# A VIRTUE APPROACH TO PUBLIC HEALTH ETHICS

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**ABSTRACT**

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While the virtues, or ideal character traits, of a physician are well established as a cornerstone of medical ethics, the focus in public health has been on policy and practice, not on professionalism. In this dissertation I focus on the contributions that a virtue ethics approach can make to discourse in public health ethics. The central points of my dissertation include (1) an aretaic concern with balancing self- and other-concern can help resist oversimplifying public health problems in terms of conflicts between group interests and individual rights (2) the virtue of trustworthiness suggests trust as an alternative to paternalistic relationships in public health practice, (3) the language of courage and its associated vices is sometimes latent in public health risk discourse, and (4) the notion of *harmartia*, or "missing the mark" can shed light on current debates regarding the scope of public health as a discipline. I consider it to be an advantage of virtue ethics that it connects what public health professionals ought to *do* with what kind of life professionals want to live, or *who* they want public health professionals to become. By speaking to the professional identity of public health workers, my contribution to ethics of public health helps to address the concern that the profession currently lacks a coherent normative foundation. My primary aim throughout this project is to demonstrate how virtues create a standard of excellence that professionals can aspire to attain.

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INTRODUCTION

"Medicine is a moral community because it is at heart a moral enterprise and its members are bound together by a common moral purpose. If this is so, they must be guided by some shared source of morality – some fundamental rules, principles, or character traits that will define a moral life…"[1] This is the way Pellegrino and Thomasma begin their account of the virtues in medicine. Within the last two decades, the call for greater attention from bioethicists to address the normative foundations of public health has grown increasingly louder, with some of the voices beginning to fill in such accounts. Public health has been traditionally understood as deeply rooted in utilitarianism, but Onora O'neill's work demonstrates that Kant can hold his ground in public health ethics as well. My purpose here is to establish a place for virtue ethics within the nascent stages of this discourse.

It is also important to say what I do not intend to offer here, which is a comprehensive account of the virtues. I draw primarily on Aristotelian notions of virtue, but also some Stoic and Platonic insights to supplement this account. I do not, however, address some of the pressing questions in ancient philosophy, including whether there is a unity of the virtues, and the related question of whether the virtues are a form of knowledge. And while my approach is eudaimonistic, I do not offer a full-fledged account of the flourishing life (*eudaimonia)*. Rather, by focusing on the virtues of professionals, the task at hand is truncated. But it is, for the same reason, incomplete. While I have provided some insights into the connections between virtues and professionalism, there are many different approaches to virtue theory. Thus, bioethicists

1 Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 3.

interested in moral theory should be cognizant of the potential for debates in ancient circles to disagree with what I have suggested here, both in matters of interpreting Aristotle, but also due to ongoing debates in virtue theory. Meanwhile, public health professionals should be aware that such conversations, while occurring primarily in the circles of philosophers and classicists, may nevertheless have implications for public health practice. For example, whether the virtues are a form of knowledge, and how we acquire them may be central to public health education and training.

The suggestion that virtues are pertinent to public health practice is not new.[2] But, for public health ethics, they are not necessarily an intuitive place to start. Given the focus of public health on collective ends and means, the agent-centered perspective of virtue ethics may seem ill suited to the nature of health policy. By approaching ethical questions from perspective of the agent, a virtue ethics approach works from the "inside out."[3] Given current feelings of professional angst, however, I consider it to be an advantage of virtue ethics that connects what public health professionals ought to do with what kind of life professionals want to live, or who they want public health professionals to become. By speaking to the professional identity of public health workers, my contribution to ethics of public health helps to address the concern that the profession currently lacks a coherent normative foundation. In addition, while I address civic friendship and civic courage in Chapters 1 and 3 respectively, my

2 Douglas L. Weed and Robert E. McKeown, "Epidemiology and Virtue Ethics." *International Journal of Epidemiology* 27, no. 3 (1998): 343-8; J. Stuart Horner, "For Debate: The Virtuous Public Health Physician." *Journal of Public Health Medicine* 22, no. 1 (2000): 48–53; Wendy Rogers, "Virtue Ethics and Public Health: A Practice-based Analysis." *Monash Bioethics Review* 23, no. 1 (2004): 10–21."

3 John McDowell, "Virtue and Reason," in *Virtue Ethics*, ed. Roger Crisp and Michael Slote (New York: Oxford University Press, 1997), 141-62.

primary aim throughout this project is to demonstrate how virtues create a standard of excellence that professionals can aspire to attain.

My approach to this project was to consider how the resources of virtue ethics could be brought to bear on four ethical aspects of public health practice: 1) How to resolve conflicts between individual rights and group interests; 2) Public health paternalism and its justifications; 3) Risk communication and risk management; and 4) The boundary problem, or how to determine the proper scope of public health.

In Chapter 1, I argue that an Aristotelian view of civic friendship can help to approach problems in public health often conceived of as conflicts between the individual and the community. I critique the tendency to characterize the options available to citizens in terms of a spectrum that runs from self-centered disregard for others, to altruistic sacrifice on behalf of others. I contend that public health professionals will play a role in fostering civic friendship, which involves *both* self- and other- concern.

Chapter 2 is divided into two parts. In the first part, I consider some faulty arguments used to justify public health paternalism, and critique the resultant suggestion that the proper relationship between public health professionals and members of the public is epistemic deference, and that the main responsibility of public health professionals is to be competent. In the second part of this chapter, I defend relationships of reliability and trust – and the corresponding traits of reliability and trustworthiness, of which only trustworthiness is a virtue.

In Chapter 3 I argue that the virtue conception of courage and its associated vices can contribute to greater clarity in risk discourse while professional expression of the virtue itself can guide appropriate responses to fear in public health practice. The main contention in this

chapter is that cultivation of the virtue of courage will help to place attitudes and perspectives regarding fearsome objects at the center of discussions of and reactions to public health hazards. I argue that the virtue of courage helps to initiate a discussion as to what kinds of attitudes of fear we might consider appropriate and inappropriate in response to public health hazards, especially in public health professionals.

In Chapter 4 I examine current debates over the boundary problem, or what counts as public health problem. I consider different candidate features of public health that are often proposed to mark the field as distinctive from any other. I consider the merits of these "models" of public health, but also their limitations and especially their potential to lead to problematic or objectionable forms of "publichealthification." I provide an Aristotelian account of *hamartia*, or missing the mark, that helps to capture a more complex picture of goal-oriented behavior by collectives, not merely by individuals. I then consider what resources a virtue account can muster in order to provide guidance for how inquiry into a philosophy (and ethics) of public health may proceed.

## CHAPTER 1: BALANCING SELF- AND OTHER-CONCERN IN PUBLIC HEALTH PRACTICE

"…there's no question of heroism in all this. It's a matter of common decency. That's an idea which may make some people smile, but the only means of fighting a plague is – common decency." -Albert Camus, *The Plague*[4]

In this chapter, I argue that an Aristotelian view of civic friendship can help to approach problems in public health often conceived of as conflicts between the individual and the community.[5] While such problems often characterized the options available to citizens in terms of self-centered disregard for others, or altruistic sacrifice on behalf of others, I seek other options available for cooperation with public health interventions. In Section 1 I outline the ways in which such conflicts are often conceptualized in public health. I then present the Aristotelian conception of civic friendship as illustrative of the ways in which self- and other-concern, as found within the aretaic tradition, complicate the picture of human motivation at play in policy conflicts. I then consider to what extent civic relationships exist in modern society. In Section 2 I consider the notion of *synoptic perspective* to articulate the way in which Aristotle envisioned a community, and its pertinence to public health practice. I conclude that public health policy will sometimes play a role in facilitating members of the public to take on the synoptic perspective. I expand on Childress and Bernheim's notion of imaginative engagement, which I conclude plays a role in fostering civic friendship, and thus one way for public health professionals, with the help of the community, to balance individual and communal interests.

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4 Albert Camus, *The Plague*, trans. Stuart Gilbert (Vintage Books, 1972), 53.
5 Throughout, I rely on Aristotle, *Nicomachean Ethics*, trans. Christopher Rowe, ed. Sarah Broadie (Oxford: Oxford University Press, 2002).

## 1.1 Civic Friendship

In this section I present the way in which individual and group conflicts are commonly portrayed in public health ethics, and how this sets up two contrasting understandings of civic attitudes as exclusively self-concerned, or entirely other-concerned. I then consider the ways in which an Aristotelian notion of civic friendship allows for a more complex notion of civic dispositions.

### 1.1.1 Altruism and Selfishness

Let us consider the classic public health challenge of an epidemic. Throughout the chapter I will consider other public health hazards, but the possibility that quarantine may be needed is often relied upon to illustrate the nature of conflicts in public health ethics. In the context of an epidemic, public health professionals must consider how to control the spread of the disease within and between populations. In such cases, the collective goods of health and safety are at stake. Containment methods, however, may require restrictions on the actions of individuals, including travel restrictions, isolation of the infected, and involuntary quarantine of the exposed. In determining when to call for such measures, the conflict is often depicted as a choice between individual liberty (sometimes in terms of rights) and collective wellbeing. For public health ethics, the challenge is to justify limiting the actions of some individuals in the name of the community – and the solutions are often expressed in terms of "trade-offs."

The value of civil liberties is often associated with political liberalism, in its diverse forms. A valuing of individual freedom in part marks a desire to allow individuals to pursue diverse conceptions of a good life, i.e., to pursue preferences and interests distinct from those

that arise due to membership within a community. Part of the challenge that this presents for public health is the ways in which it sets up a dichotomous depiction of the behavior of citizens during an epidemic. Stalwart defenders of civil liberties may appear not as advocates for human rights, but as self-centered and indifferent to the wellbeing of others. In contrast, those who willingly comply with public health efforts appear to be paragons of supererogation, making great sacrifices for the public good. Thus, the picture we get of civic attitudes in public health emergencies is pure self-concern and pure other-concern.

The false dichotomy I have articulated results from an understanding of morality that has been criticized by many proponents of virtue. Altruism is commonly understood as a willingness to place the interests of others before one's own. The notion of sacrifice as essential to moral action results from the view that acting for one's self, or valuing the individual, is to prioritize satisfaction of desires. In contrast, when individuals act on behalf of others, they act out of a sense of obligation, contrary to their desires. This picture of morality has been resoundingly criticized by Bernard Williams who notes that such a notion "makes people think that, without its very special [sense of] obligation, there is only inclination; without its utter voluntariness, there is only force…"[6] It rules out the possibility that being moral counts amongst my interests, because a moral life is one I would prefer to lead.

Public health ethicists have used many different ways to rearticulate what can be done about such conflicts between self and other, including compatibility arguments that point to

6 Bernard Williams, *Ethics and the Limits of Philosophy* (Cambridge: Harvard University Press, 1986), 196.

the deep connections between human rights and wellbeing.[7] Others have suggested "internalizing" the tension to illustrate the way that civil liberties contribute to communal wellbeing, or by articulating the ways in which individuals desire both: "We are all torn between our private wills and our civic wills, between our interests as isolated individuals or consumers and our moral interests and commitments as members of a community of shared purpose broader than ourselves. This is the symbiosis of the public and the private."[8] In one way, what I propose here is a continuation of this work. However, even amongst such work, the view of altruism is still the most dominant conception of moral action. I hope to make room for an alternative vision of civic participation that does not equate it with "a society of total commitment."[9]

### 1.1.2 Civic Friendship

For the ancients, *"Philia* is other-concern restricted to those people to whom one has a certain kind of commitment. The commitment can be deep, as with friendships based on good character, or shallow, as in utility friendships; it can be continuing or transitory. It can be based on mature choice…or can arise from an unchosen relationship."[10] Schwarzenbach notes that the notion that the positing of a "friendly feeling" that binds citizens together is often considered a rather parochial thought in modern political philosophy. But the connections put

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7 Jonathan M. Mann, "Medicine and Public Health, Ethics and Human Rights." *The Hastings Center Report* 27, no. 3 (1997): 6–13.
8 Bruce Jennings, "Public Health and Civic Republicanism," in *Ethics, Prevention, and Public Health*, ed. Angus Dawson and Marcel Verweij (Oxford: Oxford University Press, 2007), 55.
9 Ibid., 55.
10 Julia Annas, *The Morality of Happiness* (Oxford: Oxford University Press, 1995), 250.

forth can be distinguished from interpretations that depict such relationships as merely superficial ties, or its contrary, a utopian fantasy: "a society animated by civic friendship is an ideal; it is not satisfied if each citizen likes some citizen (which is far too minimal) nor can every citizen like every other personally (which is impossible). Rather, such liking and doing works via public standards of behavior, standards which ultimately do rest on the goodwill and friendly dispositions of its individual citizens."[11]

However, it would be a mistake to identify civic friendship merely with goodwill, a kind of general well-wishing or beneficent view of others, or even purely emotive feelings of affection. While such attitudes do exist, Aristotle distinguishes goodwill from friendship by pointing out that general goodwill extends to strangers, or springs up suddenly – and therefore can dissipate just as quickly. (*NE* 9.5 1166b30-1167a3) Rather, he observes that goodwill is the starting point of friendship. And the true mark of friendship is not feelings or sympathy that might develop, but rather that such interest in benefitting others is *motivating*; it moves friends to action, to do something that furthers the interests of others, or even to combine their efforts together – to unite to achieve shared ends or mutual benefit (*NE* 9.5 1167a10).

### 1.1.3 Resemblance to virtue friendship

Aristotle's view of other-concern is admittedly paradoxical – he claims that our caring for others is a development from self-concern. (*NE* 9.8) Thus, the odd conclusion is that we care for others because we care for ourselves. Aristotle's view of other-concern reflects the element of formal egoism present in his philosophy: to love one's self is to desire to live the

11 Sibyl A. Schwarzenbach, "On Civic Friendship." *Ethics* 107, no. 1 (1996): 109.

most excellent life available to one, and sometimes this also means making sacrifices which are, on balance, what one desires the most. This is counterintuitive in part because the notion of a beneficial sacrifice sounds incoherent. What is less controversial, and perhaps a feature of all human life, is the reality that it is sometimes preferable to sacrifice some desires in order to fulfill others. The virtue ethicist merely adds that the desire to live a moral life is the motivating force behind a virtuous agent's decisions.

Formal egoism should be contrasted to substantive egoism. Unlike relationships developed just for the benefits of association, prestige, or other self-serving ends, virtue-friends are not motivated by the self-centered benefits of friendship. Rather, virtuous friendship involves true concern for the wellbeing of another – but nevertheless, acting in such a way can further the happiness of an agent, precisely because caring for another often entails that two friends' happiness is tied to that of the other. Just like close friendships and family, virtue entails that the flourishing of others can be (and may even *need* to be) part and parcel of the agent's flourishing. This may be, in part, because it is hard to imagine a solitary life being the very best of lives. But, for Aristotle, the reverse is true as well. True friends care about our own wellbeing, and as a result help us to achieve happiness – they help us to attain what we cannot on our own.

Thus, the first reason that civic friendship resembles the best kinds of friendship is that it is tied to our nature. The good life for humans is a social one – characterized by the goods of experience that only companionship can provide. In addition, Aristotle's view is that some good activities are not available to us unless we engage in civic forms of activities – which help us not only to construct a good life, but also a good society. And the two are also not easily

extricated. It is also worth considering whether a flourishing life is possible outside of the context of a good community. This is a point that I come back to throughout this project, returning to it in both Chapters 2 and 3; virtues arise out of shared sets of practices, and social institutions and communities are what create and sustain such practices. For the purpose of this discussion, I am interested in the ways in which public health professionals engage in activities that are constitutive of a moral community.

Julia Annas describes the Aristotelian insight that other-concern involves a recognition that "a friend is another self." Thus, just as we care about our own-wellbeing, we can extend this capacity for concern to others. We might do this because we realize that our happiness is tied up in that of others', but another benefit of friendship is that it provides with insight into ourselves. We are often able to identify the character strengths and weaknesses of others, and as a result gain insight into our own proclivities for vice and virtue. In addition, the intimacy that friendship provides also helps us to articulate our desires, or shape new ones.[12] Friendship, then, is central to learning who we are, and who we want to be.

The second reason that civic friendship resembles virtue friendship is that it also lends us similar insights. The communities that we inhabit and identify with inform of us who we are. Ancestors provide us with ideals to emulate, and also examples of mistakes to avoid. Contemporary communities help to form our desires, for the good and for the bad. When we enter new communities, they provide similar opportunities for us to learn about ourselves, and what kind of lives we wish to lead both as individuals, but also as members of such groups. Thus civic friendship is greatly important to shaping the possibilities for my individual life to be

12 Annas, "The Morality of Happiness," 254.

the very best, but also in forming an understanding of what it means to be part of a community. I will argue in the remainder of the chapter that this aspect of civilian life is central to the work that public health professionals do.

What are the limits of civic friendship? Aristotle did not believe that other-concern extended to everyone; in his society, perhaps he failed to see how all of humanity might be able to consider themselves part of one community. But Julia Annas explains that this view of the limits of other-concern was not unanimous amongst the ancients. In contrast, the Stoics claimed that, in fact, other-concern does extend to the far reaches of the world.[13] In today's globalized world, the occurrence of pandemics illustrates the need for an ethics of public health that can accommodate such connections with strangers on the other side of the world. If an Aristotelian virtue ethics is to be modified to fill this "gap," then other-concern must be extended to any whom share the kind of connection Aristotle had in mind.[14]

Civic friendship is both based on and is found in "a good that is common not just in the sense that each severally gets some part of a sum total of distributable benefit, but in the strong sense that it is achieved in or belongs to the common activity that is the single life they all jointly live by merging their lives with one another's."[15]

13 Ibid., 251.
14 Ibid., 253.
15 Cooper, John, "Political Animals and Civic Friendships," in *Aristotle's Politics,* ed. Kraut and Skultety (Rowman & Littlefield, 2005), 79-80.

1.1.4 How can other-concern also be in my interest?

I would like to return again to the notion that friendship simultaneously involves self- and other-concern. Such a possibility will need to be examined for civic virtue more particularly because it seems incoherent to say that making a sacrifice is in my interest. According to Aristotle, the individual who dies for a greater cause knows the value of her own life and wellbeing: "for to such a person, most of all, is living worthwhile, and *this* person will knowingly be depriving himself of goods of the greatest kind." (*NE III.7 1117b10-13*). I revisit the importance of this in the context of courage in Chapter 3, but for now I wish to establish that for Aristotle, when other-concern entails that an agent put others' interests ahead of her own, she feels this as a sacrifice. Nevertheless, virtuous agents will only do this voluntarily if they are simultaneously striving for something they deem more valuable, or fine. When the happiness of others is truly tied to our own, it sometimes hurts more to watch our friends suffer than to sacrifice something of our own to save them pain. Again, Annas provides us with a simple example in the context of friendship:

> the self-sacrificing agent is *also* getting for herself what matters. Her motives will thus be mixed. She sacrifices her money, say, so that her friends can get more money. She does this for her friends' sake, because this is a fine thing to do (and not for any ulterior motive, such as showing off or feeling virtuous). But she also 'assigns the greater good to herself,' for in doing a virtuous action she is doing what matters to her more than gaining money, and so gaining what she regards as her good.[16]

The plausibility of this example illustrates that the view of self- and other-concern and their compatibility is certainly possible in everyday life. We commonly put ourselves out to accommodate those we care about, and while certainly we may be irritated sometimes, there

16 Annas, "The Morality of Happiness," 259.

are other times when we think such actions are part of what it means to be, and to have, good friends. And so while we acknowledge the sacrifice as a loss, we often downgrade its significance given that the action also helped someone we care about. Nevertheless, there is a real question of how deep of a cost we are willing to make for our fellow citizens, and whether we feel a strong enough connection to write off the costs required by public health participation.

The possibility for self- and other-concern to be expressed simultaneously is significant in public health because it shatters the two opposing options of altruistic or self-centered action. I argue this opens up more options for public health professionals to depict different motivations for engaging in public health interventions that also impose burdens. On this view, cooperation in public health interventions does not need to be selfless – citizens do not need to view public health activities as inherently implying that some individuals will be sacrificed for the greater good, i.e., will be made into public health martyrs. When public health cooperation requires small sacrifices on the part of citizens, they might think of small things, like proper disposal of household hazardous wastes, in terms of "doing one's part" or helping the community. But when large sacrifices are made – as in the case of quarantine – we need an account that explains why, on balance, this is also in the agents' own interest.

Philippa Foot provides a different picture of aretaic sacrifice, and a correspondingly alternate interpretation that is helpful for understanding large sacrifices. She is especially concerned the kind of hits to an agents' interests that seems hard to characterize as, nevertheless, a benefit to the agent "on balance." She offers us

a different example of men who were imprisoned and sentenced to death for opposing the Nazis. In their letters to loved ones, the men seem to express a sense of regret for what might have been, but not their resistance. "So one may very naturally say that they knowingly sacrificed their happiness in making their choice. And yet this does not seem to be the only thing we could say. One may think that there was a sense in which the Letter Writers did, *but also a sense in which they did not*, sacrifice their happiness in refusing to go along with the Nazis."[17] On this alternative view, the sacrifice made does not (pace Socrates*)* give the men the very best of lives. Rather, the very best of lives – ones lived with families and friends in a way consistent with justice and honor – were simply not an option. But under the circumstances, such an option was tragically unavailable. The sacrifice on this view does not, on balance, bring the agent closer to the very best life; it is simply the only better option of two terrible alternatives. Thus, we are able to say it is the very best life for her, given the circumstances.

I contend that this second view will also be necessary for public health professionals to make room for. If and when great sacrifices must be made, one might consider that options for all involved are tragic. In the case of a serious epidemic, quarantine may be a terrible method that provides the only possibility for lessening the severity of the unfolding communal tragedy. In imposing serious sacrifices on others, however, employing quarantine also imposes tragic costs on individuals.

17 Philippa Foot, *Natural Goodness* (Oxford: Oxford University Press, 2003), 95 original emphasis.

1.1.5 Do civic friendships exist in modern societies?

What evidence is there that modern citizens employ shared norms for behavior *qua* citizens? One might look at national narratives cultures share invoking such norms. The stories we tell – our local, regional, and national narratives (even if not based in fact) are expressions of and mechanisms for reinforcing such expectations. That such narratives work to draw contrasts to non-citizens marks the difference Aristotle had in mind – the notion that citizens conceive of their relationships to each other as different from their relationships to citizens of another country. As John Cooper observes in a rather prescient statement in 2005:

> The typical American when she hears, say, about the attitudes of Wall street brokers and commercial bankers have apparently quite routinely been holding about privileged information that comes their way in their professional work, about sleaziness in government circles, feels injured in ways she certainly does not feel in hearing similar things said about people in high places abroad.[18]

Bernheim and Childress, however, note that invocations of national civic identity is complicated in the United States: "they [citizens] have conflicting, often incoherent, civic ideals that fluctuate between egalitarian and inegalitarian and liberal and nonconsensual orientations, with strong populist and pragmatic sentiments predominating at different times. Share myths both shed light on the American civic identity and operate to shape that identity...they can persuade people with different philosophies, beliefs, and loyalties that they share a civic identity."[19] While civic identity is not the same as civic friendship, Bernheim and Childress reveal that civic identity is another starting point for civic friendship. Like goodwill, it sows the seeds for engaging in collective action on behalf of one's community.

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18 Cooper, "Political Animals," 73.

19 James F. Childress and Ruth Gaare Bernheim, "Beyond the Liberal and Communitarian Impasse: A Framework and Vision for Public Health," *Florida Law Review* 55, no. 5 (2003): 1213.

One objection to this view would be that modern societies are entirely too diverse to assert that all citizens do in fact have, or ought to have, such relationships. Either the content of such mutual concern will falsely presume a unity of purpose or identity, or it will postulate such "thin" commitments (be just, be civil), as to be meaningless. This critique draws our attention to the key feature of civic friendship, which is a bond that is strong enough to move one to action. But such actions span a broad array, including mere civility, all the way to dying for one's country. Civic friendship is not just a feeling, it is an activity: "there are all those activities which we perform for strangers (from giving the correct time to fighting for their liberties) as well as those institutions through which we respect others, grant them their rights, help them in troubled times, and so forth. The critical point is that to persist in seeing others in this "friendly" way requires training, repetition, and above all, public reinforcement."[20] Thus, the role of public health professionals will be this educative one, and is the topic of the next section.

## 1.2 Civic Friendship and Public Health

In this section I summarize an Aristotelian notion of synoptic perspective and examine the ways in which it is involved in public health work, as well as some possible objections to this viewpoint. I then consider the ways in which public health professionals employ strategies of imaginative engagement to reinforce and create civic friendships. Lastly, I consider some illustrative examples in contemporary public health practice.

20 Schwarzenbach, "On Civic Friendship," 121.

1.2.1 The Synoptic Perspective of Public Health

In this section, I will be drawing on David Janssens' articulation of an Aristotelian "synoptic perspective," or the vision of a community or group from an outside vantage point. Janssen develops this account from Aristotle's employment of the term *eusunoptos,* which translates roughly as the feature of being able to be "easily taken in at a glance." Synoptic perspective denotes the picture of a group, community, or citizenry that one grasps from a vantage point removed, or at some degree of distance from the group itself.[21] In context, synoptic perspective conjures up a human parallel to the common idiom that it is often difficult to see the forest for the trees; i.e., to view oneself as a member of a group, one first has to have a vision or understanding of the group as a whole, as well as one's place within it. According to Janssens, such envisioning requires a creative process of social construction by which one comes to see oneself as having a story within or as part of a community:

> Political unity is intimately connected with memory and narrative: for a political community to view itself and act on itself as a whole, easy to be taken in with a glance, it must be able to see and remember itself as involved in a plot, a common history. However, both are never simply historical facts, but poetic and rhetorical constructs…[22]

I contend that this view is also central to public health practice, where public health professionals are able to see what members of populations have in common with respect to health. The unique nature of population data, however, means that new potential communities are revealed by newfound public health commonalities. Epidemiologists may discover a higher death rate for commuters during peak hours, or a higher incidence of a

21 David Janssens, "Easily, At a Glance: Aristotle's Political Optics," *The Review of Politics* 72, no. 3 (2010): 393.
22 Ibid., 404.

disease for women ages 25-35 in the San Francisco area. By revealing that such populations have something in common, population health data sets the stage for public health interventions to create new, or build upon existing, civic friendships. If, in educating the public about new health statistics, citizens form new identities or affiliations, then they may move to act in concert with others in the group on their own, thereby creating new civic friendships. But by proposing participation in public health interventions (e.g., community walks to reduce obesity, arthritis support groups at the local community center), public health professionals also cultivate civic friendships.

### 1.2.2 Objections to the Synoptic Perspective

One objection to the synoptic perspective is that it may mislead public health professionals to assume that population health data implies that such groups already have reason to act. Importantly, the synoptic perspective does not assume that a community's coherence is already formed, or that it can or ought to be achieved in a monolithic fashion. Rather than viewing individuals and communities as purely static relationships that exist prior to political leadership, this view accommodates the dynamic process of constructing public forms of identity; "the citizen community...is neither entirely pre-given nor entirely produced: rather, it remains suspended between these two poles, and cannot be reduced to either."[23] This view harmonizes with that of Childress and Bernheim on imaginative engagement, which envisions policy as derived from both citizens and public health officials.[24] However, in

23 Ibid., 329.
24Childress and Bernheim, "Beyond the Liberal and Communitarian Impasse," 1191.

attempting to make civic beliefs explicit and community values intelligible, public health professionals will need to be wary of various pitfalls that result from misinterpreting what the synoptic perspective entails.

First, because population data alone does not establish shared interests, a public health synoptic perspective should not be interpreted to entail group homogeneity. As Schwarzenbach warns, "political friendship between citizens today can no longer refer to a state where all citizens share the same "thick" values."[25] The perspective of *eusunoptos* captures a delicate balance by which agents see themselves as part of a group from the outside, while simultaneously recognizing their particular and actual membership within the group from the inside:

> while it is true that the object will not be seen as a meaningful *whole* if the viewpoint is too close, the object will not be seen as a *meaningful* whole if the viewpoint is too far away. In the latter case, the heterogeneity of the parts can no longer be recognized, so that the whole cannot be defined as *this* or *that* particular whole, in this case, friends or enemies. Thus it would seem that *eusunoptos* involves a process of negotiating the proximity of a practical perspective and the distance of a theoretical perspective.[26]

Thus, public health statistical indices call upon us to abstract away from our particular life and see ourselves as part of a whole, whose members we previously may not have recognized as a collective. But to act upon such knowledge in civic friendship, we must come back to the particular, and act *in* community with others. But, the warnings against homogenization should not be underemphasized; public health professionals will need to be prepared for civic identities, and therefore civic friendships, to come into conflict. This may be internal to public

25 Schwarzenbach, "On Civic Friendship," 114.
26 Janssens, "Easily, At a Glance," 394.

health – I may have many disparate potential communities to identify with given population health information, and I cannot possibly act on all them, merely as a matter of expediency. But external to the possible civic friendships I can form based in collective efforts to achieve healthier societies, there are also entirely different civic friendships that may conflict – either substantively, or again, as a matter of expediency. Thus public health professionals must be careful not to assume that engaging a community will always lead to citizens prioritizing that community over others to which they feel much stronger ties. Rather, imaginative engagement (which I address in the next section) begins with the view that plurality, complexity, and even contradictory features will characterize civic identity.[27] When such professional expectations demand that citizens act on one particular civic bond – without justifying its priority over competing forms of other-concern – public health professionals *impose* rather than *express* community.[28]

Second, in tapping into existing "thicker" community narratives that build solidarity, group identity, and a shared vision of the good, public health professionals risk endorsing problematic aspects of such identities. The narratives that characterize American national identity are disparate and conflicting, even incoherent.[29] Such narratives also often achieve unification at the expense of creating an out-group; in defining who we are as a group we necessarily also identify who we are *not*. Thus, if public health professionals engage in a practice of eliciting communal forms of shared identity, they will bear some responsibility for the result, including any exclusionary and oppressive aspects of such visions. It will be a

27 Childress and Bernheim, "Beyond the Liberal and Communitarian Impasse," 1213.
28 Ibid., 1208.
29 Ibid., 1213.

challenge for public health professionals to create the space for individuals and communities within a population to express multiple and even conflicting notions of who they are.

However, one important implication that arises from the synoptic perspective is that other-concern can arise from relationships we do not choose to have; i.e., we can feel compelled to act in concert with others because we are connected in ways we did not choose to be connected. The impetus to act does not derive from the fact that I have something in common with others, but that in finding out about such interests (or such a group), these new connections *moves* me to act for our mutual benefit. For public health practice, an understanding of other-concern explains why it is that we may have an interest in population health indices – they reveal to us relationships to others that we did not know about. They illustrate to us the ways in which our health is intricately connected to the health of others, and how we may be able to achieve a better life by acting in concert.

### 1.2.3 Imaginative Engagement

With Childress and Bernheim I contend that a process of "imaginative engagement" may be central to public health efforts to navigate the polarity of communitarian and liberal characterizations of relationships between groups and individuals. The process of imaginative engagement uses "personal narratives, stories from history or literature, or revelations of personal uncertainties and vulnerabilities"[30] to depict different ways in which citizens can act together, and respond collectively. In public health for example, Jacob Heller considers the potency of stories about the development of the polio vaccine, which at the time of its advent

30 Childress and Bernheim, "Beyond the Liberal and Communitarian Impasse," 1215.

coincided with a national confidence in science and technology. Thus, such narratives were a reflection of contemporary public understandings of American ingenuity and potential – public health vaccination success represented the society citizens wanted to live in. Today, such stories still have power when used in public health because they invoke the possibility of similar success and safety in the future, and a kind of return to a golden time in American public health history.[31] Such stories remind Americans of the collective benefits of public health, and create civic ties that generate corresponding collective behaviors, such as willingness to be vaccinated.

