute for equality and at times justice and generosity.

> I set solidarity aside, leaving it in its own world, the world of interests, corporatisms, and pressure groups, whether convergent or competing, global or parochial, legitimate or spurious……Let us not delude ourselves. Africa and Latin America do not need our solidarity; they need justice and generosity (Comte-Sponville 2001p. 89).

- **Trustworthiness:** Trust is the firm reliance on the integrity, ability or character of another (Dictionary Editors 1987 p. 1615). Trust involves committing something into the care of another and being confident that he will indeed take proper care. To be trustworthy means that I warrant your trust; I can be depended or relied upon to do whatever it is you have trusted me to take care of. Beauchamp and Childress have identified five focal virtues for the practice of medicine, trust being one of them. They also note that "trust is a fading ideal in contemporary healthcare institutions" (Beauchamp, Childress 2001 pp.34-35). This discussion is primarily within the context of clinical medicine; however, within the public-health domain trust and trustworthiness need to remain central values. Earlier I quoted an example that illustrated how a

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[56] As referenced by Comte-Sponville (Comte-Sponville 2001 p. 107)

hypertension screening programme in a community in the US with a low socioeconomic status was abandoned because a cost-benefit analysis illustrated that focusing resources on those already diagnosed with hypertension rather than finding new cases, would be more cost efficient. Such an approach may represent a neglect of community trust and a deficiency of trustworthiness by those involved in health-care programme development. Public-health professionals must be able to be trusted by both civil society and by state and other institutions that fund them and their initiatives. This will undoubtedly involve a delicate balancing act, involving the exercise of some of the other virtues described here as well.

- **Discernment:** Discernment or prudence is very similar to *phronēsis* (translated as prudence in the *Nichomachean Ethics*) or practical judgement and discussed earlier (Pages 52-54)[57]. The current use of the term 'prudence' is somewhat different though, which is why I prefer 'discernment'. Prudence is used in a fairly narrow sense as "careful with respect to ones own interests; circumspect or discreet" (The Editors 1987 p. 1241). Comte-Sponville notes that "[w]ithout prudence, the other virtues are merely good intentions that pave the way to hell" and that "prudence is so burdened with history that it is inevitably the subject of misunderstanding" (Comte-Sponville 2001p. 31). Discernment brings "sensitive insight, acute judgment, and understanding to action" (Beauchamp, Childress 1994 p. 34). It involves the ability to reach decisions without being inappropriately influenced by non-relevant considerations or personal feelings of attachment, dislike or similar, to be able to move to-and-fro as it were, between knowledge of universal moral truths, and an understanding of practical considerations, in order to finally reach a practical moral judgment.

- **Respect or respectfulness:** Plato is attributed to have said that "Zeus gave to men respect and justice as the ordering principles of society" (Jonsen,

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[57] The Greek *phronesis* was apparently translated by the Romans as *prudentia* in their translations of Aristotle and the stoics (. 31Comte-Sponville 2001). 31. See Chapter III, page 44-47 for my discussion of phronesis.

Butler 1975 p. 19). Respect is often described as a principle and various codes or statements of ethics list respect as a core principle (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1979). 'Respect for persons' is closely affiliated with the principle of autonomy; however, 'respectfulness' is also a virtue. To be respectful by nature means to acknowledge human dignity in all persons no matter their standing or status and to understand how important it is to have one's dignity acknowledged and respected. True respectfulness will be accorded to all unconditionally, unlike obsequiousness, which is respectfulness used as a means to an end.

The above list of virtues applies particularly to public health practitioners. However previously I have indicated that this discussion is concerned with two sets of actors, namely those involved as professionals in the practice of public health and 'the public' or those who are recipients of public health policy and programmes. They too are often required to make moral choices that will influence both their own health and the health of those they interact with or are responsible for. Which virtues are most relevant to individuals responding to public health policy and programmes?

This is a difficult question to answer as the scope of potential public health threats and circumstances requiring response or action, in relationship to a particular policy or programme, is so broad. I shall thus not attempt to furnish a complete list here, but rather just focus on what I perceive as the most important virtues required for health related decision making. 'Courage' and 'discernment', discussed above are probably of the most important virtues or character traits required to respond appropriately to public health directives. Individuals lacking these character traits may well choose to ignore important information or fail to take required action for fear of negative or inconvenient consequences. Another pair of virtues that are also likely to be important, are a well developed and integrated sense of 'justice' and 'responsibility'. I need to be responsible about taking decisions that will benefit not only my own health and the health of my family, but also to realise that the decisions I make will ultimately also influence and impact on the health of others. 'Temperance' or self control is one of the traditional

virtues and one particularly relevant to many of the public health problems that are of concern today, such as obesity, HIV/AIDS, alcohol and drug abuse. Aristotle defines temperance quite bluntly. "A man who abstains from bodily pleasure and enjoys the very fact of so doing is temperate; if he finds it irksome he is licentious" (II,iii,1104b5-6). For Aristotle temperance is the virtue involved in the control of appetite, both sexual and physical. A broader interpretation could equate temperance to self-discipline. Well developed self-discipline is certainly needed to make healthy lifestyle choices consistently and to respond positively to public health programmes that caution, for example against smoking or excessive food and alcohol consumption.

Ensuring that virtues guide actions is not easy. It is usually easier to choose to act on either side of the mean rather than the mean itself. As Aristotle says while commenting on the difficulties of the virtues for man, "not every man can find the centre of a circle". He concludes that "…to do these things well is a rare, laudable and fine achievement" (II,ix,1109a29).

One point of concern in this discussion of virtues as character traits of individuals, is the fact that the practice of public health is something that does usually take place in institutions. Can institutions be virtuous? MacIntyre drew a clear distinction between practices and institutions (see discussion on page 64) but at the same time acknowledges their intimate relationship. He emphasises the point that a practice, and by inference those individuals involved in that practice, is always at risk of being corrupted by the pursuit of the external goods which are the primary aim of institutions. Virtuous character traits reside in the hearts of individuals, but a critical mass of individuals within a given institution, may mean that the institution could be considered 'virtuous', or rather that their collective decision-making is likely to display the quality of 'collective *phronēsis'.* However, I believe that even at high-level policymaking, decisions that potentially influence the lives of hundreds of thousands of people are often made by individuals, not groups of individuals (universities are a possible exception). George W.

Bush's policy on embryonic stem cell research and Dr Manto Tshabalala-Msimang's policies regarding HIV/AIDS are two examples that illustrate this point well[58].

A final point that needs to be made is that the development and fine-tuning of the virtues identified above will enable public-health professionals to engage in a process of internal criticism which will ensure that the practice evolves and develops over time, and is able to continually meet new challenges which are so much part of the public health arena. Without internal criticism the practice of public health will become redundant or corrupted by a quest for external goods at the expense of all other considerations[59].

VIRTUE ETHICS AND THE EDUCATION OF PUBLIC HEALTH PROFESSIONALS

It has now been established that public health can be regarded as a practice and that all those involved in this practice ideally need to have a certain character disposition in which the list of virtues listed above is well developed. The next obvious consideration is how this state of affairs will come about. Aristotle was clear on these issues. Virtues are acquired by a process of "moral training" that begins at home but becomes formalised at a later stage. In Aristotle's case his Academy was the arena for such education. He also made it clear that the purpose of this education was to not just to teach theory but to teach people "how to be good" (Aristotle 2004 II, ii, 1103b26-31). The issue of whether or not ethics can be taught is a controversial one. Ruth Macklin has asserted that the answer to this question is both "yes" and "no":

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[58] It is no secret in South Africa that the day Dr Tshabalala-Msimang was replaced as Minister of Health by Barbara Hogan, the greater medical community, particularly the academic community, breathed a collective sigh of relief, as Msimang's policies relating to HIV/AIDS were widely viewed both in South Africa and abroad, as contrary to established scientific knowledge and blatantly negligent. Within weeks of taking up this appointment the new minister displayed qualities of practical judgement and courage that had long previously, if ever, been seen within the SA ministry of health. Her outspoken stance in criticising her own government's refusal to grant the Dalai Lama a visa to attend a discussion forum on peace and human rights unfortunately probably lead to her being removed as Minister of Health, after Zuma's assent to the position of President of South Africa in April 2009.
Barrack Obama wasted no time at all in rescinding Bush's moratorium on federal funding for embryonic stem cell research after his appointment as president of the USA in January 2009. The NIH has just released a new policy allowing the federal funding of embryonic stem cell research. See http://stemcells.nih.gov/policy/2009guidelines.htm Accessed 13.08.2009.
[59] Both Alasdair MacIntyre and Martha Nussbaum have developed detailed accounts of "internal criticism". See (Nussbaum, Sen 1989).

The answer is "no" if the question means to ask whether the attitudes and behaviour of dishonest, mean, uncaring, selfish or arrogant people can be changed as a result of a course in ethics…..Character traits that have taken root by the time people become young adults are not likely to be changed by classroom teaching in ethics. However the answer is "yes" if the question means to ask whether beliefs, attitudes and behaviour pertinent to the work of professionals can be instilled by teaching ethics (Macklin 1993 p. 200).

Perhaps I am simultaneously more naïve and a little less pessimistic than Macklin. I would like to think that the characters of young adults entering into a health science education already are at least a little 'virtuous' and still malleable to a degree. I also think that having a positive effect on the 'beliefs, attitudes and behaviour pertinent to the work of professionals' is in fact developing character and the virtues that combine to make up character.

Another somewhat controversial point that Aristotle made was that his students needed already to have had experience of life and moral decision-making particularly when it comes to the development and teaching of the intellectual virtue of *phronēsis* or practical reasoning. His course was not for those considered 'wet behind the ears' (I,iii.1095a1-15). This point is in contradiction to the previous one, which proposed that we need to get students young enough to be open to change and not fixed in their attitudes. There are undoubtedly advantages and disadvantages to both perspectives. Certainly within the realm of public health, most students have more life experience, as the field of public health is generally entered into at a post-graduate rather than undergraduate level.

Jonsen and Hellegers developed a three-tier theory of medical ethics that was founded on an ethics of virtue (Jonsen, Hellegers 1974). They note that instructing medical professionals to be virtuous by way of ethical codes is no guarantee of virtuous behavior. They believe that this will only come about through a process of "socialization" that needs to occur from within the profession. They further note that developing a multiplicity of ethical codes and rules, especially if they are supposed to be self-

enforcing, which most professional codes are, is a futile exercise unless they are addressed to those who already possess the virtues required of their profession.

The topic of moral education is a vast and controversial one and has been greatly influenced by the American psychologist Lawrence Kohlberg who identified six stages of moral development (Kohlberg, Hersh 1977). A great deal has also been written about a virtue-ethics approach to education by many authors, particularly David Carr (Carr, Steutel 1999) (Carr 1996). The *Journal of Philosophy of Education* devoted an entire volume to papers discussing moral education and teaching within the context of MacIntyre's work, particularly in relation to his concept of a practice.[60]

Exploring 'moral education' per se in any depth, is beyond the scope of this discussion and I shall thus confine my discussion to one aspect only: the possible positive influence virtue ethics may conceivably have on the formal education of the wide range of professionals (doctors, nurses, teachers, economists etcetera) who may become involved in the field of public health. The teaching of "ethics" is usually incorporated into Health Sciences curricula to a lesser or greater degree, often in a didactic manner. Ethical theories such as utilitarianism, deontology, rights-based theories etcetera are introduced their application to particular situations illustrated through the use of cases[61]. Students are sometimes asked to apply different theories to one particular case and then discuss and eventually choose which they feel is best, in a manner which seems to me to be rather Nietzschean. I am not disputing that this approach may have a place and some value within the context of healthcare education generally, but it is ethics education that is removed, remote, concerned with the third person (patients or 'clients' as they are now called in certain disciplines) and has nothing really to do with *me* and how I plan to live out *my* professional life as a public health decision maker and my life in general.

A virtue-ethics approach to the moral education of health professionals I think would be somewhat different; not just about theory, but about ultimately producing 'virtuous

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[60] *Journal of Philosophy of Education*, Vol.37, No 2, 2003.
[61] 'Casuistry' and the use of 'cases' in public health moral decision making will be discussed in more detail in the next section:" Context, Cases and Rules"

healthcare professionals with finely-tuned capacities of 'practical wisdom' or 'regulative ideals'. As such, it is an approach that may make educators feel nervous, because it could be interpreted as crossing the line that divides teaching and preaching. Preaching is unlikely to be successful either. Exhorting students to develop moral virtues according to a prescribed list (as I have identified above) has no guarantee and probably little likelihood of producing the desired result. The challenge of developing a curriculum that can equip future public- health professionals with the virtues, particularly the intellectual virtues incorporated in the notion of practical wisdom they will need when faced with tough moral judgments in the future is immense. I do not have a ready answer as to the most effective way of meeting this challenge, but if we accept that virtue is a type of knowledge then it follows that virtue can indeed be taught (Begley 2006). Comte-Sponville notes that "[i]f virtue can be taught, as I believe it can be, it is not through books so much as by example" (Comte-Sponville 2001).

Martha Nussbaum has identified three key capacities or values that she sees as crucial to "equipping students well for the interlocking world in which they live" (Nussbaum 2003 p. 269). This particular article was written in the context of legal education, but was derived from previous work addressing academic education in general (Nussbaum 1997). I think her comments are equally applicable to this discussion. The three capacities are part of an approach she calls "cultivating humanity". The first core value or capacity is "Socratic Self-Examination"[62] or a capacity for critical examination of oneself and one's traditions. This capacity requires the ability to reason logically and "to test what one reads or says for consistency of reasoning, correctness of fact, and accuracy of judgment" (Nussbaum 2003 p. 269). It requires students to think reflectively about their own values and the values of the society in which they live. They need to be able to identify those values that are solid and criticize those values that are identified as being on shaky ground. One of the ways of achieving this will be to teach students to analyse, present and defend clear arguments. Also, exercises that promote value clarification and the ability to think deeply about who they (as individuals) are and what they stand for and what constitutes for them a 'good' (in an Aristotelian sense) life,

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[62] Socrates most famed and oft quoted expression is "an unexamined life is one that is not worth living"

would need to be developed and incorporated into a health science or public health curriculum.