The authors' use of narrative strikes a chord with the Aristotelian view of the *polis as"* easily taken in at a glance," and the actions that follow from imagination can be said to be an imitation of this possibility, a reproduction and discovery of a shared vision for a community. At the heart of this process lies a recognition – a glimpse of oneself in relation to the whole: "Political action, both by the individual citizen and by the community as a whole, may be said to be an imitation in order to learn and figure out what each thing is, in this case by anticipating what it is to be a citizen or a community: "That's us!" In this imitation and anticipation, we stage and look at ourselves as a whole that is *eusunoptos*, so that we are able to act as though we actually were what we cast ourselves to be."[32]

Imaginative engagement also illustrates the relationship between civil service and civic friendship: "the state plays a critical role in regulating our awareness of the facts of other citizens' lives (through education, etc.) as well as in stipulating what are to be our minimal responsibilities toward them. The ideal of civic friendship is alive and well in a society which

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31 Jacob Heller, *The Vaccine Narrative* (Nashville: Vanderbilt University Press, 2008), 6–7. Heller's analysis is also concerned with the downside of narratives.
32 Janssens, "Easily, At a Glance," 406.

respects and fosters public service."[33] To claim that imaginative engagement is part of public health work is to claim that the substantive meaning of civic ties are created by both the public and civil servants; it is to articulate a place and role for public health professionals in helping create a public understanding of the relationships that "frame the meaning of all public health actions."[34]

### 1.2.4 Examples in public health practice

What kind of support for public health does civic friendship entail? Civic friendship includes both an attitude toward others and a willingness to act on their behalf. Thus, to be a civic friend one must be concerned about other community members' wellbeing, and also willing to assist in time of need, or to achieve shared ends: "such help can range anywhere from (most minimally) my not begrudging my tax dollars…to my actively supporting such programs and even willingly performing direct public service."[35]

Let us examine one case in public health practice that illustrates the pertinence of imaginative engagement, and civic friendship. Considering the cost of life that resulted from traffic accidents prior to the passage of seat belt laws, Jean Forster articulates that while the potential risk of accident for each individual is low, the annual mortality rate has costs for all of society given the magnitude of lives lost. While it is possible to express such loss in economic terms, it is also possible to consider the ways in which so much loss of life will affect the interdependent and reciprocal relationships characteristic of a society. On this view, "coercive

33 Schwarzenbach, "On Civic Friendship," 110.
34 Childress and Bernheim, "Beyond the Liberal and Communitarian Impasse," 1209.
35 Schwarzenbach, "On Civic Friendship," 109–110.

measures provide opportunities for expression of our concern for the well-being of the whole community."[36] In such a case, citizens support (in the many nuanced ways outlined above) the cost of sacrificing some freedom (not wearing a seatbelt) for the sake of the safety of the community as a whole, or with the idea in mind that such support may save the life of a particular community member I care about *because* she is a member of my community. And we imagine that such a citizen might express her willingness to sacrifice as does the friend who lends another friend money – as being well worth the sting, or even not much of a sting at all. According to this author, an individual will never know if she has benefitted individually from the seat belt law because it saved her life, but she can nevertheless appreciate living in a society that experiences less loss of human life as a result.

But how, then, does this help us resolve the more pressing case of quarantine, when what is required a citizen is much more significant sacrifice? Can civic friendship be strong enough to motivate such actions? I suggest that another case helps to shed some light on the matter: Marcel Verwiej presents the case of immunizing residents of a nursing home, and whether there are valid reasons to support a tacit consent policy.[37] He is motivated by a concern that some justifications presume that vaccination is clearly in the interests of residents or groups. The problem with this assumption, argues Verweij, is that while all members have an interest in avoiding illness, some also have an interest in getting sick – pneumonia that results

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36 Jean L. Forster, "A Communitarian Ethical Model for Public Health Interventions: An Alternative to Individual Behavior Change Strategies," *Journal of Public Health Policy* 3, no. 2 (1982): 159.

37 Marcel Verweij, "Individual and Collective Considerations in Public Health: Influenza Vaccination in Nursing Homes," *Bioethics* 15, no. 5–6 (2001): 536–546. Original emphasis. In doing so, Verweij can be seen as claiming that residents of nursing homes are not civic friends.

from the flu may, on the view of some residents, offer a less painful death than they may face otherwise. Verweij believes that arguments from individual benefit, harm to others, herd immunity, and to protect the most vulnerable all fail. I do not review these arguments here, but it is interesting that he rejects the argument to protect the vulnerable because it presumes a "thick" sense of community amongst residents. When considering the strength of the arguments for a common interest in herd immunity, Verwiej notes that it conflicts with an interest to not protect against the flu; "it is an open question as to how these interests are to be weighed, or, in other words, what the *net* interest is of these residents."[38] Thus, we have arrived at group-individual conflict, albeit internalized in Jennings' sense (see Section 1.1). In contrast, Verweij argues that reasons for tacit consent are valid when an epidemic threatens to undermine the daily life of the nursing home residents, thereby jeopardizing, amongst other goods, quality of care and a social life. The detriment to the residents then is a threat to the collective health and very existence of the community, without which individuals also lose their chance to pursue individual interests as well. Verweij argues that in such a case, tacit consent is valid because an interest in one's social life tips the balance in determining what might be in a particular resident's *net* interest.

The notion I wish to extract from Verweij's analysis is that of damage to the community as tipping the scales as two what is in someone's *net* interest, and contrast this to the notion of a person's interest *all things considered.* The notion of *net* interest implies a calculus, in which someone's interests are tallied up. This seems to be what Verweij has in mind, for he characterizes the losses to residents in terms of benefits that accrue to the individual. Thus we

38 Ibid., 544.

can imagine that public health professionals could make the case that quarantine is, on balance, actually in an individual's best interest – just as Verweij thinks he can make this case for tacit consent for vaccination. On the advent of, or in the midst of, a truly serious epidemic, the losses accrued by widespread morbidity and mortality may be so devastating for the individual as to outweigh the loss of liberty (and other goods) that result from quarantine. When such a case is persuasive to members of the public, civic friendship is obsolete.

The difficulty with the *net* interest view is that it tends to leave out some reasons *why* something may be in my interest. Net interest accounts include a broad picture of what contributes to my wellbeing, from the physical benefits of health, to the social benefits that result from being part of a community. There is also the possibility something can be beneficial in a way that cannot be extricated from membership in a group: in such cases, I view a course of action as benefiting *me* because it benefits *us.* Missing from this picture is the possibility other's wellbeing can count toward my own interests – i.e., because I see others' wellbeing as intrinsically valuable. I may do so for any number of reasons – from an impartial perspective, or as a matter of justice, or out of affection. Such valuing gives me a reason for action, one that contributes to my happiness in a way that needs to be included in the considerations for what I ought to do *all things considered.*

This additional consideration reveals why some individuals may be supportive (and therefore cooperative) with quarantine efforts even when the argument for net interests cannot be made. This is especially the case in the advent of epidemics, when the nature of a pathogen is not entirely understood. Under such circumstances public health professionals may have an incomplete understanding of a pathogen's virulence and modes of transmission.

In such cases, the net interests argument will be hard to make because it is not clear what consequences will follow from compliance or refusal to comply. An appeal to civic friendship at this time may be what can tip the scales. For those who value the wellbeing of others, it may be the possibility of harming others unnecessarily that motivates public health cooperation. It is worth noting that the degree of uncertainty with respect to the epidemiological realities of the situation will also affect the agent's evaluation of the decision to resist quarantine. If there is scant evidence that exposing others will indeed lead to disease, or not enough evidence to establish that the disease in question significantly affects wellbeing, then it is in turn difficult to make the case that the agent is unjust, uncompassionate, or uncivil in refusing to comply. It is my contention, however, that an appeal to civic friendship can motivate support of public health by providing an additional reason for action left out of the appeal to net interests.

Nevertheless, we might have reservations as to whether it makes sense to call our civic-minded quarantined individual made *happy* by her decision. Happiness, for Aristotle, consists in activity, or the exercise of virtue. Thus, it would seem that by acting virtuously out of concern for others, the civic-minded agent ought to be happy. However, quarantine deprives individuals of a great deal of what makes for a good life, and Aristotle's view is not so insensitive to the loss of external goods – especially the loss of many or all of these, and over long periods. (*NE* 1.10 1101a10) Thus, the degree to which quarantine will affect our assessment of whether an agent leads a flourishing life will depend very much on the degree of duration of deprivation. Furthermore, periods of inactivity also prevent individuals from exercising the virtues that she has committed to, making her more like an excellent person who is asleep. (*NE* 1.6 1095b35) Thus, I argue that quarantine has the potential to resemble the

situation of Foot's Letter Writers. In their case, impending death absolutely closed off the possibility of the very best of lives. In the case of our quarantined and virtuous agent, however, her life may still turn out to be a good one, and made better by having acted to support others. Nevertheless, the period during which she is confined is not representative of the very best kind of living, and as a result we can still say that had quarantine been avoidable (she could have lived a life, in society, without the possibility of causing harm), she would have been happier.

I contend that this analysis sheds new light on calls for reciprocity in public health practices, such as quarantine. Such practices include monetary compensation, or requiring employers to either pay or refrain from laying-off workers in the midst of a public health emergency. Such efforts are usually justified on the grounds that they help to ease the burdens imposed on those who are (voluntarily or involuntarily) sacrificing freedom for the sake of others, and in terms of justice to be sure that the burdens of a policy that helps many are not exclusively born by a few. But on the civic friendship view, such policies are also ways of enabling individuals to re-evaluate the balance of different forms of other-concern. For, if valuing others motivates behavior, then part of the problem of quarantine is that we do not only have moral commitments to other citizens. A mother may not feel she should limit her movements if she does not know who will care for her child. Similarly, if compliance results in the loss of one's source of income, then the reasons for resisting quarantine are not necessarily self-directed, but other-directed. Thus, reciprocal public health measures can also be ways of enabling agents to resolve such conflicts in moral commitments. The claim is not that such public measures will make each and every citizen more beneficent. Rather, such measures can

be ways of allowing civic friendships to have greater moral salience – perhaps enough to tip the balance – when an agent is considering what she ought to do *all things considered.*

In conclusion, when reasons for action are conceived of as lying along a continuum between self-interest and group-interest, there is a temptation to view behavior in terms of the extremes of selfishness and altruism. This picture depicts moral behavior as going against one's desires. If, however, we except that "the line between self-concern and other-concern in no way corresponds to a line between desire and obligation," then we make room for the possibility for civic friendship to motivate support for public health measures in a way that does not entail altruism.[39] With this in mind, public health professionals can use a process of imaginative engagement to educate citizens about matters involving their health, and frame public responses to such information in terms of communal support. I do not believe such possible methods will obviate the need for coercive measures, but they do provide an alternative, enabling public health professionals to utilize persuasion rather than force.[40] As Williams puts it, the purpose of such engagement is "not to control the enemies of the community or its shirkers but, by giving reason to people already disposed to hear it, to help in continually creating a community held together by that same disposition."[41]

39 Williams, "Ethics and the Limits of Philosophy," 50.
40 George J. Annas, "Bioterrorism, Public Health, And Human Rights," *Health Affairs* 21, no. 6 (2002): 94–97. Public health coercion and persuasion are not mutually exclusive alternatives – the public can be persuaded the coercion is necessary.
41 Williams, "Ethics and the Limits of Philosophy," 27.

## CHAPTER 2: PUBLIC HEALTH RELATIONSHIPS: DEFERENCE, RELIANCE, AND TRUST

In their important work on the virtues and medicine, Thomasma and Pellegrino argued that the virtues fall out of the structure of medical practice, which includes the "central distinguishing feature of medical activity, that is, the healing relationship between one who is ill and one who professes to help and heal."[42] From this relationship, the authors argue, the feature of trust is ineradicable, and it follow that it is essential for the good physician corresponding virtue of fidelity to trust, or trustworthiness. Trust, then, is put forward as a crucial relationship between doctors and their patients, and it related character trait, trustworthiness, as an ideal for physicians.

In this chapter, I examine the question of whether the same ideals hold in public health practice. Given the often impersonal nature of the relationship between public health professionals and members of the public, we might imagine that the nature of the relationship is so different as to entail different virtues – or perhaps no virtues at all. To consider the place of trust, and the need for trustworthiness, in public health, I divide this chapter into two parts. In the first, I consider the alternative kinds of relationships that might hold in public health practice. I begin in Section 1 with a consideration of paternalistic attitudes, which I contend can mistakenly imply that the proper public response to public health professionals is epistemic deference, and that the main responsibility of public health professionals is to be competent. In Section 2, I contend that public health professional expectations for deference outside of paternalistic relationships, as exemplified by a case of vaccination skepticism. I argue that such

42 Pellegrino and Thomasma, "Virtues in Medical Practice."

expectations are problematic by further articulating what it means to defer, by examining Phillip Pettit's analysis of epistemic deference in Section 3.

After pointing out the flaws with uncritical expectations for epistemic deference in public health, I turn to a positive account of public health relationships in Part II. I argue in Sections 4 and 5, that a virtue approach pushes us to consider reliance and the related species of reliance, trust. The corresponding attributes that provide the basis for such relationships – reliability and trustworthiness – are thereby suggested as essential to public health practice, and public health professionalism. Included in Section 5 is also a defense of an affective account of trust over a cognitive approach. In Section 6, I contend that a virtue approach to public health relationships also requires that we reexamine dominant conceptions of trust and the virtue of trustworthiness to account for the possibility of trust in groups and virtuous institutions.

## PART I

### 2.1 Public Health Paternalism

In this section, I first distinguish between medical paternalism and one form of public health paternalism. I identify some of the attitudes and beliefs that lie behind problematic defenses of paternalism in public health, especially those that lead professionals to conceive of public health expertise solely in terms of better factual understanding. While paternalism might be defensible under other justifications, these mistaken defenses of public health paternalism translate into an expectation for public deference to expert authority, implying

that the primary feature for professionals to focus their efforts on is building professional competency.

### 2.1.1 Kinds of Paternalism

Public health interventions are often justified on the grounds that failing to act brings harms to others. Such preventive efforts are not paternalistic because they are consistent with Mill's harm principle that "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[43] In contrast, there are times when public health policies are offered up as beneficial to *all* or even of benefit to those who fail to view the intervention in question as furthering their interests. I will not engage here in a consideration of which approach is more justified for public health purposes. Rather, I wish to consider the history of paternalism in bioethics and some implications it has for public health paternalism.

Paternalism is broadly defined as actions that limit the choices or actions of an individual on the basis that such limits are his or her own interest. In medical paternalism, limits on choice are sometimes broadly construed, including the withholding of information or provision of misinformation, which is also argued to be in the individual's best interest. Two distinct forms of paternalism are often distinguished. In weak paternalism, the decision-making capacity of an agent is considered compromised, thereby requiring intervention on her behalf.

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43 John Stuart Mill, "On Liberty" in *On Liberty and Other Essays,* ed. John Gray (Cambridge: Oxford University Press, 1998); Ross E. G. Upshur, "Principles for the Justification of Public Health Intervention," *Canadian Journal of Public Health* 93, no. 2 (2002): 101–3.

In strong paternalism, agents are considered competent, and yet intervention is still performed, justified on the grounds that it benefits the agent.

In public health, paternalism is sometimes invoked in a slightly different way. According to Dan Beauchamp, public health is concerned with the ways in which health and safety are public goods. Thus, individual freedom may be restricted on the grounds that this is in the interest of the common good. Beauchamp does not mean to invoke the harm principle when articulating this vision of public health paternalism – for he wishes to distinguish this kind of public health justification from that which identifies possible or actual harms to specific individuals.[44] On this view, public health professionals are focused on limiting societal *practices*, not individual behavior. "This distinction between practices and behavior should help us see the difference between public health paternalism aimed at the group and the "personal paternalism" of the doctor-patient, lawyer-client relationship.[45] The crux of Beauchamp's argument is not that limits are being placed on individual autonomy, but rather on *everyone's* autonomy, because of the effects of certain choices on a general level of population health. It is not my intent consider all defenses of this view of public health paternalism.

The kind of paternalism Beauchamp has in mind is sometimes invoked, as when public health professionals characterize policy outcomes in terms of a public good whose benefits are best attributed to an entire community. Health can be a public good in part because public health benefits are sometimes indivisible, or "cannot be broken down or divided up into

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44 Dan E. Beauchamp, "Community: The Neglected Tradition of Public Health," *The Hastings Center Report* 15, no. 6 (1985): 28–36.
45 Ibid., 34.

individual or private goods to be distributed amongst the members of a group or population."[46] This perspective contrasts with the aggregate view of public health, where the policy offers additive protection because each individual saved will benefit from compliance. On the collective view, policies like helmet laws provide a public good by reducing mortality rates throughout society. Even though some citizens might never individually benefit from such a policy, so the argument goes, it is best for all members to live in safer and healthier communities.[47] On the public good view, the benefit is social, and the benefit might be articulated as a boon to all members of a group since the society or community is designed to be safer for the targeted subpopulation.

And yet, it is not clear that the collective form of paternalism is all public health professionals have in mind when they articulate justifications for public health limits on choice. Bayer and Moreno, while taking into account Beauchamp's views, also consider the possibility of 'personal' paternalism in public health. According to these authors, "[t]he goal of justifiable paternalism is to protect the individual from the consequences of actions that he or she would not choose to engage in were the capacity for free choice truly present."[48] In public health contexts, such paternalism is justified by reaching the high evidentiary standards required to establish that individual behaviors do not result from free choices. And while behaviors like alcoholism and smoking may exhibit impaired decision-making capacity that result from the

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46 Angus Dawson "Herd Protection as a Public Good: Vaccination and our Obligations to Others," in *Ethics, Prevention, and Public Health*, ed. Angus Dawson and Marcel Verweij (Oxford: Oxford University Press, 2007), 164.
47 Beauchamp, "Community," 35.
48 Ronald Bayer and Jonathan D. Moreno, "Health Promotion: Ethical and Social Dilemmas of Government Policy," *Health Affairs* 5, no. 2 (1986): 72 –85.

addictive properties of the products, it is not clear that these meet the high bar set by fierce advocates of autonomy. Thus, Bayer and Moreno conclude that if public health professionals are to successfully argue for a form of paternalism in public health, it will need to be weak paternalism, and only in those cases with strong indications for compromised decision-making capacity.[49]

A reluctance to endorse paternalism in public health is in part a reflection of critiques of medical paternalism, and defenses of the importance of individual autonomy in matters of health. In the next section I shall consider what kind of relationships paternalistic attitudes set up, why these were found to undesirable in clinical medicine, and whether the same conclusions apply in public health.

### 2.1.2 Professional Relationships with the Public

Paternalism in all its forms assumes a dependency in which one party, it is asserted, needs another to intervene on her behalf. When viewed in this light, it is clear why paternalism is often interpreted as presumptuous. Individuals or groups may reject the notion of dependency as even pertaining to the situation at hand (e.g., "I am perfectly capable of making up my own mind,") or may assert that there are better ways to handle current needs for depending on others than restricting individual choice or freedom of action (e.g., capacity-building).

In this section, I argue that flawed paternalistic reasoning results in a characterization of the ideal public health professional as merely competent. The flaws I present are (1) the failure

49 Ibid.

to acknowledge the element of evaluative judgment necessary to paternalism and (2) a conflation of public health as *a* public good and public health as *the* public good. I contend that the resultant picture of professionalism is inadequate because it is devoid of any notion of excellence; both bad and good public health professionals can be competent. I conclude that the ideal of public health expert competency helps set the conditions for identifying the proper public response to expertise: deference.

There is no doubt that epidemiological data and professional experience gained from public health interventions can lend professionals insight into what has an effect on human health, as well as what may create obstacles to human understanding of various benefits and harms. However, it is important for public health professionals to recognize two important limits on the nature of professional expertise.

The first confusion can result from an overly inflated understanding of public health or epidemiological knowledge. Due to the epidemiological basis of public health knowledge, public health professionals can mistakenly believe that health policy recommendations are matters of objective or scientific fact, rather than normatively laden decisions involving value judgments about how we ought to live. I will address this normativity more specifically with respect to conceptions of risk in Chapter 3. Here, I wish to draw attention to the possibility that paternalism is in part grounded on the claim that experts have a kind of insight unavailable to non-experts. When this knowledge is identified as purely empirical or objective, public health professionals may be failing to recognize the normative dimensions of public health insight.

To illustrate the case with which it can occur, I will adapt an argument against medical paternalism. Allen Buchanan outlines a common argument in favor of medical paternalism:

1. The physician's duty – to which he is bound by the Oath of Hippocrates – is to prevent or at least minimize harm to his patient.
2. Giving the patient information X will do great harm to him.
3. (Therefore) It is permissible for the physician to withhold information X from the patient.[50]

While Buchanan finds many faults with the argument, I wish to focus here on his observation of a missing premise which he identifies as 2': giving information X will do the patient greater harm on balance than withholding of the information will. Buchanan claims that this missing premise reveals the central feature of paternalistic reasoning to be a "comparative judgment" between two possible sets of actions and their outcomes.

Let us construct the parallel argument necessary for public health paternalism. We will need to modify it if it is to accommodate the more positive formula[51] Beauchamp envisions:

A. The public health professional's duty is to establish and sustain public health in its form as a public good.
B. Allowing certain practices, such as X's freedom to Y, will do significant damage to public health, and thereby the public good.
C. (Therefore) It is permissible for the public health professional to restrict the freedom of X to Y.

50 Allen Buchanan, "Medical Paternalism," *Philosophy & Public Affairs* 7, no. 4 (1978): 377.
51 If left in the preventive form to forestall harm to others, the argument is not paternalistic but merely an invocation of the harm principle. Thanks to Tom Tomlinson for this point.

In this parallel argument, the missing "comparative judgment" premise is B': Allowing certain practices, such as X's freedom to Y, will do significantly *more* damage to the public good than limiting such freedoms either in a restricted or general fashion.

The significance of (B') is that (B) without modification falls entirely within the realm of public health technical expertise. The only burden of proof that falls upon the public health professional when making a case for (B) is to demonstrate a real or potential detriment to the public's health. Without the explicit acknowledgment of comparative judgment it would seem that determination of what is in the public's interest is a matter of fact – of assessing what improves and harms the public's overall level of safety from injury and provides relief from the harms of disease and premature death. Thus, public health expertise is identified as competency – the knowledge and skills necessary to identify and forestall detriments to the public's health. By ignoring the role of moral judgment required to execute the evaluative judgments of (B'), the corresponding notion of the ideal public health professionals is devoid of any qualifications that would ground such judgment.

The second, but related confusion, can occur because in the midst of epidemiological methodologies and analyses, it is possible to equate knowledge of public health with knowledge of human wellbeing. This is especially the case in public health, where broad definitions of health and pervasive determinants of public health seem to imply that every aspect of life can fall under the domain of public health. For example, the World Health Organization's definition of health has been widely criticized precisely because it fails to

differentiate a healthy life from more general human wellbeing.[52] In Chapter 4, I address the ethical dimensions of such broad definitions in more detail. For the moment I merely wish to draw attention to the potential for a failure to recognize the distinction between health as *a* public good and *the* public good. While health is arguably a constituent of or means to achieve many formulations of a good life, even a broad understanding of health and its determinants ought not to encompass all the aspects of wellbeing. Given the ease with which one can conflate health and wellbeing, one possible mistake in public health constitutes a failure to recognize the limits of public health insight into the public good.

This kind of slip is especially relevant as it can provide another faulty foundation for paternalistic reasoning. In public health, such a mistake is the equivalent to those made by many in curative medical practice when paternalism was the norm; many clinicians assumed that clinical expertise was sufficient for making decisions in a health care context, failing to see that such decisions had bearing on all aspects of human wellbeing, not just those relating to health. Thus, while a physician might argue that surgery is in a patient's interest with respect to maximizing her health, it does not follow that surgery is in her interests *all things considered.* As many have argued, different patients may value quality of life vs. quantity of life differently, illustrating how other aspects of human wellbeing may be weighted differently by different individuals. The parallel in public health is that different communities might strike different trade-offs between social values.

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52 Rodolfo Saracci, "The World Health Organisation Needs to Reconsider Its Definition of Health," *British Medical Journal* 314, no. 7091 (1997): 1409–1410; Johannes Bircher, "Towards a Dynamic Definition of Health and Disease," *Medicine, Health Care, and Philosophy* 8, no. 3 (2005): 335–41.

For public health practice, my claim here is that public health paternalism is sometimes rooted in a similar mistake – in a belief that public health understanding is sufficient to provide guidance in what is deemed to be a public health context. This problem is reinforced by the failure to see comparative judgment as an inherently normative endeavor, but it is also a distinct concern. Here, I am concerned with the possibility that public health professionals will view the public health as the only constituent of the overall public good. In doing so, professionals fail to articulate the relationship of the public's health to the overall public good, and why it is worth sacrificing some liberties to sustain it.

In this section, I have argued that both mistaken foundations for public health paternalism that I have described here present a picture of the public health professional as ideally competent. By failing to see public health as an endeavor that requires articulating the public's health as one of many public goods to choose between, or as part of an overall notion of the public good *all things considered*, flawed paternalism constructs a correspondingly false picture of public health professionalism. The bar for ideal public health professionals is set surprisingly low – at mere competency. The problem with this view is that it fails to distinguish between good and bad public health professionals – a person can be competent but nevertheless exercise their expert knowledge and skills toward good or bad ends. By illegitimately erasing value judgments from the work of public health, the resultant ideal for public health professionalism is a flat picture of the public health professional, one who lacks any criteria for exercising proper moral judgment.

The ideal of competency also sets up expectations for public responses to public health professionals. If what is (mistakenly) required to justify public health paternalism is public

health technical expertise, members of the public must be prepared to defer to the judgment of those experts inside the context of public health. By constructing an account of public health devoid of normativity, public health professionals set the stage for public relationships that center around who is more qualified to make expert assessments. If public health policy is solely a matter of empirical knowledge and epidemiological skill, then public health policy will be entirely a matter for professionals to determine. Because public health professionals have greater knowledge, so the argument goes, the public must defer to this superior knowledge. In the next section I consider a case study that illustrates this picture of public health and expertise in action.

## 2.2 Case Study: MMR Vaccination

In this section I present the arguments of Tom Sorell in the context of the vaccination-autism debates as an example of the call for public deference to public health expertise. Sorell does contend that his arguments justify strong public health paternalism, but also seems to advocate for a different form of public health policy when he contends that his arguments establish that the public has a moral duty to defer to public health expertise, and thereby follow public health professional recommendations voluntarily: "where the coercive policy is backed by a clear medical consensus, appropriately reconsidered in the light of claims of doubters, there is sometimes a moral obligation on the part of the public to defer to

experts."[53] Thus, it is possible to conceive of Sorell as advancing the view that the relationship of deference entails both acquiescence to mandatory vaccination and also voluntary participation in vaccination programs. The kind of deference Sorell has in mind is epistemic deference; he expects parents to understand that public health professionals will have greater knowledge in areas of epidemiology, including vaccination, and thinks that the weight of professional opinion ought to convince parents that vaccination is safe, and indeed, the right thing to do for one's child. Despite not characterizing his argument as disagreements about the proper relationship between citizens and public health professionals, I argue that a virtue ethics approach pushes us to consider his arguments in this light by calling our attention to the ways in which policy recommendations are tied to conceptions of appropriate relationships in public health.

The source of the controversy began in 1998, as a result from an article published (and since retracted) by Andrew Wakefield and colleagues in the Lancet. In this paper and a subsequent press conference, researchers put forth the possibility of a causal link between a vaccine for measles, mumps, and rubella (MMR), bowel disease, and autism. The subsequent public demand for investigation and scientific criticism of the research was complicated by a lack of a scientific process for handling suspected misconduct in research, as well as the media furor that followed. [54] In this section I examine one argument that calls for public deference to experts with respect to vaccine safety. And while I use the MMR case for illustration, for the

53 Tom Sorell, "Parental Choice and Expert Knowledge in the Debate About MMR and Autism," in *Ethics, Prevention, and Public Health*, ed. Angus Dawson and Marcel Verweij (Oxford: Oxford University Press, 2007), 95.
54 Richard Horton, "The Lessons of MMR," *The Lancet* 363, no. 9411 (2004): 747–9.

remainder of this chapter I treat skepticism of public health efforts more broadly. The lessons of the MMR debate can at the very least be applied to other instances of vaccination skepticism, including Nigerian boycotts of the polio vaccination campaign in 2003, or objections to the human papilloma virus (HPV) more recently in the United States. In this section, I argue that the MMR case illustrates a common thread with the paternalistic rationales outlined in Section 1.1, even when not explicit defenses of public health paternalism. I contend that this analysis leads us to question examine the justification for expectations of deference.

There are several different reasons that members of the public might object to vaccination. The first, which seems to be the one most commonly attributed to those who question vaccination, is a belief that they are unsafe. This belief may result from knowledge of the controversial studies. It may also come from ignorance of the studies that demonstrate vaccine safety, misleading rumors, or any number of faulty forms of inference. It may also be supported independently by a second view that public health professionals have a vested interest in not disclosing harms that accompany vaccination. Vaccines, after all, are the hallmark of public health. Both reputations and livelihoods may be staked on continuation of vaccines as standard public health policy. A third reason to resist vaccination might be based on a kind of free-rider mentality, understanding that the statistics entail that some adverse events do result from vaccination (even if not autism), and thus one can hedge one's bets by simply relying on herd immunity. Lastly, a fourth group may not consider themselves as either for or against vaccines, but are just not sure what to do. This rather ambivalent group may have some of the information, and want assurances both as to the safety of vaccinations, but also as the underlying justification for compliance – whether expressed in moral or legal terms.

This list is not meant to be exhaustive, but merely a collection of the kind of reasons at play. It is often the case that some of them are extraordinarily well articulated, while other may be implicit in the attitudes expressed by those engaging in the debate.

In the previous section I argued that in some faulty forms of paternalistic reasoning it is possible to mistakenly view the problem as merely a factual one. This type of reasoning leads public health professionals to characterize the need for vaccine compliance as an entirely empirical matter – the problem is that the public either fails to (or even refuses to) understand the facts. Sorell's characterization illustrates this thought process: "In the MMR case, I want to argue, parental opinion is no more relevant than public opinion in general, since what matters is the actual effects of the MMR vaccine."[55] In this instance, Sorell understands "the public good" to be a matter of fact, and fails to see it as a normative concept, about which non-professionals may have insight and understanding.[56] Thus, by failing to see public health assessment as including a comparative judgment, Sorell views the main task of public health as demonstrating the harms of non-vaccination to human health. If he were to adopt the view that public health professionals help to inform public decisions about whether coercion[57] or voluntary policy is better for the public good, he might begin to see that public health technical expertise is not the only consideration required to form a judgment.

Sorell's flawed paternalistic arguments nevertheless have some merit, in that they would be a good reason to support greater educational interventions that accompany

55 Sorell, "Parental Choice and Autism," 97.
56 Ibid., 95.
57 Ibid., 106. Sorell speaks of a "duty to defer to experts," which I will address shortly, but he also seems to think that the same arguments – once provided to individuals in question – also justify coercive measures to vaccinate children.

vaccination. Sorell envisions a different model for managing public health expertise – one akin to the educational system. Much like parents often depend on professionals to help educate their children, Sorell contends they must also call on public health professionals to help them make decisions regarding their child's wellbeing. To help him make this case, he contends that deep concern for a particular individual's wellbeing does not necessarily translate into a better understanding of what constitutes her interests and how to fulfill them: "...actively helping one's children is only going to be successful within the limits of one's competence. If you are lousy at maths, then no matter how conscientiously you try to help your children with the maths homework, it is not going to do them any mathematical good."[58] Sorell envisions that while parents may have some insight into what benefits or harms their children, only public health competency can ground conclusions about vaccination safety. Sorell envisions a "division of labor" in which parents consult the experts in matters outside their own knowledge base.

Sorell's points are well taken; we have good reason to believe that sometimes those closest to us may misunderstand or miscalculate our own interests – partiality can familiarize one with another's concerns, but it can also create blinders to open alternatives. But while there are certainly drawbacks to partiality, there are also excellent reasons to believe that parents do have intimate understanding of their children's needs, *especially* their particular preferences, desires, and needs that differentiate them from other children. Once one has gathered the empirical data, it may be that other considerations, including normative ones, are also necessary to determine not what *is* the case, but what one *ought* to do. Thus, expert

58 Ibid., 100.

consultation may be necessary in child rearing, but it is hardly sufficient. Sorell is right to conclude that partiality is not a definitive source of insight into a child's wellbeing (or all children's wellbeing), but neither is public health knowledge.

Sorell's education solution may indeed provide some peace of mind to parents, especially to those who are merely uncertain about why there is a controversy in the first place, and merely wish to know where the scientific consensus lies. However, this is unlikely to convince any who have moral objections to, or even concerns with, vaccination policy. Technical expertise alone does not give skeptics a reason to believe that the *source* of information has no conflict of interest. By articulating a concern for the public good over attention paid to individual good, without acknowledging the value-laden nature of this perspective, public health professionals may be reinforcing a public perception that professionals are willing to accept costs to the few for the sake of the many.

For example, a parent might also question whether a public policy designed for many ought to be implemented in the same way for every member of society. A parent might be concerned that what is good for the average child is not necessarily good for his or her particular child and may seek not only factual reassurance, but a normative justification for uniform public policy, especially one with an acknowledged incidence of adverse events. Such questions regarding vaccination policy are intelligent questions with both scientific and normative aspects. They express a wish to understand the justifications for policies designed for all people, which as a result may inherently lack flexibility. It is not surprising then, that part of the backlash against vaccinations sparked requests for alterations in the timing of childhood

vaccinations. The public questioned not only whether vaccines were safe, but also what justifies uniformity in public policy implementation.[59]

To express this concern in Beauchamp's terms, such groups argue that this practice does not, on balance, further the public good. From this perspective, their comparative judgment comes out differently, on balance. This difference is often articulated as the conflict between individuals and groups, but as I argued in Chapter 1, we can view it as an internal social conflict (i.e., parents generally care both about societal options *and* lower levels of disease) regarding how to balance societal freedom of choice with the public's health. It may also be an argument from justice regarding how to balance maximizing general utility with the harms this may entail for a minority. This difference in balancing values may actually be exacerbated by focusing on expertise, which draws divisions between professionals and the public. Rather than viewing the policy as a mutual endeavor collectively devised by citizens (or their representatives) and professionals, vaccination policy becomes viewed as something professionals do *to* the public, not *with* the public. In the end, what may reasonably justify resistance to mandatory vaccination is twofold: (1) an absence of an articulated underlying justification for the comparative judgment made by public health professionals (why the public good, in this case, is furthered by compulsory vaccination over freedom of choice) and (2) the feeling that the public has not been adequately included in the conversation that generates social policy.

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59 It is likely Sorell would claim again that this argument is based on mistaken views of the harms of vaccination – but it need not be. It is reasonable for a parent who has a child with a history of adverse reactions to vaccination to question how to handle future vaccination, and to expect that the recommendations for her child (or children) be different from the recommendations for families with no such history. That public health professionals do not believe that an alternate vaccination schedule offers any such benefit is not a reason to conclude that no alteration in policy implementation is reasonable.

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How then should public health professionals consider the merits of Sorell's arguments? While he may be incorrect to characterize public health policy solely in empirical terms, it is

60 It is also possible to read Sorell's arguments as merely advocating for morally obligatory public health adherence, in which case they are not paternalistic, although they exhibit many of the same features.

worth considering when it *is* reasonable to expect deference within public health relationships. In the next section, I turn to a more in-depth consideration of the notion of deference.

## 2.3 Deference

When public health professionals expect deference to their expertise, this provides one candidate relationship that might structure public health interactions. In this section I consider Philip Pettit's account of when it is more or less reasonable to expect epistemic deference. In the course of this analysis, I argue that (1) marginalization of public health skepticism can backfire. In addition, when a more reflective understanding of deference is articulated, it becomes clear that (2) epistemic deference to public health expertise may be epistemically arduous and (3) appeals to expert authority may actually demand deference to moral or legal authority. I conclude that this analysis illustrates why the source of public health information is as important to the public as its veracity. This, in turn, sets the stage for the second half of the chapter, and a turn toward virtue as an alternate guide for public health professionals.

### 2.3.1 Deference and Reforming Belief

Philip Pettit's analysis of epistemic deference to majority testimony helps to fill in what it might mean to have reason to defer.[61] Pettit offers us the instance of a car accident, in which you believe you saw a car run a red light and cause the subsequent crash. However, a large number of other witnesses swear that the light was green. Pettit claims that in such an

61 Philip Pettit, "When to Defer to Majority Testimony – and When Not," *Analysis* 66, no. 3 (2006): 179 –187.

instance, we can offer good reasons to believe that you ought to defer to the opinion of other witnesses – namely, the unreliability of perceptions and how quickly the accident occurred. When Sorell characterizes vaccination skepticism as a matter of fact, it is reasonable to expect a similar process of revision in this public health context. A parent, having heard of the Wakefield paper, questions whether vaccination is the right course of action for her child. Sorell believes that, on the basis of expert consensus, a parent ought to be willing to override her initial misgivings, and revise her belief in line with expert opinion.

However, our expectations for when it is appropriate to revise belief based on the testimony of others may sometimes differ in matters of scientific expertise, or once moral convictions are involved. Pettit offers us the examples of a staunch believer in intelligent design, confronted by a large number of defenders of evolution; and in turn, a person who believes that abortion is morally wrong, but faced with a majority who believe the contrary.

> The difference between the first case and the other two is that the belief under pressure in that case is not deeply embedded in your Quinean web of belief, whereas the beliefs in the other cases are. You can come to think that the car went through on the green without revising any of your other beliefs…But you cannot come to think that intelligent design is false, or that abortion is not grievously wrong, without a range of adjustments in other matters of belief.[62]

This does not mean that the person in question is *justified* in maintaining a belief in intelligent design or the immorality of abortion – the deeply embedded network of beliefs that support this view may indeed suffer from significant falsities and/or invalidities. Pettit's conclusion is that *deference* in such cases is unreasonable to expect, and even unwarranted, for

62 Ibid., 181.

the depth of a conviction has bearing on whether we think belief ought to be swayed by others. A tendency to bend wherever the wind of majority opinion blows, especially in matters of conscience, reflects a kind of "epistemic timidity or servility."[63] Thus, while it may be a relatively trivial matter to revise one's opinion of what one saw in a rushed and hurried moment, it is not nearly such a simple matter to revise a complex of beliefs, or a deeply rooted moral conviction.

Pettit's analysis, however, also assumes several preconditions of the disagreement that do not hold in the MMR-vaccination case. Pettit's view assumes that the parties in question are intelligent, informed, and impartial.[64] But for those that question or defend vaccine safety and efficacy, the sources of information on vaccines may be dubious to begin with. Whether the parties in question are equally informed is part of what is at stake. In addition, the impartiality of public health professionals may be particularly in question, for professional reputations may hinge on the status of vaccine safety, or there may be a perception that careers may be staked on a high degree of public participation in vaccination campaigns. As I argued in Section 2.2, parents may view this as a potential conflict of interest. Similarly, professionals may believe, for example, that a citizen's unbending and general distrust of all government authorities creates a bias that prevents her from weighing expert opinions appropriately. Thus, the factual disagreement of the MMR case is set within a wider set of beliefs and attitudes, including views about the government, and perhaps even the structures and nature of society. Challenging this system of beliefs, especially when it can be characterized as a coherent world-view, requires far

63 Ibid.
64 Ibid., 186.

more revision than public health professionals can expect to occur overnight, or simply by pointing to studies and statistics.

Health professionals and the media paint vaccine skeptics as ignorant, dogmatic, irrational, and extreme. Such depiction may be strategic in an attempt to contain and control public doubt. I argue that such a tack is counterproductive insofar as it sets up an undesirable relationship between citizens and public health professionals. Even if such a depiction were accurate, one might reasonably wonder how effective ridicule, scorn, and condescension are at inspiring greater confidence. The call for public deference itself often extends this patronizing attitude to anyone associated with vaccination skepticism – even those for whom epistemic revision may be a reasonable expectation. While there may be staunch opponents to vaccination who lie beyond the reach of reason or patience, we have little reason to believe that this is true of all who question vaccine safety, and even less reason to characterize such concern as a "forgivable" transgression when it constitutes a simple request for greater accountability on the part of public health professionals.[65] The public outcry and popular press magnification of the MMR controversy exposed large numbers of people to skepticism about vaccine safety, and even referenced significant historical lapses of public health and vaccination dependability, such as the Guillian-Barré cases caused by swine flu vaccination in 1976. In this context, one might find it unsurprising that parents now expect, at the least, more information from clinicians regarding the safety of vaccinations. It is reasonable, in such a context, to assume that these less convinced, or merely concerned, parents are more akin to Pettit's

65 Sorell, "Parental Choice and Autism," 101.

witness who can reasonably expected to revise her opinion of what she saw, or at least her degree of certainty that she saw it. Such parents are, self-admittedly, already on the fence.

However, there are also a moral elements to the vaccination and car accident cases that reveals why deference in our mistaken witness's case is not only a lesser epistemic challenge, but also less likely to earn the pejorative label of "servility." For, in the case of the accident, the stubborn witness who refuses to revise her beliefs subjects the driver in question to the possibility of liability, a heavy conscience, and public attribution of recklessness. To do so despite evidence that such condemnation is unwarranted is not only epistemic folly, but also potential cruelty. Thus, our car accident witness has a moral reason to take into account other witness' statements – to fail to do so may indicate a *moral* failure on her part to have an appropriate self-awareness of her own fallibility. In contrast, while the epistemic state of our on-the-fence parent parallels that of the witness (she does not necessarily know which evidence to believe), her moral state does not. On the contrary, she has moral reason to be *more* cautious regarding belief revision given her role as a parent and her concerns for the safety of her child – for her to incautiously defer (even to expert consensus) can more reasonably merit the label of epistemic subservience.

It has been my intention throughout this chapter to question what kind of relationship we desire between public health professionals and members of the public. I hope to have demonstrated that insofar as public health professionals expect epistemic deference, we might wonder whether there are better ways to understand what it is that inspires confidence in public health. Epistemic revision can be inspired by acquiescence to the weight of others' views, but also by justifications provided in a clear and accessible way; parents can choose to

vaccinate based on (1) professional opinion, or (2) by coming to understand the explicit rationale that lies behind such professional judgments. As Larson and Heymann observe, this second alternative method of handling public skepticism acknowledges that the epistemic burden of proof lies on those with expertise: "New social media and the emergence of a postdeferential society are challenging traditional trusted sources of information…rather than becoming defensive in the face of an increasingly questioning public, the medical and public health communities must recognize the importance of changing the conversation with individual patients and the public and the importance of being open to hearing real concerns that will affect the acceptance or rejection of health services."[66] I claim that, in cases like the MMR debate, the public is not unreasonable to prefer such comprehensive arguments in order to avoid the self-ascription of epistemic timidity which is now associated with a bygone era.

### 2.3.2 Epistemic vs. Moral and Legal Deference

When beliefs are also connected to values, the question is not only one of revision of a complex of cognitive commitments. It is also a question of redefining who one is, and what Bernard Williams calls one's ground projects.[67] In virtue terms, the question of what we ought to do with respect to vaccination is revealed as related to the wider question of who we ought to be. In such cases, where a deep set of integrated and interdependent beliefs and commitments prevent someone from recognizing what is in their own interests, what is needed

66 Heidi J. Larson and David L. Heymann, "Public Health Response to Influenza A(H1N1) as an Opportunity to Build Public Trust," *JAMA: The Journal of the American Medical Association* 303, no. 3 (2010): 272.
67 Bernard Williams, Moral Luck (Cambridge: Cambridge University Press, 1982), 13.

is "a substantive account of how people may fail to recognize their real interests."[68] Such an account may either justify weak paternalism because it establishes why some people aren't capable of making the best decisions, or else it may also suggest other avenues that build autonomy, thereby allowing individuals to make informed decisions. In the absence of such an account, the only alternative open to public health professionals may be to abandon the call for deference and turn to other forms of relationships with the public. It is these other candidate relationships that I consider for the remainder of this chapter.

I contend here that structuring public health relationships in terms of obstacles to knowledge only captures part of the story; since ignorance is the proposed problem, expertise appears to the be the obvious solution. Sorell believes that the conflict hinges on epistemological premises, and as such makes a case that parents ought to defer to the epistemic authority of public health professionals. He is not so unreasonable as to assume that public concern does not require a response, but his interpretation of taking such concerns seriously is again scientific – the beliefs in question need to be "confirmed or refuted."[69] If the objections to vaccination are not solely matters of factual belief, then the resources professionals bring to bear must acknowledge the human and moral elements of public health policy in their proffered justifications. If they are asking for public beneficence, then this ought to be clear, if they are demanding public compliance, than this ought to be morally or legally justified. By making the normative demands of public health policy explicit, it becomes apparent that the argument in question does not request only deference to *epistemic*

68 Bernard Williams, "Ethics and the Limits of Philosophy," 43.
69 Sorell, "Parental Choice and Autism," 100.

authority, but a call for deference to *moral* or *public* authority. And the question remains whether public health professionals can justify claims to, and exercise of, this kind of authority. It is worth considering whether public health professionals ever expect these other forms of deference, including moral or legal deference, thereby suggesting other candidate relationships for public health.

In the absence of an account of what has obscured self-knowledge, public health professional contentions that individuals should nevertheless comply with vaccination campaigns is not merely to demand what Pettit's analysis reveals is a kind of whole-sale epistemic deference, but is also to expect moral deference. It is to ask some citizens to abandon their own moral commitments, reconsider their identities, and shift perspectives on the grounds of greater authority in such matters. In other words, to claim that citizens ought to give public health consensus more weight in their deliberations, professionals may be claiming that public health professionals have greater *moral* authority to judge what is best for a population, or a member of that population. But it is precisely this moral authority that vaccination skeptics do not recognize, and which merely "factual" public health arguments fail to justify. If arguments in favor of adherence in public health policy invoke public or moral authority, they ought to do so more explicitly and distinguish these claims from empirical arguments. When compliance is expected, It is not clear whether what is sought is moral or legal deference.

2.3.3 A Mutual Desire for Respect

Sorell's analysis of the MMR-vaccine debate illustrates how expectations of deference can cause differing parties to speak past one another. While professionals feel slighted when individuals disregard their professional opinion, members of the public feel silenced and frustrated when they perceive that the priority of professional opinion downgrades the voices of citizens in public policy-making. Thus, Sorell's determination that the MMR-Autism debate is merely a question of fact implies that it *cannot also* be a matter of respect: "The issue is precisely *not* one of respect…It is to do with the state of the evidence of MMR and the risks of having a different scheme of vaccination."[70] In this section, I argue that the call for deference to public health expertise is also a demand for respect. My analysis establishes that developing norms for relationships between public health professionals and citizens are at the heart of public health skepticism.

Objections to public health paternalism bring to light the possibility that public health attitudes to members of the public can reflect a lack of respect. Some objections to paternalism are concerned that lack of respect stems from faulty premises involving the decision-making capacity of others. In characterizing vaccination as a matter of scientific fact alone, Sorell demonstrates how public health claims to superior knowledge of how to achieve and what constitutes a flourishing life may reflect a failure to understand the pertinence of non-expert communal and individual insights into the public good. Importantly, concerns for disrespect are not limited to those on the receiving end of public health interventions. Resistance to public health efforts and skepticism of public health claims can leave public health

70 Ibid., 98, original emphasis.

professionals feeling as if their knowledge, skills, and hard work on behalf of others are not properly recognized.[71] Such offense is more likely to occur when public health resistance is interpreted as purely factual disagreement; if members of the public feel free to disregard public health opinion, this seems to entail a devaluation of epidemiological expertise. Thus, some public health calls for deference are partially motivated by a desire for greater public respect for public health expertise. It is certainly the case that there is a paucity of public awareness regarding the role of public health in everyday lives, as well as a long history of relegating public health professionals lower social status than other health professionals.

But this concern for respect goes awry by framing the debate in terms of who has more knowledge of public health empirical matters. Such umbrage is often expressed in terms of a usurpation of power, e.g., "When a pressure group or individual parents decide that single vaccinations would do just as well as the triple vaccine, however, they are precisely taking over the doctoring role from the doctors."[72] By capitalizing on professional feelings of societal neglect for the importance of public health, Sorell's analysis depicts vaccination skeptics as ignorant, ungrateful, and overstepping their bounds, thereby masking any legitimacy to their concerns. An uncritical call for deference rationalizes the reaction of professionals to dig in their heels, and defend a high valuation of public health without offering adequate defense for such priority.

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71 Georges Benjamin, "Message from the Executive Director: Refusing to Be Invisible," *Annual Report of the American Public Health Association* (2011), accessed September 4, 2012, http://www.apha.org/NR/rdonlyres/77372C3C-82DA-43F7-A152-1CE6583F2E5B/0/AnnReport2011_final.pdf.
72 Sorell, "Parental Choice and Autism," 100.

Respect, its absence (lack of respect), and its contrary (disrespect) are notoriously vague terms. This is, in part, because their normative force is called upon in such a wide array of contexts, from mere breeches of etiquette to the most egregious of injustices. I suggest here that it is possible to view unjustified paternalism as a misguided demand for either (or both) epistemic or moral deference. One might interpret the content or attitudes associated with the paternalism identified here as expressing disrespect for non-expert forms of knowledge. At the very least, the refusal to view members of the public as having something to contribute to the application of public health policy is a form of unjustified "epistemic exclusion."[73] In other words, "the public health community must recognize that the realm of rumors and perceptions may include clues about reasons for concern," i.e., even if misinformed, or poorly articulated, public skepticism may be grounded in reasonable calls for public health justification.[74] What Sorell fails to note is his how expectations of epistemic deference not only provide a solution to disagreements about the facts, but also a remedy to the injury felt by professionals when others question their professionalism. Contrary to Sorell's assertion, debates about public health policy often *are* tied to respect – for both members of the public and professionals alike.

In this first part of the chapter, I have argued that some defenses of public health paternalism are flawed. They result in a picture of public health policy and public health expertise that fails to incorporate the normative dimensions of public health practice and public

73 Nancy Daukas, "Epistemic Trust and Social Location," *Episteme* 3, no. 1–2 (2006): 109–124. Daukas is primarily concerned with those whose assertions are not taken seriously due to social problems such as sexism and racism, whereas I am using the term more broadly to include all those who are not deemed to have the authority to express worthy opinions in a certain context.

74 Larson and Heymann, "Opportunity to Build Public Trust," 271.

health professionalism. The acknowledgement that a hidden demand for respect is built into the call for deference reveals that there is more to be said about public health relationships with communities. In this first half of the chapter I have demonstrated the inadequacy of an account of public health professionals that fails to pay attention to the virtues. In the second half of Chapter 2, I present a positive account of public health professionals in which I defend the virtue of trustworthiness as the foundation for public health relationships of trust.

PART II

In this second part of the chapter I defend an account of public health relationships of trust, and the corollary virtue of trustworthiness. To do so I: (1) consider and reject the possibility that reliance and reliability might suffice; (2) articulate why trust and trustworthiness are an ineradicable part of public health practice; (3) support affective conceptions of trust and trustworthiness over the most dominant cognitive alternative and; (4) present some preliminary considerations for the implications of this analysis for trust in institutions and the possibilities of virtuous institutions.

## 2.4 Reliance and Reliability

One reason to revise beliefs, or to reconsider others, is the confidence one places in the sources of information provided. Sorrel is right – belief in matters of public health is partly about competency; if public confidence in professional competency falters, the veracity of such experts come into question. Of equal importance are professionals' motives that inform why they will tell the truth, or hide it. In matters of public health, generating public confidence in

public health information will in part hinge upon shoring up public attitudes regarding the sources behind that information. In matters of public health, there are often calls for instilling, building, and inspiring greater public trust. A virtue ethics of public health calls us to examine the assumption that a trusting relationship is an ideal that ought to structure public health-community interactions, as well as what constitutes such a relationship. The call for improving public trust is often unexamined, and while determinants of trust have been identified, greater attention to conceptual and causal understandings of trust can help to establish a firmer foundation for building trust, as well as why it is desirable. In this section, I will argue that trust in public health offers us a striking alternative to the picture of epistemic deference alone. However, trust must considered side by side with relationships of reliance.

Both empirical evidence and some formal features of public health support greater attention to relationships of trust. For example, Whetten et al. indicate that socioeconomic status, but not race, was most correlated with lower levels of trust in government and in health care providers. In addition, the study revealed that greater trust among HIV-positive patients correlated to an increased number of clinic visits, but the general paucity of research on trust and health services utilization often results in a lack of clarity about causal mechanisms; researchers were unable to conclude whether lack of care causes a corresponding lack of trust, or the reverse – lack of trust meant fewer patients seeking continued care.[75] Elsewhere, distrust of international vaccination efforts to eradicate polio led to disastrous results which some have argued could have been avoided by paying more attention to building community

75 Kathryn Whetten et al., "Exploring Lack of Trust in Care Providers and the Government as a Barrier to Health Service Use," *American Journal of Public Health* 96, no. 4 (2006): 716–21.

relationships in order to cultivate trust.[76] There are also conceptual reasons to think that public health efforts and trust are linked. Part of what differentiates public health from medicine is that it is *public* in the sense that it requires "a specific sort of practice, intervention, or public policy that is aiming at population health through collective means."[77] In addition, trust has long been viewed as an essential or integral component of collective efforts.[78] If cooperation and trust are so linked, then public health professionals would do well to establish trust in part due to its instrumental value in furthering collective efforts.

Prior to endorsing trust as an ideal relationship within public health practice, we must first consider what differentiates trust from the related notion of reliance, as well as why one might be preferable to the other. Trust is generally understood to be a species of the larger category of relationships known as reliance. Reliance is a kind of dependence on the consistency or regularity of behavior, or any sequence of events. While people and their behaviors can be reliable – exhibit a kind of regularity and consistency – so can inanimate objects. The classic philosophical example to distinguish trust from reliance draws upon the behavior of famous moral philosopher, Immanuel Kant, whose punctuality was well known. "Kant's neighbors who counted on his regular habits as a clock for their own less automatically regular ones might be disappointed with him if he slept in one day, but not let down by him, let

76 Larson and Heymann, "Opportunity to Build Public Trust."
77 Marcel Verweij and Angus Dawson, "The Meaning of 'Public' in 'Public Health,'" in *Ethics, Prevention, and Public Health*, ed. Angus Dawson and Marcel Verweij (Oxford: Oxford University Press), 2007, 25.
78 Diego Gambetta, ed. *Trust: Making and Breaking Cooperative Relations* (Blackwell Publishing, 1990). Cf. Karen S. Cook, Russell Hardin, and Margaret Levi, eds., *Cooperation Without Trust?* (New York: Russell Sage Foundation Series, 2007).

alone had their trust betrayed."[79] Our use of language blurs these conceptual distinctions – thus, we say that we "trust" that the sun will rise tomorrow. To get to the crux of what trust is, conceptualizations aim to be more precise than the common conflation of the two terms. In contrast to *mere* reliance, the relationship of trust is thought to rest upon a particular kind of regularity, i.e., the regularity of human intentions. Thus, Kant's neighbors can *rely* on his timeliness, but only *trust* him if he is aware of their dependence. If they ground their clock-setting not on his regularity of behavior, but on his concern for their dependence on him, then this can be said to be trust. In other words, while trains and watches can prove unreliable, whether people prove to be worthy or unworthy of trust turns upon the content of their intentions and how these motivate responsive behavior. Only people can be motivated by the dependence of others, and use this concern as an impetus for regular and dependable action. Thus, common ground in theorizing on trust finds agreement on this distinction between *mere* reliance and trust, as well as the view that trust is best understood as a three part relationship in which agent A trusts agent B with some object(ive), X. Theorists greatly disagree, however, on which intentions are the most important in providing the foundation for trust, i.e., what might move an individual to find the dependence of another motivating?

The relationships of reliance and trust imply corresponding attributes of public health professionals that provide the foundation for such relationships. If reliance and trust are essential relationships for public health practice, then it will be necessary for public health professionals to build reliability and cultivate trustworthiness. Another example can help to illustrate the difference between these two traits:

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79 Annette Baier, "Trust and Antitrust," *Ethics* 96, no. 2 (1986): 235.

> Suppose I am driving into a city that I do not know and I wish to get to the town center. I see a bus and, knowing the pattern on which bus routes are generally organized, I decide to rely on the bus driver to lead me to the center. This is a straightforward case of active reliance…But the reliance that his example illustrates assumes a more specific and interesting form if it becomes interactive as well as active. Suppose that I worry about what the bus driver will think about a car that stops every time the bus stops and that follows the bus faithfully on its route. This may lead me to get out at a bus stop and let the driver know that I am relying on him to lead me to the center…I may expect that the driver will be positively moved by seeing that I have made myself vulnerable and will be motivated all the more strongly to do that which am relying on them to do…[80]

Much like our consideration of the punctuality of Kant, in the first case the bus driver exhibits reliability if she sticks to her route. In the second case, she exhibits trustworthiness if she does indeed have the motivations attributed to her. Of the two, only trustworthiness is a virtue. Reliability is an attribute, and it may indeed require appropriate attitudes (e.g., an appreciation for precision, and commitment to consistency). But a person can be reliably cruel as well as kind, or unwittingly reliable by just being a creature of habit. Reliability, on its own, is not a laudable trait until we assess the ends it achieves.

What may give us pause in placing trust at the center of public health are the realities of public health practice, in which the public may be unaware of what is being done, purportedly on their behalf. Just as common as overt cooperation, the public may have little to no knowledge of the systems in place that work to protect and improve health. From the presence of iodine in salt, to the infrastructure in place to ensure a potable water supply, public health measures save lives or prevent illness in ways that are statistically measureable, but not necessarily personally apparent. Prevention often results in invisible successes. We may be

80 Philip Pettit, "The Cunning of Trust," *Philosophy and Public Affairs* 24, no. 3 (1995): 204–5.

able to quantify how many did not die, or how many did not fall ill, but we might not be able to point to who or when with any precision. The invisibility of public health successes make it seem less likely that trust is at the heart of the relationship between public health professionals and the public. Rather, many people drink from the tap without thinking, and go on about their lives without marveling at food enrichment. They are either unconcerned or unaware of the presence of health policy in their everyday lives precisely because success is so common as to become a background condition. In such instances, public response to the presence and action of public health interventions looks more like reliance on consistent processes and constant practices than trust in the motives of others.

Such examples also illustrate how public attitudes span a range of actions that can be characterized as reliance, trust, both, or neither. Individuals who question the safety of public drinking water, for example, may be questioning the reliability of the water safety system itself. Perhaps its age, or the presence of newer compounds not designed to be picked up by older filters, raise a concern that current filtration is insufficient. In such a case, the concern can be understood as resting on a belief that present water safety lacks effectiveness; the consistency and regularity of the system in achieving the ends it was designed to meet cannot be relied upon. In contrast, however, there are some who question the *motives* of those who ensure the safety of the nation's drinking water. While publicly justified on the grounds of benefits to dental health, there are some who still claim that water fluoridation aims at a form of governmental mind control, a claim tracing back to anti-communist sentiments.[81] Such

81 Jason M. Armfield, "When Public Action Undermines Public Health: a Critical Examination of Antifluoridationist Literature," *Australia and New Zealand Health Policy* 4, no. 1 (2007): 25.

individuals do not only find the water safety system unreliable, their trust in the professionals behind the system has faltered. Distrust in public health, whether well-founded or not, rests on a perception that the vulnerability of the public is no longer a motivating force for such professionals. The example also helps to illustrate both reliance and trust in public health can falter – for example a citizen who feels that current water filtration systems are inadequate *and* that regulatory oversight has been corrupted by conflicts of interest. In such an instance, citizens may feel that public health cannot be relied upon and cannot be trusted.

For those implementing public health policy and interventions, it may be the case that establishing reliability is sufficient for obtaining the majority of public cooperation. That this more minimal requirement can be so successful is at the root of a great deal of public health professional frustration; reliability often goes unrecognized, and unappreciated, precisely because a high degree of it can coincide with obliviousness to the efforts of those who ensure consistency. Reliability, at its best and most enduring, can be taken for granted. But as much as we might think improved awareness and appreciation for public health may be necessary and desirable in order to sustain public health investment, for a great deal of public health interventions reliability may be a desirable relationship to maintain in public health matters. A great deal of prevention results in reliance on healthy lives that are often only comprehensible as benefits in contrast to what could have been otherwise. Without a counterfactual perspective, a healthy life is not experienced *as* the absence of an illness, disability, or death. And, indeed, while we might desire for the sake of public health maintenance that citizens be more aware of the importance of public health efforts, a relationship of reliance on public health is not only an accurate depiction of current states of affairs between professionals and

members of the public, it may be a relationship to strive for, despite such potential drawbacks. Since one can also rely on consistency that one fully understands as being hard-fought for and requiring maintenance, it is only the case that reliance and blindness to public health are contingently connected. Trust, as I will argue, requires a great deal more effort on the part of public health professionals to establish and on the part of citizens to extend. Thus, before claiming that public health professionals ought to aim to increase public trust, one might wonder whether all that is needed is to foster public reliance.

## 2.5 When reliance is not enough

In her recent work, Onora O'neil notes three important reasons why trust is an essential part of public policy, even if difficult to attain. Relationships of trust cannot be replaced by policy and regulation alone for three reasons: first, ethical principles underdetermine behavior; second, accountability procedures may ensure reliability of behavior, but not trustworthiness, and third, such procedures cannot eliminate trust, but rather shift the object of trust from some agents to those in charge of ensuring and monitoring compliance.[82] In what follows, I expand on each of these points in the context of public health professionalism.

First, principles, like many normative commitments, are general and require interpretation and implementation into practicable courses of action. Even if a commitment to a principle of trustworthiness demands that one reject deception and coercion,[83] putting such principles into practice requires discernment and experience. Because it is often not possible

82 Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002)., Chapter 6.
83 Ibid.

to delimit the scope and priorities that accompany a particular professional's set of obligations, the general principles that require and proscribe action cannot be explicit enough to eradicate the elements of personal judgment required in professional fields. As a result, professional discretion is an ineliminable part of public health. As Annette Baier observed, "the more extensive the discretionary powers of the trusted, the less clear-cut will be the answer to the question of when trust is disappointed."[84] In other words, the more discretion citizens give to public health professionals to pursue the public good, the more they expose themselves to disappointment and betrayal. This does not mean that general ethical principles do not have their place, or that regulation cannot help ensure a greater consistency of professional conduct. But, in matters of professional policy implementation, there are limits on the practicability of policies. In the end, good judgment mediated by excellence of character will be an essential part of effective professional practice.