Nussbaum's second capacity is what she calls "World citizenship". "Citizens who cultivate humanity need, second, an ability to see themselves as not simply citizens of some local region or group but also and above all, as human beings bound to all other human beings by ties of recognition and concern" (Nussbaum 2003 p. 270). This may initially seem contrary to what has been said previously about the central role that 'tradition' and local context play in the moral life. However, as we have seen MacIntyre vigorously defended his, and by inference Aristotle's, ethics against accusations of relativism. The core of Aristotle's moral scheme concerns "man as human being", whose overall *telos* or function, that of achieving *eudaimonia,* can only be achieved by living in accordance with virtue. This so-called 'functions argument' (elaborated in Chapter III) is common to all humankind and can be interpreted as constituting, in part, our common humanity. "Cultivating our humanity in a complex interlocking world involves understanding the ways in which common needs and aims are differently realised in different circumstances" (2003 p. 270). Public-health issues so often transcend geographical and cultural boundaries, so finding ways of developing students of public health into "world citizens" who can connect in a meaningful way with other cultures and communities must be seen as an essential part of their education.

The third capacity identified by Nussbaum as crucial to students is the 'narrative imagination'. This is similar to what I described above as empathy; the ability to "think what it might be like to be in the shoes of a person different from one-self, to be an intelligent reader of that person's story, and to understand the emotions, wishes and desires that someone so placed may have." She notes in accordance with Kopelman, that the narrative imagination is not uncritical as we "always bring ourselves and our own judgments to the encounter with another" (Nussbaum 2003 p.271). However, we cannot even begin to assess or judge others responsibly until we have developed an understanding of their world as seen from their eyes. For example, implementing a workplace peer TB or Antiretroviral Treatment adherence programme without trying to understand stigma from the perspective of one suffering from TB or HIV, may well mean

that the programme is doomed to fail from the outset. This ability (of being able to see the world through the eyes of another), Nussbaum believes, is cultivated particularly by exposure to literature and the arts and by confronting students with works that "deal vividly with the experience of minority groups in their own society and of people in distant nations" (2003 p.271). She concludes by commenting that "the moral imagination can often become lazy, according sympathy to the near and familiar, but refusing it to people who look different" (2003 p. 271).

There may well be aspects of the above three capacities that are already incorporated into South African Health Sciences curricula at both undergraduate and postgraduate level. However, my personal experience as both a student and a teacher indicates that generally this approach is not followed. Rather, didactic lectures on topics such as "Scientific Integrity" or "Research Ethics" or "On being a professional" are slotted in, here and there, at various points in the curriculum. It may require a great deal of innovative thinking 'outside of the box' to develop both undergraduate and postgraduate curricula that force students to confront their own humanity. By engaging in a process which develops at least these three capacities, students would hopefully become the kind of professionals that Aristotle would truly regard as having the attributes of practical wisdom needed to navigate the complex moral dilemmas prevalent within the domain of public health.

Another perspective on this topic is provided in the book *Emotional Intelligence* (Goleman 1996). The concept of 'emotional intelligence', a term first used by Yale psychologist Peter Salovey, has become a very popular one, particularly in the fairly new field of 'corporate management development' and 'leadership coaching' where Goleman's book has become something of a bible. Goleman, a psychologist not a philosopher, starts his book with a preface entitled "Aristotle's challenge" and comments:

> In the Nicomachean Ethics, Aristotle's philosophical enquiry into
> virtue, character and the good life, his challenge is to manage
> our emotional life with intelligence. Our passions, when well
> exercised, have wisdom; they guide our thinking, our values

and our survival. But they can easily go awry and do so all too often. ….The question is how can we bring intelligence to our emotions…?

Goleman, argues that 'emotional intelligence' can be formally taught and devotes his book to explaining how this can be achieved. This concept of 'emotional intelligence' is, I believe, very similar to Aristotle's concept of the intellectual virtue of *phronēsis* or practical wisdom. Although the concept of emotional intelligence is developed and explored by Goleman and many others writing in this field, from an 'educational psychology' perspective rather than a philosophical perspective, these arguments do support the notion that the rational use of emotion guided by the intellectual virtue of phronesis can be formally taught and incorporated into educational curricula, at least to some degree.

CONTEXT, CASES AND RULES

The previous discussion illustrates that 'virtue ethics' involves the notion of *phronēsis* or 'practical reasoning'; the ability to exercise certain character traits in a way that guides emotions and incorporates all aspects of a particular set of circumstances into an eventual moral judgment. Moral judgments are thus circumstance specific and do not necessarily always adhere completely to a particular norm or rule. Jonsen has succinctly summarised this position:

> Thus we side with Aristotle, who affirmed that "*phronēsis* deals with the ultimate particular and this is done by perception (*aisthesis*) rather than science (*episteme*)" (VI,1142a26). The perception or *aisthesis* of which he speaks in my reading of the text, is not an insight or intuition into the essence of the problem, but the appreciative sight of a constellation of ideas, arguments and facts about the case, seen as a whole. Justification of any particular moral claim comes rarely from a single principle, as many theories would like, but usually from the

convergence of many considerations, each partially persuasive but together convincing with plausible probability (Jonsen 1991 p.15).

Virtue ethics seems to acknowledge and accommodate the 'grey' in moral decision-making. Hursthouse's application of virtue theory to abortion illustrates this point very well (Hursthouse 1991). However some critics do see this 'flexibility' as a major weakness (Fuller 1998 p. 49). Part of the ongoing development of virtuous character traits occurs by using experience gained in one set of circumstances and applying it to another. A virtue ethics approach to moral decision-making seems to be closely aligned with 'Casuistry', a method of ethics that has medieval roots but which has been redeveloped within a bioethics context. Lessons learnt from one 'case' get applied to the next similar one, until principles are derived from cases; that is, the cases come first, then the principles (Arras 1991, Jonsen, Toulmin 1988).

Much energy has been spent on a chicken-and-egg debate as to whether or not cases give rise to principles, or in fact the principles were there in the first place (Beauchamp, Childress 2001 393-397). Historically, within the context of public-health ethics, cases have been used extensively to frame, illustrate and shape the development of this field. A peek into many of the recently published anthologies on the topic will support this assertion.[63] At the time of finalising this dissertation (2009), the world finds itself on the brink of an influenza (so called 'swine flu' or H1N1) pandemic. There is no doubt that lessons learnt from the SARS (Sudden Acute Respiratory Syndrome) epidemic of 2003, and other influenza epidemics of the past, will be used by public-health policymakers to navigate some of the ethical and other dilemmas likely to arise in the course of this pandemic (Fogarty International Centre 2009). Using lessons learnt from one set of cases and applying them to others seems to be common sense, and the issues as to whether or not there are some or other prima-facie principles guiding action behind the scenes, so to speak, of minimal relevance. Childress et al describe casuistical reasoning as indispensable to a conception of public-health ethics

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[63] See for example the Nuffield Council Report which uses a range of case studies such as Infectious Disease, Obesity, Alcohol and Tobacco etcetera to explore the domain of public health ethics (Nuffield Council on Bioethics 2007).

(Childress et al. 2002). Previous discussion also indicates that a "virtue ethics" moral decision-making paradigm is not, by definition, completely devoid of rules or principles.

What is important here is to what extent virtue ethics can contribute positively towards an ethics framework for policy making. Policies usually do equate to a collection of fairly inflexible rules and are often broadly applicable over a wide scope of varying circumstances. They are generally quite 'black and white' and do not easily accommodate so-called 'grey' areas easily. In fact a policy that does may well be one that is considered to be applied unfairly or inconsistently. A virtue-ethics or quasi-casuistical approach to public-health policy would acknowledge that there needs to be some form of reflexivity between the policy and the 'on-the-ground' context and circumstance. The broader the global reach or scope of a policy, the greater the degree of reflexivity required. Policies which are very specific to a particular local context, can in themselves accommodate and respond to the particular demands of that context and can thus possibly be more rigid. At the other extreme, policies which originate from international bodies such as the WHO need to have mechanisms built into them which accommodate and even require some form of local and context-specific modification and validation.

Daniels' and Sabin's "Accountability for Reasonableness" is not a public-health policy as such, but a four-step method for developing policy for just health-resource allocation in resource-limited contexts. Four conditions of policy development are outlined. The third condition is labeled the "[r]evision and appeals condition [and involves] mechanisms for challenge and dispute resolution [and] opportunities for revision and improvement of policies in the light of new evidence or arguments" (Daniels, Sabin 2002 p. 45). Although I am sure these authors were not thinking much about virtue ethics or casuistry, their approach is an example of the kind of necessary reflexivity referred to earlier. I think it would be foolish to imagine that public health could do without policy altogether and that virtue-inspired public-health practitioners could navigate easily from case to case dishing out tailor-made solutions to problems, as they go. My intention, as previously stated, was never to attempt to propose a virtue-ethics coup-d'état of the ethical domain of public health, but to identify areas where

virtue ethics could influence the discourse. I think finding ways to achieve a balance between local context and 'cases', and overarching policies, as discussed here, is one such area.

MOTIVE

In Chapter III I discussed the essential role that 'motive' plays in a virtue ethics moral paradigm. The underlying motive guiding choices or action are of critical importance when attempting to establish if such action is 'good'. The question that I now need to consider is, why is it so important to interrogate 'deep' motive within the context of public health? I think the answer to this question lies in considering the following questions:

1. Are the aims of a public-health programme always roughly equivalent or in accordance with the motives or real reasons behind the programme?
2. Are there sometimes instances where the real or deep motives for a particular programme or policy are partly or completely concealed and at odds with the purported aims?
3. Are there ever good reasons for concealing underlying motive in a public health context?
4. Would a commitment to exploring and declaring motive, or 'deep reasons', contribute to transparency within the context of public health?
5. Would such transparency be a good thing?

I believe that in most cases the stated aims of policy or programme do tie in closely with the underlying motives or reasons for the programme. However, I do believe that there are many examples in the history of public health where the 'real or underlying reasons for a particular policy have not been fully declared or transparently stated. The reasons for this are quite obvious. The domain of public health is influenced and controlled by a complicated political and economic web of conflicting and intersecting interests and powers. The most obvious example of a public-health issue which is clearly complicated by the competing interests of different parties is that of tobacco control. A close look at

the history of tobacco control and anti-smoking campaigns over the last 50 years, in a country like the USA, where the tobacco industry undoubtedly wielded a significant amount of economic and political power and influence during the decades when the scientific evidence against smoking was rapidly accumulating, would support this claim. Paediatric vaccination policy in the USA is another area of public health which has been embroiled in controversy with allegations that those responsible for developing and implementing policy often have financial conflicts of interests involving pharmaceutical companies that manufacture the vaccinations (Committee report. 2000).

Sometimes such influence may mean that rather than policies or programmes having hidden motives or the hidden motives (in the form of undeclared conflicts of interest) in fact result in such programmes being delayed, indefinitely postponed or completely unrealised. For example political back-scratching and expediency may well have been the underlying motive for the protracted delay in the implementation of a Prevention of Mother to Child HIV Transmission (PMTCT) programme in South Africa in the 1990's. Cost-effectiveness Analysis (CEA) may also play a dominant role in the development and implementation of programmes or policy and the influence of CEA data such as Disability Adjusted Life Years (DALYs) and Quality Adjusted Life Years (QALYs) on policy, particularly related to healthcare-resource allocation, may often not be wholly evident or transparently declared. (Brock, D.W 2004).

Various ethical frameworks have been proposed for evaluating public-health programmes. Kass proposes a six-point framework (Kass 2001); Gostin and Mann's human- rights public-health policy framework has seven points (Gostin, Mann 1999). Both require, first and foremost, that the goals or purpose of the programme are clarified or stated. However, neither of these frameworks specifically prompt public-health policymakers themselves, or those in a position to evaluate the policy, to critically explore the distinction between purported aims and *deep* motives or hidden agendas. Public-health history has demonstrated over and over that the assumption that they are one and the same cannot always be safely made.

VII. THEORY AND PRACTICE: CRITICAL PERSPECTIVES

INTRODUCTION

> Assuming, then, that we have given (in outline) a sufficient account of happiness and the several virtues, and also of friendship and pleasure, may we regard our undertaking as now completed? Or is the correct view that (as we have been saying) in the case of conduct the end consists not in gaining theoretical knowledge of the several points at issue, but rather in putting our knowledge into practice? In that case it is not enough to know about goodness; we must endeavor to possess and use it, or adopt any other means to become good ourselves (Aristotle X; ix. 1179a33 -1179b4).

Applying philosophical theory to real life context is challenging. Albert Jonsen, in an article whimsically entitled "Of Balloons and Bicycles", starts by commenting: "The relationship between ethical theory and practical judgment is not a happy or a stable one; while the two live together in some fashion, the terms of the cohabitation are not clear to most interested observers" (Jonsen 1991 p. 14). In this article Jonsen uses a picture of a statue that was given to him by one of his students, as a metaphor for the relationship between theory and practice. He supposes that a man is riding a bicycle and attached to the handlebars is a hot air balloon, flying high in the sky. The man and the bicycle are likened to practical judgment and the hot air balloon to theory. Jonsen makes several points about this analogy. First, the philosophical problem of the relationship between theory and practice is much older than bicycles and hot air balloons and is one that greatly concerned both Plato and Aristotle. Second, the view from the balloon is of the wide landscape, but lacks the detail visible from close up. On the other hand, the view from the bicycle is of the "bumpy road ahead, the fallen tree limbs and the dogs in bushes" (1991 p.14) Theory is "free floating" and not troubled by ground level realities. One can read theorists like Rawls and "five hundred pages go by without a detail of the casuists' "who, what, when, where, why and how?" (1991 p.15). Jonsen comments wryly on this point. He believes that all theorists, including Kant and Plato feel that "the higher one can get" the surer one can be of "where you are". (1991 p.15)

The third point, related closely to the second is that theory "floats free" while the bicycle needs to have its wheels pumped up and be steered. Practical reasoning and judgment require that one's eyes are focused on the potholed road ahead and can occur with little recourse to theory, only a glance every now and then at the balloon for guidance. Jonsen's interpretation of practical reasoning or *phronēsis* is very similar to that of Bernstein.

> Thus we side with Aristotle, who affirmed that "phronēsis deals with the ultimate particular and this is done by perception (aesthesis) rather than science (episteme)" (6.1142a). The perception or *aesthesis* of which he speaks, in my reading of the text, is not an insight into the essence of the problem, but the appreciative sight of a constellation of ideas, arguments and facts about the case, seen as a whole. Justification of any particular moral claim comes rarely from a single principle, as many theories would like, but usually from the convergence of many considerations, each partially persuasive but together convincing with plausible probability. (Jonsen 1991 p. 15)

In this dissertation I have engaged in a theoretical discussion of the application of virtue ethics to public health policymaking. In chapter five I applied virtue ethics theory indirectly to the domain of social justice by considering how a theory of social justice, closely aligned to key elements of virtue ethics would be constituted. I concluded that the theory of justice proposed but Faden and Powers was in fact one such theory. In chapter six I attempt a more direct application of virtue ethics to the domain of public health by adapting MacIntyre's model of a practice to the domain of public health, and by considering the implications that virtue ethics would have for public health as a profession, both in terms of the virtues required and the moral education of public health professionals. In this final chapter, before my conclusion, I plan to attempt to bring theory and practice together more closely, bearing in mind Jonsen's warning about the complexity and pitfalls of such an endeavor. I critically consider some of these

theoretical perspectives within the context of actual public health issues. I shall use specific examples of public health problems that are of current relevance to South Africa, and ask to what extent a virtue ethics approach is relevant for addressing them. South Africa is a particularly appropriate and challenging context to frame this discussion, as it has of the highest incidence of TB and HIV in the world but, as a country with arguably parallel and coexisting first world and developing world economies, it also faces many of the public health lifestyle and behavior related problems that are prevalent in Western first world economies, such as obesity, cardio-vascular disease, drug and alcohol abuse.

This dissertation specifically focuses on the possible application of virtue ethics to the moral dimension of public health *policymaking.* In order to make public health policy, public health issues need to be considered and thought about at many levels and in many different environments and domains. These include international economic and political discussion and policy making forums, national government, both from an internal and a trans-border perspective, local government and discussions with and among other stake holders such as Civil Society Organisations (CSOs) and NGOs. In order to explore this in more detail I shall divide the sphere of public health policymaking roughly and no doubt somewhat artificially, into two broad levels or environments. The first and largest part of this discussion will focus on public health policy and programmes at a national and community level. It is particularly at this level that virtue ethics has, I believe some application. The second part of this discussion will concern public health at a 'macro' or global level. It is in this context that virtue ethics, as theory that can inform public health policy, meets its toughest challenge and may be found wanting.

PUBLIC HEALTH POLICYMAKING AND PROGRAMME DEVELOPMENT AT A NATIONAL AND COMMUNITY LEVEL

I concluded chapter two with the following working definition of public health. *Public health is about the health of 'societies' and 'communities' rather than the health of individuals and it involves all those spheres of health, where collective action by governments and other organizations can make a positive impact.* I have also argued

that the moral foundation of public health ought to rest on a 'good' concept of social justice. The aim of this section is to consider some of the theoretical elements discussed in previous chapters, in the context of actual public health problems. In chapter six I adapted MacIntyre's model of a practice to public health. In this model, discussed and illustrated in the previous chapter, a sufficiency of six dimensions of well-being is used as the 'benchmark of excellence' for assessing institutions and practices as they exit in actual circumstances, for identifying appropriate remedial action and to guide future public health policy development. To accomplish this, public health professionals need a wide variety of skills, such as expertise in epidemiology and biostatistics, or a master degree in public health (MPH) as well as particular virtues or character traits, the most important of which is arguably *phronēsis* or practical wisdom or reasoning. The goods or outcomes of such programmes are both quantifiable outcomes, which I called 'external goods' and unquantifiable outcomes or 'internal goods'. Both sets of outcomes are important and often the unquantifiable outcomes such as fostering tolerance or decreasing levels of stigma within a community are as important as the quantifiable outcomes.

I also noted in the introduction to this dissertation that for the purposes of this discussion, moral agents could be considered to fall into one of two categories. They are either public health professionals, or members of the public, that is programme or policy recipients. The application of virtue ethics theory is applicable to both categories of moral agents, public health practitioners (using the term practitioner in a broad and inclusive manner, to mean anybody involved in both the development and implementation of public health policy and programmes) as well as the recipients of public health policy who are actors in their own life stories and require certain virtues or character traits to enable them to make the kinds of choices that will contribute towards a state of optimal wellbeing or flourishing rather than act as a barrier to achieving such wellbeing.

 I shall consider these theoretical perspectives within the context of three specific public health issues, focusing on the application of different theoretical aspects in each example. These examples relate to public health in South Africa in particular. The first

problem that I shall discuss is that of alcohol abuse and foetal alcohol syndrome in rural communities of the Northern and Western cape. This is an example of a public health problem which is fairly (although not exclusively) localised to these specific communities. It is a good example of a public health problem that has arisen from patterns of 'systematic disadvantage' and historical injustice. The second problem I shall reflect on is a case study that involved the management of XDR and MDR-TB, particularly the issue of involuntary hospitalisation that caused such a stir in the media both in South Africa and abroad in the recent past.

The last public health problem, I shall explore, involves the prevention of HIV, focusing particularly on sexual behavior. In this example I shall particularly consider the role of programme recipients as moral agents, within the context of health promotion and prevention programmes.

Foetal alcohol spectrum disorders (FASD) as a public health problem.

South Africa has the highest rates of foetal alcohol syndrome in the world with a prevalence rate of more than 40 cases per 1000 children in the Northern and Western Cape and 20 cases per thousand in Gauteng compared to a rate of 0.05 to 2 cases per 1000 births across the United States (May et al. 2005). Social scientists and clinicians have researched this problem in various communities in the Western Cape and have identified a list of associations with FASD such as binge drinking, low socioeconomic status, high levels of family alcohol abuse, poor levels of education and being unmarried (May et al. 2008). Low self efficacy, poorly developed life goals and having limited interests are also associated features (May et al. 2005). Various strategies for addressing the problem have been made. The majority of these proposals focus on "targeting high risk women" and surveillance methods for identifying alcohol abuse in pregnancy (Rosenthal, Christianson & Cordero 2005).

The problem of foetal alcohol abuse in the agricultural towns and communities of the Western and Northern Cape has very deep historical roots that are intertwined with the injustices of both apartheid and pre-apartheid colonialism and the infamous 'dop'

system, whereby farm workers were paid, in part, with alcohol. Although this history is now in the past, its legacy is still very much in existence today. To ignore these roots and to focus on public health interventions primarily aimed at mothers, is to ignore an extensive and complex range of factors which allow this problem to perpetuate. It is to fail to see this as a community and societal problem, rather than just an individual health problem.

The question "How should we live?" or "What constitutes the 'good' for me, my children and my community?" is one that could be incorporated into a FASD public health programme. Much of the research which is currently being done in these communities is focused on identifying the epidemiological variables associated with these patterns of alcohol abuse (Viljoen et al. 2005). The underlying reasons as to why these patterns continue seem to remain largely obscured from view. Evaluating the social institutions, norms and practices from the perspective of sufficiency of six dimensions of well being, not just the dimension of 'health' may well represent an alternative viewing box for the problem of foetal alcohol syndrome. The findings of such an evaluation and the remedial actions that these findings may point to, could assist public health policy makers in developing programmes which are innovative and ultimately effective at a community level.

In 2008 a *FASD Prevention Symposium* (Foetal Alcohol Spectrum Disorders*)* was held in the Western Cape to discuss this problem and presentations were given by a wide variety of participants including academic researchers and public health practitioners. A policy brief was published as a result of this symposium and is reproduced in full in Appendix 1 (FASD Symposium Programme and Proceedings. 2008). This brief summarised the scope and complexity of the problem and proposed five "Key Strategies for FASD Prevention and Support" (p.5):

- Surveillance and Monitoring
- Screening and Brief Interventions
- Awareness raising and education
- Liquor controls

- Research gap

The suggestions covered under these points fall largely directly within the dimension of 'health', although the need to build capacity and educate community leaders such as teachers and religious leaders is included. The role of partners of women who abuse alcohol in pregnancy is only mentioned briefly under "Research gaps" as "In what way can the partner or other family member be incorporated into the brief intervention?" The underlying problem of alcohol abuse has a community wide problem is not addressed or covered in detail in this policy brief.

I plan to adapt the model of 'public health as a practice' that I illustrated on page 167 to this particular problem in some detail, in order to explore both the strengths and weakness of this approach.

I have interpreted MacIntyre's model of a practice to be one that has three core elements and I have portrayed this by three tiers. Every practice aspires to certain 'benchmarks of excellence'. I have chosen Powers and Faden's six dimensions of wellbeing as the benchmarks for this model because, as I have argued in previous chapters, I believe a   conception of social justice should be the foundation of public health policy, and this particular conception is closely aligned with the central elements of virtue ethics. Next, every 'practice' aims to achieve both 'external goods' and 'internal goods'. This 'practice' is the 'practice of public health' and hence I have equated 'external goods' to measurable program outcomes and 'internal goods' to those desirable and important program outcomes which are often very difficult to measure. This differentiation will be illustrated shortly. The third component of a practice is the combination of both skills and virtues need to achieve both internal and external outcomes. MacIntyre's central point is that skills can produce external goods but that a combination of skills and certain character traits or virtues are require to produce the 'internal goods' that are hallmarks of a practice.
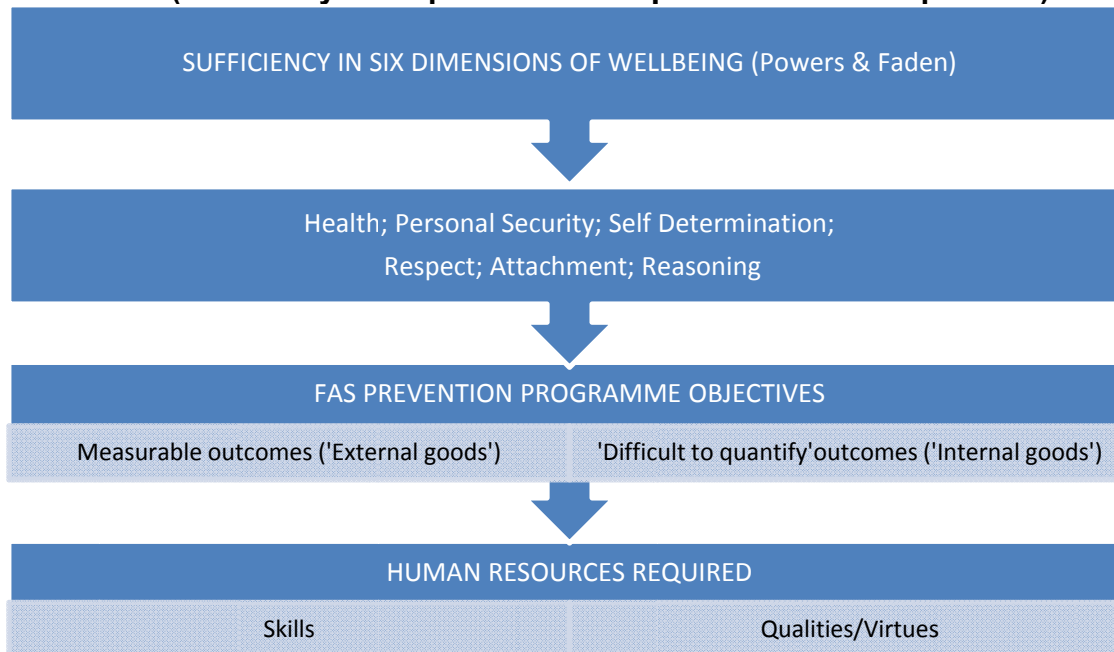
The diagram on the page 196 represents this model of a practice applied to the public health domain of the prevention and management of Foetal Alcohol Spectrum

Disorders. The six dimensions of well being are to be used as yardsticks to assess the "on the ground" context in which such a programme will need to operate and will also be used to develop and shape desired programme aims and outcomes. Programme outcomes are then separated into quantifiable or measurable outcomes (external goods) as well as desirable outcomes that are not quantifiable (internal goods). However, the essential point of this model claims that unless the public health programme successfully addresses both sets of outcomes, it is unlikely to produce only measurable outcomes in a long term and sustainable manner. In order to achieve both internal and external goods, practitioners require a combination of both skills and virtues.

A PUBLIC HEALTH PROGRAMME TO ADDRESS THE PROBLEM OF ALCHOHOL ABUSE AND FOETAL ALCHOLHOL SYNDROME (FAS) IN RURAL COMMUNITIES IN THE WESTERN AND NORTHERN CAPE
(A 'MacIntyre' inspired model of public health as a practice).

SUFFICIENCY IN SIX DIMENSIONS OF WELLBEING (Powers & Faden)

Health; Personal Security; Self Determination;

Respect; Attachment; Reasoning

FAS PREVENTION PROGRAMME OBJECTIVES

Measurable outcomes ('External goods')	'Difficult to quantify'outcomes ('Internal goods')

HUMAN RESOURCES REQUIRED

Skills	Qualities/Virtues

Measurable Outcomes (Examples):
- % reduction in babies born with suspected FAS over a 5 year period.
- % uptake of alcohol prevention community based programmes.
- % uptake of alcohol abuse treatment programmes etcetera

'Difficult to quantify' outcomes (Examples):
- Improved self esteem of community members , particularly women
- Improved self efficacy of community members, particularly women
- Improved levels of community solidarity and mobilization around the problem of alcohol abuse
- Improved levels of mutual respect
- Improved self determination etc

Skills:
- Epidemiology
- Sociology
- Psychology
- Counseling skills
- Research skills
- Clinical skills

Qualities / Virtues
- Empathy
- Trustworthiness
- Practical reasoning
- Integrity
- Solidarity
- Tolerance

<u>Evaluation of six dimensions of well-being for a rural FASD and alcohol abuse prevention programme.</u>

I shall start by considering each of the six dimensions of well-being within the context of rural communities in the Western Cape, South Africa that have a high prevalence of FASD. These six dimensions could be used to guide questions, (including those posed by researchers across multiple disciplines) and ultimately to develop 'benchmarks of sufficiency' in each area, which would serve as the 'standards of excellence' for a comprehensive and holistic community wide alcohol abuse prevention programme, which would in turn address the root causes of FASD.

'Reasoning': Epidemiological research has associated FAS in children with a low level of maternal education. But a far deeper analysis of the aspects of knowledge and education within this context, is required. The dimension of 'reasoning would require the public health programme developer (PHPD) to find answers for the following questions. Some of these answers will already be available or accessible to the PHPD as for example publications or reports on the results of many of the research projects which have been done in this field. Some of the questions will point at areas where there are gaps in research or in to areas where a specific body of knowledge or understanding still requires exploration. Examples of such questions are:

- What is the level of understanding of FAS at a community wide level, in this particular community?