The second reason trust may be needed in public health is that reliability may simply be insufficient reassurance when certain kinds of confidence in public health falter. It is easy to confuse professional compliance with policy recommendations with trustworthiness. When incorrectly implemented, regulations are rightly seen as impediments to achieving professional aims, and may even undermine professional standards of right conduct. For example, regulations protecting patient confidentiality can be interpreted too rigidly, blocking legitimate attempts by epidemiologists to gather health information that serves the public good.[85] Alternatively, incentives lined up to provide additional motivation for right conduct can end up

84 Baier, "Trust and Antitrust," 238.
85 Amy Iversen et al., "Consent, Confidentiality, and the Data Protection Act," *British Medical Journal* 332, no. 7534 (2006): 165 –9.

motivating counterproductive adversarial behavior. Finally, regulatory oversight schemes can ensure that professionals desire to comply in order to achieve promotion or avoid censure. Such motives, however, do not guarantee that professionals will be moved by the vulnerability of the public's dependence on the profession – the key feature of trust. Regulatory oversight at its best requires that professionals behave with regularity. But because public health requires greater flexibility, there will be times when the public will need to depend upon the properly exercised discretion of professionals. This explains the extension of public wariness to not merely the functioning or consistency of public health behaviors, but to the intensions that motivate professionals themselves.

Lastly, the third reason that regulatory processes often fail to advance public cooperation is that, as much as reliability can complement trustworthiness, it cannot replace it. Rather, procedures that ensure compliance and openness merely shift the locus of trust to the auditors and regulators in charge of the system. "Standard political processes of reform, regulation and scrutiny cannot provide a remedy to the loss of trust *because they too are mistrusted*."[86] This is often the case because regulation, even when effective, can increase complexity and obscurity. Paradoxically, the very regulatory mechanism put into place to improve accountability and transparency may simultaneously increase public perceptions that policies are precisely the opposite. The conclusion that we are regrettably forced to acknowledge is that systems that enforce compliance, even when not overly burdensome and directed to ensure right conduct, offer no guarantee to cultivate public confidence. In addition, having such systems in place can signal to the public that the professionals in question need

86 O'Neill, "Autonomy and Trust in Bioethics," 138. Original emphasis.

such oversight precisely because they (or a significant majority among them) cannot be trusted. In the worst of cases, regulatory oversight can unintentionally result in replacing the standard of conduct associated with trustworthiness, genuine concern for human wellbeing, and professional responsibility with the lower bars of compliance and adherence.[87]

Reliance, like deference, is one possible response to public health practices. At times, however, the public requires knowledge and evidence of the intentions of those who lie behind the policies. The limits to ensuring reliability outlined here reveal that trust is sometimes necessary to public health practice. This does not mean that oversight and resulting reliability are not important – merely that they are sometimes insufficient. Establishing that there are conditions under which trust will be required in public health gives some backing to the calls to establish such relationships. In the next section, I turn to conceptual and empirical work done on trust to further illuminate what it might mean to heed such calls.

One might object at this point that mere reliance on public health measures is impossible – there appears to always be underlying assumptions regarding, at the very least, benign motives on the part of public health professionals. The answer to this objection depends very much on which account of trust one endorses. I will articulate these differences in greater detail in Section 2.6. For now, let us consider an example that might help illustrate how various accounts differentiate mere reliance from trust. In the case of food enrichment, some might say the public relies on the food production process to add substances that fulfill nutritional needs and simultaneously trusts the motives of food manufacturers to produce a quality product. For those who envision this wider notion of trust, having any vested interest in

87 Ibid., chap. 7.

the welfare of another may be enough to constitute the right kind of motivation characteristic of trusting relationships.[88] In other words, once humans are involved, the question of their motives is always a matter of trust, distrust, or one of the other variants.

However, others might set the bar higher, saying that even highly abiding benevolent motives are not enough – that trust is founded in another's commitment to acting on the notion that someone else is counting on them.[89] On this view, merely wishing everyone well (or no harm) is not enough; rather, one must take the possibility of disappointing others as significant reason for action. This second conception of trust drastically shifts the way we understand the distinction between mere reliance and trust. Under this second view, if our food producer complies with regulations because she fears she might otherwise have to pay a fine, this is merely public reliance on motives that mimic the actions of the trustworthy. In other words, conditions can be properly aligned such that agents with great power over public health must behave *as if* they truly care about the dependency of others on their action. But if such agents do not in fact care, then this regularity of behavior more closely resembles the reliability of inanimate objects and processes. My argument here is that human behavior, under the proper conditions, can be remarkably similar to the activities of a train system set up to run punctually. Put in the right starting conditions, and the train will arrive on time. Put in the right incentives, and agents will behave rightly. According to this view, however, we should not consider the fact that we count on incentives to motivate others the same as *trusting*

88 Russell Hardin, *Trust and Trustworthiness* (New York: Russell Sage Foundation, 2002), 90. For Hardin, trust is belief that another has reason to act in your interests, whereas distrust is believing another has reason to not to act in your interest; the middle ground is wariness, when an agent may not be convinced either way regarding the motives of another.
89 Karen Jones, "Trust as an Affective Attitude," *Ethics* 107, no. 1 (1996): 4–25.

others. Rather, we should consider this a case in which the public merely relies on both food production and the self-interest of producers.[90]

Reliance on public health professionals and practices is a laudable public health relationship to aim for. I have argued in this section, however, that at times in developing and implementing public health policy it may not be enough. That human behavior is so unlikely to become so regular, or that we may have good reason to desire greater flexibility than regulations can assure (e.g., allowing for the use of discretion), leads us to the conclusion that trust will play a significant role in public health. At such times, communities may want to know that their dependence on public health professionals is a motivating force influencing the design and application of public health interventions. Such motives are the central feature of the trustworthy, which I address in the next section.

## 2.6 Interpersonal Trust and Trustworthiness

In Section 2.4 I outlined the general agreement amongst theorists regarding the nature of relationships of trust, especially its distinction from reliance. In establishing that trust is a relationship that is sometimes ideal in public health, it will be helpful to delineate a matter of contention amongst such theorists, i.e., what makes someone trustworthy. In this section, I outline the two main competing understandings of interpersonal trust and their corollary

90 O'Neill, "Autonomy and Trust in Bioethics." O'neill's contends, however, that reliance often only removes trust to a farther distance does imply that the public trusts someone when evaluating public health policy. Thus, in our food enrichment case, trust is redirected from food manufacturers to regulatory agencies or, even farther, to those who oversee the regulators. Whether this implies that there are no instances of mere reliance depends on how far out in the policy framework one goes to find who is, ultimately, trusted. If one truncates the field of vision, it is possible to describe all that is going on within that frame in terms of reliance.

notions of trustworthiness, including Russell Hardin's notion of trust as encapsulated-interest, and affective notions of trust as goodwill, or optimism about goodwill. I defend the affective notions of trust and a virtue approach to trustworthiness.

### 2.6.1 The Encapsulated-Interest Account

Russell Hardin's notion of encapsulated-interest is perhaps the most well-known and utilized conceptualization of trust. Let us recall that the distinction between reliance and trust is that the trusted party finds the dependence of another a motivating reason for action. According to Hardin, what matters for trust is "that you deliberately take my interests into account because they are mine."[91] In public health, there may be many reasons for professionals to consider the interests of citizens (as a group, or as individuals), and Hardin's analysis attempts to cast a wide net to capture all such reasons. He identifies encapsulated-interest as coinciding with, or grouped under, a more general desire to sustain a continuing relationship.[92] There can be many reasons for desiring a relationship to continue, and Hardin seeks an account of trust that can accommodate all such motives for trust, without being so broad as to capture untrustworthy motives. With this in mind, he rules out merely coincidental interests. For example, a public health professional may be motivated to stem the tide of an epidemic in order to limit her own exposure. While this may make her motivated to perform well, common or shared interests alone do not capture the nature of a trusting relationship. Rather, the professional must have genuine reason for taking on board the interests of others.

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91 Hardin, "Trust and Trustworthiness," 11.
92 Hardin, "Trust and Trustworthiness," 1.

Such reasons might include a concern for reputation, economic incentive, a desire for promotion, or even personal affection or particularity.

Hardin's account is grounded in rational choice theory. For trusting parties to develop knowledge of another's potential for encapsulating her interests, she must engage in a series of iterated encounters that confirm or refute her belief in the other's possession of appropriate motives for grounding trust. Hardin wishes to encompass the range of relationships that we can allow constitute trust, drawing us out of the classic "thick" relationships of mutual, enduring, and wide-ranging trust.[93] Rather, Hardin contends that thick relationships are merely an excellent way to obtain knowledge about the capacity and tendency of another to encapsulate one's interests. Rather than assuming that trust can only obtain in such relationships, Hardin's encapsulated-interest account allows for a wider range of trusting relationships, and especially helps to challenge our predilection for characterizing trust as mutual. Such an account may prove especially helpful for public health professionals, where unidirectional trust may especially characterize initial or fleeting public health relationships, especially in public health emergencies.

For Hardin, drawing a wider boundary for trust in part derives from a desire to distinguish relationships of trust from the traits that inspire trust, or trustworthiness. Too often, Hardin claims, trust is assumed to be something desirable, a moral good, whereas Hardin thinks an account of trust ought to make room for the less laudable instances of the relationship. Hardin identifies his highly rationalistic account as potentially consistent with Aristotle's, noting particularly the connection between the ancient usage of the term *pistis* for

93 Ibid.

trust, confidence, and belief. Hardin interprets this as evidence that an Aristotelian account of trust would be cognitivist in nature.[94] This is consistent with Hardin's determination to develop not only a cognitive account of trust, but also one that eschews moralization of trust.

Hardin's encapsulated-interest account is broad enough to allow for a wide variety of motives within the trusted, including motives we do not normally admire. Thus, Hardin's quintessential example of trust is drawn from literature, and Dostoyevsky's *The Brother's Karamazov* is meant to offer us an illustration of the wide range of contexts for trust. Hardin offers up the story of a lieutenant colonel who embezzles funds in exchange for profit ensured by his partner in crime, the merchant Trifonov. Upon the eve of discovering impending exposure, Trifonov's motive for a continued relationship has been undermined, and he betrays the lieutenant colonel by refusing to return the most recently "borrowed" sum of public funds and denying any previous relationship. Hardin wishes to develop an account of trust that allows us to understand what occurs between these two characters as a legitimate instance of trust, not misplaced trust, or unjustified trust. And indeed, on Hardin's account, this follows. For prior to discovery, both the lieutenant colonel and Trifonov benefit from their illicit cooperation, and have reason to continue their relationship. Trifonov has reason to maintain a good reputation with the lieutenant colonel in order to profit from future transactions, and to avoid reprisals from a powerful man. The lieutenant can rely on their mutual interests to motivate Trifonov to continue returning his periodic installments, with added interest. In other words, Hardin wishes to establish an account of trust that allows, if not for honor among thieves, then trust between them – even if it is a fragile or contingent trust. According to

94 Ibid., Chap. 1, note 7.

Hardin's view, a normative account of trustworthiness, one that requires ethical motives for trust and trustworthy behavior, would reject such an instance as one of genuine trust. Or, it would try to project more noble motives onto the agents in question, which Hardin interprets as unnecessary.

There are three reasons to think that the encapsulated-interest account of trustworthiness is inadequate, especially within a virtue ethics approach. First, interpretation of Aristotelian rationality is incorrect. Virtues are more commonly understood to include both cognitive and affective aspects, including emotions and emotional sensitivity.[95] Second, the encapsulated interest account tries to eradicate moral motives, and indeed all aspects of character, explaining relationships of trust as existing due to the mutual self-interest of those involved. As such, Hardin's view implies, contrary to virtue ethics, "that 'being moral' does not count among my interests" (see Chapter 1).[96] These first two reasons are not a points against an encapsulated-interest account generally, but do give us reason to reject its place in a virtue approach to public health ethics.

However, one reason to think that Hardin's account of trust is not adequate is that character is sometimes necessary to explain some instances of trust. Thomas Simpson gives a more extensive defense of this view, but in the context of public health I will merely point to one of his main contentions.[97] According to Simpson, "high stakes" scenarios provide counterexamples to Hardin's account of trust because on his view, it would be irrational for

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95 Nancy Nyquist Potter, *How Can I Be Trusted? A Virtue Theory of Trustworthiness* (Oxford: Rowman & Littlefield, 2002), 14.
96 Thomas W. Simpson. "Trustworthiness and Moral Character," *Ethical Theory and Moral Practice* (2012): 1-15 DOI 10.1007/s10677-012-9373-4.
97 Simpson, "Trustworthiness and Moral Character."

anyone to trust in such cases – those in power might be too tempted to feel any compulsion to continue the relationship. However, such relationships are often at play in public policy matters, or whenever someone gives another person great power from which she might gain a great deal without having to fulfill trust. In other words, there are times when trusting grants another person such powers that enable them to take advantage of us, and to accomplish a great deal that may be of personal worth to the trusted. Arguably, public health powers are precisely the kind that Simpson has in mind. Given what public health professionals *can* do with the capacity to perform surveillance, muster public resources, and compel citizens, on Hardin's account it would be irrational to risk the possibility that professionals would be tempted to use such extensive powers. The potential for such abuse is not out of the realm of imagination, as exhibited by Soviet public health practices, and expanding public health powers in response to acts of terrorism that arguably create the potential for abuse.[98] Simpson contends that when self-interest (in Hardin's sense) cannot explain all instances of trust, then another aspect of human psychology must. He concludes the stable character traits – such as the virtues – can provide the missing element.

### 2.6.2 Affective Accounts of Trust and Trustworthiness

On an alternative account of trust, Annette Baier and Karen Jones articulate a view that proposes that trust is not merely a matter of beliefs about another's motives, but also a matter of trusting attitudes. On Baier's goodwill account, trust is a relationship that makes one

98 Ronald Bayer and James Colgrove, "Public Health Vs. Civil Liberties," *Science* 297, no. 5588, New Series (2002): 1811.

vulnerable to betrayal; therefore, what we seek in those we trust is evidence of motives to handle that vulnerability carefully.[99] As Baier observes, an account of trust acknowledges that relationships of trust are always marked by inequality – one partner has the power to betray the other. For Baier, trust provides us with "a morality to guide us in our dealings with those who either cannot or should not achieve equality of power."[100] Such an observation is highly pertinent to public health practice, where members of the public are inherently in positions of lesser power than professionals for two distinct reasons: first, due to a lack of epidemiological knowledge and experience that might help them form their own independent views of public health policy and practice, and second, as dependent parties, as trusters in a relationship of trust, citizens make themselves vulnerable to the possibility of betrayal in the form of abuse, neglect, and abdication of public health professional discretion. I will discuss in greater detail in Chapter 3 the nature of public health risk, but it is sufficient for my purposes here to identify the trusting relationship itself as a matter of vulnerability for members of the public.

Baier's account departs from Hardin's in that she adds attitudes to the beliefs that ground trust. It is not enough that a citizen believes that the public health professional has her interests in mind. Such expectations are also accompanied by a hopefulness or optimism about public health motives. Such an account does not rule out fragile or tentative relationships of trust – we can, after all, be cautiously optimistic. Similarly, Karen Jones wishes to further articulate what kind of attitude is at play in relationships of trust, and claims that it is not merely some kind of hopeful attitude combined with beliefs about the goodwill of another, but

99 Baier, "Trust and Antitrust."
100Ibid., 249.

specifically optimism about the goodwill of another. For Jones, a consistent attitude of goodwill may simply reveal beneficence, not trustworthiness.[101] What such affective, or non-cognitive, depictions of trust offer are an account of the ways in which attitude-belief complexes structure the perceptions and behaviors of those who trust: "…the attitude of optimism constitutive of trust is a distinctive way of seeing another…The cognitive set constitutive of trust restricts the interpretations of another's behavior an motives that we consider."[102] While beliefs can also structure how we perceive the world, the addition of emotions and attitudes has explanatory power in helping to establish why such beliefs can be, as is often the case in matters of trust, evidence-resistant. This is especially true in "thick" relationships of trust, where we might rule out condemnatory evidence precisely because it is inconsistent with our experience and knowledge of the trusted party.[103] Thus, in a long-lasting relationship with a clinician, one patient may disregard the complaints of another patient, considering them to be anomalous with respect to her own judgments of the physician's nature and intentions. Such evidence-resistance may be unlikely in the more fleeting personal encounters citizens have with public health personnel. And yet the contrary case may be highly relevant; attitudes of distrust may frame experiences so as to confirm the suspicions and wariness of those who are hesitant to trust. This is highly pertinent in public health, where distrust of government generally impedes upon trust of public health as a distinct practice. Thus, affective accounts offer us some vision of the ways in which relationships are not a matter of evidence and belief alone, but also of

101 Jones, "Trust as an Affective Attitude."
102 Ibid., 11.
103 Judith Baker, "Trust and Rationality," *Pacific Philosophical Quarterly* 68 (1987): 1–13.

ongoing perceptions that include both beliefs and attitudes, which simultaneously influence one's understanding and perspective on potential relationships.

The importance of public perceptions cannot be overemphasized, as they explain the disconnect between being trustworthy and being trusted. While trustworthiness provides a justified foundation for trust, this does not always mean that agents will perceive the evidence that provides the justification. Because we do not always have access to another's motives, we may be unable to assess whether they are trustworthy. I mentioned this possibility in the last section – while regulatory oversight may sometimes fall short by encouraging compliance in place of trustworthiness, it nevertheless can also provide the context for trustworthiness to flourish by emphasizing the importance of accountability and the protective purposes that initiate the creation of such systems. But because such systems are so complex and distant, they may paradoxically decrease trust by obscuring access to the motives of public health professionals. This is known as the Cassandra problem, named for the greek mythical woman who had the gift of foresight, but was cursed to have no one believe her.[104] One frustrating implication for those in public health is that they can be extraordinarily trustworthy, and nevertheless not trusted. But, as Aristotle notes, it is the work of civil servants to provide assurances nonetheless: "the task of the legislator is to manage perceived as well as real injustices and hence to strengthen the civic bond."[105]

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104 O'Neill, "Autonomy and Trust in Bioethics," chap. 7.

105 Schwarzenbach, "On Civic Friendship," 106. Thus Aristotle conceives of cultivating civic friendship as a central purpose of public professionals. I argued in Chapter 1 that this aspect of public health work can increase public cooperation with interventions. The possibility of distrust despite what professionals do calls our attention to a need to consider the limits to public health professionals' role in creating community.

Nancy Nyquist-Potter's virtue account of trustworthiness corresponds well to the affective approach to trust, as it provides a character foundation for the expression of goodwill. According to Nyquist-Potter, trustworthiness is the trait that ensure that "one can be counted, on as a matter of the sort of person he or she is, to take care of those things that other entrust to one and…whose ways of caring are neither excessive nor deficient."[106] Nyquist-Potter's approach to trustworthiness places the vulnerability of the trusting party at the center of the relationship of trust. Trustworthy individuals are those who consistently respond to that vulnerability appropriately, including understanding that burden of proof lies on those in a position of relative power. In placing interdependency at the center of public health relationships, a virtue approach fits well with the need to develop a relational approach to public health.[107]

For public health, the distance between cultivating trustworthiness and establishing trust is integral to public health communication and interaction. The most frustrating aspect of trust is that expectations are built on perceptions of trustworthiness, which means that public distrust can be unfounded, and the contrary, that public trust can be misplaced. Nyquist-Potter's account of the virtue of trustworthiness attempts to bridge this divide by establishing a need for the trustworthy to signal trustworthiness, or provide evidence that professionals or programs are designed with such vulnerability in mind. To provide assurance of trustworthiness is one of the main indicators of the trustworthy, as the tendency to distrust or be wary of trust is a defense mechanism employed by the more vulnerable party in

106 Nyquist Potter, "How Can I Be Trusted?," 16.
107 Francoise Baylis, Kenny Kenny, and Susan Sherwin, "A Relational Account of Public Health Ethics," *Public Health Ethics* (2008): 1–14.

relationships of trust. It is therefore more incumbent on those with greater power in public health relationships to bear the burden of establishing trustworthiness, even when distrust or a hesitancy to trust is unfounded.[108] The virtue account of trustworthiness also acknowledges that, paradoxically, sometimes breaking a trust is the most trustworthy thing to do. For example, even justified quarantine procedures in public health may undermine public trust. Unlike more principled approaches, however, the virtue approach can accommodate the moral remainder of such a decision. The trustworthy person will recognize that in the aftermath of broken trust, the proper response is to make amends, even if betrayal was necessary in the moment.[109]

It is easy to conflate the difference between the relationship of trust and the features that we believe ought to inspire or provide a foundation for such relationships. In public health, trust often receives attention when it is deemed essential for public safety or critical to the success of a particular intervention. And while a great deal of the work done to suggest greater transparency, reciprocity, and minimal intrusiveness on the part of public health policies may inspire greater trust in the midst of a public health crisis, it is likely that relationships of trust are established well before the onset of an emergency.[110] Additionally, emphasis on building trust draws attention to the importance of how to respond to perceived and real public health failures. As this analysis shows, such failures will not only disappoint, but also be publicly understood as instances of betrayal. On this account, unfulfilled trust provides confirmation to existing skeptics, and new evidence of untrustworthiness to those who were previously

108 Nyquist Potter, "How Can I Be Trusted?," Chapter 2.
109 Ibid., chap. 3.
110 Larson and Heymann, “Opportunity to Build Public Trust.”

supportive of health policy. If public health professionals wish to build greater participation, it will be as important to cultivate relationships before and after public health disasters, not just during them.

The interpersonal accounts of trust display limitations because in order to account for trust outside of relationships between two individuals, they must be stretched. As Annette Baier observes of her own goodwill account, it "ignores the *network* of trust, and treats only two-party trust relationships."[111] Similarly, Hardin acknowledges that in trying to account for trust outside of interpersonal relationships "the central problem is the translation of individual-to-individual relationships to individual-to-group or individual-to-institution relationships."[112] This "individualist limitation" will be necessary to overcome for any account of trust that wishes to contend for a more complex operation of trust in public health practice.

## 2.7 Group Trust, Institutional Trustworthiness

In this section, I will examine the notion of social capital, which attempts to account for trust as a social phenomenon in addition to outlining the ways in which different interpersonal accounts of trust can be "stretched" to account for trust in society and in institutions. I will also address the difficulties of such strategies, since they risk anthropomorphism.

111 Baier, "Trust and Antitrust," 258.
112 Hardin, "Trust and Trustworthiness," 152.

2.7.1 Social Capital

Before turning to how an affective or encapsulated-interest conception of trust could be extended outside the context of interpersonal relationships, I will first examine an account of that takes social networks, rather than individuals, as the basis for trust. Robert Putnam's account of trust in relation to social capital offers an alternative to conceiving of trust on an interpersonal level. According to Putnam, social capital constitutes "the features of social life – networks, norms, and trust – that enable participants to act together more effectively to pursue shared objectives."[113] Thus, the connections one has as a member of society give one social capital - the ability to engage in collective activity, or to harness the resources of the others in one's network. Drawing on the purported link between cooperation and trust, the social capital account builds trust in as what makes collective action possible, or what lends individuals who have greater social connections increased capacity to achieve their own ends.

One benefit of the social capital account is that it attempts to account for the historical and social context in which trust takes place. In this way, the social capital account is a part of "social contextualism" reactions to interpersonal trust accounts. The social capital account attempts to understand changes in trust as resulting from changing social conditions, rather than solely a matter of individual beliefs or attitudes.[114] One consistent weakness of the account, however, is that it fails to articulate the relationships between social capital and trust,

113 Robert Putnam, "Tuning In, Tuning Out:The Strange Disappearance of Social Capital in America," *PS: Political Science & Politics* 28, no. 4 (1995): 664–665.
114 Roderick M Kramer and Tom R. Tyler, eds., *Trust in Organizations: Frontiers of Theory and Research*, (New York: Russell Sage Foundation, 1995), 3.

leaving social capital both conceptually indeterminate and methodologically difficult to measure.

### 2.7.2 Generalized Trust

What concerns Putnam most are declining levels of social capital throughout society. Relying on survey data that inquires into people's trust in society Putnam points to a striking decline in social capital in society, or what we might otherwise call generalized trust. Generalized trust is the degree to which individuals in society are willing to trust unidentified others, or the "average" person. As I mentioned, the relationship between trust and social capital is not entirely clear; in the case of generalized trust, relationships of trust appear to be the most significant subjective ties that bind individuals into a social network.[115] Research on generalized trust bears significant importance to public health practice since these other levels or relationships of trust are likely to mediate the relationships that can and will be formed between citizens and public health professionals.

Levels of generalized trust in a society are gathered via the American National Election Studies survey, which has been performed for decades and was originally designed to assess levels of voter cynicism. The questions asked as part of the survey include the following:

1. Do you think most people would try to take advantage of you, or would they try to be fair?

115 Pamela Paxton, "Is Social Capital Declining in the United States? A Multiple Indicator Assessment," *American Journal of Sociology* 105, no. 1 (1999): 88–127.

2. Would you say that most of the time people try to be helpful, or that they are mostly looking out for themselves?
3. Generally speaking, would you say that most people can be trusted, or that you can't be too careful dealing with people?

Such questions have been critiqued for being poorly worded and therefore not accurate at capturing the kind of trust in question.[116] They fail to acknowledge the general agreement among theorists that trust is a three-part relationship, leaving it up to those answering to fill in the blanks regarding *what* the average person is being trusted to do or be. In addition, each respondent is expected to provide her own interpretation of who the phrase "most people" includes.[117] However, the answers of people over time do appear to reflect declining levels of generalized trust (or perhaps confidence) in society, not just over time, but also over successive generations.[118] Whether such data reveal a "crisis" in public trust is not clear, nor are the subsequent ramifications for public health. If public health is understood as "what we, as a society, do collectively to assure the conditions in which people can be healthy," then it is likely that decreased trust in society will undermine public health efforts broadly. However, given the many bases on which trust can be founded, it will be difficult to tease out what effects decreasing levels of generalized trust have on public health efforts. Nonetheless, determining causes of falling levels of trust in society has important ties to public health practice.

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116 Alan S. Miller and Tomoko Mitamura, "Are Surveys on Trust Trustworthy?," *Social Psychology Quarterly* 66, no. 1 (2003): 62–70.
117 Peter Nannestad, "What Have We Learned About Generalized Trust, If Anything?," *Annual Review of Political Science* 11, no. 1 (2008): 413–36.
118 Miller and Mitamura, "Are Surveys on Trust Trustworthy?"; Robert V. Robinson and Elton F. Jackson, "Is Trust in Others Declining in America? An Age-Period-Cohort Analysis," *Social Science Research* 30, no. 1 (2001): 117–45.

Recent efforts in public health ethics have sought for a foundation of public health in social justice.[119] Such efforts, as well as those aimed at improving trust in public health, can be bolstered by evidence indicating links between inequality, civic participation, and trust. For example, Ulsaner and Brown found that likely linkages include the potential for inequality to influence lower levels of generalized trust by decreasing individuals' optimism about the future, and by undermining a sense of shared fate or communal wellbeing.[120] More recent research confirms that falling levels of trust are causally linked to both inequality and health outcomes independently of public expenditures on health care.[121] In the context of public health, disparities in health outcomes may, in a parallel fashion, reduce individual optimism about the possibility for leading healthy lives, as well as increase skepticism that public health interventions are likely to deliver benefits equitably. However, the authors also conclude the context of inequality and trust matters greatly; what holds for improving community participation may not hold for political participation, and it is even more difficult to determine how low generalized trust will affect more immediate instances of interpersonal trust between a single professional and a citizen.

This analysis of generalized trust has important implications for public health, some conceptual, some empirical, and some practical. First, if public health professionals wish to increase public trust, it will behoove them to consider the faults and strengths of the various

119 Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy,* (Oxford: Oxford University Press, 2008); Jennifer Prah Ruger, *Health and Social Justice,* (Oxford: Oxford University Press, 2012).
120 Eric Uslaner and Mitchell Brown, "Inequality, Trust, and Civic Engagement," *American Politics Research* 33, no. 6 (2005): 868–94.
121 Frank J. Elgar, "Income Inequality, Trust, and Population Health in 33 Countries," *American Journal of Public Health* 100, no. 11 (2010): 2311–15.

conceptions of trust. Social capital may be best suited to institutional or population contexts where the trust in question is that of a group, not individuals. If one finds the various conceptions of interpersonal trust more appealing, they will need to be adapted to accommodate how we come to assess the "average" person's motives, whether they be encapsulating or of goodwill. Second, whatever conception of trust one settles on, researchers will need to reconsider methods for assessing generalized trust and determine if they are adequate – if not, what we claim to know of generalized trust so far may be knowledge of some other unnamed social phenomenon. Third, public health professionals need to decide how and when levels of generalized trust pertain to their work. In some cases, levels of generalized trust may be irrelevant, while in others, the general level of trust in society may place limits on the degree of trust public health professionals can hope to inspire.

### 2.7.3 Trust, Trustworthiness, and Institutions

It might appear that interpersonal accounts of trust are impossible to extend to institutions. Indeed, if motives are required to distinguish trust from mere reliance, then it would appear that since institutions are inanimate, they cannot, by default, be trusted, only relied upon. However, it is possible to pursue limited extension of both the encapsulated-interest account and the affective account of trust in institutions. As Jones claims, "insofar as it is metaphorical to attribute affective states to nonnatural agents, the meaning (of trust) is not precisely the same...Sometimes government policies can enact something similar to the selective vision characteristic of trust, and the rationale for those policies can duplicate the

expectation constitutive of trust."[122] Here, Jones is concerned that one might be able say that institutions place trust in others, whereas elsewhere, Hardin and Baier express concern about whether it is reasonable to talk about trust *in* institutions. To do so, there are two alternatives: first, one might develop an aggregate account of trust that reduces trust in institutions to trust in professionals *within* those institutions; secondly, one might take a more collective approach to trust, and extend to institutions the motives characteristic of trust, at least figuratively, and explain how this is possible.