- If there is a degree of knowledge and understanding, what are the barriers that prevent all community members, including community leaders, partners, and other family members from using this knowledge to provide a web of support for pregnant women? How can this dimension be built into a public health programme that seeks to makes this a community issue, rather than a predominantly women's health issue?

- What educational support programmes are offered to children diagnosed with FAS in order to maximize their potential and avoid a perpetual cycle?

- How are families with FAS children supported from an emotional and educational perspective? What facilities are available to achieve this and how can they be improved?

'Personal Security': In this setting personal security can mean a lot of things, including freedom from domestic abuse and violence and food security. The policy brief referred to above acknowledges that research in these communities where conditions of poverty prevail, has revealed that women often feel isolated and hopeless, are victims of domestic abuse and resort to substance and alcohol abuse as a result. The need to target men every bit as much as women in FASD prevention programmes is self evident, as well as the need for programmes that address all these issues as holistically as possible, rather than focusing on only one manifestation of a deeply entrenched community based problem. Thus this dimension will encourage the PHPD to ask:

- How can programmes that jointly address alcohol abuse and domestic violence be developed and effectively implemented?

- What role should community structures such as churches and Civic Organisations play in such programmes and how can these organizations be integrated into such programmes?

'Self-determination': Research by May and others has linked "low levels of self-efficacy"[64] with FAS (May et al. 2005 p.1190). Self-determination is what Isaiah Berlin has called positive freedom:

> I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody; a doer – deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal, or a slave incapable of playing a human role, that is, of conceiving goals and policies of my own and realizing them (Berlin 1958 p.160-161).

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[64] Self-efficacy is a concept developed by psychologist Albert Bandura as part of his social cognitive theory and defined as a belief in one's ability to successfully complete a task (Bandura.1993)

The dimension of self-determination, if used by the PHPD as a yardstick to identify deficiencies that impact directly on FASD as a public health problem, may use some of the following questions and their respective answers to shape a prevention programme:

- How do women and others in these communities understand the concepts of self-efficacy and self-determination?
- What represents a 'sufficiency of self-determination' and how can steps to improve this dimension be incorporated into a holistic alcohol prevention and FASD public health prevention programme?
- What factors exist in the community that undermine self determination and perpetuate a legacy of hopelessness?
- What skills development programmes exist? How can these be improved?
- What life skills programmes exist? How can the uptake of these programmes be increased? Are they effective and how can they be improved?

'Attachment': Buchanan uses the example of alcohol abuse to illustrate his argument that successful health prevention programmes need to engage with the core aspects of human nature and how we perceive ourselves situated in the world around us. (Buchanan. 2000). He notes that despite billions of dollars of money spent on research into alcohol abuse, the most effective treatment to date still remains Alcoholics Anonymous. This therapy simply involves groups of people who identify themselves as alcoholics, meeting regularly to discuss their problems and to support each other. There are no therapists or other trained healthcare professionals involved. The success of AA seems to draw on our need for social inter-connectedness and to hone in on a more holistic concept of well-being; one that acknowledges that 'bonds of human attachment', self worth, self respect and respect from others, are required to enable individuals to make the kind of choices they need to make to lead fulfilled and 'healthy lives.

Our universal need for human interaction and support has been used successfully in other public health programmes in Southern Africa. For example Mothers2Mothers

(m2m) is a HIV mentoring programme and hotline, where HIV positive mothers are employed as mentors and peer educators and counselors specifically as part of the national PMTCT programme[65]. The aim of this initiative is to improve both maternal and infant outcomes. Thus the Foetal Alcohol Prevention Programme Developer or Development Team may ask:

- What is the potential for similarly mentorship programmes to be used in this context, involving for example mothers with children diagnosed with FASD as mentors to pregnant mothers, or women who are recovering alcoholics and actively involved in an alcohol abuse programme as mentors?

- Would support groups for men whose partners are pregnant be effective in this context?

- What incentives could be used to encourage membership of such groups?

'Respect': Respect refers to both self respect and respect for and from others. As noted previously it is an essential component of human flourishing and human dignity. It is a concept closely interwoven with self esteem, self efficacy and self determination. Respect is notably absent in contexts of domestic abuse, abusive and disempowering labour practices which may still be prevalent on farms in some rural communities, and self abuse in the form of alcohol and substance abuse. The dimension of 'respect' when used as a benchmark in the context of a FASD prevention programme may prompt these questions and innovative ways to answer them:

- How can the value of mutual respect be strengthened within rural communities at all levels, that is among farm workers and their partners, as well as between employers and workers?

- What community practices undermine mutual respect and how can they be addressed? How can land owners and employers be positively involved in addressing these issues? Under what circumstances can landowners and others be held accountable, particularly for making cheap liquor easily available?

- What remedial action can be taken to address instances of abuse and increase mutual respect?

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[65] See www.m2m.org

'Health': The dimension of health in this context relates directly to the physical and mental effects of alcohol abuse and the strategies needed to detect, treat and prevent such abuse. A sufficiency in health is fairly easily determined and means that alcohol is used only in moderation by non-pregnant individuals and avoided altogether by pregnant women and children, in order to avoid all negative outcomes such as FASD, liver disease, adverse social and behavioral outcomes etcetera. This dimension is fairly well covered in the policy brief discussed and includes activities such as epidemiological surveillance and monitoring, introduction of screening tools for alcohol and substance abuse in all health services; "brief interventions that match the level of risk"; strengthening of "referral chains and follow-up of women at risk for AEP (alcohol exposed pregnancies) to ensure continuum of care"; enforcement of liquor control regulations etcetera (FASD Symposium Programme and Proceedings. 2008) . Other health related issues that would also need to be assessed in order to establish the required level of sufficiency of health and health related services would be an evaluation of available formal drug and alcohol rehabilitation services.

The above sets of questions are all difficult questions to answer and a full exploration of the six dimensions of well-being within this context will require a combination of extensive empirical research and a multi-disciplined and multi-pronged approach to a holistic assessment of results. Ultimately though, such an approach could result in the establishment of comprehensive and far reaching overarching programme with aims and goals directly guided by the 'bench mark standards of excellence' represented in this context as six dimensions of wellbeing. There are however also disadvantages to this approach, or barriers to achieving this ideal and these will be discussed shortly.

Assessing Programme Outcomes.

In the illustration on page 184 I divided specific programme objectives into two interlinked and interdependent sets of outcomes: - measurable outcomes which I have equated to 'external goods', and outcomes which are more difficult to measure ('internal goods') but would be apprehended by public health practitioners working in the field with the necessary skills and qualities to make such practical judgments. These two sets of outcomes are interlinked and it is unlikely that the measurable

outcomes will be successfully acheived if the programme does not also acheive 'internal goods'. Examples are given above of both sets of outcomes.

Measurable outcomes could be assessed by formal research initiatives, internal programme evaluation and routine surveillance methods. However the "difficult to quantify outcomes" are, I believe, as important as the measurable outcomes. It is only when programme developers and implementers acknowledge the real importance of these particular desired outcomes, that true long term success of a programme such as this one can be achieved. MacIntyre argues that 'internal goods' can only be achieved by practitioners who have more than 'mere' skills such as clinical epidemiologists, or social anthropologists or public health nurses. They also have certain character traits and qualities that allow them to identify the value and importance of such things as facilitating mutual respect between partners, or improving the self-esteem and self-efficacy of pregnant women and mothers, or enabling fathers to ask "What is the 'good life' for myself and my family? Does it involve drinking my entire week's wages every Friday and beating my wife, or neglecting my children or encouraging my pregnant wife to drink with me? A good public health practitioner can measure and weigh and screen and report according to pre-defined programme objectives and requirements. However, it is the public health practitioner with qualities of courage, compassion and trustworthiness that may manage to effect the real change of heart and understanding required for lasting outcomes, which will reverberate at a community level and ultimately, over time, result in a reduction of FASD.

Human Resources

In the diagram of this model above, I have divided human resources into two categories, 'skills' and 'virtues', or qualities of character that are required for the implementation of such a programme. Examples of skills listed are self evident and certainly readily available at many of the academic institutions, non-government organisations, and in the public sector departments involved in this particular field. I have also listed examples of the virtues or qualities that I believe would also be required by practitioners of these skills (certain qualities attached to certain types of

role players) in order for the programme to be implemented as holistically and successfully as possible. The question now arises how can one identify the additional qualities or virtues needed for each skills category; how can one assess whether or not they are present and how can these qualities be instilled? This is a very difficult question to answer and admittedly presents one of the biggest challenges to this approach. The question of teaching the virtues was addressed in the section on the education of public health practitioners in the previous chapter, but it remains a contentious issue and undoubtedly one of the weaknesses of this model. Even if it is unrealistic to attempt to 'teach' moral virtues to public health professionals an in-depth discussion of these particular character traits within the context of this approach to public health programme development, may be a starting place. The possibility of developing courses or modules to improve critical thinking skills and practical reasoning is a reality and could be incorporated into public health curricula.

Strengths and Weaknesses

The most obvious strength (and potential pitfall) of this model, clearly illustrated in the preceding discussion, is that it is overarching and holistic, because it does not focus on only one dimension of well-being such as physical and mental health. It thus has the potential to address root causes of manifestations of problems. FASD is largely manifestation of a societal malady, not just a problem caused by pregnant women who remain ignorant, or choose to ignore health warnings and consequently consume too much alcohol in their pregnancies. Many of the questions posed above may have in fact already been answered by the extensive research that has been done and is being done in this field and there may well be existing endeavors in some towns and communities that are attempting to fulfill these needs. Some of these questions no doubt still require answers and may thus lead to additional targeted research. This approach would enable programme developers to develop a cohesive framework for action that is multidisciplinary and multi-pronged, engaging many different role players and tapping into a wide range of resources, as well as identifying resources that are required. Although the scope of such a programme would be daunting it may well have the ability to effect real change at community wide level.

This model does encounter many challenges though. Perhaps the most obvious is that it would result in the kind of 'public health scope creep' that has been criticised by authors such as Rothstein and Dawson and Verweij, and discussed previously. The scope of such a programme would have to be so broad that it could be in danger of losing its focus and would need to address broad issues such as poverty alleviation and skills development.

Another problem or weakness, alluded to above is the differentiation between skills and qualities of character, or virtues. A lot of work would be required to convince many people working in the field of public health that such a notion has any value what-so-ever. A code of ethics for public health, or a code of professional conduct may be one thing, but a list of virtues that public health practitioners should aspire to is quite another! Even if such a notion is accepted in principle, the challenge remains as to how to develop these virtues in public health policy makers, programme developers and programme implementers.

Separating programme outcomes into 'measureable outcomes' and 'difficult to quantify' outcomes is also problematic for the very reason that the latter outcomes are just that- difficult to measure and thus difficult to evaluate successes and failures and difficult to report on. All public health programmes have to be funded either by the state or from other sources. Funders, especially foundations and NGOs require reports and evidence that programmes are being successful. 'Measurable outcomes' may well only be measurable once successes have been achieved in the 'difficult to quantify' outcomes and may manifest as limited programme success or even programme failure.

Despite these significant challenges I do believe that this model does have worth and if applied to local contexts particularly, like that described above, would result in a ' Policy brief' or programme framework that was a lot more comprehensive, cohesive and holistic than the one attached as an example in Appendix I.

The above discussion focuses on the application of virtue theory within the context of the practice of public health. Thus the moral agents we are primarily concerned with are those individuals involved as *practitioners*. However, it is also important to consider the role of *programme recipients* as moral agents and architects, at least to some degree, of their own narrative quests and life stories. The 'public' involved in public health are not empty vessels, but capable of making choices that ultimately will have profound effects on themselves, their health and in this case the health and potential of their own offspring. Women who drink in pregnancy do choose to do so. There may be a multitude of factors that encourage them to drink, but ultimately it is their choice and one that they have to be held accountable for. A public health prevention programme such as the one described above does also need to tap into or emphasise this particular fact and find ways to help women understand that they can develop the character traits and strength of character needed to be actors in their own lives and take decisions that will contribute to the 'good life' for them and their families. I do believe that a virtue ethics approach to public health, that assisted individuals to see the health related choices that they make as not isolated choices with limited consequences, but as being part of a bigger picture that contributed to answering the questions- How should I live? and What constitutes the good life for me? would be a useful and important component of a wider public health programme. Achieving this is certainly not easy and we know that public health efforts to get people to change health related behaviors often seem to 'fall on deaf ears'. However some of the questions that I listed above, such as those related to the dimensions of self-determination, respect and attachment could very well lead to the kind of innovative FASD prevention initiative that could assist women and their partners to face up to these issues, acknowledge their own accountability and their own ability to bring about change for the good.

MDR and XDR TB and Involuntary Hospitalization: A Case Study

The causal root of the problem of tuberculosis in South Africa and other developing world countries, is primarily poverty and other injustices that fall outside of the direct domain of public health policy. Until these issues are addressed at a global level, the

problem of tuberculosis will continue unabated. However while the problem continues it does require the development and implementation of public health policy, even if we concede that this policy may have limited effect, if issues such as poverty, continue to prevail. One such policy that attracted a great deal of negative attention a few years ago involved the involuntary hospitalisation of patients diagnosed with XDR-TB. This account is now largely historical and approaches to this problem currently appear to be less radical, with adverse media coverage now a thing of the past. However this 'case study' does illustrate very well the tension created between a predominantly utilitarian approach to public health matters and a human rights approach. In this section I thus want to investigate whether a virtue ethics based approach to policy development in this context is viable and of any potential benefit.

A startling report, released by the World Health Organization (WHO) on the 1st September 2006, and widely reported in the media, revealed that 53 patients, hospitalized in the Tugela Ferry district in Kwa-Zulu Natal had been diagnosed with an extremely drug resistant form of TB. 52 of the 53 patients died within 20 days of been tested for drug resistance (SA Press Association 2006c). Within days a flurry of dramatic local headlines followed: "Deadly new TB must be stopped" (SA Press Association 2006a);"Drug-resistant TB raises global fears" (SA Press Association 2006b); "True outbreak of TB superbug at Tugela Ferry" (Faul 2006); and others in a similar vein. These were quickly followed by calls in both local and international media to isolate victims. BBC News reported: "South Africa should forcibly isolate patients infected with a deadly strain of TB to stop the disease spreading on the HIV- hit continent, experts say" (BBC News 2007). Many similar calls were echoed in the local press (Beresford 2006).

The media frenzy surrounding this issue continued unabated, especially when a Johannesburg woman confirmed with XDR-TB discharged herself from hospital and was "hunted down" and arrested (South African Press Association 2006). The government funded South African Medical Research Council (SAMRC) released an official statement on the matter in January 2007 (Weyer 2007). The statement entitled "Detention of patients with extensively drug-resistant tuberculosis: Position Statement

by the SAMRC" warrants close scrutiny. The opening paragraph states that "enforced hospitalization of patients with XDR-TB is only justifiable as last resort after all reasonable voluntary measures to isolate individual patients have failed". Furthermore the authors state that isolation can only be considered if all the criteria of the 'Siracusa Principles'[66] have been met. These criteria state that the restriction must be provided for and carried out in accordance with the law; must be in the interest of a legitimate objective of general interest, be strictly necessary to achieve that objective and be the only means of achieving the objective. The statement continues by pointing out that SA law currently allows detention of patients "until the disease no longer poses a public health threat", but then adds:

> [H]erein lies the dilemma: many XDR-TB patients may have untreatable disease and confinement would have to be until death, or conceivably could be indefinite. From a human rights perspective prolonged isolation could, without sufficient procedural safeguards, violate several SA constitutional rights and international human rights law…… Enforced treatment of XDR-TB patients under quarantine conditions represents a most severe invasion of an individual's right to freedom and security of person (Weyer 2007).

The toxicity of drugs required to treat this form of TB, the low success rate, prolonged and indefinite treatment and the poor life expectancy of these patients have prompted the South African Medical Research Council (SA MRC) to assert that there is "no sufficiently strong legal justification for coerced treatment", that is: patients should always have the right to refuse treatment.[67] A more detailed discussion of the current status of SA legislation follows. The SA MRC statement notes that certain laws that may be invoked to detain persons with XDR-TB, such as the "Communicable

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[66] United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, **Siracusa Principles** on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, Annex, UN Doc E/CN.4/1984/4 (1984). Available at http://hei.unige.ch/~clapham/hrdoc/docs/siracusa.html
Accessed 04.05.2008
[67] Of interest, this seems to be contrary to the WHO "Patients Charter for Tuberculosis care" which gives patients the "right to choose to refuse surgical interventions if chemotherapy is possible" but is silent on a right to refuse treatment (World Care Council 2006)

Diseases Regulations of 1987" date from the apartheid era. Thus such laws, while still in force, predate the SA Constitution and may well be in direct conflict with the 'Bill of Rights' contained in the constitution. The position statement lists all the rights that may be violated by detention of XDR-TB patients and concludes with this paragraph:

> The utilitarian approach, advocating that government policies be directed to provide for the greatest good to the largest component of the population, certainly makes sense from a public health perspective. Nevertheless, the humanitarian approach in which patient dignity, equality and freedom constitute core values, also need to be taken into account for management of XDR-TB, a disease that can in large part be traced to the failure of implementation of government policies. The challenge to all South Africans therefore is to develop an ethically justifiable framework for management of XDR-TB based on sound legal principles (Weyer 2007).

The tone of this document, which is decidedly pro-human rights, is in noticeable contrast to an article published in the Policy Forum section of the open access journal *Plos Medicine* by Jerome Singh and colleagues (Singh, Upshur & Padayatchi 2007). This article begins with a description of the Tugela Ferry XDR-TB outbreak and then proceeds to discuss the "threat to regional and global health" this new development may herald:

> South Africa is one of the world's fastest growing tourist destinations, home to millions of migrant labourers from neighbouring countries, and its ports and roads service several other African countries. Sero-prevalence rates for HIV in South Africa and in adjoining nations such as Lesotho and Swaziland are very high. Cumulatively, these factors make for a potentially explosive international health crisis (Singh, Upshur & Padayatchi 2007 p. 19).

Whether or not this statement represents an over dramatisation of the facts, or is proved accurate, only time will tell. It does however set the tone of the rest of the article which is pragmatic and utilitarian and places the welfare and safety of the public first and over that of individual rights and preferences. "We believe that the forced isolation and confinement of individuals infected with XDR-TB may be an appropriate response in defined situations, given the extreme risk posed by both strains and the fact that less severe measures may be insufficient to safeguard public interest" (2007 p. 22) The article ends by stating "Ultimately in such crises, the interests of public health must prevail over the rights of the individual" (2007 p. 24).

These two documents, both published simultaneously in Jan 2007, approximately four months after the Tugela Ferry XDR-TB outbreak, succinctly underscore the ethical dilemma usually regarded as at the core of public health ethics, that is the tension between the rights and autonomy of the individual and the state's role as caretaker and protector of the 'common good' or 'public best interest'. They also each take what seems to have become opposing standpoints in recent debates and discussions about 'public health ethics'. The SAMRC statement promotes a predominantly human rights perspective, whereas the standpoint of Singh and colleagues is utilitarian and is in accordance with 'Mill's Harm Principle'.[68,]

An issue raised and questioned in Singh et al's article is the government policy to suspend social grants to all TB patients admitted to hospital. The authors argue that this policy encourages patients to abscond and should be revisited. The South African government's social grant policy with respect to tuberculosis has long been a source of debate and controversy. Unemployed healthy South African adults have no recourse to any form of government support. Repeated calls from many quarters for the introduction of a 'Basic Income Grant' (BIG) have been ignored by the current government (Nattrass 2005). Patients diagnosed with tuberculosis and too sick to work are eligible for a disability grant. The reality is that many newly diagnosed patients are unemployed anyway and a diagnosis of TB suddenly opens up the possibility of a

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[68]What has become known as 'Mills Harm Principle', was first published by J.S. Mill in 1859 in an essay entitled "On Liberty". See *On Liberty and Other Essays* 1989 Collini, S. (Ed) Cambridge University Press. p.13. I discussed this principle in some detail in Chapter IV.

social grant for the duration of their illness. This grant is often used to support an extended family. Recovering from TB means losing the grant and thus many healthcare workers believe that social grants linked to tuberculosis encourage patients to default as they approach the end of their treatment. However treating patients without addressing food security issues is equally problematic. The MDR and XDR-TB epidemic has also focused attention on the social grant issue. Singh et al point out that it is government policy to suspend social grants for any patient admitted to hospital. Patients with drug resistant TB who receive social grants also have their grants suspended on admission because government is now accommodating, feeding and treating them (Singh, Upshur & Padayatchi 2007 p.0020). However as their hospitalisation may be involuntary and indefinite, this means that they are unable to work to support their families and have lost all means of social support. This seems to add yet another layer of "rights" that may be infringed, in order to protect the public against infectious MDR and XDR patients.

Developing MDR or XDR-TB is not likely to be an out-of-the-blue- event, like catching 'flu'. Rather it is a diagnosis, that in the majority of cases, comes at some point in an already protracted illness. Most of these patients have been ill for many months. They usually already have a relationship with the TB treatment programme and are 'known' patients. Sometimes this relationship is a stormy one, because drug resistance is frequently associated with a history of erratic treatment adherence. Thus these patients may well be viewed negatively by the health authorities (the local TB clinic staff) and labeled as 'non-compliers'. The vast majority of these patients are unemployed and poor, living in conditions of overcrowding and struggling with issues related to food security. It is now estimated that about 70 percent of these patients will have underlying HIV infection or AIDS that has not as yet being diagnosed, or they may well be aware of this co-infection. Some of these patients may already be on antiretroviral (ARV) treatment, but for many others the diagnosis of MDR or XDR-TB will prompt further investigation and ultimately result in a co-diagnosis of HIV and AIDS. This will then mean a double treatment burden, easily resulting in the need to take about 15 or more tablets a day. Treatment for MDR almost always includes one injectable agent usually given three to five times a week for many months. All of these

medications have side effects and many of these side effects are additive and affect the gastro-intestinal tract causing nausea, vomiting and diarrhea. Both HIV and TB, particularly MDR-TB, still attract significant stigma within local communities. This burden of stigma may prompt individuals to conceal their illness from family, from members of their community and from employers. By so doing they place others at risk, get labeled as "irresponsible" and further displease the health authorities.

I believe the above picture represents a narrative that is common to many if not the majority of patients currently being managed in the healthcare system with MDR-TB. Each individual will also have their own narrative detail appended to this broad base. If investigated, these individual narratives would further add to a tapestry of complexity and patterns of extreme hardship and 'systematic disadvantage', which forms both an historical narrative *and* informs, or often restricts a 'narrative quest'. This then is the background that should enlighten the development and the application of XDR and MDR TB public health policy especially as it relates to the hospitalisation of patients for extended periods of time.

As discussed previously 'Justice as well-being' is, in this dissertation, put forward as a theory of social justice that could act as a foundation for public health programs and be used as a basis of evaluating institutions and their practices in order to guide remedial action and adjustment of practices towards an ideal. This theory incorporates six separate dimensions of well being, each of which is regarded as an essential component of overall well-being. I shall discuss each of these dimensions within the context of ethical challenges related to the management of patients with MDR and XDR-TB. The first dimension 'Health' is the dimension directly addressed by public health TB programmes. In South Africa the right to access health care services is enshrined in the constitution and all South African do currently have a right to at least some level of basic health service. Unfortunately severe resource constraints continue to limit the availability and accessibility of health care services and services are not always well integrated or available at one location. For example TB services often fall under the municipal health authority and are provided for by municipal TB clinics, whereas HIV wellness programmes fall under the provincial health authority and are

still fairly centralised, that is they are situated at provincial hospital level. The political situation in the Western Cape in the recent past has been unstable, with changes of political 'ownership' and opposing political entities sometimes being in control of these different authorities. As indicated, the majority of patients affected by MDR-TB, are also HIV positive and need to access HIV related health services. The fragmentation of these services further adds to the patient's burden already created by the condition of ill health.

'Reasoning' refers to the cognitive capacities that enable one to fully grasp and understand one's situation and is influenced by many factors including the availability and quality of basic education. Many adults in South Africa have been historically disadvantaged during the apartheid era because of very poor or nonexistent basic education. This problem continues in post-apartheid south Africa with schooling in many disadvantaged areas little better today than it was fifteen years ago. At a TB programme and policy level, this dimension of well-being relates particularly to adequate understanding of the messages, both formal and veiled, that emanate from the programme, as well as the level of communication attainable between patient and TB health service-provider. A poor understanding of one's illness and the treatment options available contributes to a sense of disempowerment. Poor, negative, or even threatening communication between patient and health service-provider may contribute to a sort of mental disconnection. Likely consequences of this are poor compliance with treatment protocols, placing others at unnecessary risk, and dropping out of the treatment programme altogether. (This is usually never permanent though, because eventually patients get so sick they reappear, often now with MDR-TB). Adequate attention to patient education and understanding at both formal and informal levels needs to be an integral part of a successful TB public health programme. Unfortunately this essential task is often dealt with in an adhoc or unstructured manner and left in the hands of overworked and harassed clinic staff. Lack of attention to this essential component of a public-health TB programme is likely to contribute to its failure rather than its success. A novel and innovate approach to improving this dimension could be to liaise with other stake holders and use community based clinic facilities as a venue and base for adult literacy programmes. Such an integrated health

and education programme, even if only loosely associated with one another, may promote a sense of community ownership and empowerment, positively influencing other dimensions of well-being, such as respect.

'Respect', including self respect, respect for others and respect from others is an essential component of human well-being. Lack of respect may lead to discrimination or judgment of persons that is biased or unjust. Being affected by HIV and TB, particularly MDR-TB, means that this dimension of well-being is particularly vulnerable to being eroded on every front. Pellegrino has stated that "[t]he central feature of healthcare is the personal relationship between the health professional and the person seeking help" (Pellegrino 1999 p.274). Those of us fortunate to access our healthcare in the private sector in South Africa know only to well that this statement is true. This relationship is often virtually non-existent in over-burdened and under-resourced healthcare environments. Unfortunately, patients who default on their treatment for whatever reason are often labeled as non-compliers or troublemakers and are treated paternalistically and with limited respect. The Directly Observed Treatment Strategy (DOTS) strategy in itself can be viewed as one that fosters mistrust and disrespect. The fact that I need to attend the TB clinic every day and swallow my pills in front of you can only really mean one thing - you do not trust me to take my medication myself. DOTS has long been a controversial strategy for various reasons, including this one. If DOTS remains in place, which seems very likely as it remains part of the Department of Health TB strategic plan, then this aspect does need to be openly acknowledged and somehow counteracted.

Stigma remains a significant problem within the context of both TB and HIV, and negatively affects both self-respect and respect from others (Suri, Gan & Carpenter 2007) (Daftary, Padayatchi & Padilla 2007). Lastly, and perhaps most importantly, the vicious cycle of debilitating illness and poverty conspire to also diminish respect on all fronts. Patients who need to be hospitalised or isolated from families for protracted periods, because of MDR or XDR-TB, may well feel this lack of respect most acutely as they are unable to provide any form of financial support for their families. Even

worse, such patients often leave their families or children in very vulnerable circumstances.

Incentivising TB treatment fairly, by rewarding progress and cure instead of providing disability grants to those who are ill, may well be a means of improving self-respect and, at the same time, reducing issues related to food security and poverty and the problems created by non-adherence. This strategy addresses some of the factors that fuel the multi-drug resistant TB epidemic at source.[69] Finding additional effective ways to address the dimension of respect within a public health TB programme will be very challenging. However, if this dimension of well-being is ignored, or not specifically considered and integrated into TB policy, then the cycle of TB non-compliance and multi-drug resistance is likely to be perpetuated.

'Attachment' refers to the close human bonds of attachment that are so important to well-being. MDR and XDR-TB is an infectious disease which is airborne. It also has a very protracted course and patients require treatment for eighteen months or even longer. Those that are very ill, or considered to be non-compliant and placing others at unacceptable risk, are often hospitalised for long periods of time. In the case of XDR-TB this hospitalisation and isolation may well be until death. To make matters worse, TB hospitals are often poorly-resourced, very few in number, built in the apartheid era and usually a great distance away from the communities they serve (Makinana 2008). For example, Cape Town has only two TB hospitals (although others are now being built) and neither of them is situated in the Cape Flats, the area that has one of the highest incidences of TB in the world. Thus, hospital patients are geographically isolated from friends and family, a fact that makes their illness and protracted treatment all the more difficult to bear. This geographical isolation places an additional financial burden on family members who need to pay transport costs.