National Election Survey data on trust in the government, mirroring that of generalized trust, reveals falling levels over time. As public health professionals are also government employees, national levels of trust, or distrust, in government will mediate interpersonal relationships of trust. In addition, because encounters in institutional settings will not always provide an opportunity for citizens to determine the intentions of individual professionals, they may use roles or categories to fill in the gaps in order to assess professional motivations for protecting civic vulnerability.[123] Thus, an individual's trust in medical professionals will also mediate his or her trust in public health, as will her trust of the social groups associated with the professional in question. In addition, institutional practice and cultures create a context for interpersonal forms of trust. According to Hardin, "We can build institutional devices that mimic the incentives of the encapsulated-interest account, so that we can relatively easily see

122 Jones, "Trust as an Affective Attitude," 14.
123 Kramer M. Roderick and Karen S. Cook, eds., *Trust and Distrust in Organizations: Dilemmas and Approaches* (New York: Russell Sage Foundation, 2007).

how to overcome problems of the lack of trust in trustworthiness in many contexts in which, for example, ongoing relationships cannot motivate cooperation."[124]

The account that Hardin develops as the institutional corollary to encapsulated-interest account is aggregative.[125] However, "in principle at least, the encapsulated-interest conception of trust can be generalized to fit institutions, although in practice it might not generally fit because the knowledge and the iterated interaction conditions cannot be met."[126] The main challenge to this view is that people simply do not have the knowledge of the motives of professionals within institutions that would be necessary to form opinions of institutional trustworthiness. Thus, Hardin is concerned that while citizens may reasonably be expected to encounter evidence of institutional reliability, they are unlikely to obtain knowledge of any intentional design or conscious institutional effort to take the interests of citizens directly into consideration. Hardin also allows that a less demanding account of institutional trust might allow for citizens to trust in the role held by various professionals, believing it to ensure certain interests or motives. This role approach might be interpreted as a kind of collective approach to trust in that it attempts to link trust in institutions to roles, structures, and policies, without reducing it to the behavior of individuals. Hardin again identifies the main obstacle to finding such role-trust in practice: to trust an institutional role, one would require knowledge of the

124 Hardin, "Trust and Trustworthiness," 52.
125 Ibid., Chapter 7.
126 Ibid., 153.

structure and incentives offered to those within particular roles. In the case of government institutions like public health, it is again unlikely many citizens will have such knowledge.[127]

Baier's affective account of trust directly addresses the limits to her interpersonal account without directly addressing how trust in groups or systems is possible. Nevertheless, she obliquely addresses trust in institutions in the context of systemic injustice, where members of a group may assess that structures in question are systematically opposed to their own interests; "in such conditions, it may take fortitude to display distrust and heroism to disappoint the trust of the powerful."[128] Baier warns institutions like public health, then, of inferring trust from compliance alone. A distrustful populace may act as if they trust if the penalties of distrust are too great. In addressing this possibility, she opens the door to trust of groups and institutions, and we might wonder how to extend her affective account. To do so would require addressing how individuals acquire understanding of institutional intent, whether these are interpretations of professional behavior or roles, or perceptions of intentions embedded in the structures and practices of institutions themselves. Nyquist-Potter's account adds to this, asserting that trust involves a process of induction in which trust can shift from individuals to groups when institutions appear to endorse or condone abuses of trust, or protection of interests is only extended to some groups at the expense of others.[129]

The attribution of intention to institutions, or at least the group agency they may exhibit reveals one option for attributing the virtue of trustworthiness to institutions. In addition, institutions can create the conditions for individual trustworthiness, cultivating the skills and

127 Ibid., 154.
128 Baier, "Trust and Antitrust," 259.
129 Nyquist Potter, "How Can I Be Trusted?," 24.

character traits necessary for professional capacities to build relationships of interpersonal trust with individual citizens. Making the case for the latter kind of institutional virtue is much easier than the former – trust that accrues to institutions as a result of some kind of aggregation of virtue in the individuals that comprise its members is certainly more intuitive than the kind of virtue that can be ascribed distinctly to the institution independently.

Susan Goold claims that normative structure is built into the very fabric of institutions, and is expressed in various dimensions of institutional design. For example, by creating role expectations, institutions shape professional behavior, creating the conditions for the encouragement, development, and expression of trustworthiness in individual professionals. In terms of virtue, creating an environment or culture of trustworthiness entails processes of enculturation and habituation in which what it means to be trustworthy in public health practice by cultivating trustworthiness through education, training, and mentoring as professionals are groomed for public health practice. As Annette Baier expressed it, "we take it for granted that people will perform their role-related duties and trust any individual worker to look after whatever her job requires her to. The very existence of that job, as a standard occupation, creates a climate of some trust in those with that job."[130]

The case for organizational virtue beyond the aggregate view requires some kind of parallel not just to the intentions, but also the thought processes, attitudes, and perceptions that so characterize the trustworthy person. In other words, what is required is an account of group agency. Many, including Peter French, have advanced that we may treat groups as

130 Baier, "Trust and Antitrust," 254.

having agency.[131] Drawing on his work view, Michael Smith asserts, "in certain contexts acts by persons will count *as* decisions or acts by an organization."[132] This may especially be true of public health leadership, which may, as a body, direct policy formation and articulation. The same might be said of working groups that gather information and provide policy recommendations in the form of consensus expert opinion, including unresolved issues where professionals could not reach agreement. Furthermore, when such actions are normatively laden, or the specific goals of an organization are explicitly ethical in nature, then it is possible to view such agency as the proper object of moral attribution.[133] Thus the policies and structures of an institution, like the actions and decisions of individuals, can be said to exhibit virtue. For example, setting goals and expressing values in policies can be interpreted as institutions actions that reflect global institutional intent in policy design.[134] On this analysis, it can be argued that institutions can be said to be virtuous not solely due to the virtue of the individuals within the institution but due to a capacity to exhibit a collective kind of virtue.

To attribute intentions to institutions has potential drawbacks using either an aggregative or collective tack. The aggregative approach carries a great risk of committing a fallacy of composition.[135] That professionals within an institution have developed motivations

131 Peter A. French, *Individual and Collective Responsibility*, (Cambridge: Schenkman Books, 1998).
132 Michael D. Smith, "The Virtuous Organization," *Journal of Medicine and Philosophy* 7, no. 1 (1982): 36.
133 Ibid.; Stephen Holland, "The Virtue Ethics Approach to Bioethics," *Bioethics* 25, no. 4 (2011): 192–201.
134 Susan Dorr Goold, "Trust and the Ethics of Health Care Insitutions," T*he Hastings Center Report* 31, no. 6 (2001): 27.
135 Hardin, "Trust and Trustworthiness."

is not reason to believe that the institutions can be attributed to also protect interests in the same way. Such inferences disguise any diversity of intentions, character, and disagreement within an institution. In contrast, the collective approach to trust in groups tends to reify the independence of institutions from those who comprise them, divorcing institutional design and function from those who keep the institution functioning. If intentions are "read" off institutional roles, policies, and structures, the collective approach must reconcile how such supra-intentions may conflict with the explicit and expressed intentions of individuals within an organization. For example, the collective account must explain how trustworthy professionals work within untrustworthy cultures, or how the collective attribution of trustworthiness may be apt even when facing corruption amongst a significant minority.

Attributions of agency and virtue to groups ought to be done with caution, at the risk of reifying the nature of the group over its component parts, and forgetting the integral relationship between them. When this occurs, we will end up with not just an inflated ontology, but misattribution of moral worth. For example, virtues are often compared to good habits because they are said to result in regularity of behavior. And such regularity may inspire the attribution of virtue:

> we ought to accord a very special kind of moral admiration to those [institutions] that not only manage to [satisfy their obligations] but are so structured that we can feel confident that they will do so easily and regularly what they ought to do.[136]

Regularity of intentions that capture and respond to the vulnerability of the public – attitudes towards and perceptions of that vulnerability which trigger appropriate responses – are indeed

136 Smith, "The Virtuous Organization," 41.

the kind of features that I have in mind as deserving of the name of virtue. However, it was my purpose in Section 3.4 to warn against conflating trust with reliance, and the same is true of the conditions that inspire such relationships; we ought not confuse trustworthiness with reliability. And institutional regularity, even of ensuring right behavior, is not identical to trustworthiness. Just as oversight and incentives can align professional behavior to mirror that of the trustworthy, institutions thrive on uniformity. We ought not attribute trustworthiness where mere reliability exists, nor seek institutional trustworthiness when reliability is all that is required. In public health, we may desire our professionals to cultivate and sustain trustworthy motives, but reliability, in its many forms of institutional regulation, or appropriate professional compensation and promotion, can provide a failsafe when individual and institutional virtue falter. That I wish to make room for the possibility of institutional trustworthiness does not mean we ought to mistake it for something much easier to come by.

In conclusion, faulty arguments for public health paternalism and deference, as illustrated by the MMR-vaccination debate, offer us examples of unexamined proposals for public health relationships. As citizens are increasingly raised in an era in which patient autonomy, not clinical deference, is the order of the day, they expect that the burden of proof falls on professionals to make the case for public cooperation. And in an odd turn of events, this is perhaps consistent with Sorell's call for a "division of labor."[137] Except, in this new light, parents and citizens see expert consultation as an opportunity to gain more information about how and *why* one might want to raise one's children in a certain way – not as an interaction in which advice and recommendations are provided with the expectation of adherence to without

137 Sorell, "Parental Choice and Autism," 100.

question. I have suggested here that deference, reliance, and trust offer us three different relationships to consider in public health. We ought not consider these as mutually exclusive alternatives; deference to legal authority may be required in times when public safety can no longer afford to wait for individual compliance – and indeed, we may epistemically defer precisely *because* we trust. In addition, it is also quite likely that success in public health employs both relationships simultaneously, employing mechanisms to ensure reliability as a back up to, or reinforcement of, normative expectations of trustworthiness. In such a way, institutions may prove to the public to have ensured professional behaviors that can both be relied upon and trusted, or even relied upon to be trustworthy.

## CHAPTER 3: COURAGE IN PUBLIC HEALTH RISK COMMUNICATION AND MANAGEMENT

It is a major assumption of public health practice that illness and death constitute harms – as such, they are reasonable objects of fear. Unlike medicine, however, the hazards of public health are almost always characterized in probabilistic terms. This again leads to a scientific view of public health risk characterization, one that I contend fails to acknowledge attributions of character at work in public health discourse. Of specific interest is courage, which is primarily correct attitudes that inspire proper reactions, to objects of fear. In this chapter, I advance a conception of the virtue of courage, which can contribute to greater clarity in risk discourse and provide guidance to appropriate responses to fear in public health practice. The main contention in this chapter is that cultivation of the virtue of courage will help to place attitudes and perspectives regarding fearsome objects at the center of discussions of, and reactions to, public health risks. I argue that the virtue of courage helps to initiate a discussion as to what kinds of attitudes of fear we might consider appropriate and inappropriate in response to public health hazards, especially in public health professionals.

In Section 1 I outline different perspectives on risk and argue that latent notions of courage are at play in risk identification and management. In Section 2 I examine an Aristotelian notion of courage and its associated vices that includes attitudes of fear, the trait of boldness that moves one to act, self-confidence in one's capacity to respond. I then consider the ways in which an understanding of the virtue of courage can help public health professionals clarify some aspects of risk discourse, and also the ways in which exhibiting courage will enable professionals to better respond to public health hazards. In Section 3 I

examine other ways in which one can fear in the wrong way which are not captured by terms of excess and deficiency, and contend that such reactions exhibit the need for public health professionals to model courageous behavior for the public. In the remaining sections, I consider different kinds of courage in public health, courage and institutions, and the candidate alternative response to risk – prudence.

## 3.1 Risk

In public policy circles 'risk' refers to the relative probability that a hazard is likely to cause harm. In such contexts, risk is contrasted against uncertainty. Under conditions of uncertainty, the probability of an event occurring is unknown, and the nature of the hazard in question may also be unclear. In contrast, when probabilities have been calculated and hazards causally linked to detrimental outcomes, risk can be clearly articulated. Thus, professionals involved in risk assessment differentiate the probability of a risk occurring from the degree or severity of the harm in question. As a result, there may be a low risk of a hazard causing serious harm, or a high risk of a hazard causing minimal harm. The purpose behind this way of the thinking is a desire to develop a solid empirical foundation for public health policy. Once again, the driving responsibility of risk assessors is interpreted in terms of veracity and accuracy. Let us consider food safety as an example that illustrates this way of thinking. Under this conception of risk, risk assessment is meant to answer such questions as: Can we causally connect the substance in question to an undesired outcome? What is the likelihood that exposure will result in such an outcome? Is the degree of exposure from food production different than levels of exposure elsewhere in human life? How strong is the evidence that

establishes such claims? Risk assessment, then, is characterized as an empirical process by which the facts about potential hazards are discovered. For risk assessors involved in public health matters, normative considerations – values judgments – do not enter into consideration until we decide when and if we need to manage the potential hazard.

This picture has been criticized for artificially truncating where values enter into discussions about and evaluations of risk. Before examining the contribution of virtue ethics to risk discourse in public health practice, let us first consider one way the problem of risk can be characterized in terms of scientific values for accuracy and objectivity, and then reconsider the same problems in light of other values at play. According to many in the field of risk characterization, one of the most difficult problems facing risk analysts involves the process of considering evidence, especially regarding determinations of statistical significance.[138] Such determinations change the likelihood of making faulty causal inferences. Slight variations in statistical analysis vary whether one is more likely to commit two kinds of errors. Select one set of preconditions for statistical analysis, and one may be more likely to erroneously conclude that a correlation or causal relationship does exist (a Type I error), select another set of statistical assumptions and one is more likely to make the false inference that a correlation is not present (a Type II error). For example, when considering whether a substance presents a hazard to human health, a Type I error would falsely imply that the substances is in fact hazardous, raising undue alarm. In contrast, a Type II error would incorrectly indicate that the

138 Robert E. McKeown and R. Max Lerner, "Ethics in Public Health Practice." in Ethics and Epidemiology, 2nd ed., ed. Stephen Coughlin, Dan Beauchamp, and Douglas L. Weed (Oxford: Oxford University Press, 2009), 175; Douglas L. Weed, "Precaution, Prevention, and Public Health Ethics," *The Journal of Medicine and Philosophy* 29, no. 3 (2004): 313–32.

substances is safe, or presents no harm. For those concerned with accuracy, the decision as to which evidence counts is also a potential matter of stacking the deck, or faulty science. In a discipline where causal inferences are often made conservatively on the sound basis of historical trends to the contrary, statisticians often prefer more and better data to ground their conclusions, i.e., they prefer to avoid Type I errors. Out of concern for scientific rigor and integrity, from this perspective, it is better to have high standards of evidence and find no causal relation for the moment, because such a conclusion does not rule out the possibility that such a relationship might be discovered farther on down the line. In science, there is always more data to be gathered. To lower evidential standards and get things wrong is viewed as poor science, to have high standards and perhaps not have found the truth *yet* is considered rigorous. In the end, for scientists, what matters is arriving at the most powerful explanation, and getting it right may mean taking the long view.

The analysis above is already value-laden, invoking the importance of rigor and integrity, truth and accuracy. But while these are scientific values, it is possible to express the nature of the problem not in terms of factual error, but about which type of *moral* error is more important to avoid. It is possible to express this concern not in terms of the importance of veracity but in terms of *injustice.* Carl Cranor captures this concern using a legal analogy.[139] Let us imagine not a potential hazard, but a potential criminal. According to this comparison, risk analysis is like putting a substance, industrial process, or even a potential pathogen on trial. In the United States justice system we proceed on the assumption that the burden of proof is

139 Carl F. Cranor, "Toward Understanding Aspects of the Precautionary Principle," *The Journal of Medicine and Philosophy* 29, no. 3 (2004): 259–279.

on the prosecution – the accused is innocent until proven guilty. We make such an assumption because we wish to avoid the judicial equivalent of a Type I error – wrongful conviction. But imagine a contrary justice system, in which the assumption is guilt, not innocence.[140] In such a system, the driving concern is to prevent the analogy of a Type II error – releasing a guilty criminal onto the unprotected public. Cranor's analogy captures an additional moral concern involved in risk assessment. In public health matters, do we create a system with a high bar of evidentiary proof, with the potential outcome that harmful substances are considered innocent and let loose on the community, or do we construct a process that leans toward raising the alarm unnecessarily, and wrongfully convicts some substances (or often an industry, or technology) in the hopes that it will effectively capture more culprits? When risk assessors characterize this choice as a concern for precision alone, they fail to capture the presence of this other value judgment present in the process.

According to this more explicitly normatively laden analysis, risk assessment is not merely concerned with upholding the scientific values of accuracy and rigor, but also with creating a process that strikes a proper balance between the societal values of safety and fairness. At other times, the values at play include economic benefits, the potential for progress, and establishing assurances of accountability. In public health, such debates take place with respect to workplace safety and environmental contaminants that bear implications for human health. Less obviously, however, the same concern for balance affects risk

140 Cranor's analogy is actually more nuanced than I have represented it here. He delineates the ways in which burdens of proof, standards of proof, and presumptions all play a role in the legal system, and analogously, in risk assessment. I focus on burden of proof here, although similar arguments could be made mutatis mutandis with respect to the other elements of the analogy.

assessment and management with respect to epidemic preparedness.[141] In this arena of public health, Type I errors have serious economic repercussions, as the quarantine of economic goods and travel restrictions can result in serious costs, and some worry these will be imposed unnecessarily. Epidemiological risks are also complicated by the involvement of disease vectors. Because people are often a source of contagion the counterpart to the criminal element in Cranor's analogy – pathogens – often cannot be the sole object of containment strategies. Whereas in matters of crime human defendants can themselves be imprisoned, in public health matters it is not potential pathogens, but their human vectors, whose liberties might be constrained. In such instances, the concern for avoiding Type II errors involves a third party who is often simultaneously a victim.[142] Thus, while the judicial analogy helps to make the ethical aspect of risk more explicit, the analogy can be harmful insofar as it only partially captures what is at stake.

While professionals in risk management understand the concept of risk to be a metric of probability distinct from evaluations of severity of the harm, members of the public operate using a different conception of risk, and often such common understandings incorporate the probability and severity aspects that policy experts prefer to differentiate. In addition, the public is also highly concerned about the source of harm, as well as the potential distribution of damage. Thus, whereas risk assessment often tries to disentangle the quantitative and

141 Elizabeth Wishnick, "Dilemmas of Securitization and Health Risk Management in the People's Republic of China: The Cases of SARS and Avian Influenza," *Health Policy and Planning* 25, no. 6 (2010): 454–66.

142 For an in-depth analysis of how this dual nature of patients has been neglected in bioethics more generally, see Margaret P. Battin et al., *The Patient as Victim and Vecto*r (Oxford: Oxford University Press, 2008).

evaluative aspects of risk, the public conception of risk does not, and folds in additional features of danger. For the public, who (as well as what) causes a potential hazard and who will bear the brunt of exposure are central concerns.

The result is that normative aspects of risk are an inextricable aspect of conversations about risk: "one must assume an *ethical point of view* in order to discuss risks meaningfully at all. Risk determinations are *based* on mathematical *possibilities* and social interests."[143] Discussions of risk, then, involve both a concern for greater knowledge of outcomes, but in such a way that this knowledge is not easily separated from the ways in which those outcomes are valued and, I would add, what decision-making about risk reveals about who we are individually, and collectively. "In short, people want to know the things that scientists can tell them, as opposed to what philosophers can tell them, but they would prefer that scientists have some ability to present their information in an ethics-oriented framework."[144] The conception of courage and its counterparts that I offer here is meant to provide public health professionals with such a picture.

In part, to risk something is to take a chance; it is an expression of one's attitudes toward the fearful aspects of our world, and one's willingness to face them for the sake of something of even greater value. For members of the public, questions about whether something constitutes a risk are intricately tied to our attitudes toward that risk. The question whether something is a hazard is in part a question of whether it is something to fear. The decisions about what risks to study and which risk management policies to prioritize are

143 Ulrich Beck, *Risk Society: Towards a New Modernity,* trans. Mark Ritter (London: Sage Publications, 1992), 29 original emphasis.
144 Paul B. Thompson, *Food Biotechnology in Ethical Perspective* (Springer, 2007), 287.

reflections of what we fear, to what degree we fear them, and how this informs our behavior. With this alternative vision of risk in mind, an action or policy endorsed by public health professionals may be interpreted as indicative of a predilection to assess the world more optimistically or pessimistically, to take chances or avoid them, i.e., as a reflection of policy-makers' characters. In the next section, I will present a conception of the elements of courage that map on to these attitudes. To the extent that public health professionals appear risk-averse or risk-prone, the public will evaluate risk assessment and management policies not merely on the criterion of accuracy, but also interpret such policy in light of such attitudes. My contention, then, is that latent notions of courage and its related character traits are at play in risk discourse. If the public will view policies as incorporating attitudes to risk, as including normative assessments of whether what may be lost is worthy of such possible sacrifice, then a better understanding of the nature of courage can help public health professionals frame responses to risk in a way that makes these implicit notions more explicit.

## 3.2 Public Health Courage

In this section, I (1) present examples to indicate the initial plausibility for courage on the part of public health professionals; I then (2) provide an Aristotelian account of courage, which consists of three aspects, of which fear is the most important; and finally (3) defend the contribution a conception of courage can make to public health risk discourse and the practical assistance the virtue of courage provides to risk management, or public health practice.

### 3.2.1 Professional Courage in Public Health Practice

So far in this chapter I have spoken very generally about courage, especially in public health risk assessment and management. Intuitively, we can imagine that courage might be important for public health professionals in a variety of public health contexts, such as facing possible exposure and infection during an epidemic, or potential harm while identifying new pathogens (e.g., in the early stages of severe acute respiratory syndrome, or SARS). In such cases, the uncertainty surrounding the nature of the harm, and the urgent need to act quickly are additional pressures that public health professionals must face and overcome. In general, public health emergencies – including disaster relief – may require that public health professionals confront daunting challenges such as geographic barriers in reaching rural locations with much-needed medical supplies, chaos due to damaged infrastructure, and unanticipated problems that require professionals to think and act quickly. There are many character traits that might serve professionals well under such circumstances, but among them are the proper attitudes and perspective required to overcome fear of personal harm in order to achieve public health purposes. The lesser among us would quail, or be overwhelmed, in similar circumstances.

Thus, the physical dangers of public health work are quite obvious sources of personal harm that professionals must overcome if they are to serve the public. But we must also think of the psychological burdens and the personal sacrifices that must be born to provide excellent public health service. Consider the potential for retribution if a public health worker speaks out against corruption – both internally within the profession, but also perhaps externally in other areas of government or society where public health work may reveal underhandedness. In such

cases, public health professionals will need to overcome their fear of the damage that might be done to their financial security or their professional reputation if they are to speak out. In addition, outside the realm of acute emergencies, public health activities require a great deal of endurance. Let us consider the parallel of curative medicine, where American culture often reflects a deep admiration for the courage of physicians (with notable exceptions). It is not just that doctors risk physical exposure to all kinds of pathogens in the process of healing, but also that they confront a number of common sources of anxiety including the pain and suffering of the ill, tragic deaths, and perhaps just as disconcerting, mortality itself and its inevitability. We admire physicians not only because they face physical harm in performing their obligations, but also because their work requires a kind of psychological bravery in order to shoulder the weight of such experiences day in and day out. Similarly, I argue, a good public health worker faces psychological encumbrances. I expand on this point in more detail in Section 3.4.

In addition, I contend that public health professional courage is also required due to its relation to civic courage. While I will not here defend the view that citizens are required to be courageous when faced with public health hazards, I do contend that public attitudes and responses to such jeopardy are mediated by professional responses. Thus, while professionals and citizens need to be courageous in different ways, professional public health courage can set the tone for public responses to epidemics and other potential hazards. In virtue terms, the virtuous public health professional serves a model, a *phronimos,* for exemplary behavior.

3.2.2 What is courage**?**

Virtues are character traits that have both rational and affective elements, i.e., virtues are dispositions that complexes of belief, attitude, emotion, sensitivity, desire, and especially in the case of courage, aversion.[145] For Aristotle, virtue is a kind of balance or harmony of the affective and desiderative elements with the rational ones. Such ideal combinations enable us to pursue the human good in the most excellent way. In the case of courage, beliefs about what is harmful contribute to the fear we feel. For Aristotle, courage involves an attitude of fear (which is primary), an honest evaluation of one's abilities given the circumstances, which he articulates in terms of optimism and pessimism (or hope), and a degree of boldness that propels one into action. I will expand on these in turn.

According to Aristotle, courage can be understood as an appropriate emotional and practical response to what is fearsome as well as a balanced attitude of boldness. (*NE III.6-III.8*) In envisioning each component as a lying on a continuum, he offers an array of possible explanations for cowardly and rash behavior. On the first continuum of fear, to feel too little fear can lead to foolhardiness, or the kind of impetuous actions of the young and inexperienced. To feel too much fear, especially when this results in immobility, is a quintessential component of cowardice. The second continuum, known in ancient greek as *tharos*, does not have an exact translation. It is, however, roughly equivalent to boldness, or gumption. To be excessively bold is to be intrepid, but headstrong. To be deficient in gumption can again lead a person to exhibit cowardice, but in a way that results not from being

145 McDowell, "Virtue and Reason."; Hursthouse, Rosalind. "Virtue Ethics and the Emotions" in *Virtue Ethics: A Critical Reader,* ed. Daniel Statman (Washington, D.C.: Georgetown University Press, 1997), 99-117.

immobilized by fear, but rather lacking enough nerve to overcome even a moderate amount of fear. In the case where boldness is wanting, a person may recognize what is at stake but nonetheless find herself unable to impel herself to action.

Aristotle also acknowledges that one's worldview is also in important part of her understanding and attitudes toward objects of fear. Attitudes of confidence, or optimistic and pessimistic perspectives, correspond to the virtues and vices associate with courage: "The coward, then, is a kind of person who lacks hope (*elpis*), because he is afraid about everything. The rash man is in the contrary condition; for someone who has too much hope has an overly bold attitude." (*NE III.7 1116a2-3*) On this account, calculation of success and failure also appear to mediate other aspects of courage. While confidence can lessen fear of harm, pessimism can put a damper on boldness. In turn, hubris can encourage rash behavior. Aristotle emphasizes that of the continuums, fear is primary; i.e. one may achieve the intermediately bold attitude and yet not be courageous due to an excess or deficiency of fear. Hope also fails to be exclusively constitutive of courage in a similar fashion. One may correctly judge both one's own abilities and accurately assess the harm in question, but in matters of courage, attitudes of fear are the most important. Both cognitive and affective aspects of the character trait of courage inform one's perspective, or worldview. The inclusion of hopefulness in Aristotle's account also acknowledges that a frank assessment of probability is never value-neutral – one's general tendency toward optimism or pessimism will inevitably shade one's assessment of the odds. Together, these aspects of the virtue reveal that *a courageous person is one who can be counted on, due to the kind of person she is, to assess and respond appropriately to objects of fear.*

3.2.3 Courage and public health communication

The affective components of courage are essential to acknowledge and articulate because they help to reveal that there is more going on in risk assessment and management than a need for accuracy. For example, in response to recent outbreaks of H1N1 influenza, public health professionals were concerned about the possibility of a pandemic flu that resembled the 1918 outbreak. In such a context, McKee and Coker observe, the media tended toward two contrary characterizations of public health response: an excess of fear, sounding a needless alarm and advocating for responses that are "overkill," and the opposite, a deficiency of fear, in which professionals are characterized as blasé in the face of grave and serious harm.[146] Thus, notions of excess and deficiency are arguably already involved in risk discourse.

In a striking resemblance to Aristotle's understanding of virtue as moderation, the authors advocate for a way to interpret public health attitudes to the outbreak in terms of moderation; contrary to media exaggeration, the authors assert, actions of the World Health Organization and British public health workers exemplify how "it is possible to find a middle way."[147] However, McKee and Coker also note that the success of public health professionals to "get it right" requires that policy makers communicate by making their normative commitment and perspectives explicit. Such assumptions "may be optimist, pessimistic, and sometimes hopelessly heroic," but by making them explicit, professionals make it possible for the public to have a greater understanding of the professional values that govern the creation

146 Martin McKee and Richard Coker, "Trust, Terrorism and Public Health," *Journal of Public Health* 31, no. 4 (2009): 462 –65.
147 Ibid., 464.

of policy.[148] Thus, for example, it is necessary for public health professionals to place concerns for future influenza outbreaks into the context of the 1918 outbreaks, but also the 1957 slowness to vaccinate and the arguably reactive 1978 efforts to institute a national vaccination program prematurely. As Harvey Fineberg notes,

> Policymaking for avian influenza preparedness is problematic in part because an influenza pandemic is a low-likelihood, high consequence event. In such cases, steps toward preparedness are subject to criticism as both unnecessary (in the likely case of no event) and inadequate (if a catastrophic event occurs). This politically precarious double bind reinforces the value of learning the strategic lessons from past errors of over- and underreaction and applying them to the realities of today.[149]

Such context provides experience from which public health professionals can draw, but also examples from which public health professionals can illustrate why new policies do not exhibit the features of excess and deficiency that marked the past. While Fineberg expresses concern that "the public, like many experts, has a hard time separating likelihood from severity," and yet simultaneously uses character terms to describe the mistakes of the past, including "overconfidence" and a "zealous" desire on the part of public health professionals to be "heroes."[150] Given his advocacy for a more dispassionate rhetoric in risk discourse, is difficult to tell if he employs such terms with any intentional sense of irony.

Fineberg's analysis raises the possible objection that the route forward for public health discourse ought not to be a call for *more* talk of courage, rashness, or heroism, but rather to make such character talk explicit in order to eliminate it. It is certainly the case that the media,

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148 Ibid.
149 Harvey V. Fineberg, "Preparing for Avian Influenza: Lessons from the 'Swine Flu Affair,'" *The Journal of Infectious Diseases* 197, no. s1 (2008): S18.
150 Ibid., 17.

which always love a good story, can hijack such narratives. Public health narratives that invoke character so intentionally, it might be argued, can create professional a blind spot where contradicting evidence or other perspectives are ignored or silenced because they fail to match the dominant narrative.[151] Thus, a virtue approach to public health ethics must meet this objection by explaining why talk of the virtues and vices of professionalism may not do more harm than good.

A virtue proponent must respond, I think, that stories are a part of the way in which we do, and should, approach moral questions. Unlike other ethical approaches, the central question is not "what should we do?" but "how should we live?" As this discussion reveals, the public tends to think of risk policy in such terms – but so do the professionals. Notions of courage and heroism are invoked to inspire public health professionals to bear the burdens that I have outlined here. Furthermore, it is not only that the public reads attitudes off of policy-makers' determinations. Public policy in a democracy is also representative of national attitudes. This is why risk determinations are often inflected with the notion that regulation is obstructive to the entrepreneurial spirit of the American people. It is also why members of the public may feel so personally invested in how risks to society are publicly handled. For it is not only the public's safety or other values on the line. It is also that rash policy is performed on their behalf, and it thereby paints Americans as rash. From the other side, overly cautious policy, it is argued, depicts the United States as a timid society. I argue that such language is already at work, and that policy-makers might benefit from a framework that explicitly acknowledges it, and may also give them a more varied set of character language, and virtue

151 For extensive arguments on vaccination specifically, see Heller, "The Vaccine Narrative."

conceptions, to draw from. Courageousness, optimism, and boldness are just a few suggestions – but as current debates are dominated by invoking contrary vices of excesses and deficiencies, the significant contribution of virtue theory may be inflecting risk discourse with some more positive alternatives.

### 3.2.4 Practical excellence and courage in public health practice

It is not just useful for public health professionals to describe their actions in terms of virtue. Rather, as Feinberg's analysis reveals, it is important for public health professionals to learn from their mistakes – the times when they have erred by being too pessimistic about the potential for a pathogen to cause real harm before the evidence was in, or to react too slowly out of fear for the lives that might be lost. This call for greater attention to past experience is in keeping with the picture of virtue, which is deeply connected to experience. Unlike principles, which can be general guides for action, virtues are the attributes of those with the most experience, which lends knowledge of particulars and the skills to grapple with different contexts (*NE* VI.8 114a15). Thus, it is important to cultivate proper professional attitudes toward fearsome public health hazards so that they may be sensitive to the fine-tuned aspects of their work, not just the more general features. This attention to particulars is often lauded as a admirable aspect of a virtue approach in contrast to other ethical theories which often abstract away from the details. Virtue ethics, therefore, may make a good match for public health ethical challenges that require sensitivity to context. And, as the rapidly changing nature of emerging public health hazards demonstrates, public health professionals need to be prepared to react to changing circumstances, to resist feeling daunted by uncertainty, and to

keep in mind the lessons of the past. As the pandemic flu cases reveal, this is how professionals learn to know what it is to react to fears inappropriately, or to misjudge the necessity for action. Thus, it is not only important for public health professionals to describe their actions in terms of virtue, it is important for them to *be* virtuous.

This attention to context also reveals partly why public health professionals' courage differs from that of the public, or even other contexts in which courage is displayed. The objects of fear (public health hazards) are different for professionals and members of the public, and so are the reasons one strives to overcome fear. For public health professionals, the goal may be expressed in terms of professional excellence, or integrity. To attain improvements in public health, professionals must bear burdens that the public does not, and therefore overcome their fear in distinctive ways, some of which I have outlined in the previous section. However, we also need professionals to display and defend an ideal of proper attitudes to public health hazards in order to aid public understanding of how to react. I turn more to this leadership aspect of courage in the next section.

One advantage of the views I have presented here is that they expand beyond the judicial analogy depicted by Cranor. Viewing risk assessment in terms of justice leads us to think of risk determinations in terms of the binaries of "innocent" or "guilty." On my view, courage can contribute to risk discourse by offering a wider array of alternative reactions to fear of potential hazards than Cranor's judicial analogy suggests. The options are not expressed in terms of binaries, but as along several gradients which allow for more or less optimism, excess and deficiency of fear, and greater or lesser moderation in bold attitudes. I argue that such language has the advantage of providing an explicitly ethical framework that McKee and

Coker reveal is already implicitly at work in public health risk discourse. In addition, by providing a vocabulary that stresses a matter of degree, the responses available to public health professionals in risk policy may avoid the "double bind" that Fineberg envisions. Rather, a more nuanced view of human tendencies when reacting to fear may allow for professionals to make the case for a "middle way." In addition, by constructing right action in contrast to a variety of ways to go astray, an Aristotelian model of courage does provide some guidance for practical action in risk management policy; by knowing which reactions to avoid, policy-makers are more likely to aim correctly. In the next section I expand on the picture of courage and its associated vices that I have developed here. In doing so, I identify other ways in which public health professionals can be courageous, thereby illustrating the practical guidance provided by thinking in terms of virtues.

### 3.3 Beyond the Doctrine of the Mean

Thus far I have presented an account of courage that is in keeping with Aristotle's praise for moderation and the Doctrine of the Mean. Already in his account of courage Aristotle muddies the waters by lauding moderation along three different continua, resulting in a picture of courage that accounts for mistakes in kind, not just degree. However, even this structure of courage is incomplete, for there are many other ways of reacting to fear and uncertainty than described thus far. In this section, I combine some of the concerns of Deborah Lupton's account of risk in public health with an account of courage as virtue. By placing dispositions to fearsome objects at the center of risk discourse, I argue that virtue ethics can facilitate a more open acknowledgement of problematic attitudes to objects of fear without pushing such

elements to the level of subtext.[152] The account of courage needed, however, must accommodate the psychological reactions to fear that do not fit a model of excess and deficiency. These responses are not necessarily what we might consider fearing too much, or too little, but examples of how people "don't fear in the way one should." (*EN III.7 115b16)* There are two such reactions that are of special concern to Lupton: (1) denial and (2) victim-blaming; both reactions are more fully illuminated when viewed in light of courage and its associated character traits. Throughout this section I am concerned with the ways in which anyone – including public health professionals and the public – can exhibit such attitudes in response to threats to the public's health.

While public health hazards are in and of themselves fearsome objects, risks are not the same as dangers due to the association with probability. One of the most noted aspects of the development of risk in modern society is the way in which potential hazards permeate every aspect of daily life, but average individuals have limited capacity to identify and manage exposure on their own. In times of great uncertainty with regards to health hazards, people must turn to public health expertise for a way out of epistemic obscurity. Whether something constitutes a hazard, how likely such a hazard is to inflict harm, what the consequences are of such harms, are all matters of contestation during public health crises, or even only *potential* public health crises that are not even certain to emerge. It is likely that experts may find the loudest voices during such times, when "expertise is seen as a potential means of bringing light

152 Deborah Lupton, "Risk as Moral Danger: The Social and Political Functions of Risk Discourse in Public Health," *International Journal of Health Services* 23, no. 3 (1993): 425–35.

to the shadows and, in doing so, aiding the sense-making process and reducing uncertainty."[153] The spotlight placed on public health expertise in such circumstances helps reveal that harms of living in a society characterized by the ubiquity of risk cannot be solely attributed to the hazards themselves. Rather, risks to the public health draw our attention to the vulnerability resulting from dependency on expert opinion: "the extent and the symptom's of people's endangerment are fundamentally *dependent on external knowledge.*"[154] Thus, if we turn back to our example of the safety of vaccinations in Chapter 2, members of the public have no means to assure themselves of safety – to obtain by their own investigation – whether vaccines are indeed safe. They must rely on the evidence gathered and conclusions drawn by others. The same can be said about food safety, environmental contaminants, or the development of new strains of infectious disease. Part of what is terrifying about risk, then, is not the hazard in question but its attendant exposure of human frailty and lack of control. Ulrich Beck identifies such lack of control over what one can even know as a "loss of cognitive sovereignty,"[155] but the associated feeling of disempowerment is not only associated with an inability to know *about* the harm, but also with anxiety that one lacks control to protect oneself *against* harm.

153 Denis Fischbacher-Smith, Alan Irwin, and Moira Fischbacher-Smith. "Bringing light to the shadows and shadows to the light: risk, risk management, and risk communication," in *Risk Communication and Public Health*, 2nd ed., ed. Peter Bennett et al., (Oxford: Oxford University Press, 2010), 25.
154 Ulrich Beck, "Risk Society," 53, original emphasis.
155 Ibid.

First, one possible way to react to risk is to reclaim control by projecting that susceptibility onto others.[156] In identifying threats to population health, public health professionals may inadvertently become part of a tendency to equate vectors of disease with the threat itself. Historical associations of disease with immigrant groups especially help to illustrate the ways in which fear was directed not at disease, but a group linked (rhetorically or otherwise) to that disease. For example, during the SARS epidemic, the origins of SARS in China resulted in a media discourse that identified "traditional" practices as setting the stage for the development of new zoonotic pathogens. Anthropologist Laura Eichelberger attributes the 30-70% loss of business in New York city's Chinatown to such framing of the epidemic, which overshadowed the lack of a single incident of SARS within that community.[157] This example illustrates a form of psychological deflection in response to vulnerability. As Lupton observes, the "notion of risk thus servers to categorize individuals or groups into 'those at risk' and 'those posing a risk' " thereby enabling individuals to maintain a sense of control over their exposure

156 As articulated here, deflection involves projecting vulnerability on to others. Another strategy can be to project vulnerability onto everyone, thereby downplaying the gravity of the harm in question. This form of deflection may accompany a kind of personal identity ennui that results from not being able to locate oneself within the categories of those who are and are not at risk. The more risk permeates society – the more we recognize that risk is an ineliminable part of life – the more this presents a challenge to the view of health as a stable source of identity. Rather, each person becomes one who is potentially ill, and as such it is not clear where one stands, or more precisely, who one is. As the boundaries of "healthy" and "unhealthy" become obscured, public health messaging may lose its sense of immediacy when individuals feel inundated and even desensitized by the prospect of fearsome health detriments underlying every apparent course of action.

157 Laura Eichelberger, "SARS and New York's Chinatown: The Politics of Risk and Blame During an Epidemic of Fear," *Social Science & Medicine* 65, no. 6 (2007): 1284–95.

by avoiding exposure to a particular group, or by identifying oneself as less vulnerable because one is not part of the "at risk" group.[158]

This kind of response to fear is problematic when it is inaccurate because it will result in ineffective responses to public health hazards. There is a risk that policy-makers, and the public in following their lead (but also on their own), will associate the risk with one community, and as such conceive of others as safer than they really are. This will lead to ineffective methods of controlling the spread, and ineffective distribution of efforts and resources. The example of HIV-AIDS exhibits some of these problems by illustrating the ways in which the problem was conceived of as limited to homosexual communities. While in this case, it is more common for public health professionals to now see the HIV epidemics as affecting all communities, during the early stages of the epidemic, it is still possible to see the disease linked to "risky behaviors" in some health promotion circles.

Second, another possible way to react to the vulnerability revealed by public health hazards is to locate responsibility for the hazard in those who suffer the harms of exposure. According to anthropologist Robert Crawford, "the individual's fear of loss of control and loss of life engenders a defense: a perception of the afflicted as *particularly* susceptible due to their distinctive behaviors, emotional predispositions, social or geographic environment, or unexplained susceptibilities believed to be the property of the group."[159] This kind of reaction is similar and often coupled with the first, but rather than causally equating the health hazard with populations that may be vectors, this form of "blaming the victim" more directly attributes

158 Lupton, "Risk as Moral Danger," 428.
159 Crawford, "The Boundaries of the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS," *Social Science & Medicine* 38, no. 10 (1994), 1355.

responsibility for the disease to the behaviors and moral failures of members of the group in question. Combined, reactions to public health hazards that locate the threat in others, and then attribute responsibility for suffering in the actions of those others, exemplify a kind of denial rooted in self-protection.

This kind of reaction is problematic because it can attribute culpability for illness without adequately establishing the ways in which those who are ill behaved inappropriately. This happens both when attributions of claims to behavioral causality are correct, and incorrect. When incorrect, this kind of reaction deflects away from the real causes of diseases. Even when behavior is partly to explain for an individual's illness, projecting responsibility onto the individual as a coping mechanism for fear can also distract attention away from the structural factors that influence behavior. Both kinds of distraction will be a detriment to public health practice. Even when accurate (assuming the claim is causal), attributing personal responsibility for illness can be a way of imposing extra burdens, such as social ostracism, on individuals who are sick. Mere causal responsibility is not enough to attach moral culpability. The workers in nuclear facilities in Japan are *causally* responsible for any subsequent illness that results from radiation exposures (since they are volunteering to continue exposing themselves), but we would not say such actions are morally reprehensible. Professionals should be especially wary of claims for moral responsibility for ill health, as the implication is that such individuals – and communities – are less deserving of public health resources. Public health professionals should also be alive to the likelihood that the tendency to deflect in these ways is often linked to biases – the groups blamed are often those who are already oppressed, building on racial, class, and national prejudices.

Public health professionals would do well to consider these two additional ways of handling fear of public health risks, both to cultivate proper attitudes of their own as well as model appropriate reactions for the public, and mitigate projection of fears onto marginalized groups. In the case of SARS, a large community health center worked to do precisely this, both discouraging discriminatory reactions to fear of exposure, as well as working to reduce the very high levels of anxiety that were in part behind such deflection.[160] It is often difficult in such settings to see courage at work when we focus on the language of cowardice or rashness. Earlier in this section I identified public health contexts in which we sometimes do make use of such contrasts. Here, I have presented examples of reactions to fear that require us to articulate an account of courage that anticipates responses to fear which are often better understood in terms of anxiety, deflection, and in their extreme, paranoia. Our contemporary terms do not easily attach to character, but visceral reactions to fear of vulnerability. Understanding such reactions in terms of attitudes of fear helps to avoid the tendency to characterize problematic reactions to public health hazards solely in terms of inaccuracy, or merely false "risk perceptions." Such characterization implies that all that is needed is more information, rather than marking out a contrasting attitude required on the part of public professionals, and perhaps citizens.[161] Such character development is important for

160 Eichelberger, "SARS and New York's Chinatown."

161 I endeavor in this chapter to focus on the attitudes of professionals, since the account offered here is meant to be one of professional virtue, not civic virtue. When necessary, I point to some important connections between the two.

professionals, especially given historical trends that depict professional attitudes of deflection, which "tell a story of racial restrictions masquerading as public health policy."[162]

I contend that such reactions are more completely understood in the light of the impulse to regain a sense of self-sufficiency that is shattered during public health crises – both acute and chronic. This possibility reveals one way in which professional courage differs from civic courage, and ways in which professional courage will need to overlap with professional trustworthiness, as both require sensitivity to the vulnerability of others. Courage as a virtue has a dual utility for public health ethics – it suggests strategies for public health communication by creating discursive room for public health professionals to articulate views of public health policy as collective and collaborative responses to fear – in contrast to unidirectional relationships of dependency. By articulating the ways in which public health interventions are inherently collective, public health professionals can reveal the need for cooperation. By making it clear that public health professionals need the public to respond appropriately in order to make public health interventions successful, public health professionals can restore a sense of control to the public. Secondly, I have argued that by exhibiting courage themselves, public health professionals will serve communities by avoiding the inappropriate reactions to fear outlined here, and in doing so, I contend that public health professionals can help show the way for the public by leading by example.

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162 Amy L. Fairchild, "Policies of Inclusion: Immigrants, Disease, Dependency, and American Immigration Policy at the Dawn and Dusk of the 20th Century," *American Journal of Public Health* 94, no. 4 (2004): 528–39.

## 3.4 Types of Courage

In this section I consider different kinds of courage and some of their implications for public health practice. I consider the courage needed by public health professionals when facing physical harm, psychological harm, and also ways in which courage and justice may overlap.

### 3.4.1 Heroic Courage

First, we must consider those contexts in public health that *do* seem to fit with the traditional greek notion of courage, or courage on the battlefield. It is rather obvious that when public health professionals must risk their lives to stop the spread of a disease that would otherwise kill many, such circumstances parallel those of battle. As Giovanni De Grandis observes, both war and infectious disease share the common features of disruption of daily life and uncertainty regarding the future, and as a result create the opportunity for "extremes of selfish, anti-social and cowardly behavior or the opposite: selflessness, courage, and extreme endurance."[163] And we have excellent reasons to believe that in the "battle" to contain an epidemic, all public health professionals will be equally likely to confront fear of personal harm and endure for the sake of others. We might imagine it important for all public health professionals to cultivate this form of courage in light of the possibility that those in the field may encounter such tests of character. But while personal tales of public health courage ought to inspire others, we also ought to beware the pitfalls of comparing public health action to war.

163 Giovanni De Grandis, "On the Analogy Between Infectious Diseases and War: How to Use It and Not to Use It," *Public Health Ethics* 4, no. 1 (2011): 71–2.

We are prone to use the imagery of battle in the context of epidemics and other public health hazards in ways that require more thoughtful consideration for the messages we may inadvertently endorse through the use of violent imagery. Many authors have observed that there are serious drawbacks to using wartime analogies with respect to health.[164] For example, such metaphors can encourage those who buy into them to overlook harmful effects of public health interventions themselves as part of the expected "costs of war." In public health especially, such a mentality complements an unsophisticated public health utilitarianism that is willing to sacrifice a few for the sake of the many. Thus, an adequate public health ethics will need to resist the rhetoric of war due its tendency to distort and normalize human loss of life.

However, De Grandis is also right to examine the possibility that such analogies may possibly hold useful insights. He contends that the imagery of battle or fighting an enemy can also sometimes be helpful in the context of public health challenges such as responding to drug-resistant bacteria. By highlighting why some pathogens are not merely a threat to personal health, but a danger to the community, public health can help place individual infections into a wider institutional and social context. For example, while finishing off a round of antibiotics may offer no immediate individual benefit, it provides great social benefit. Rather than viewing those infected as a threat to society, by characterizing pathogens as a "common enemy," public health professionals can thereby help to re-envision those who have

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164 George Annas, "Reframing the Debate on Health Care Reform by Replacing Our Metaphors," *New England Journal of Medicine* 332, no. 11 (1995): 745–8; Ann Mongoven, "The War on Disease and the War on Terror: A Dangerous Metaphorical Nexus?," *Cambridge Quarterly of Healthcare Ethics* 15, no. 4 (2006): 403–16; Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors*, (New York: Picador, 2001).

experienced the disease as survivors, part of efforts to defend others against public health hazards, and help to motivate collective public health actions in terms of shared efforts.[165] The difficulty is that disease and war analogies are so prevalent in modern discussions of health already, and so likely to be taken up and amplified by media sources, that they may inevitably carry their pitfalls with them, not allowing us to choose between their capacity to unite and their potential to mislead.

### 3.4.2 Courage-Fortitude

Next we must turn to the second route for pursuing a revise account of courage, one that reconsiders the notion that courage is exhibited only in short bursts, or as overcoming fear of personal physical harm. The writings of Aristotle and Plato do indicate that discourse on courage should address what contexts, outside the battlefield, create the opportunities to demonstrate the virtue of courage. The examples we find include a novice at sea in the midst of a storm, and someone facing the harms of illness or poverty. (*NE III.6 1115a29-11156; Lch.* 191d-e; 195d) Such cases illustrate a range of instances in which we think individuals may manifest courage, in part because there appears to be something fearsome to face. David Pears identifies these as examples of courage in the "extended sense."[166] I argue that much of the fearsome prospects that characterize the work and sacrifice of public health professionals illustrate this wider notion of courage as endurance, or steadfastness. In public health, such

165 De Grandis, "On the Analogy Between Infectious Diseases and War," 71.
166 David Pears. "Courage as a Mean," in *Essays on Aristotle's Ethics*, ed. Amélie Oksenberg Rorty (Berkeley: University of California Press, 1980), 185.

courage will be necessary in the face of continuous public health hazards, and in the difficult work of persevering when success is uncertain.

To re-envision what courage can be requires challenging common assumptions about courage, including the intuition that "being a decent parent or a good teacher may sometimes require courage, though it is hard to see how that could be a routine requirement."[167] Such observations reflect our notions of courage as rare and infrequent tests of one's mettle. One might object that the attribute I have described here is more akin to patience – an ability to respond appropriately to despair and frustration.[168] This objection does well to illustrate how virtues are often traits that enable us to overcome common human failings – or act as correctives to the most frequently encountered excesses and deficiencies of character.[169] However, I believe that heroic courage often depicts the harms that befall us as physical in nature, and in remapping the terrain of courage we ought to consider how much we also fear psychological burdens, and how few of us are willing to carry the weight of others' suffering. I have argued here that, at times, the kind of work that public health professionals do, takes endurance, time (and, yes, patience), but also a willingness to face the potential for both physical and psychological harm - including professional burnout – for the sake of others. I conclude that in articulating courage as appropriate responses to fear, we must consider the personal costs that are a long time coming, that require repeated sacrifice for their effects to

167 Eamonn Callan, "Patience and Courage," *Philosophy* 68, no. 266 (1993): 526.
168 Ibid.
169 Philippa Foot, "Virtues and Vices," in *Virtue Ethics*, ed. Stephen L. Darwall (Malden: Blackwell Publishing, 2003), 105–20.

become apparent, and which may result from consistent and sustained efforts to fulfill a commitment to the public good.

The possibility of sacrifice is not lost on the courageous – they knows the value of their own lives and wellbeing, especially since under Aristotle's notion, the virtuous are living the very best of lives: "for to such a person, most of all, is living worth while, and *this* person will knowingly be depriving himself of goods of the greatest kind." (*NE III.7 1117b10-13*) For Aristotle, a person is inspired to be courageous because she perceives that the sacrifice is paradoxically also good for her. He does not go so far as Socrates to claim that the act fails to be a harm to her, but he does think that the virtuous sometimes judge that some harms are worth undergoing to obtain something of value *to the agent* as well to others who may benefit. It is from this larger goal, whether it is victory, or helping others, that courage gets its nobility, and its distinction from mere risk-taking.

In understanding the psychological harms public health professionals face, we must envision courage as a virtue that can be sustained over time, not merely displayed in bursts during times of extreme, but short-lived, danger. In truth, war can be a grueling process, one that tests not just one's capacity to respond to immediate and grave danger, but to endure long and arduous tests of one's endurance. For public health professionals this kind of courage, which I will call courage-fortitude, can be as important to cultivate given the complexity and duration of public health challenges. Fortitude alone is an admirable trait, but I categorize the trait I have in mind under the wider category of courage because it requires the same force of will, the same vision of possibilities, and the same frank assessment of what there is to fear.

Courage-fortitude is important in public health practice that requires ongoing investments of public health professionals' time and energy. For example, as chronic disease rather than infectious disease increasingly accounts for population morbidity and mortality, public health professionals need to cultivate this enduring form of courage. Several features of chronic diseases set them apart from other forms of illness. Chronic diseases like diabetes, arthritis, and chronic obstructive pulmonary disorder (COPD) may require long-term behavioral changes that professionals may find both daunting and wearing to achieve via both preventive and ameliorative public health efforts. As providers of interventions aim at reducing the incidence of such chronic ailments and their attendant comorbidities, a kind of courage linked with patience will prove invaluable. The same might be said of overcoming health disparities, given the magnitude of social change that may be required to achieve real and lasting health justice. The internal resources needed to meet such challenges cannot be captured by the military analogy. Instead, they require public health professionals to take the long view, and conceive of public health interventions over a lifetime. Simultaneously, such fortitude requires cultivating a willingness to overcome the despair characteristic of professional burnout and the psychological pressures that such commitments may entail. Due to their less immediate and pressing nature, such health detriments may receive less public attention than acute illnesses, but also less public admiration for ameliorating. Developing the kind of attitudes and character to respond to the repeating and enduring nature of human vulnerability over time is the mark of the truly courageous public health professional.

The decision, then, to commit oneself to the profession of public health must be acknowledged to entail the possibility of great sacrifice, which on balance helps professionals

feel they have made a contribution, a difference, or lived the best kind of life they could. The vivid images and more acute impeding peril of contagion and mortality that characterize epidemics are often what come to mind when such costs are considered part and parcel of the role played by public health professionals. But there is also a kind of courage required of the public health professional that is less glorious, and even less likely to receive the recognition it merits. In facing the enormity of the task of a wide web of causal forces that affect disease, in tackling complex and lasting widespread detriments to health, the public health professional commits a lifetime to what is often a grueling or marathon-like task. What's more, the successes that may result from such efforts are likely to go unnoticed. Even those public health workers whose endeavors lead to close work with specific individuals or communities may only find themselves able point to statistical, not tangible, evidence of success. Like the statistical nature of the evidence that informs the derivation and employment of risk policies, the metrics of epidemiological success will measure victory in statistical years gained, or probabilities of lives saved. The absence of faces and stories, personal connection and professional recognition, can render public health steadfastness invisible. For all its collective emphasis, the invisibility of the profession can make public health work a lonely practice, requiring a durability of spirit, or courage-fortitude.

### 3.4.3 Courage and Justice

In the previous section I briefly mentioned courage in response to health disparities. The judicial analogy also calls attention the ways in which courage and justice may both be at issue when public health risks are discussed and managed. In this section, I expand on this

overlap between courage and justice by examining the contexts in which justice may call on public health professionals to be brave. In such instances, it is not a notion of public good that lends courage its nobility, but a concern for justice. This kind of courage is not a subtype of courage, but required in the context where the virtues of courage and justice overlap. I address the degree to which both forms of courage (heroic and fortitude) can help to counter the potential for creating and exacerbating injustice in public health.

Some analyses of public health draw attention to the ways in which health promotion and risk communication strategies can serve to reinforce, create, and exacerbate forms of social ostracism. Health promotion exemplifies a shift in modern understandings of risk: "whereas what assails the individual was previously considered a 'blow of fate' sent by God or nature (e.g., war, natural catastrophes, death of a spouse), it is now much more likely to be events that are considered a 'personal failure,' such as not passing an examination, unemployment or divorce."[170] As a result, public health campaigns can result in the creation of expectations that individuals will constantly pursue self-regulation and self-improvement in order to avoid culpability in their own ill health.[171] Insofar as individuals fail to live up to the expectations for behavioral modification and self-reconstruction, such efforts can stigmatize morbidity, characterizing infection, chronic disease, or disability, as due to lack of self-control. Stigmatization is a process by which "the sick are not only made responsible for their illness, they are also made different."[172] As I mentioned in Section 3.3, sometimes such blame is

170 Alan Petersen, "Foucault, Health and Medicine," in *Foucault, Health and Medicine*, ed. Alan Petersen and Robin Burton (Florence, KY: Routledge, 1997), 216.
171 Ibid., 194.
172 Crawford, "The Boundaries of the Self and the Unhealthy Other," 1356.

assigned as a way of denying that harm can happen to anyone, but it is also a way of avoiding any social responsibility for remediation.

The main danger is that public health interventions may increase the tendency to connect health and normality with moral worth.[173] Because epidemiology and prevention use counterfactual notions of causation, the profession has the potential to construct a conception of the self as malleable. In doing so, public health can participate in the cultural construction of two forms of social identity, one *actual* and one *virtual.* When the moral valance of these two selves is significantly different, the result is a discrepancy between the actual and virtual versions of social identity, i.e., a stigma.[174] This discrepancy can mark a person as not merely *different* from who she could have been, but "in the extreme, a person who is quite thoroughly bad, or dangerous, or weak."[175] Thus, public health, in constructing a self that is counterfactually distinguishable from a self that otherwise could have been, creates the opportunity for stigmatization.

Furthermore, when the metaphorical language comparing epidemics to war are interpreted too literally, the resulting stigmatization and victim-blaming can result in a tendency to treat the infected as enemies, rather than as vectors or survivors. In the context of quarantine implementation, viewing the sick as the source of the threat can create a climate rife with the potential for violations of human rights. Even if the infected are not equated with

173 Petersen, "Foucault, Health and Medicine," 198.
174 Erving Goffman, *Stigma: Notes on The Management of Spoiled Identity* (Englewood Cliffs, NJ: Prentice- Hall,1963), Chapter 1.
175 Ibid., 3.

an "invading force," the language of war may imply that such individuals can be considered "collateral damage" in the efforts to win the battle against the spread of disease.

Outside the context of infectious disease, chronic disease can be feared on the basis of biased opinions that the disabled experience a lower quality of life.[176] Indeed, public health practices like pre-natal screening have been accused of perpetuating the notion that disabled lives are less worthy, or even not worth living at all.[177] The arguments as to what extent such a position is defensible are too in-depth to consider here. However, what I wish to draw attention to are the possibility that public health can fail to adequately distinguish between the fearsome prospect of a disease, and the fearsome prospect of the stigma that accompanies the disease. The harms that come from each are difficult to extricate from each other, but the lens of courage may be of service to public health professionals by calling on them to think clearly about what harms we *ought* to fear. Thus, courage can support the observation that the good life is more open to those with disabilities that is commonly assumed:

> brief acquaintances with people who have disabilities and who work, play, study, love, and enjoy the world should demonstrate that few conditions preclude participating in the basic activities of life, even if some conditions limit some classes of them, or methods of engaging them.[178]

By illustrating that some diseases do not impose the harms we often think they do, such observations clarify the need for proper attitudes of fear in public health. Public health professionals must be open to conversations about which forms of disease entail a lower

176 Trude Arnesen and Erik Nord, "The Value of DALY Life: Problems with Ethics and Validity of Disability Adjusted Life Years,"*British Medical Journal* 319, no. 7222 (1999): 1423–5.
177 Adrienne Asch, "Disability Equality and Prenatal Testing: Contradictory or Compatible," *Florida State University Law Review* 30 (2003): 315.
178 Ibid., 3204.

quality of life, and why. Thus part of the contribution of courage is in part to call on professionals to seriously question what detriments to human health are truly fearsome, and to avoid overreaction to any risk of illness. If professionals incorrectly identify a malady as something fearsome, they may attempt to protect others when unnecessary. Insofar as such protection is based on, or perpetuates, faulty views of the quality of life such individuals lead, they are arguably unjust.[179]

In conclusion, courageous public health professionals will need to attend to the possibility of fear that leads to injustices such as stigma, but also to overcome their own fear of reprisal for speaking out against injustices supported or created by public health itself. Thus, one can envision that both forms of courage – heroic and enduring fortitude – will be necessary in public health efforts as far ranging as whistle-blowing to redressing health disparities. It is in such work that public health professionals have the potential to prove themselves to be those who may not share stigmatization, but understand and sympathize with those who experience the harmful effects that reflect injustice, not misfortune. In such circumstances, public health professionals can prove themselves to be, in a sense, "wise" to the flaws of some societal attitudes, and join in conversations regarding the comparative harms injustice causes relative to harms of the illness itself.[180] In demonstrating such understanding, the courageous reveal a

179 This argument is not meant to endorse an expressivist view that all public health actions to forestall illness imply that unhealthy lives are less worth living. Rather, because some evaluations of disability and illness are arguably faulty, public health professionals should avoid perpetuating such problematic misconceptions and be aware of the possibility that the harms of some health conditions arise from societal attitudes. For a very different view, cf. Ronald Bayer, "Stigma and the ethics of public health: Not can we but should we," *Social Science and Medicine*. 67 (2008): 463-72.

180 Goffman, "Stigma," 28.

nexus of virtue, public health ethics, and their compatibility with human rights, where the locus of attention is fixed on the ways in which those "at the margins of society" often bear the burdens of disease.[181]

## 3.5 Institutional Courage

One objection to the virtue approach I have suggested here is that it merely shifts and amplifies the rhetoric of blame to public health professionals. By explicitly characterizing public health responses to risk in terms of cowardice and rashness, some would argue we merely entrench a problematic moralization of public policy. This argument claims that the problem is not that the imagery of cowardice and rashness is implicit, but that it ought to be eliminated from risk discourse entirely. Attributing errors in public health to failures in moral character of professionals merely facilitates the tendency to seek scapegoats, rather than legitimately improve accountability in public health. The objection against character, however, does have merit in that not all errors in public health policy are moral errors, and not all moral errors are solely attributable to human character. The human proclivity for seeking to blame someone's human frailty when things go wrong may be a reason to examine other sources that lead to mistakes, including the main concern of risk assessors – uncertainty and ignorance – as well as the structures that surround moral agents that contribute to moral and immoral behaviors. Thus the concern for a downside to talk about virtues in public health policy is also tied to the more theoretical objection that virtue ethics tends to focus too exclusively on the individual, and so may be an inappropriate match to public health activities. I hope that my analysis of

181 Mann, "Medicine and Public Health."

courage so far reveals that concern for character is at play even in policy, but I have also throughout identified a need to place the virtues in their proper setting. Excellence of character, for all of the ancients, does not emerge from the ether. Thus the question of whether the virtues can be learned, and how it is that the ancients seemed to think institutions could be virtuous, will be important for a virtue ethics of public health to spell out.

I believe that virtue ethics offers us the resources to meet this critique by forging a strong link between structural forces and personal character. Central to ancient discussions of virtue are notions of moral education, development, and how one acquires the virtues. For Aristotle, the process of a habituation is learning until something has become internalized, or second nature.[182] For virtue theorists, understanding moral behavior in terms of who a person has become is to simultaneously direct attention to the social, and in this case professional, structures that mold character and create incentives and disincentives for right action. In reply to the concern that virtue ethics will merely foster witch hunts for professional "bad apples" when things go poorly in public health, a virtue ethics of public health points to the professional tradition in which individual public health workers are trained. Virtue cannot be separated from such practices; on the contrary, it is what makes them possible both by creating them, but also by creating the context which lends them value: "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."[183] To grossly simplify, it is

182 M. F. Burnyeat, "Aristotle on Learning to Be Good," in *Essays on Aristotle's Ethics*, ed. Amelie Rorty (Berkeley: University of California Press, 1980), 69–92.
183 Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd ed. (Notre Dame: University of Notre Dame Press, 2007), 195.

impossible to be an excellent public health professional without public health. A virtue ethics approach to public health would frame the question of how this one professional came to err in terms of how the institutions of public health facilitate or condone such errors.