Self-determination is the ability to be self-governing and to choose one's own course in life, at least to a greater rather than a lesser degree.

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[69] A pilot research project that does just this is currently underway in a number of TB clinics in greater Cape Town. (Unpublished information obtained via direct communication with research team)

The kind of self-determination expressed by Berlin and quoted earlier exists only in the dreams of most TB sufferers. They usually have very limited choice of health-care options. The ability to self-direct their lives in general is also usually severely limited by their illness and by other factors such as poverty. TB patients get told what to do, what medication to take, and what clinic to attend, and often don't even have the freedom to choose to swallow their tablets when and how they want to. Obviously there are extensive limits on the degrees of freedom that a resource limited public-health TB programme can accommodate. However, the importance of the human need to retain as much self-determination as possible needs to be acknowledged and accommodated to the extent that it is feasible. Coupling TB treatment programmes with some form of skills development programme in an innovate manner, utilizing collaborations with other government agencies, CSOs or NGOs, may be a way of improving the well-being dimensions of both self-determination and respect.

The need for the *involuntary* hospitalisation of XDR and MDR-TB cases could be significantly reduced, and perhaps avoided altogether, if all the issues discussed above were considered and taken into account by policy-makers. Patients who develop XDR-TB are in most instances victims of social injustice and health system failure at multiple levels. If it was possible to eliminate these broader system failures by addressing all the issues identified in this discussion concerning dimensions of well-being, then perhaps the need to 'detain' XDR-TB patients without their consent could be avoided altogether. Voluntary hospitalisation will continue to be necessary for particularly sick patients and those deemed highly infectious. However, as has been discussed, policy in this regard needs to be flexible enough to consider every case on its own merits. In some instances it may well be feasible to manage even XDR-TB patients in a home environment. In other instances (for example shack dwellers living in confined spaces with others who are HIV infected), this would be out of the question.

The dimension of **'personal security'** is one that could be regarded as fairly peripheral to this particular discussion although it is relevant to South African society in

general. However, high levels of crime, especially domestic violence, may impact negatively on TB-related health outcomes and adherence to planned treatment regimens. Hence, the perspective that services related to broader social support fall completely outside of a public health TB programme will result in factors that impact directly on the successful completion of TB treatment being ignored.

As discussed in the FASD example previously, the first stage in the development of this framework (MacIntyre's adapted model), involves using the six dimensions of well being to establish overall programme goals and benchmark standards of sufficiency of well being within the context of a XDR/MDR management programme. The second stage is to identify two sets of outcomes:- measurable outcomes and 'difficult to measure but desirable' outcomes. Examples of measurable outcomes could be a reduction in the number of diagnosed MDR cases, reduction in patients requiring hospitalisation, reduction in patients absconding from hospital or defaulting treatment etcetera. Some examples of 'difficult to measure but desirable' outcomes could be decreased levels of stigmatization of HIV and TB within communities and an increased openness about HIV and TB status, improved levels of self-esteem and self-efficacy among those involved in TB programme-associated life skills development initiatives, improved understanding and acceptance of one's own roles and responsibility with respect to the transmission of TB and the development and transmission of drug resistant forms of TB.

The third and final stage of framework programme development involves the identification of the necessary human skills and resources needed to implement and evaluate all aspects of the programme. Much of what was said in the FASD example discussed earlier applies equally in this context and I shall thus not repeat myself. Those working in these programmes need specifically to develop and be taught the capacity of *phronēsis* or practical wisdom, to enable them to adapt flexible policies to specific circumstances appropriately. An example of in this particular setting, would be the ability to determine, after "appreciative sight of a constellation of ideas, arguments and facts about the case" when a patient with MDR TB needs to be hospitalised, even against his will and when such a patient can be safely and effectively managed in his

home environment (Jonsen 1991. p15).   Similarly my comments related to the strengths and weaknesses of such an approach are also applicable.

The above examples represent a preliminary exploration of these complex ethical issues, using a virtue ethics-inspired framework as a viewing box. I believe that this discussion has illustrated that a virtue ethics framework does hold some promise as a complementary framework, which could be used to garner additional insights into the moral dimensions of public health problems. As already stated, this approach appears particularly applicable when applied to a specific problem in a specific localized social, cultural and geographical context. It appears to have far less applicability when public health issues involve matters of global concern and international justice. (See further discussion of this point on pages 221-225) In the following section I shall discuss HIV prevention and sexual behavior, focusing particularly on the development of programmes that regard the programme recipient as moral agents.

HIV/AIDS And Sexual Behavior

Discussing sexual behavior in the context of HIV is to enter a true minefield. Van Niekerk comments:

> HIV/AIDS carries forward the brutalization of the everyday lives of the destitute in Africa into the sphere of the private. The result is the eventual brutalization of intimacy itself. Now sex becomes the topic of a depersonalized, mechanized, instrumentalist discourse. Condoms- a kind of technology hardly reconcilable with African sexual practices-become the avenue to security. Control over the management of privacy is increasingly lost;…..Again, as in the case of most true complexities it is almost fundamentally unclear what could be done about this problem (Van Niekerk 2005 pp.64-65).

For me to suggest that a virtue ethics approach to HIV/AIDS prevention programmes would provide the solutions that have evaded public health professionals every since

the epidemic first appeared in the 1980s would be simultaneously naive and imprudent. It would be to trivialize the complexity of this issue. I therefore will end this overall discussion by exploring one aspect of this particular very difficult and multifaceted problem. In my introduction I made the following comment:

> I would thus like to investigate whether a virtue-based ethics, -which is concerned with a notion of human flourishing that is not primarily atomistic but intricately linked to the mutual well being of others and to notions of what the 'good life for man' means within the context of a shared history and connectedness with fellow human beings,- could contribute positively to the current 'public health ethics' discourse.

Sexual health promotion and HIV prevention campaigns, like the *Love Life*[70] campaign, aimed particularly at the youth, do seem to have in the past placed emphasis on health promotion messages that are very individualistic. The focus has been on steps that one should take to protect one's self and one's own future. Buchanan concurs with this perspective and comments that the main approach to health promotion in general seems to be the idea that individuals are affected by various separate risk factors that encourage them to engage in behaviors which have the potential to threaten their health. These risk factors are then targeted. However, he asks: "What if choices are much more complexly intertwined with one's character and an outlook permeating the whole of one's perceptions, passions and sense of possibilities?" (Buchanan 2000 p.113). He develops this further by arguing that health promotion needs to focus on a far richer and broader notion of how people conceive and interpret well-being.

The human rights approach to HIV has meant that the whole domain of HIV and sex has been largely kept in a protected private sphere. While undoubtedly there were many very valid reasons why this occurred, it has meant that really deep discussion

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[70]The *Love Life* HIV prevention campaign is aimed at youth and has been running for more than ten years. http://www.lovelife.org.za/

among people most likely to be affected by this devastating epidemic, about what HIV means to both how I plan to live my life, and how my life fits into a broader life of family and community, does not happen easily (Ahmed et al. 2009). Research into attitudes related to HIV among youth illustrates that there remains a lot of confusion and general denialism (Ragnarsson, Onya & Aaro 2009) (Camlin, Chimbwete 2003, Olley et al. 2005). A paradigm shift in the way sexual health promotion campaigns, are developed and implemented may help in promoting the kinds of life sustaining choices that we require people to make in this regard. "[T]he field of health promotion should re-orientate its practices along the lines of engaging community members in discussion about the kinds of institutional practices that will help all of us to see more clearly values that matter and bring our actions more in harmony with those values (Buchanan 2000 p.118).

Returning again to the introduction to this dissertation, I noted that virtue ethics is a moral theory that focuses on moral agents rather than moral acts or the consequences of acts. Also, within the context of our discussion moral agents could arguably be considered in two categories, those that are 'public health practitioners' and those that make up 'the public'. Recipients of public health policy are as stated above in the FASD example, moral agents who have the ability, at least to a point, to make choices and influence outcomes. I thus stated in my introduction:

> Public health policies aimed at addressing public health problems may be paternalistic and regulatory, or confined to the fairly narrow language of individual rights. The arguably richer moral language of virtue ethics and particularly its focus on considering individual lives as always relational and existing within a detailed social fabric of community could possibly be used to bring about a paradigm shift in the way these problems are viewed and managed.

The majority of HIV prevention programmes aimed at changing sexual behaviour in South- Africa over the previous two decades have aimed their messages at individuals and at attempting to encourage individuals to protect themselves by the

HIV prevention 'ABC' of 'abstaining', 'being faithful' and when that is unlikely to happen-an unwritten presumption that has always seemed to be there-, to use condoms. Spiralling SA HIV statistics over the last two decades are sufficient testimony to the fact that this message has somehow failed and a new one is very much needed.

The Department of Health's *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 i*s a detailed and comprehensive public health policy document that has ushered in a seemingly new era of HIV/AIDs policy in SA (Department of Health. 2007). What is particularly encouraging to me is that the policy is overarching and holistic and does indeed include many of the "difficult to quantify" types of outcomes that I have discussed earlier. Prevention is named as the first "priority area" and includes objectives such as "poverty reduction strategies"; programmes to "empower women and educate men" on issues related to human rights and women's rights in particular; strategies to "address gender based violence" and strategies to "support national efforts to strengthen social cohesion in communities and support the institution of the family". Of course the danger and the disadvantage of such a broad approach, as already highlighted, is that these strategies remain good intentions on the paper of policy documents. Translating them into effective public health educational messages and programmes is very challenging indeed. But if we, as a nation don't find a way of doing this and getting individuals, especially men, to see HIV prevention as a personal responsibility within the context of the importance of *my* human relationships, including those with *my* partner(s), *my* children and *my* community, our HIV statistics will continue to be the worst in the world.

I believe that a virtue ethics approach in this context would shift programme emphasis to include a focus on not just the immediate act, that is the need not to have unprotected sex, or to take drugs that will result in risky sexy behaviour, or to have multiple sexual partners. Such an approach would not focus just on the rightness or wrongness of actions but would encourage programme recipients to consider all of these issues in a far broader and richer context of a whole life, all the relationships involved and the human qualities needed to live that life in a way that will realise some

conception of the 'good life' for me and those that I experiences bonds of attachment with. Such programmes would probably need to rely a lot less on written and verbal media communication and I lot more on methods that incorporate mentoring and life skills coaching from an early age. Hence such programmes would need to be widely inclusive of school communities, church communities, parent communities, sports communities' etcetera. Some of the character traits or virtues that I discussed earlier (page 168) for example the meaning and value of virtues such as 'courage', 'discernment', 'responsibility and accountability', 'justice' and 'temperance' could be incorporated into health promotion and life skills programmes.

Of course programmes which require the teaching of virtues do seem unrealistic and a poor fit within the domain of public health. As I have already mentioned one of the biggest weaknesses of the approach to public health that I have developed in this dissertation is the problem of teaching and developing virtue. I concede that like Aristotle, I have not been able to provide a clear method to describe how virtuous character traits can be developed and taught other than by sensitisation in the kind of life skills program discussed above, habitual practice and mentoring. Hence this approach to HIV prevention and public health in general, is not and cannot be considered comprehensive, but rather a strategy that can be incorporated into other more conventional prevention programmes. Never-the-less I do believe that particularly in public health contexts that involve individual behaviours and choices, a virtue ethics approach does have some potential positive role to play.

PUBLIC HEALTH: MACRO CONSIDERATIONS.

In the introduction to this dissertation I noted that there appear to be issues, including moral issues, which profoundly influence public health, but that fall outside of the domain of public health policymaking and programme development. That is, there does seem to be much that public health policy makers, those who consider themselves to be working predominantly in the field of public health, have very little control over. This point was further briefly explored in chapter five in the context of

theories of global justice and the application of virtue ethics within the context of global justice.

Tuberculosis, particularly in a South African context, is a good example of a disease which is profoundly influenced by a factor other than tuberculosis-directed public health policy, namely poverty. Obviously there is much public health policy that does pertain directly to the management of the spiraling developing world tuberculosis epidemic. The WHO and the South African Government both have Tuberculosis strategic plans in place (WHO 2006, WHO Stop TB Partnership 2007, Department of Health, South Africa 2007). But, the fact that this epidemic continues to accelerate in places like South Africa, arguably relates more to issues of economics and global justice and less to the development and implementation of health policy. We have seen that authors such as Pogge have been outspoken in focusing attention on the complicity of first world nations and institutions, such as the World Bank, on producing contexts that promote, rather than alleviate, third world poverty (Pogge 2002).

The link between TB and poverty is generally undisputed. An investigation into the resurgence of tuberculosis mortality in England and Wales from 1982 to 1992 showed a clear link between household overcrowding and TB mortality over and above AIDS related mortality. "Regression analysis indicates that it is the overcrowding and poverty among ethnic populations that accounts for their TB mortality" (Elender, Bentham & Langford 1998 p. 673). Archbishop Desmond Tutu has been quoted as saying. "TB is the child of poverty- and also its parent and provider." This statement succinctly captures the downward spiralling cycle of TB and poverty.[71] The WHO has estimated that the average TB patient looses three to four months of income and often up to one third of yearly income (TB Alliance 2009). Economic growth in post apartheid South Africa has resulted in the establishment of a new black middle class. However the number of people living in conditions of severe economic deprivation has increased. In 1994, 31 percent of the population were recorded as unemployed. This has increased to almost 40 percent in 2005 (Kingdon, Knight 2005). Informal shack settlements have

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[71] TB Alert is the UK's national tuberculosis charity. http://www.tbalert.org/worldwide/TBandpoverty.php
Archbishop Desmond Tutu is quoted on their webpage, accessed 02.08.2009

developed adjacent to every town and city. Conservatively, at least one third of South Africa's population live in conditions that promote the spread of infectious diseases, particularly TB (Benatar 2006). Similar circumstances and TB statistics are found in many other poverty affected developing world countries including parts of India, Asia and Eastern Europe. How all of this relates to the interplay between national and international economic policy and degrees and limits of trans-border responsibility and obligation, is exceedingly complex. This moral domain appears far more suited to debates that involve global or trans-border concepts of distributive justice, such as theories of justice that fall under the broad umbrella of cosmopolitan justice, and discussed previously in chapter six pages 125-128 than a discussion of the application of virtue ethics to a framework for public health policymaking. The virtue ethics model developed and illustrated with the FASD example does admittedly have its main application in situations where public health policy is being developed and applied to a problem that exits in a specific, well circumscribed and fairly local context, where issues of social justice are especially relevant. It has limited application when public health issues cross borders and continents and involve or require a trans-global response to a particular problem, like the recent H1N1 epidemic. In these contexts, alternative approaches such as principle based or utilitarian theories of public health ethics seem better suited or more appropriate as a guide to public health policy making.

Another example of a tuberculosis related public health issue that would be better served by a cosmopolitan theory of justice, then by a virtue ethics inspired approach relates to the development of new tuberculosis drugs and diagnostics. The development of essential drugs to fight TB has been left largely in the hands of a market driven private pharmaceutical industry. An article published in *SA Family Practice* in the aftermath of the 2007 KZN XDR-TB outbreak stated "Years of extensive research into effective therapeutic strategies to combat this disease have not succeeded in eradicating the causative agent mycobacterium tuberculosis" (Thaver, Ogubanjo 2006/f p. 58). This assertion must be challenged. One of the most striking facts about the treatment of tuberculosis is how little research has been done over the last 40 years to develop new therapeutic strategies for TB. The drugs in use

today as first line therapeutic agents, are much the same ones that were introduced more than 40 years ago. Current TB treatment regimens require a combination of four drugs over a period of at least six months. TB drugs have significant adverse interactions with some antiretroviral agents and the pill burden for patients on both TB and ARV treatment is often in excess of 15 tablets per day. Only one new anti-tuberculosis agent, Rifapentine, was approved by the FDA between 1972 and 1998 (Gordin 2004). Up until 2008 no other drugs available for first line use have followed. BCG vaccine was developed in the early twentieth century and is still in use today despite limited effectiveness. According to a report commissioned by the program for Research and Training in Tropical Diseases (TDR), the main reason for lack of new drug development is lack of interest from the pharmaceutical industry because of limited profitability.[72] The costs of new drug development are excessive, in the region of $300 million dollars and returns are considered likely to be low, as most TB patients are in the developing world and cannot afford to pay for drugs. There is also a perception that patents may not be respected by developing world governments. The Global Alliance for TB Drug Development was established in 2000 as a non-profit public-private partnership to advance TB drug and vaccine research in response to the accelerating TB/HIV epidemic in sub-Saharan Africa and other developing world countries. Now eight years later, several candidate drugs have entered clinical trials and although progress seems slow, this is a significant improvement over the last 40 years.[73] The reasons for what could be described as gross neglect of a global health issue from a drug development perspective, do need close moral scrutiny. However they do appear to reside primarily in the domain of global justice and international moral responsibility and have little to do with public health policymaking per se.

International public health organisations like the World Health Organisation are involved in public health policymaking at an international level. However the implementation of this policy is usually done in conjunction and co-operation with country level public health structures at both a national and community level. The

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[72] Research Training in Tropical Diseases. TDR) is a special program established in 1975 and sponsored jointly by UNESCO, UNDP, World Bank and WHO for research into diseases of poverty. See http://apps.who.int/tdr/;jsessionid=9B1F5E9D5B07CF6FB72E1E2618A93802. Accessed 02.08.2009
[73] The Global TB Alliance website URL is http://www.tballiance.org/home/home.php accessed 02.08.2009

ability of such institutions to address matters of global injustice that negatively affect public health, particularly in developing world countries, is limited, and often, as Powers and Faden have conceded, the most effective language to bring about change still remains the language of human rights. However, as was discussed in chapter five, a virtue ethics aligned richer account of social and distributive justice can be used to strengthen and justify positive rights claims such as the right to an adequate level of health services, the right to human dignity and self respect and the right to self-determination.

In conclusion, the above discussion of virtue ethics in the context of particular public health problems has illustrated two things. Virtue ethics can be incorporated into a model for public health policy making, based on MacIntyre's concept of a practice and this model may well be useful in assisting with the development of holistic public health programmes, when applied to specific contextualized public health issues. However, when public health issues are trans-global or involve matters related to global justice, then more conventional public health ethical frameworks appear to be more appropriate guides in such contexts.

VIII. CONCLUSION

The research question at the centre of this dissertation was a short one. Can character or virtue ethics contribute positively to the moral debates surrounding many vexing public-health issues? The last almost two hundred odd pages have been spent arriving at an answer, which in itself is fairly short, but required lengthy explanation and justification. I believe that I have shown that virtue ethics can contribute positively towards the development of a theoretical ethical framework for public-health policymaking particularly when applied to a well circumscribed local context However this contribution is likely to remain within a pluralistic public health ethics framework and has limited usefulness when applied to public health issues that are trans-global or entail concerns relating to international justice.

I began my argument by exploring the concept of public health. I examined various definitions of public health and explored arguments for supporting a broader definition of public health over a narrow interpretation of the concept. I also considered whether or not the concept of public health is (and ought to be) a universal one. I took a hermeneutic position and argued that it is a largely particular concept, shaped by and understood within the context of prevailing policies of distributive and social justice. I concluded by asserting, in accordance with most authors, that public health is about the health of 'societies' and 'communities' rather than the health of individuals. However I supported a broader rather than a narrow concept and noted that public health ought to include all those spheres of health, where collective action by governments and other organizations can make a positive impact. I concluded that the exact scope or range of programmes and interventions that falls under the umbrella of public health, in a particular nation-state, is intricately interwoven with, and contingent on, some prevailing concept of social justice. I agreed with authors such as Powers and Faden, that the domain of public health must have its foundations on a concept of social justice that "attaches a special moral urgency to remediating the conditions of those whose life prospects are poor across multiple dimensions of well-being. Placing a priority on those so situated is a hallmark of public health" (Powers, Faden 2006 p. 82).

The focus of this dissertation is simultaneously virtue ethics and public health ethics, thus both these domains required detailed exploration. This was accomplished in Chapters III and IV. In Chapter III I discussed virtue ethics in some detail, noting in my introduction Martha Nussbaum's concern that virtue ethics is not a single moral theory, in the same way as Kant or Mills' theories are. Even though there is a common thread of unity between contemporary virtue-ethicists, this thread is rather thin. Nussbaum identifies three common claims made by all proponents of virtue ethics: Moral philosophy should be concerned with the moral agent, not only with actions; it must focus on motive and intention and the character of moral agents; it should be concerned with an agent's moral life as a whole and not just on isolated choices or action (Nussbaum 1999).

The main focus of this chapter is on virtue ethics as portrayed by Aristotle in the *Nichomachean Ethics* and by Alasdair MacIntyre in *After Virtue*. However, I also examine contributions made to this topic by several contemporary virtue ethicists including Rosalind Hurthouse, Michael Stocker and Michael Slote. I concluded this section by summarising the virtue-ethics 'take-home-messages' for public health and by briefly indicating how I planned to expand on these initial ideas. In particular, I concluded that two aspects of this discussion required further detailed exploration. First, as I argued in Chapter II, a conception of public health should be founded on an appropriate conception of social justice. Therefore a 'virtue ethics-aligned' concept of social justice and its implications for the ethical dominion of public health must be fully explored and developed. (This was accomplished in Chapter V) Second, MacIntyre's exposition of virtues relied on the development of a very specific concept of a *practice* and a discussion of goods internal to practices. The domain of public health appeared to align very well with this concept. It was thus obvious that I needed to explore the notion of public health as a *practice*, discover what the goods 'internal' to the practice of public health actually are and how they are obtained.

Chapter IV is essentially a literature review of the current status of the fairly new and evolving field of public-health ethics. I discussed the evolution of public-health ethics over the last decade and identified three core themes. These relate to issues involving

tension between individual autonomy and the so called 'common good', issues relating to distributive and social justice and issues concerning trans-border or global justice. I then explored what I perceive as the three dominant and current frameworks of public health ethics: a human rights approach, utilitarianism and a modified version of principlism. I note that these three approaches are part of a liberal tradition of moral and political philosophy, even though utilitarianism does view all rights as secondary to utility. The discussion revealed that this tradition is essentially individualistic and thus may not always be fully compatible with the resolution of moral dilemmas within the context of public health. Finally I explored some of the challenges to liberalism that are present in the recent public-health ethics literature and noted that these discussions are a very useful platform from which to proceed to the next and central part of this dissertation.

Chapter V represents the crux of this dissertation. My central argument revolves around the fact that I believe a 'good' concept of social justice should be the foundation on which the field of public health is built. Without this foundation, the enterprise of public health rests on an unstable and insecure platform. The answer to the question -- can virtue ethics contribute positively public-health policy making? -- therefore lies in the related question, can virtue ethics contribute positively to a concept of social justice? In this chapter I set out to demonstrate that virtue ethics can indeed help formulate, in a constructive manner, a theory of social justice that is eminently suitable to act as a foundation for public health. Before embarking on this task it was important to gain an understanding of the notion of justice as a virtue, as well as insight into the strengths and weaknesses of common theories of distributive justice, including more recent theories of global justice and how these theories relate to social justice. I therefore examined these related issues in some detail.

The second half of this chapter was devoted to developing a virtue ethics inspired notion of social justice. I identified six conditions which I believe need to be present in such a conception of social justice.

Six Conditions required for a Virtue Ethics inspired Conception of Social Justice for Public health:

	CONDITION	EXPLANATION
1	**'Universal and particular'**	Be specific to local social context, while acknowledging a universal understanding of the human good.
2	**Well-being as end point**	Human well-being or flourishing accepted as the end point
3	**Longitudinal or holistic**	Acknowledge the importance of a human life seen as a narrative whole, from birth to death
4	**Capacity to choose**	Acknowledge the importance of the ability to choose a 'narrative quest' and the variety of 'internal' and 'external' goods required to complete this journey.
5	**Partiality**	Accommodate the fact that close human relationships play an essential role within the broader notion of well-being.
6	**Motive**	Acknowledge that underlying motive is an essential part of moral life.

After discussing, explaining and justifying these six conditions in more detail I proceeded to demonstrate that they are well accommodated in a theory of social justice developed specifically for the domain of public health by Madison Powers and Ruth Faden. 'Justice as well being' incorporates six dimensions of well-being and asserts that a concept of social justice is inadequate if any one or more of these six dimensions (health, respect, reasoning, self-determination, attachment, personal security) is significantly missing. I discussed the derivative distributive principles associated with this theory as well as its usefulness in an expanded human rights discourse. Finally in this chapter I considered the problem of global justice within the light of these insights. I concluded that while the virtue ethics aligned theory of justice proposed does appear to be compatible with cosmopolitan principles of justice, it presents limitations when applied to the realm of global justice. Other approaches to issues of global and economic injustices that directly influence the sphere of public health may be more suitable.

In chapter VI I returned to the work of Alasdair MacIntyre and adapted his concept of a practice to that of public health. Three questions needed to be considered.

What are the standards of excellence of public health that will act as benchmarks for achieving those internal goods? What are the internal goods (and external goods) of public health? And, what human excellences or virtues need to be developed to achieve these internal goods and how will the development of these virtues extend the vision and meaning of the practice of public health for those involved? These questions were fully explored and I was able to conclude that this concept of a practice, within the context of public health, could be a useful one and could also be represented diagrammatically. This concept, or model of the practice of public health, was further developed in the final chapter and applied to specific contextualised public health problems.

I also discussed and explored the contributions of several other authors and examined the virtues that I believe would be essential for a public-health practitioner to develop in some detail. Furthermore, I considered other topics such as the role that virtue ethics could play with respect to the moral education of public- health practitioners and the possible beneficial relationship between virtue ethics and public health cases.

Finally, in the penultimate chapter of this dissertation I explored these theoretical considerations within the context of various public health problems. I drew on Jonsen's insightful discussion of "Balloons and Bicycles" to illustrate the relationship between ethical theory and public health. This dissertation specifically focuses on the possible application of virtue ethics to the moral dimension of public health *policymaking* and in order to make public health policy, public health issues need to be extensively debated in many different environments and contexts. I thus divided the sphere of public health policymaking, into two broad levels or environments, public health policy and programmes at a national and community level and public health policy at a macro level. I then went on to discuss three specific South African public health issues under the heading "Public health policymaking and programme development at a national and community level". First, MacIntyre's model of a practice was applied in some detail to the problem of the high prevalence of Foetal Alcohol Spectrum Disorders

(FASD) in many rural communities in the Western Cape. The six dimensions of wellbeing, identified as programme benchmarks, were used to explore the scope of such a possible public health programme. Specific programme outcomes were identified and grouped as either measurable outcomes or external goods, or as desirable but poorly quantifiable outcomes or internal goods. Finally the human resources required in terms of both skills and character qualities were explored. I also specifically noted that this approach had both advantages and disadvantages or weaknesses. The main advantage was that it would result in a holistic approach to this problem. However the disadvantages were that such an approach was very broad and thus difficult to manage, relied on programme outcomes which were almost impossible to monitor or measure and required that practitioners had both skills and virtues. Virtues are in themselves difficult to measure and especially difficult to teach or develop as part of any structured programme.

Programme recipients are also moral agents and responsible for moral choices that influence health outcomes. Perhaps nowhere is this truer than in the FASD example discussed here. I thus concluded this section by considering mothers and their family members as moral agents and enquired as to the benefits of incorporating a virtue ethics inspired approach to moral choice, into such programmes. I concluded that while challenging, encouraging mothers and others involved to consider actions in the context of the bigger picture of their life stories and that of their unborn children may well be a potentially useful and beneficial approach.

The second contextualized example I discussed was a 'case study' of the management of XDR and MDR TB particularly related to involuntary hospitalization of sufferers. I used this now essentially historical example to illustrate the utility of the virtue ethics model when applied to another specific, well circumscribed and locally contextualized example. However I also conceded that the model does again have the same limitations as were identified in the previous FASD example.

As a final point I discussed HIV prevention and sexual behavior. In this section I specifically focused on the role of public health recipients as moral agents and

explored the usefulness of applying a virtue ethics inspired approach to this complex moral domain.

In the second part of this chapter I focused on what I called 'macro' public health issues. I noted that there appear to be issues, including moral issues, which profoundly influence public health, but that fall outside of the direct domain of public health policymaking and programme development. I used poverty and delayed drug development in relationship to tuberculosis to illustrate this point and concluded that virtue ethics has limited, if any applicability in this context. Rather, international human rights, global theories of social justice and well established public health ethical frameworks or principles, such as the principle of utility are more appropriate guides to decision making.