The possibility that institutions can be the bearers of character predicates like "trustworthiness" was addressed in Chapter 2, via either an aggregate or collective approach. But to call organizations "courageous" seems to stretch the imagination even more. Institutional trustworthiness required the attribution of intent or attitudes of goodwill to groups who create and inhabit structures and implement practices. Insofar as institutions are designed both to cultivate individual virtue and to forestall the possibility of inappropriate collective reactions to fear, I would argue they could be said to be virtuous. The connection of habituation to institutional courage can also be found in Plato, where Socrates observes that it is through training that soldiers "absorb" beliefs about what to fear and how to respond. (*Rep. IV, 429b-430b*) And yet, Socrates wishes to ascribe the virtue of courage not to the soldiers, but to the city, by virtue of its capacity to cultivate courage in its soldiers. It does so, claims Socrates, via its "power to preserve through everything belief about what things are to be feared" (*Rep. IV, 429c*) Thus, institutions that (1) cultivate appropriate attitudes of fear, (2) establish awareness of what public health can accomplish, and (3) inspire the boldness to act can be said to be courageous. By giving greater prominence to the communal nature of courage, an organization "cannot deny that it has any influence on the courage shown by its members on the ground that courage is only a matter for individuals…"[184] In developing

184 Howard Harris, "Courage As A Management Virtue," *Business & Professional Ethics Journal* 18, no. 3/4 (1999): 40.

accounts of how institutions cultivate courage, or fail to, a virtue ethics of public health supports greater accountability in public health leadership.

3.6 Courage and Prudence

In addition to Aristotle's account of virtue, the work of Plato can also provide insight into the ancient notion of the character trait that both guides our understanding of – and our reactions to – what inspires fear. In this section, I examine Plato's analysis of courage in the dialogue of the *Laches*.[185] In her recent analysis of courage, Linda Rabieh identifies the Platonic discussion of courage as a series of revelations regarding conceptual puzzles regarding the nature of courage, including the relationships of courage to knowledge.[186] Within the *Laches*, the character of Nicias serves as a foil to Laches' refusal to view courage as requiring wisdom. In this section, I consider such prospects in part because in times of uncertainty, it is natural to identify prudence as a solution and guide for practical action. In this section I point to the ways in which courage is a distinct character virtue related to the capacity for practical wisdom.

Laches is unable to defend his definition of courage because he fails to understand the importance of an external goal. Believing that courage ought to be chosen for its own nobility, Laches' view of courage cannot be distinguished from risk-taking for the sake of risk-taking. The other participant in the dialogue, Nicias, hopes to shed further light on the virtue of courage by

185 Plato, *Plato: Complete Works*, ed. John M. Cooper and D. S. Hutchinson (Indianapolis: Hackett Publishing Co., 1997).
186 Linda R. Rabieh, *Plato and the Virtue of Courage* (Baltimore: The Johns Hopkins University Press, 2006).

avoiding the unsavory conclusion that courage requires us to praise the foolhardy. He does so by trying to articulate a stronger relationship between courage and prudence. Although Socrates often seems to advocate for the view that virtue is knowledge, the notion that knowledge helps to differentiate the virtuous from the vicious has appeal in contemporary times as well. In Chapter 3 we saw that knowledge (including skill) in the form of competency can provide a foundation for trust in public health professionals. Similarly, knowledge of what pathogens or public health hazards are harmful, how they are harmful, and how to meet such harms, can provide a foundation for courage within the public health professional. Indeed, just as Nichias contends that knowledge is central to the nature of courage, those in public health that characterize risk assessment as a mostly cognitive endeavor appear to align themselves with a similar position.[187]

The difficulty with *this* tack is that Nichias sets the bar of knowledge required for courage impossibly high, claiming that the kind of knowledge needed is extensive. For example, Nicias denies that doctors can be courageous because while they may know what course of action will likely lead to health, the courageous would know more than this; they would know whether health is in fact in the interest of their patients.[188] Thus, Nicias takes a position similar to the one I outlined in Chapter 2 regarding the need to recognize not just a component of the good life (health), but its place relative to other goods. While I argued there

187 This is especially the case because Nicias initially seems to identify the kind of knowledge needed for courage as scientific (episteme.) Through the elenchus (196d-199e), Socrates reveals that the kind of knowledge at play in courage is wisdom (sophia), while others still believe that prudence is what is at stake. See Rabieh, "Plato and the Virtue of Courage," Chapter 3 especially p. 69.

188 Rabieh, "Plato and the Virtue of Courage," 71–7.

that such perspective sets the backdrop for relationships of trust, Nicias considers *complete* knowledge of the good as constitutive of courage as well. Nichias' standard of knowledge for the courageous is so demanding as to require extensive understanding of "the grounds of fear and hope" as well as profound insight into the future. (*Lch.* 196d; 198c) Insofar as Nichias goes too far in expecting complete understanding, his view arguably represents some of what is concerning about the search for enough evidence to adequately quantify probabilities during the course of risk assessment. Just as some scientists worry that evidentiary standards can be set too low, those concerned for public safety may worry that such standards are too demanding. Nicias illustrates to us how expecting such firmly grounded foresight can be mistakenly identified as the proper response to fear of possible harm, i.e., in circumstances of uncertainty one may expect that the proper solution is to seek certainty. The Socrates of the *Laches* reveals to us not only that such expectations may be unrealistically high, but that the kind of knowledge Nichias has in mind is not merely an empirical matter, but one that is also extraordinarily moral; to have complete knowledge of "practically all goods and evils put together" is to be aiming for complete virtue, not the single virtue known as courage. (*Lch.* 199d-e)

The *Laches*, then, is partly an anticipation of one possible objection to the arguments presented here, and my main contention that courage is the character trait most suited to risk discourse in public health. Such an objection would counter that what is needed is not courage,

but prudence itself.[189] This seems to be what Pellegrino and Thomasma had in mind when they envisioned the role of prudence in clinical medicine:

> In the maelstrom of anxiety, uncertainty, and urgency characteristic of the medical encounter, it is the virtue of prudence to which we turn to…Such a conclusion is worrisome for those who see clinical decision making as an exercise in probability and stochastic reasoning or game theory. There is nothing intrinsically wrong with trying to make the process of moral choice as rigorous, explicit, and theoretically sound as possible, or even the constructing moral algorithms. What must be kept in mind, however, is that at every junction, some prudential assessment of competing values, principles, or virtues must be made. Without such decisions, the branching decision-making tree must stop growing. Like it or not, the decision analyst, as well as the clinician whose thought processes he wishes to describe, use prudence.[190]

And indeed, we have good reason to consider, in public health matters, whether even *risk* is the appropriate terminology to be using. For example, some research shows that when individuals engage in choices about food, they do not frame such choices in terms of risk or fear; rather, such individuals seem concerned with aiming *toward* an ideal, rather than avoiding or facing something potentially harmful. As Judith Green observes in the context of analyzing consumers' food selection, "one could frame this [concern with nutrition] as about 'risk,' in that it relates to balancing the long term risks to health for their families, but this would be a warping of the data, which seemed to reflect more a concern with a 'good life…'"[191] Thus, the argument for prudence is a claim that sometimes risk is not what is at issue, and what a virtue ethics account requires is a more general character trait, one that is involved in decision-making

189 Weed and McKeown, "Epidemiology and Virtue Ethics."; For prudence as a guide during times of uncertainty see Cynthia M. Geppert, "Prudence: The Guide for Perplexed Physicians in the Third Millienium," *Pharos* 58 (1995): 2–7.
190 Pellegrino and Thomasma, "Virtues in Medical Practice," 89.
191 Judith Green, "Is It Time for the Sociology of Health to Abandon 'Risk'?," *Health, Risk and Society* 11, no. 6 (2009): 499.

about the good life more broadly. To characterize many human behaviors that relate to health in terms of risk is to read risk into such actions inappropriately; to assume that courage is required is to expect that fear is at play. The case for prudence, then, is in part a claim that the risk mentality currently dominates decision-making, and that we ought to be careful, both descriptively and normatively, before we assume that such a framework is more salient.[192]

In public health there are, however, times when an understanding of the good and the bad more generally, or an articulation of a vision of a 'good life' may be pertinent to public discourse. I argued in Chapter 2 that some mistaken justifications of public health paternalism miss this point. In addition, the nutrition example above indicates that health promotion may be more concerned with what we wish to strive *toward* than the harms to health that inspire aversion and fear. This possibility indicates that public health professionals may be primed to view public health practice in terms of detriments, not ideals, and the call for greater prudence may facilitate greater caution. But in many cases of public health emergencies, in epidemics or natural disasters, in occupational safety, and environmental contamination, public health professionals will need the perspective and attitudes of courage to guide their reactions to fearsome prospects. I contend that such a character trait has distinct value in public health practice than the benefits of prudence.

As Nichias shows us, it is possible to reach for a more generalized knowledge, or knowledge with a wider domain, than is required when seeking grounded responses to fearsome prospects. Nichias initially considers the wisdom necessary to be scientific knowledge, but Socrates reveals that he has all knowledge of the good in mind, or all of virtue

192 Ibid., 507.

(*Lch.*, 199e), and an Aristotlean would most likely counter that perhaps what Nichias has characterized is the "capstone" virtue of *phronesis*, or practical wisdom. But character excellence, like courage, and prudence are meant to work in conjunction – they are not the same kind of character virtues. For Aristotle, virtue is what helps moral agents identify good ends, and prudence (practical wisdom) is the faculty that enables moral agents to select appropriate means to achieve these ends. (*NE* VI.12 1144a8) Thus, virtue and prudence are always employed together. It is beyond my resources here to delineate the complex relationship between prudence and courage. I will merely claim that if we are to seek a character excellence – a virtue – that helps professionals evaluate the prospect of a harm, assess their own capacities for success, and muster their own boldness, then courage is the trait we seek. Prudence may be employed wherever virtues are realized, but courage provides a particular guide in response to fear.

In conclusion, the focus on many writings in risk is "on the 'rational' strategies that people adopt when conceptualizing and dealing with risk. They have much less to say about the ways in which risk discourse tends to operate at a more latent, extra-rational level of meaning."[193] By making character a central part of public health responses to public health hazards, virtue ethics helps to place the ethical subtext of risk discourse at center stage. It does so in part by articulating how and why ethical attitudes ought to be a part of professional responses to health hazards, rather than artificially relegating emotions and values to a realm

193 Deborah Lupton, "Food, Risk, and Subjectivity," in *Health, Medicine, and Society: Key Theories, Future Agendas*, ed. Jonathan Gabe, Michael Calnan, and Simon J. Williams (London: Routledge, 2000), 205–18.

outside public policy. I have argued here that making more explicit the language of the virtue of courage already at play in risk discourse can provide greater clarity to both the rational and "extra rational" aspects of such decision-making. In addition, I contend that the virtues of courage offers us a conception of psychologically how such rational and affective aspects can combine to support both inappropriate and appropriate action.

# CHAPTER 4: THE BOUNDARY PROBLEM AND THE SCOPE OF PUBLIC HEALTH

## 4.1 The Boundary Problem

To take a virtue ethics approach to public health is, in part, to ask what unites the public health community – what shared ends and practices are commonly held to be standards by which individual actions and motivations can be assessed. Under this approach, virtue ethics attempts to articulate the professional standard that can serve as a "regulative ideal":

> to say that an agent has a regulative ideal is to say that they have internalized a certain conception of correctness or excellence, in such a way that they are able to adjust their motivation and conduct so that it conforms – or at least does not conflict – with that standard.[194]

This articulation of ideals is broader than a mere identification of professional goals. Rather, the *ergon,* or function, of public health includes the goals (*telos)*, but also includes standards that regulate the methods by which such goals are attained. Aristotle identified this aspect of teleology in the function argument. (*NE* I.7 1097b24-1098a29) By focusing on *activity* a virtue approach links the means and ends of practices to an integrated standard of behavior that incorporates a concern for both outcomes and the methods used to attain these. The function argument also links virtues to an agent's happiness – frustrated attempts to perform one's function (due to vicious character, ignorance of the proper ends, inexperience in achieving these ends, or poor fortune) will result in an incomplete life. In this chapter, I present reasons to conclude that this account of a good life has its parallel in the public health profession, and that a virtue approach offers both resources to approach the boundary problem, and explanatory

194 Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles* (Cambridge: Cambridge University Press, 2006), 25.

power to account for why confusion about the functions of public health account for professional investment in both initiating and relying on the outcome of the debate.

The boundary problem in public health concerns how public health problems ought to be identified or defined. While core concerns like sanitation and contagious diseases provide uncontested examples of what falls within the scope of public health, problems like obesity, violence, and income inequality are all disputed objects of public health attention. Positions in debates on the boundary problem are often labeled as advocacy for "narrow" versus "broad" approaches to public health. As Powers and Faden observe, "part of what may make such diverse things as war, social response to natural disasters and environmental hazards, and political oppression unjust is their effect on health. In this sense, they are all public health problems."[195] Advocates of the narrow approach, however, are concerned that an ambitious public health program will outstrip the political will, professional expertise, and legitimate limits placed on public authority.[196]

This chapter consists of two sections. In the first, I consider different candidate features of public health that are often proposed to mark the field as distinctive from any other. Such features are often the starting points for articulating the goals (*telos*) of public health (e.g., if causal determinants of disease are the significant features of public health, then the goal of public health may be to disrupt such causal mechanisms). I consider the merits of these "models"

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195 Powers and Faden, "Social Justice," 83; for another example of arguments in favor of the broad approach, see Daniel S. Goldberg, "In Support of a Broad Model of Public Health: Disparities, Social Epidemiology and Public Health Causation," *Public Health Ethics* 2, no. 1 (2009): 70–83.

196 See for example Lawrence O. Gostin, "Public health, ethics, and human rights: A tribute to the late Jonathan Mann," *The Journal of Law, Medicine and Ethics* 29, no. 2 (2001): 121-30, especially 122–3.

of public health, but also their limitations and especially their potential to lead to problematic or objectionable forms of "publichealthification." In the second section, I provide an Aristotelian account of *hamartia*, or missing the mark, that helps to capture a more complex picture of goal-oriented behavior by collectives, not merely by individuals. I then consider what resources a virtue account can muster in order to provide guidance for how inquiry into a philosophy (and ethics) of public health may proceed. I then conclude with some considerations of the implications for professional flourishing.

## 4.2 Models of Public Health

There are many different ways professionals could, and do, go about defining public health to gain greater clarity about the legitimate goals and accurate scope of the profession. It is a common method to identify a feature of public health practice that is meant to be unique to the discipline. While the following list is not meant to be exhaustive, I consider the relative merits of models that focus on the following distinctive features of public health: causation, critical mass, prevention, collective action, redefinitions of health, and governmental authority. While curative medical ethics has its sister discipline of philosophy of medicine, an ethics of public health must also have a philosophy of public health to clarify its functions.

**The Causation Model:** One approach focuses on disease etiology as the significant feature of public health problems.[197] By focusing on those causal factors for which there is strong epidemiological evidence of causal connection, public health professionals might be thought to

197 See, for example, Bruce G. Link and Jo Phelan, "Social Conditions As Fundamental Causes of Disease," *Journal of Health and Social Behavior* 35 (1995): 80–94.

provide an empirical justification for the professional boundaries. It is not clear how far out in a causal mechanism a determinant may be if it is to count as a public health problem. A focus on causes too proximal to individual sickness treads on the toes of curative medicine by approaching what leads to disease in a particular case, rather than in society more widely. A focus on causes too distal risks what Meyer and Schwartz call "publichealthification," or the transformation of a phenomenon previously not associated with either the public or with health into one characterized by both such aspects.[198]

The causation model of determining the scope of public health reveals the aptness of the term "boundaries;" it is likely that some causes can be firmly pinned down as determinants of population health, while the importance of others may be less clear. What is needed is not only an account of determinants of public health, but of causal significance. As others have argued, public health professionals might deem a particular determinant significant because they have interventions available to effectively disrupt that determinant.[199] Thus, under this view, expediency is one reason to include a problem under the public health banner. This implies that the scope of public health will expand as new interventions develop. In contrast, the impetus behind some advocates of the social determinants of public health has been that such causal forces have been neglected in public health. The significance of a determinant may also be a concern for correcting an oversight committed in the past. In addition, a philosophy of public health must address how distal causes of morbidity and mortality rates – as far ranging as

198 Ilan Meyer and Sharon Schwartz, "Social Issues as Public Health: Promise and Peril," *American Journal of Public Health* 90, no. 8 (2000): 1189–91.
199 Karhausen, Lucien R., ed. "Causation in Epidemiology: a Socratic Dialogue: Plato." *International Journal of Epidemiology* 30, no. 4 (2001): 704–6.

socioeconomic status, public transportation, or violence – are also causes of other social ills. If social problems have a public health aspect to them, it must be clear how public health resources can be harnessed to mitigate such detriments without enveloping the entire problem under the umbrella of public health.

**The Critical Mass Model**: An alternative way to identify public health problems is to claim that there is a significant level or threshold incidence of disease such that it qualifies as a public health problem. Thus, the claim that a disease has reached "epidemic" levels is a reason to include it in the public health lexicon. Public health discourse regarding obesity in the United States arguably follows this model, perhaps in combination with causal accounts of how obesity contributes to increased morbidity and mortality.[200] Medicalization of obesity dates back to the 1950's but arguably also gains the attention of public health around the same time.[201] Initially obesity was seen by the public health community as a risk factor: populations with greater obesity rates exhibit higher rates of morbidity with regards to arthritis and Type II diabetes, and mortality due to stroke and cardiovascular disease. As new metrics reflect increased prevalence of obesity in both developed and developing contexts, prevention of weight gain and promotion of weight loss were increasingly accepted as a major concern of the public health profession.

However, as Kerch and Morone argue, redefining a social problem as a public health one in part requires relocating a problem fixed in the private sphere into the public sphere, and it is

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200 Rogan Kersh and James Morone, "How the Personal Becomes Political: Prohibitions, Public Health, and Obesity," *Studies in American Political Development* 16, no. 02 (2002): 162–175; Cf. Paul Campos et al., "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?," *International Journal of Epidemiology* 35, no. 1 (2006): 55–60.

201 Rebecca K. Simmons and Nicholas J. Wareham, "Commentary: Obesity Is Not a Newly Recognized Public Health Problem—a Commentary of Breslow's 1952 Paper on 'Public Health Aspects of Weight Control,'" *International Journal of Epidemiology* 35, no. 1 (2006): 14–6.

not obvious that the process is complete in the case of obesity.[202] The authors' examination of public health policy implementation indicates that empirical evidence of increasing incidence is insufficient for establishing something as a public health problem. While there is arguably a great deal of public interest in weight loss, such measures are often still primarily couched in private terms of individual self-control, rather than focusing on environmental and social causes that effect changes at the level of population health. The authors present an overview of other instances of "publichealthification" – from prohibition to anti-smoking campaigns – that indicate the importance of mass movements, or popular support for political action. Kerch and Morone argue that the subsequent step, policy formation, can originate from a variety of interest groups, among which public health professionals are included: "perhaps a policy actor within the federal government could play the same role, translating protests into policies."[203] According to this view, policy formation is the result, not the cause, of "publichealthification." The process of "publichealthification" thus bears an important relationship to the discussion of imaginative engagement I mentioned in Chapter 1; members of the public must first come to see the problems they experience as resultant from forces outside their individual control, requiring a public response.

It is a mistake, then, to oversimplify public health problems by establishing a solely quantitative account of the critical mass at which professionals ought to become concerned. In other words, it matters *who* perceives the problem, and that the public views it as a particular *kind* of problem, a shared or collective health concern, not a private matter. This is why merely

202 Kersh and Morone, "How the Personal Becomes Political."
203 Ibid., 166.

documenting a significant increase in the incidence of disease is unlikely to be sufficient to harness public health resources. Given the common social (and arguably problematic) association of weight with personal self-control, it is likely that a critical mass approach to including obesity within public health will be insufficient because it fails to account for these additional elements of both the social construction of public health problems, and the practical mechanisms that set the public health agenda.[204]

In addition, the metaphorical language invoked by referring to potential public health problems as "epidemics" can be stretched too far. Take, for example, the argument that gambling should be considered a public health problem:

> Worldwide, one may speak of the expansion of gambling as a "pandemic." Groups at risk of developing gambling related harms may be termed highly "susceptible." From a public health perspective, we can characterize the prevention of gambling related problems as a form of "prophylaxis," and coping skills as the development of "resistance." "Virulence" may develop as a result of advances in technology such as VLTs [video lottery terminals]. Unwanted gambling environments could be thought of as "contaminated" and a "reservoir" for problems. There may be a need for "quarantine" and "disinfection."[205]

Advocates of a broader public health agenda are pushed by the critical mass approach to seek parallels between their candidate problems and infectious diseases, which are paradigm examples of a public health problem. Rothstein is correct, however, to be concerned that this creates confusion as to when it is legitimate to invoke the powerful public health authority to

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204 This is not to say that there may be public health problems that go unrecognized by the public. Given the degree of general ignorance regarding what constitutes public health activity, there is likely to be a difference between what the public and professionals recognize as public health problems. Nevertheless, it is worth asking whether such differences in perspective result in substantive challenges to defining the boundaries of public health, rather than presenting solely practical challenges to resolving professionally-identified problems.

205 David A. Korn and Howard J. Shaffer, "Gambling and the Health of the Public: Adopting a Public Health Perspective," *Journal of Gambling Studies* 15, no. 4 (1999): 312.

use coercive action.[206] It might be reasonable to call for quarantine in response to an epidemic, but it is difficult to imagine doing so due to the "outbreak" of obesity or gambling. It is equally challenging to consider what about such health conditions would justify any kind of limitation on civil liberties by public health professionals. Furthermore, the language of "contamination" is more likely to result in a public health reinforcement of the social stigmas often already ascribed to those with "bad habits." As I argued in Chapter 3, public health professionals have an obligation not to exacerbate stigmatization and to do their best to design policies to minimize or even reduce negative social attitudes affixed to health conditions. The symbolic baggage of the epidemic metaphor may overwhelm its usefulness.

**The Prevention Model:** It is also commonly asserted that the distinctive feature of public health is its focus on preventive measures. Rather than reacting to the onset of disease, disability, and death by providing treatment, public health seeks to be proactive, and head off disease, disability, and death before they occur. Thus, one approach to the boundary problem is to claim that the province of public health is to contend with only those health outcomes that can be prevented. For example, recent advocates of using public health resources to address interpersonal violence argue that "the essence of public health is prevention, and it is that very essence that will enable the public health community to address the issues and problems [of violence] in a manner that complements the efforts of the criminal justice system."[207] Here, the authors acknowledge that violence is not *solely* a public health problem, but that the current

206 Mark A. Rothstein, "Rethinking the Meaning of Public Health," *The Journal of Law, Medicine and Ethics* 30, no. 2 (2002): 144–9.
207 Mark L. Rosenberg, Patrick W. O'Carroll, and Kenneth E. Powell, "Let's Be Clear: Violence Is a Public Health Problem," *The Journal of the American Medical Association* 267, no. 22 (1992): 3071.

categorization of the problem as a criminal matter results in limiting public response to reactive measures, not proactive ones.

On this preventive view, public health is characterized by existing public health methodologies as well as epidemiological metrics of successful interventions that indicate new avenues for prevention. This aspect of the prevention view has some explanatory power by capturing the changing nature of public health; it is partly the increasing evidence for social determinants of health, documentation of correlations between inequality and health, etc. that have initiated and bolstered arguments for the broad approach. Inter-population comparisons are especially illuminating as they reveal the potential for large-scale public health interventions that might be successful. The prevention view, when combined with the causation model, suggests that the future of public health lies in developing innovative preventive interventions that correspond to newly-identified determinants in addition to the current public health toolbox, and its catalogue of previously-identified causal factors.

One drawback to this approach is that it is subject to an interpretation that fails to place any reasonable limits on the preventive efforts of public health. For example, public health professionals might aim to reduce homeless-related morbidities by improving mental health services for veterans. However, it does not follow that public health ought to invest resources in preventing all determinants of homelessness itself. For example, such a commitment would entail public health involvement in foster care, or preventing children and adolescents from running away from home, which are also contributing factors to homelessness. It is easy to slip from talk of preventing outcomes into language of preventing the determinants of morbidity

and mortality. For example, public health professionals speak of preventing transmission of a disease in order to prevent the spread of an epidemic.

In the context of infectious disease, routes of transmission are arguably the sole and significant modes for spreading a disease, and therefore the central focus of public health efforts. However, in directing public health attention to structural drivers of human health outcomes, it is not clear that public health can be similarly focused. As Susser *et al*. observe, the structural forces in question often involve dynamic causal pathways and feedback mechanisms that are not easily interrupted at one point. Thus, while psychiatric disorders are highly correlated to rates of homelessness, so are low levels of education, housing conditions, and disruptive childhood events that may precipitate entrance into foster care or running away. Rates of homelessness, and as a result, strategies for reducing such rates, are best understood in terms of such causal interactions:

> We believe that the role individual-level risk factors play in homelessness can be fully understood only in the context of such broad societal processes. For instance, when housing is scarce, it is more likely that the functional disabilities of a person with mental illness will lead to homelessness.[208]

Advocates of the broad approach to public health are correct to defend the claim that morbidity and mortality rates cannot be fully understood without taking into account social and structural determinants of health. However, critics of this approach are also correct that the broad array of determinants involved goes far beyond the limits of public health expertise.[209] The problem of homelessness illustrates, like many other "broad" candidate public health

208 Ezra Susser, Robert Moore, and Bruce Link, "Risk Factors for Homelessness," *Epidemiologic Reviews* 15, no. 2 (1993): 552.
209 I owe this point to Tom Tomlinson.

problems, the importance of education and socioeconomic status in determining health outcomes. The easy slip from talking of preventing health outcomes to preventing health determinants raises the question of whether public health professionals should be seriously invested in reducing secondary education attrition rates, or in the foster care system. In other words, the broad approach to public health reveals a large degree of interdependency between social support systems, suggesting a greater need for institutional forms of cooperation. However, we might also consider whether the correlation between homelessness and education and disruptive childhood events (for example) make a better case for society to invest in education and health and social work rather than public health.

The prevention approach also fails to acknowledge that prevention is a central aspect of clinical medicine as well. While public health engages in prevention of disease for a population, such efforts can and do often overlap with medical efforts to forestall morbidity and mortality in an individual case. It is not enough to say that unqualified prevention is involved. Sometimes, what the linguistic slip reveals are the complex relationships between elements of a causal network. Rather than thinking of homelessness as a public health problem that gives professionals good reason to focus on public mental health services, narrow approach advocates might suggest this is putting the cart before the horse; we might save everyone some time by agreeing that increased clinical and public health resources ought to be put toward improving access to and quality of mental health services. On such a view, the health conditions associated with homelessness (like hepatitis) can be considered co-morbidities of psychiatric illnesses. Under this view, individual treating physicians can arguably handle such problems better than public health. Or, a narrow approach advocate might claim, the health detriments of homelessness

would be addressed by refocusing on mental health problems within public health – something much more palatable to traditionalists. Thus, the argument might be that there is no need to extend public health prevention to all determinants, since some may fall under the clinical realm, and elsewhere might be accommodated by the narrow approach. In any case, it will be important, when invoking the prevention model, for advocates to not merely propound the importance of unqualified prevention. Rather, the broad model for public health pushes the discipline to further articulate precisely *what* is worth preventing.

**The Collective Action Model**: The most commonly cited definition of public health, the 1988 IOM definition, employs the notion of collectivity: public health is "what we, as a society, do collectively to ensure the conditions for a healthy life."[210] Thus, one way of identifying public health problems is arguably to identify those health problems that can only be solved by collective action.[211] This invokes what Verweij and Dawson identify as one of the senses of 'public' evoked by the practice of public health; it is both *for* the public, but also only possible via action taken *by* the public.[212] The collective action approach to defining the boundaries of public health thus captures an important aspect of the means by which public health achieves its ends. Arguably, focusing on prevention as a signature feature of public health also highlights the importance of public health methods, not merely ends, in marking it as distinct from other forms of medicine, or other public activities.

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210 Institute of Medicine, "The Future of Public Health" (Washington, D.C.: National Academy Press, 1988), accessed September 5, 2012, http://www.nap.edu/openbook.php?record_id=1091.
211 See for example, Nancy Kass, "An Ethics Framework for Public Health," *American Journal of Public Health* 91, no. 11 (2001): 1776.
212 Verweij and Dawson, "The Meaning of 'Public' in 'Public Health.'"

In this way, it might be argued that both the collective action and prevention approaches to delimiting public health mistakenly identify the means of public health *as* ends. However, a virtue ethics approach to public health suggests a reply to this criticism. Aristotle's function argument establishes that what is characteristic of a practice is not merely the good toward which is directed (the *telos)*, but also the activities central to the practice. Indeed, as virtue itself is considered activity (*NE I.7* 1098a7), the function, or *ergon,* of public health entails a necessary connection between means and ends. The function of public health, therefore, is not merely what it achieves (e.g., lowering morbidity and mortality) but simultaneously the means by which it achieves them (i.e., the actions of lowering morbidity and mortality). Additionally, once the function(s) of public health have been identified, evaluative criteria can be developed to assess whether particular departments, institutions, or countries can be said to perform said functions poorly, or excellently.[213]

The collective action approach can misfire by encouraging public health professionals to include problems merely because they require a collective response. Civil rights movements, labor struggles, and social work – as collective activities – become indistinguishable from public health. The collective action approach to public health in the United States in part results from a strong tendency for the public to be skeptical of government intervention. And yet health, especially population health, is still considered by many to be a legitimate aspect of government responsibility. Unlike many other values, health is often one that is seen to have (near) universal appeal. Thus, while a culture that values individualism and self-reliance can often miss the ways

213 Christine M. Korsgaard, "Aristotle on Function and Virtue," *History of Philosophy Quarterly* 3, no. 3 (July 1, 1986): 259–79.

in which individual health derives from wider social determinants, this tendency is arguably offset by a similar cultural emphasis on the importance of human health. As a result, because collective action is tolerated in the arena of public health, it is tempting to categorize social problems as public health problems precisely because such a move can harness both political will, and public resources, that may be otherwise unattainable. Nevertheless, critics of the broad approach are correct to assert that the collective action approach, when misused for such pragmatic reasons, is likely to do a disservice to public health by assigning problems that squarely fall on the shoulders of public health professionals a lesser status and decreased attention. If public health professionals commit to the kinds of activities required to redress complex social problems, valuable resources, including time, may not be available to address traditional public health problems. In addition, identifying public health alone with collective action is also unwise because it reinforces the notion that human interdependency is an exception, rather than the rule. I have argued elsewhere that the tendency to focus on patient and physician interpersonal relationships erases the much larger context of collective cooperation necessary to create and sustain such relationships in clinical medical practice.[214] Likewise, the collective action is also integral to other important public professions, including civil service, social work, environmental policy, education, and criminal justice. Identifying public health with collective action may do a disservice to these other professions, what they can and do achieve, and the role of collaborative efforts in attaining such success.

214 Karen Meagher, "Considering virtue: public health and clinical ethics," *Journal of Clinical Evaluation and Practice* 17, no. 5 (2011): 888-93.

**The Redefining Health Model**: There are two different ways public health professionals can and do redefine 'health' in an attempt to broaden the scope of public health. First, they can simply adopt a more expansive definition of health than the traditional biomechanical model. Secondly, they can advocate for health as a public good, transforming it from a benefit, not only to the individuals with healthy lives, but also to society.