The aim of this investigation was to explore whether virtue ethics could provide a meaningful and applicable moral alternative to the more established approaches to public- health ethics. My hypothesis was that virtue ethics does indeed offer possibilities that make it worth exploring. I did not hypothesise that virtue ethics would be able to *wholly* replace dimensions of the other approaches described. My hypothesis was rather that virtue ethics can supplement other approaches when reflecting on the theoretical and moral basis of public policymaking in healthcare. My intention was not to try and argue that virtue ethics should completely supplant other more established ethical frameworks and hence I am advocating a degree of ethical pluralism. However, I do believe that the discussion, especially that of the previous chapter, demonstrates that a virtue-ethics-inspired framework for public health policy making does provide a perspective that is both constructive and holistic and that holds promise for further development and exploration when applied to public health issues within a specific local context, or to specific public health cases. This, given the very nature of virtue ethics, a moral theory that relies quite heavily on the notion of *phronēsis* -- practical wisdom applied in context -- is not an unexpected finding.

In summary, the virtue ethics based approach or practice model developed in this dissertation offers the following contributions to the field of public health ethics. This approach:

- Is holistic and multidimensional as it focuses public health policy development on several dimensions of human well being rather than an exclusively biological perspective of health.

- Is context sensitive and "promotes a dialectic interaction between universal norms and practical 'on-the- ground' knowledge and understanding". (P130)

- Acknowledges the importance of 'the public' as moral agent and that moral choice and responsibility, viewed from the broader perspective of -- How should I live? and What constitutes 'the good life' for me and those with whom I interact?-- impacts significantly on many matters falling under the broad umbrella of public health.

- Avoids casting public health issues as a contest between individual rights and interests and the 'common good' or public best interest and thus avoids the archetypical public health ethics tension between utilitarianism and rights based approaches to these issues.

- Identifies desired programme or policy outcomes that are both measurable and quantifiable and those that are difficult to measure or quantify but equally important for the overall success of the programme.

- Asserts that public health practitioners require both skills and certain character traits or virtues that can be taught or developed to some degree, in order to ensure they are able to fulfil their rolls in the 'practice' of public health adequately.

However, as indicated in the conclusion to the previous chapter, the moral dimension of public health is often a lot like Jonsen's balloon, floating fairly high up in the worlds of trans-global economics and politics and justice. In this setting a virtue ethics approach, which is very much rooted in actual on-the-ground context has limited, if any applicability. On an individual level one would hope to encounter leaders that play critical roles in the arena of global public health, that do have well developed virtues, particularly that of *phronēsis* and are able to visualize and implement public health programmes which are far reaching and holistic. Other ethical frameworks, including

the human rights approach to the moral dimension of public will continue to play an essential role in discussion of public health issues, particularly at an international level. Public health ethics is likely to continue to remain a fairly pluralistic ethical domain.

Appendix I

This policy document has been converted into a text file from a PDF document.

No content has been altered although some of the formatting has been altered

by the conversion. The original PDF document is available at

http://www.mrc.ac.za/techncalpolcybriefs/Policy%20Brief%20Fetal%20Alcohol%20Spectrum%20Disorders%20in%20South%20Africa.pdf

Accessed 13.07.2010

POLICY BRIEF

Fetal Alcohol Spectrum Disorders in Cape Town, South Africa:
A huge challenge requiring multi-faceted prevention strategies

BACKGROUND

Sadly, a common problem In South Africa

The term Fetal Alcohol Spectrum Disorders (FASD) is used to include the range of permanent conditions that result from exposure to alcohol of the growing fetus, with Fetal Alcohol Syndrome (FAS) being the most severe condition. To diagnose any of the FASD conditions a specialised multidisciplinary team is needed, however, the availability of such teams is very limited across the country. Prevalence studies in high risk areas of South Africa have found rates of FASD that are the highest in the world (up to 119/1000 in one high risk area). Since there is no surveillance system to collect information on the number of diagnosed cases nationally, the prevalence in the general population is unknown. Based on burden of disease estimates it is estimated that the prevalence of FAS in South Africa could be as high as 14/1000.

What are the health consequences of FAS and FASD?

The typical impairments that characterise a child with FAS are related to brain damage, resulting in low intelligence, behavioural disorders, poor social judgement, and general difficulty performing everyday tasks. Without specialised intervention and a supportive home environment, secondary disabilities in adolescence and adulthood will follow, leading to increased risk for mental health problems, inappropriate intimate relationships, unemployment and involvement in criminal activity. Use of alcohol by the mother, and the cognitive damage of her offspring, place both generations at higher risk of abuse and HIV infection than the average person in their specific community.

Identifying FAS and FASD for intervention

Since diagnostic and support services are very limited in South Africa, it is unknown how many children, adolescents and adults who utilise health and mental health services, or who are end up in correctional services facilities, are in fact people with FASD. The needs of children with FASD are most noticeable in the schools where teachers are often ill-equipped to adapt their teaching and classroom environment to cater for the learning difficulties of FASD children.

There is also limited awareness amongst professionals and lay people about FASD, making it difficult to assess the needs of people with FASD, and evaluate the extent to which services are meeting their needs. The prevention of FASD requires a thorough understanding of the context in which childbearing age women live, and their alcohol and contraceptive use patterns and norms. From prevalence studies, we can infer the typical profile of woman at risk to an alcohol exposed pregnancy (AEP) as being poorly educated and living in poverty. However, this does not hold true in every situation since some women who do not fit this profile may have children with FASD. There is limited screening for AEPs in primary health care clinics, and health service providers often lack the skills to carry out brief interventions where indicated. There are very few alcohol rehabilitation programmes in the country and those that exist are inaccessible, due to location and cost, to most women. Currently, a number of funded prevention studies are being implemented predominantly in the Western Cape. Findings from these projects were recently presented at a Symposium held on the 9th & 10th September 2008, at the MRC in the Western Cape. This brief summarises some of results and their implications for interventions and policies.

Prevalence of FAS and characteristics of women at risk of having a FAS child.

Prevalence studies, mainly in the Western and Northern Cape, have found the prevalence of FAS in high risk areas to be as high as 119/1000. This is more than a hundred-fold higher than other comparable sites in other countries and considerably higher than so-called 'high-risk' populations elsewhere. Where prevalence has been measured more than once, an increase has been found.

Studies of the risk factors for having an alcohol exposed pregnancy (AEP) indicate that the rural, farm based women in the Western Cape are at higher risk than urban women. This risk applies not only to women living on wine producing farms but for all types of farms. Although beer is preferred amongst rural adults, the poorest people drink papsak wine, which is associated with harmful levels of drinking. Other factors associated with the risk of an AEP include smoking, low educational level and unplanned pregnancy. Urban women who are at risk of an AEP may be those who are better educated, presumably have more disposable income, and have access to recreational facilities that include alcoholic beverages.

The rate of contraceptive use among women who use alcohol does not differ from that of women who don't use alcohol, and access to contraceptives is fairly good (65% of women use modern contraceptives, according to SADHS 2003), however, the effectiveness of the use of contraceptives may differ.

There is no national surveillance system for FASD, or extrapolation from alcohol use survey data, on which to estimate national or regional prevalence. However, the rates of risk for AEP (at high levels of alcohol use) found in an urban and a rural area of one study matched the FAS rates found in another study in similar communities. It may be possible to use surveys of female

alcohol use to estimate the prevalence of FASD in a community.

Context of the women at risk

It became clear that the majority of women at risk of AEP were living in poverty, and faced daily struggles in difficult circumstances. There was some evidence that many had some level of depression, and substance use was seen as a coping mechanism. Women feel isolated and hopeless in the face of food insecurity, domestic violence and abuse. Typically, the men in the community also used alcohol with many of them using very high amounts in a weekend binge pattern.

Consequently the problems of women and their partners needed to be understood and managed in a more holistic way. Further, people with alcohol-related problems, especially in rural areas, in need of specialist substance abuse rehabilitation services (in or outpatient basis) are unlikely to have access to such services due to the scarcity of such services and the urban bias in their location.

Liquor availability, quality and controls

Alcohol is readily available in most communities, and in some areas the licensed and unlicensed outlets are plentiful. Although the liquor control legislation differs from province to province, there is sufficient legislation to protect pregnant women and children from use of alcohol in public outlets. However, there is insufficient enforcement of such as clauses, and the unlicensed outlets still need to comply with a
license application before codes of conduct are adopted.

There is evidence that some wine sold in papsakke or in plastic bottles have unacceptable levels of chemical contaminants such as mercury, pthalates and ochratoxin. The combination of these chemicals and the ethanol in the wine could be responsible for more damage to the fetus than the ethanol alone.

Living with FASD

Although children with FASD assessed at 7-12 months did not display marked developmental problems compared to non-FASD children at the same age, when a comparison was made at 5 years of age, the difference was marked, showing the FASD is a disorder that affects the child more as they develop. However, in the high

risk areas the general level of malnutrition leading to stunting is high, and the level of stimulation for children is poor. These factors affect both FAS and non-FAS children.

Families are offered little support regarding how to manage their FAS child's behaviour and stimulate them appropriately. There is some evidence to suggest that foster parents receive more support from government services than biological parents.

The educational services are too overwhelmed in high prevalence areas to effectively deal with the needs of learners with FASD. It is possible that people with FASD are disproportionately represented in correctional facilities.

PROMISING PREVENTION STRATEGIES

There is support for a public health approach to the prevention of FASD through a comprehensive model that includes universal (community wide), selected (women of childbearing age) and indicated (high risk women) strategies.

Community -wide

Raising awareness on a community level, and engaging community members in action around alcohol problems, is an important component of a comprehensive approach to FASD prevention. However, although there is some local government support, communities find it difficult to make appropriate plans and take action as they are struggling with issues of daily survival. Existing programmes (such as Ke Moja) and new initiatives (such as the "Sober SA, Safer SA") could provide resources for community action.

Women in general

The training of service providers to screen all women of childbearing age for alcohol use, to offer educational information to low risk women, and refer women at high risk of AEP, was tested and results appear promising.

High risk women

There is growing evidence to suggest that a brief intervention with women at high risk of AEP, and especially those who have previously had a FASD child, can improve contraceptive use and or reduce alcohol consumption. The intervention can be either before or during pregnancy, and can reduce the exposure to alcohol. Studies made use of standardised screening tools, such as the AUDIT, and 3-5 brief intervention sessions, with educational material. In all the studies presented there was improvement in both the control and intervention groups, however, those receiving the full brief interventions showed the most change. It was recommended that lay counsellors are the most appropriate personnel to carry out the intervention. A similar approach was applied to women who smoke in pregnancy and came to similar conclusions, and recommended the use of peer counsellors.

In assessing outcomes, it is never possible to be sure if women answer truthfully in their responses to questions on substances. A computer assisted self assessment in clinics was discussed as a future possibility, but the consensus was that for now the emphasis should be on establishing an empathetic rapport between service provider and client, increasing the possibility of an honest and fruitful discussion.

PROPOSED KEY STRATEGIES FOR FASD PREVENTION AND SUPPORT

Surveillance and monitoring

- **Extrapolate from surveys to estimate AEP**
- **Improve registration of diagnosed cases**

Screening and brief interventions

- **Introduce standardised screening for substance abuse in all health services**
- **Introduce a protocol for brief interventions that match the level of risk**
- **Improve routine record keeping of screening and brief interventions**
- **Strengthen the referral chains and follow-up of women at risk of AEP to ensure continuum of care**

Awareness raising and education

- **Build capacity in key categories such as teachers and religious leaders to be able to educate people on the prevention of FASD**
- **Include FASD prevention messages in other campaigns and services where relevant**
- **Build capacity in key categories such as teachers, social workers, and police, to understand and support families with an alcohol-related FASD member**

Liquor controls

- **Consider diagrammatic warning messages on alcoholic beverages + standard drinks**
- **Improve the testing of all alcoholic beverages and the removal of those found with unacceptable levels of various chemicals**
- **Improve the enforcement of liquor serving controls i.e. not to pregnant or breastfeeding women, and youth under 18 years.**
- **Introduce universal training of liquor sellers on strategies to prevent alcohol abuse**
- **Integrate substance abuse prevention activities with broader poverty alleviation programmes and life skills programmes.**
- **Use positive role models to convey messages of hope and success especially in areas seriously affected by substance abuse.**

Research Gaps

- **What screening tool should be introduced across the country?**
- **What is the ideal number of brief sessions with women at risk of AEP, and who should deliver this?**
- **How can screening and brief interventions for substance abuse be integrated into other health programmes such as VCT?**
- **In what way can the partner or other family member be incorporated into the brief interventions?**
- **How is depression in women linked to substance abuse?**

- How can specialist rehabilitation services be made more appropriate and locally available to the highest risk women/ families?
- What role could religious leaders play in the prevention of FASD?
- What training needs to be provided to Educare and school teachers to enable them to support the needs of FASD learners?
- What support needs to be provided to families with a FASD member in order that they
- reach their potential?

PRESENTATIONS INFORMING THE POLICY BRIEF

Davies, L *Davies, L*	Neurodevelopmental functioning among infants with FASD in the N Cape. The pattern of maternal depression amongst women with a FASD infant within a community in the N Cape.
Jacobs, N *Jordaan, E*	Local action: FASD community awareness raising and mobilisation. Confirmed and unconfirmed drinking in pregnant women: does this affect the intervention outcome in the Ceres FAS study?
London, L	If the alcohol doesn't get you, then the other toxins will: Potential role of contaminant toxicants in high FAS prevalence in the W Cape.
Marais, S	Preventing FAS: effects of screening and brief interventions on the drinking behaviour of pregnant women - a cluster RCT.
Moodley,	Proposals to change drinking behaviour in pregnant women: findings from a Ceres FAS study.
Morojele, N	Reducing the risk of alcohol exposed pregnancies in the W Cape: a randomised controlled trial evaluating motivational interviewing and life skills training.
Mwanza, *J Olivier,*	Predictors of risk of alcohol exposed pregnancies among urban and rural women in South Africa.
Parry, C *Rendall-Mkosi, K*	The evaluation of a service provider short course on the prevention of FASD Epidemiology of FASD in the N Cape.
Steyn, K	FAS prevention study (FASER-SA). The barriers to preventing and managing FAS in South Africa.
Viljoen, D	The development and evaluation of a smoking cessation intervention for disadvantaged, pregnant women attending public sector clinics in Cape Town. Epidemiology and risk factors for FAS in the W Cape.

URL link to UP website where FASD Symposium Programme and Proceedings docs can be found.
http://research.newsbeat.co.za/projects/FAS.html

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