In the first case, the adoption of a broad notion of health follows those that have lauded it as necessary to include such challenges as mental health, or the other aspects of suffering that can accompany disease and disability.[215] However, expansive definitions that equate health with all of human wellbeing have been widely criticized for such conflation: "the World Health Organization's definition of health as a state of physical, mental, and social well-being…is perhaps the most extreme."[216] Any successful philosophy of public health will need to engage in such debates, and consider whether different conceptions of health might be more appropriate to employ in public health contexts rather than clinical settings – or whether such contextualism entails an unsustainable form of inconsistency.

An additional ramification of publichealthification (whether appropriate or not) is that by characterizing a problem in terms of public health, one also reconstrues what constitutes success. One reason for embracing a broad scope for public health results from adopting broad definitions of health. Such definitions tend to conflate health with other aspects of human wellbeing, resulting in confusion and reduction of the harms of a complex social problem to its affects on

215 Johannes Bircher, "Towards a Dynamic Definition."; Francesc Borrell-Carrió, Anthony L. Suchman, and Ronald M. Epstein, "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry," *The Annals of Family Medicine* 2, no. 6 (2004): 576–82.
216 Powers and Faden, "Social Justice," 83; See also Saracci, "Definition of Health," 1409.

human health.[217] Alternatively, a broad approach to public health might try to avoid an overly broad definition of health, but in enveloping a problem like poverty under the public health umbrella, it has a potential to magnify the detriments to human health to the exclusion of deprivations in other areas of human flourishing. In this way, a broad approach to public health carries the potential drawback of oversimplification, and suggests faulty metrics of progress. To reduce morbidity associated with a social problem like domestic violence may constitute a public health success, but it does not necessarily reflect any reduction in the incidence of the larger problem, any amelioration of its root causes, or any resolution of its more multifaceted harms. The conclusion of this analysis is that any appeals broad model advocates might make to greater efficacy must be tempered by such potential for misdirection.

In the second case, health is reconceptualized in public health as a public good. While there are many accounts of what constitutes a public good, there are three distinctive features of public goods that I will consider here. They are dependence on collective action, non-excludability, and jointness in consumption or non-rivalry.[218]

1. *Collective action:* I have already discussed the collective action model as a distinct way of considering the boundaries of public health. This approach is incorporated into the public goods model of public health insofar as one endorses the view that public goods are those communal benefits that can only be achieved by collective action. In part, this is one possible result of a collective action problem: while

217 Powers and Faden, "Social Justice," 83.
218 Dawson "Herd Protection as a Public Good," 164; Randall Holcombe, "Public Goods Theory and Public Policy," *The Journal of Value Inquiry* 34, no. 2 (2000): 273–86.

everyone will benefit from a certain action, no one person has sufficient reason to act alone.[219]

2. *Non-excludability*: In addition, once achieved, a public good provides benefits to all members of the community. This results in what is known as the "free-rider" problem: certain members of the public can benefit without having to contribute to efforts that produce or maintain the good. Classic examples include environmental resources like clean air, or safe and available drinking water. However, this feature also characterizes other goods highly relevant to other aspects of public health policy, such as the provision of herd immunity via vaccination programs. Using this model, advocates of a broad approach to public health might try to articulate how amelioration of candidate public health problems results not in health benefits to individual members of target populations, but to the entire population.
3. *Non-rivalry*: This aspect of public goods acknowledges the unrestricted nature of a resource. Non-rivalry means that use or enjoyment of the good does not preclude its use or enjoyment for others. A radio broadcast is a common example of a non-rival good – a radio listener does not "use up" or prevent others from listening to the same broadcast.[220] It's important to note that this example presumes equal access to radios. Such assumptions reveal that rivalry can arise elsewhere in the process of production or consumption of a good.

219 Ibid., 144.
220 Ibid.

Some accounts of public goods assert that all three characteristics be met in order for a benefit to qualify as a public good. Other views emphasize one feature rather than others; thus, it is not clear whether these attributes are necessary or sufficient conditions for public goods, either alone or as a group. A philosophy of public health that advocates for this model will need to defend whether improvements in population health must necessarily be public goods to fall within the domain of the public health profession, or whether qualifying as a public good merely increases the cause for inclusion within the public health catalogue.

**The Governmental Model:** Rothstein's main defense of a narrow approach to public health stems from a concern that broader approaches will outstrip social support and the legitimate reach of public health authority. Rothstein is especially interested in limiting the scope of public to health to problems that justify governmental use of coercive powers: "in the absence of such legal authority, the participation of individuals in health enhancing activities ordinarily must be voluntary."[221] The difficulty with this view is that it appears to relegate all health promotion activities to outside the realm of public health, or at least governmental public health responsibilities.[222] Under this view, public health is not what we, as a society, do to ensure the conditions for a health life, but rather what we do to ensure that some do not impose an unhealthy life on others. One purported advantage of this approach, according to Rothstein, is that it is more likely to receive political support from citizens by avoiding highly politicized recommendations, like income redistribution schemes to reduce the health effects of inequality.

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221 Rothstein, "Rethinking the Meaning of Public Health," 146.

222 This is arguably a consequences of a narrow approach that some might wish to endorse, at least insofar as health promotion presumes an "overarching" value of health that had not been supported – see Lubomira Radoilska, "Public Health Ethics and Liberalism" *Public Health Ethics* 2, no. 2 (2009): 135–45.

The notion that the broad notion of public health is "politicized" is a common critique.[223] However, it is often not entirely clear what is meant by such a claim. Certainly, by virtue of being performed by governmental professionals on behalf of citizens, public health is considered political activity. The concern, then, may be that the broad approach is too *partisan*, which may undermine public health efforts by provoking resistance from both political leaders and the public.

However, it is worth ensuring that the critique is not the claim that somehow the broad approach is political in a way that the narrow approach is not, at least as far as taking a stance on what constitutes the proper role of government. If this is the claim, then Rothstein's position is merely stipulative: the proper scope of public health ought to be narrow because it falls more within the range of appropriate governmental authority, and the legitimate purview of government authority ought to be narrowly construed. Clearly such a view also requires a political philosophy regarding the role of government, and such narrowness may also be, perhaps uncharitably, interpreted as highly partisan if equated with advocacy for "limited government." I do not mean to claim that this is Rothstein's intent, but I do contend that no view of the proper limits of governmental authority can claim political neutrality – although it may be able to claim relative *partisan* neutrality given the current political climate.

Arguments against politicization are similarly flawed if they include a claim that public health somehow inherits some degree of objectivity that might be attributed to the underlying science of epidemiology. Thus, some have claimed that the broad approach to public health is

223 As noted earlier, Gostin anticipates Rothstein's argument in, "Public health, ethics, and human rights."

inappropriate because it causes the profession to "drift from its scientific and clinical moorings."[224] I have critiqued the view of public health practice as devoid of normative elements throughout my arguments, but it will not hurt to summarize them here. Such a position leads to two possibilities, it either (1) reflects an uncritical understanding of the normative aspects of epidemiological practice,[225] in which case a stronger defense of the objectivity of a narrow approach is required, or proponents of the broad approach may muster epidemiological evidence to bolster their claims; i.e., they may employ the causation model of public health and meet critics on their own terms; or (2) it fails to acknowledge that all health policy must be similarly political and normatively justified; all public health interventions move from epidemiology to policy, and in doing so require justifications that are inherently normative, and often political. In this second case, proponents of a broader approach may be able to illuminate the ways in which all public health practices require justification, and what may be in contention is not what counts as a public health problem, but what counts as the justificatory conditions that legitimate public health policy.

To be charitable, defenses of the governmental model of public health are worthy of careful consideration when they express a worry that broader approaches may entail a corresponding expansion of public health authority. In such cases, a growing public health agenda arguably runs counter to a public health "ethics of restraint," especially when it increases the potential for abuse of public health powers.[226] To make this critique stick, however, it is not

224 Sally Satel, "The politicization of public health," *Wall Street Journal,* December 1996.
225 Steve Wing, "Whose Epidemiology, Whose Health?," *International Journal of Health Services* 28, no. 2 (1998): 241–52.
226 Nancy Kass, "An Ethics Framework for Public Health," 1777.

enough to merely claim that inclusion of poverty, or obesity, or violence within public health expands public health powers – rather critics must explicate what powers are expanded, and why this is inappropriate.

I believe that these analyses reveal that it is extraordinarily difficult to identify a single feature of public health will enable us to clearly differentiate between public health and other social services. However, this does not mean that discourse surrounding the distinctive features of public health cannot be productive. What these considerations have indicated is that what may be in contention is not what counts as a public health problem, but what counts as the justificatory conditions that legitimate public health policy. It is to addressing this complexity that I now turn.

## 4.3 A Virtue Approach to the Boundary Problem

What, then, would a virtue ethics approach suggest as a resolution to the boundary problem? The boundary problem involves both conceptual and normative challenges – questions of what are and ought to be the limits of a discipline. However, concern over the boundary problem is often expressed by public health professionals as a *pragmatic* concern, one regarding definitive guidelines to help determine the core of the profession, and how to set priorities. The conceptual and normative challenges are related, but distinct. In this section, I argue that a virtue ethics approach to the boundary problem suggests that the Aristotelian notion of *hamartia* provides a metaphor can help to illustrate the differences between the moral psychology of individuals and groups.

As I have argued, the concern for the boundary problem is a conceptual matter, but also of ethical concern to those engaging in the debate. The call to articulate a shared set of values for the field involves a need for a clearer picture of public health practice to provide a guide for action, i.e., the boundary problem is in part a desire to articulate a shared moral vision for public health professionals. I argue that this notion of shared vision invokes an aspect of practical ethics familiar to virtue ethics – the connection between moral perception and guidelines for action. For Aristotle, virtues lend agents a perceptual capacity, "the eye of the soul does not come to be in its proper condition without excellence." (*EN* VI.12 1144a30) By drawing out the saliency of features of the moral landscape, virtue enables the agent to identify good ends.[227] While these particulars are not what those interested in an ethics of public health have in mind, the general idea is not far off: by getting clearer on the values of the profession, professionals will have a better idea of what to do. I argue that a better understanding of Aristotle's picture of moral psychology, as expressed by his notion of *hamartia*, or missing the mark, can help public health professionals distinguish between the clear vision of an individual, and the clear vision of a group.

While Aristotle's use of the term *hamartia,* "missing the mark" or "error," is contested,[228] his employment of the imagery of target practice can be harnessed to reconceptualize the boundary problem. For Aristotle, "…being excellent is something difficult to achieve. For, in any context getting hold of the intermediate is difficult – as for example finding the center of a circle is not a task for anyone, but for the skilled person…which explains why getting things right is a

227 McDowell, John. "Virtue and Reason."
228 T. C. W. Stinton, "Hamartia in Aristotle and Greek Tragedy," *The Classical Quarterly* 25, no. 2, New Series (1975): 221–54; cf. Isaiah Smithson, "The Moral View of Aristotle's Poetics," *Journal of the History of Ideas* 44, no. 1 (1983): 3–17.

rare thing." (*NE* II.9 1109a24-30) Excellences of character, virtues, lend clarity about our ends by distinguishing good ends from bad ones, thereby correcting our aim, whereas experience helps hone our practical reasoning, skills, and perception of particulars such that we might achieve our ends. (*NE VI* 1144a20ff; 1143b5-15) This view of the moral psychology of an agent captures the instrumental value of virtues: "an *arête* is not merely one of a thing's good points; it is specifically a quality that makes something good at performing its function." While the virtues are not only instrumental to achieving the good, their utility is certainly an advantage. In public health, the professional virtues thereby speak to one of the driving concerns for a solution to the boundary problem – the desire for greater public health *efficacy*. Throughout this section I examine the underlying concern for greater efficacy that drives advocates of both narrow and broad approaches to the boundary problem, and then consider how the metaphor of "missing the mark" can shed light on what this might mean for efficacy in public health.

In his article, "Rethinking the Meaning of Public Health," Mark Rothstein outlines some objections to a broad approach to public health. Among his concerns with a broader scope for public health is that "such an approach is ill-defined, with diverse actors pursuing widely divergent strategies to deal with the same health problems, tackling health problems of varying severity, and often pursuing their own agendas with little coordination or accountability." From Rothstein's perspective, a narrow approach to public health would prioritize threats to the public health that clearly justify invocation of the harm principle, problems that are solidly grounded in public health expertise, and interventions that have proven efficacy.[229] Rothstein contends that such an approach will provide *greater efficacy* because the resulting public health agenda will be

229 Rothstein, "Rethinking the Meaning of Public Health," 146.

limited to problems supported by broad public and professional consensus, consist of fixed public health priorities, and be firmly grounded in public health understanding of both the problems and the respective methodologies needed for resolution.

Advocates for a broad model share this concern for efficacy. There exists a persistent feeling among many such professionals that public health fails in its mission to forestall ill health, or improve overall health, by abdicating a responsibility to attend to social determinants of health in favor of a more limited focus on traditional goals and methods.[230] However, when public health professionals take on complex social problems like poverty or domestic violence, the conceptual and methodological resources required to attain success may outstrip the expertise of public health professionals. For example, Meyer and Schwartz identify problematic or counterproductive forms of "publichealthification" in public health inclusion of homelessness that illustrate how public health attention can undermine the intent of advocates of the broad model due to a mismatch between social problems and epidemiological concepts and methods. When public health employs an aggregative notion of population health, this encourages a tendency to reduce cumulative outcomes to individual behavior. Thus, causes of homelessness become characterized not in terms of lack of affordable housing or flaws in housing subsidy structures, but individual "risk factors," such as socioeconomic status or mental health

230 Link and Phelan, "Social Conditions As Fundamental Causes of Disease"; David Evans, Simon Cauchemez, and Frederick G Hayden, "'Prepandemic' Immunization for Novel Influenza Viruses, 'Swine Flu' Vaccine, Guillain-Barré Syndrome, and the Detection of Rare Severe Adverse Events," *Journal of Infectious Diseases* 200, no. 3 (2009): 321 –8; Wing, "Whose Epidemiology, Whose Health?"; Amy L. Fairchild et al., "The EXODUS of Public Health," *American Journal of Public Health* 100, no. 1 (2010): 54–63.

diagnosis.[231] To provide another example, Sankar et al. argue that a public health research agenda that includes genetic determinants of health disparities may overshadow social and environmental determinants, and reinforce racial stereotypes.[232] Such considerations reveal how a concern for efficacy often lies behind an appeal to a broader causal model of public health; merely being a determinant of health is not enough – what is needed are guides for which causes to focus on and why. The examples provided here serve as a warning as to how classic concepts and methods in public health can actually subvert the intent of advocates of the broad approach by incorporating assumptions that undermine actualization of the broad approach's potential for improved efficacy.

Debates regarding the boundary problem in public health reveal how an additional concern for *unity* of purpose gets mixed up with calls for efficacy. The demand that the limits to public health be firmly placed within public health expertise must acknowledge the dynamic nature of public health and epistemic authority. Disparate goals in public health may reflect a myriad set of aims, disagreements on their priority, as well as varying on-the-ground realities such as funding structures. But it does not follow that such apparent heterogeneity necessarily sacrifices efficacy for the sake of plurality. Advocacy for a broad model of public health can also be interpreted as a call for understanding that efficacy can be evaluated at many levels. What is successful locally may not be an efficacious state-wide or national policy. This is due to local context, but also to due to variety in population needs. For example, Florida state, with a large elderly population, may require not only a different set of public health priorities, but perhaps

231 Meyer and Schwartz, "Social Issues as Public Health."
232 P. Sankar, "Genetic Research and Health Disparities," *The Journal of the American Medical Association* 291, no. 24 (2004): 2985–9.

even unique public health ends. The same might be said for the difference between urban and rural populations. With this in mind, advocacy for a broad approach to public health can also be grounded in a concern for context. Thus, the same moral considerations needn't be the guiding considerations for each and every public health professional. Rothstein believes that a narrow approach to public health is more likely to encounter public support, but this again depends on *which* public is in question, and whether public support is required, or guarantees, public health efficacy. The central claim of this section is that it is not clear that professions are more efficacious when they engage in a more limited or even unified set of goals. It is also possible to envision that collectives can employ multiple methods to achieve the same targets, or new means to achieve innovative ends, before deciding which methods to embrace on a wider basis – or even whether such homogeneity is desirable in and of itself. A virtue ethics approach would start by differentiating between the public health calls for efficacy and unity in order to clarify which values are at play in determining the boundaries of public health practice.

Aristotle's metaphor regarding *hamartia*, or missing the mark, is a helpful metaphor when considered in terms of target-practice. It makes sense that clarity of purpose, by virtue of character excellence, helps to sharpen the focus of the moral agent. The image also helps reveal why unity and efficacy are so easy to conflate. It is an intuitive notion that having less to aim for – a more narrow scope of objectives – would make agents more effective at attaining such goals. But the imagery of missing, or hitting, the mark must be stretched when scaled up to the practical undertakings of an entire profession. Collectives do not pursue targets in the same way as individuals, and as a result, the features of the efficacious public health professional may not be the same as the features of an efficacious profession.

Collectives, unlike individual moral agents, can aim to achieve objectives that individuals alone cannot accomplish. Collaboration may require individual agents to aim for intermediate goals in order to collectively obtain overarching objectives. Let us call this *the matroishka model* of public health because smaller goals are nested under larger ones, like these Russian nesting dolls. For example, consider the traditional goal of reducing the incidence of hepatitis within a population. When considered in conjunction with the previous example, public health advocates of a broader approach to public health may contend that it is possible to understand some instances of hepatitis as a homelessness-related morbidity. Thus, aiming to reduce the rate of homelessness might become a minor objective in a larger public health effort to reduce incidence of hepatitis more generally. By viewing homelessness itself as a public health objective, some public health professionals may also be able to address other related co-morbidities associated with homelessness or the mental illness that may lead to them. Under this view, broader public health goals and methods might be subsumed under a more traditional public health goal, or work in tandem with more traditional approaches that achieve related or shared ends. The point here is that because all those engaged in discourse on the boundary problem share a concern for seeking efficacy, advocates of a broad approach might do well to emphasize how newer goals and methods work in conjunction with, rather than to the exclusion of, the pursuit of traditional goals in order to achieve wider shared ends.

One objection to the matroishka model is that there is no guarantee that a more varied set of sub-goals in public health will necessarily lead to greater efficacy. In other words, if we cannot assume that greater unity lends greater efficacy, neither can we assume that greater plurality of objectives does the same. The reply that an advocate of the matroishka model must

provide will necessarily need to appeal to evidence and rationale as to why a broader set of subgoals is more efficacious. Thus, one revelation of the considerations so far is that professionals cannot solely pin their hopes for greater professional efficacy on philosophy of public health. Rather, while such deliberations can perhaps lend insight and greater clarity, the evidentiary burdens fall equally on advocates of both approaches to supply reasons to support one model over another on the grounds of greater efficacy.

The target metaphor can again be used to envision how collective goal-directed action must be conceptualized in ways that distinguish them from the trappings of individual agency. In other public health contexts, collectives may employ different strategies to achieve the same goals in ways that individuals cannot. Thus, Rothstein is correct that constantly shifting sands in an overall public health agenda will be counterproductive – especially to the long-term achievements of the profession. This is especially the case when we conceive of collectives as psychologically akin to individuals – more likely to succeed when focusing on a single or discrete set of goals. Thus, while Rothstein envisions the myriad foci of individual public health professionals as disorganized and ineffective, employing disparate means to achieve the same objective can also be understood as an optimal strategy for success – i.e., if one strategy fails, another might succeed. Let us call this the *fail-safe method* of public health. For example, while preventive efforts may form a central element of forestalling the harms of an epidemic, so, too, do countermeasures after an epidemic has begun, even if such efforts wade into the murky area of overlap between clinical practice and public health policy. Public health may therefore actually undermine efficacy if it equates it with unity of vision and purpose. What to some might appear as redundancy or confused heterogeneity might in reality be a system of mutually reinforcing

methods that ensure security, where one set of public health activities serves to achieve similar goals in case first-line efforts fall short.

One advantage of the models I have suggested here, that arise from the target imagery invoked by the notion of *hamartia*, is that they do not endorse one particular model of delimiting public health problems discussed in Section 1. Rather, both the matroishka and fail-safe models of public health accommodate the reality that no single feature of public health marks it as distinct. Instead, each of the models outlined in the first section are good reason to consider the merits of incorporating a problem in the public health lexicon. In addition, by calling attention to the underlying values that drive discourse concerning the boundary problem, I hope to have highlighted the ways in which what counts as public health activity will sometimes *not* be clear. Sometimes, prevention pushes public health into the curative realm; at other times, public health objectives may be shared with other public entities or even private institution. What critics of the broad approach appropriately note, however, is that the implications of shared responsibility need to be more clearly delineated. This, then, will also be a criterion for a successful philosophy of public health.

Another advantage of this view is that it accommodates the fluid and changing nature of professional knowledge. We might state simply that epidemiology is the study of the processes that contribute to population health. There is no reason to think, however, that such knowledge will stay within the bounds of preventive efforts, be limited by current understandings of what constitutes health, or even be captured by the dominant understanding of causation. Meyer and Schwartz focus their critique of the broad model of public health in the context of public health research because it is precisely in this area that "publichealthification" is likely to take root, and

perhaps go astray. It is our increasing understanding of the ways in which our health is wrapped up in the health of others that creates the potential for new public health problems. The approach I put forth here acknowledges that one source of the movement for expanding the scope of public health partially results from expanding epidemiological knowledge; the more evidence and understanding professionals gain regarding the social determinants of health, the more professionals feel an obligation to develop new methods of intervention. Sometimes such professionals express that obligation in terms of a professional duty to increase public health efficacy, other times out of a concern for fairness or justice, which I will turn to shortly.

The claim I wish to defend here is that the scope of public health may never be a fixed and determinate matter: methodological expertise will need to be developed to speak to expanding public health expertise in disease etiology, and may sometimes lag behind. In the contrary cases, public health methods of intervention (especially in the form of technology) are sometimes developed and understanding of etiology follows in a reverse order. Advocates for a broader approach to public health may need to be patient and respond to demands that there be evidence of methodological efficacy before such public health problems join the lexicon indefinitely. Narrow defenders may also need to allow for greater flexibility in epidemiology than in public health; i.e., something may count as a public health problem before a solution has been found.

## 4.4 Toward public health inquiry into the nature of the profession

The shared desire for greater efficacy reflects that one possible solution to the boundary problem is to articulate the underlying values that both camps share so as to help to develop

evaluative criteria for assessing justifications for expanding or restricting public health boundaries. In other words, it is one thing to articulate a public health *telos* and another thing to outline what it means to achieve those ends well. In discourse surrounding the boundary problem, both aspects are at play because there is an overriding consideration to develop not just *a* public health agenda, but also a *good* public health agenda. As so often happens in debates regarding what something is, we are often simultaneously debating what something ought to be – the philosophy of public health and an ethics of public health are therefore inextricably linked, and debates over the boundary problem often fail to distinguish these two issues. In this section, I explore ways in which recent discussions regarding Aristotle's view of inquiry can provide some guidance for how discourse ought to proceed. In doing so, I lay some of the preliminary groundwork for developing a fruitful philosophy and ethics of public health by considering the following questions: 1) Is there a distinctive ethics of public health? 2) What shared assumptions can provide starting points? 3) What are the rules of engagement? and 4) What are the desired outcomes of discourse?

### 4.4.1 Is there a distinctive ethics of public health?

As Salmieri notes, "except in cases where it is already obvious, it is necessary to inquire 'if something is' before inquiring into 'what it is.'"[233] While it may be perfectly obvious to some

233 Gregory Salmieri, "Aristotle's Non-'Dialectical' Methodology in the Nicomachean Ethics," *Ancient Philosophy* 29, no. 2 (2009): 320; Throughout this section I draw from a variety of articles regarding the nature of Aristotle's position on dialectic. Rather than endorse one position, however, I draw more on the implications of these discussions to articulate Aristotle's view how we ought to inquire, rather than what category of discourse such inquiry ought to be considered. My account owes a great debt, however, to that of Salmieri. For differing views on

that there is a distinct ethics of public health to be found, it is worth asking whether such an ethics will be limited to public health practice. This concern partly arises because discussions over the distinctiveness of public health ethics overlap with discussions regarding the future of bioethics. Thus, the predominant concern for justice that characterizes much of the recent work in public health ethics also reflects a dearth of attention to such matters in clinical organization contexts.[234] For example, at the Nuffield Council's Annual Lecture, Onora O'neill concludes "that too strong a focus on individual choice and informed consent by patients and research subjects will not only marginalize public health and the ethical questions it raises, but hide much that is fundamental to clinical medicine and to the conduct of biomedical research."[235] The same might be said for striking the proper balance between group interests and individual autonomy, the pertinence of organization ethics, and the social context of clinical care.[236] Thus, as each of the models articulated in section one is a common, but not distinctive feature of public health, we ought also to use similar caution in assuming that some ethical concepts are more pertinent to public health than clinical medicine. The population level of analysis that is characteristic of much of public health does not entail that public health professionals do not address individuals,

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dialectic, see D.W. Hamlyn, "Aristotle on Dialectic," *Philosophy* 65, no. 254 (1990): 465–76 and Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, 2nd ed. (Cambridge University Press, 2001), Chapter 8.

234 Norman Daniels, "Equity and Population Health: Toward a Broader Bioethics Agenda," *The Hastings Center Report* 36, no. 4 (2006): 22–35.

235 Onora O'Neill, "Broadening Bioethics: Clinical Ethics, Public Health and Global Health" (presentation, The Nuffield Council on Bioethics Annual Lecture, Royal Society of the Arts, London, UK, May 19, 2011), p. 13. Available at: http://www.nuffieldbioethics.org/sites/default/files/files/Broadening_bioethics_clinical_ethics_public_health_&global_health.pdf.

236 Elsewhere I have established preliminary arguments to this effect in Meagher, "Considering Virtue."; see also Ronald Bayer and Amy L. Fairchild, "The Genesis of Public Health Ethics," *Bioethics* 18, no. 6 (2004): 473–92.

but it does indicate that what may be distinctive of public health is a division of labor that lends greater salience to groups. The discourse within bioethics more broadly, however, indicates that a public health ethics would be premature in assuming that this necessitates giving priority to groups over individuals, or incorporating an ethics of community exclusive to public health. Rather public health will still need to strike a balance between self- and other-regard, and this may bear important implications for how such balances ought to similarly be struck in clinical contexts including hospital policy and organizational structure.[237] The implication of this analysis is that a philosophy of public health, and its related ethics of public health, is deeply tied to conversations about other aspects of clinical care; in the end, they may have more in common than appears at first blush.

4.4.2 What shared assumptions can provide starting points?

Once we have established that the lessons of public health ethics may not necessarily be limited to the profession, we might return to the arguments of the previous section and examine the shared concern for efficacy. The notion that debate can be beneficial to a community of professionals is not new. And while what may be sought can be thought of as a philosophy or ethics of public health, there is good reason to believe that it will be a more fruitful discourse if it is not limited to philosophers, or even those who are concerned about the ethical implications of the field. As Callahan and Jennings observe, "[ethical] code developments and revisions…have often been most successful when they are accompanied by lengthy and strenuous debate

237For a nuance approached, see Sally Bean, "Navigating the Murkey Intersection Between Clinical and Organization Ethics: A Hybrid Case Taxonomy," *Bioethics* 25, no. 6 (2011): 320–5.

engaging the entire professional community and not simply those with a special interest in ethics."[238] Recently, some authors have endeavored to articulate these underlying values that might be shared by many of the suggested models of public health.[239] This move may indicate greater unity, or consensus, toward a prescriptive account of public health so often desired from discourse around the boundary problem. However, another way to understand such shared values is to view them as starting points to initiate, rather than come out of, inquiry into the nature of public health.

The nature of starting points in the *Nicomachean Ethics* and elsewhere in Aristotelian philosophy is up for debate – especially whether such beginnings are understood due to insight (*nous),* or some other form of epistemic access. However, starting points are commonly understood to be "mutually accepted," either due to a common set of beliefs (*endoxa),* a shared set of experiences, or the nature of the subject matter.[240] Thus one way to begin conversations around the boundary problem is to propose candidate starting points. I have argued that proponents of both the narrow and broad approaches share a concern for efficacy, and one might also consider other commonly invoked values such as efficiency, community, utility, and justice.[241] From there, participants in the conversation will need to assess the assumption that

238 Daniel Callahan and Bruce Jennings, "Ethics and Public Health: Forging a Strong Relationship," *American Journal of Public Health* 92, no. 2 (2002): 173.
239 Christian Munthe, "The Goals of Public Health: An Integrated, Multidimensional Model," *Public Health Ethics* 1, no. 1 (2008): 39–52; Lisa M. Lee, "Public Health Ethics Theory: Review and Path to Convergence," *The Journal of Law, Medicine and Ethics* 40, no. 1 (2012): 85–98.
240 Hamlyn, "Aristotle on Dialectic," 475; Salmieri, "Aristotle's Non-'Dialectical' Methodology," 319.
241 I have said very little up to this point regarding justice, in part because the relationship of the virtue of justice and political justice is so complex, and beyond the scope of this project.

such values are shared, examine whether all public health professionals mean the same thing by the terms invoked, and consider whether such values can coherently be endorsed, amongst other considerations within the subsequent debate.

4.4.3 What are the rules of engagement?

In addition to these considerations, those engaging in discourse regarding the scope of public health can also look to Aristotle for guidance as to how to conduct oneself during such an inquiry. Thus, Aristotle says of the beliefs of the wise and experienced (*endoxa), "*it is not reasonable to suppose that either set of people are wholly wrong, but rather that they are getting it right in at least some respect, or else in most respects." (*NE* I.8 1098b29) Here, again, the imagery of *hamartia* is at the forefront, and Aristotle cautions those engaged in debate to throw one's opponents a bone, and try to find – and accommodate – the merits of another's position.[242] In advocating for charitability in discourse, Aristotle endorses the value of the intellectual virtues –

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However, its dominance as a topic in contemporary public health ethics indicates that any ethics of public health, including a virtue ethics approach, is incomplete without an accompanying theory of justice. For work on social justice and public health, see Ruger, "Health and Social Justice."; Powers and Faden, "Social Justice."; Dan Beauchamp, "Public Health as Social Justice," *Inquiry* 13, no. 1 (1976): 3–14; Nancy E. Kass, "Public Health Ethics From Foundations and Frameworks to Justice and Global Public Health," *The Journal of Law, Medicine and Ethics* 32, no. 2 (2004): 232–42; For an account of justice as a virtue, see Bernard Williams, "Justice as a Virtue" in *Essays on Aristotle's Ethics*, ed. Rorty, Amélie Oksenberg (Berkeley: University of California Press, 1980): 189-200. For an initial discussion on the relationship between the virtue of justice an Aristotle's notion of political justice, see Thornton C. Lockwood, "Ethical Justice and Political Justice," *Phronesis: A Journal for Ancient Philosophy* 51, no. 1 (2006): 29–48.

242 I owe this point to Roger Crisp, "Aristotle on Dialectic," *Philosophy* 66, no. 258 (1991): 522–4.

those features of intellectual character that are truth-conducive.[243] We find further evidence in Aristotle to be moderately amiable when "sharing in discussions" generally.[244] When adapted for the context of a profession, this virtue resembles something like collegiality – neither agreeing too easily with what others say, nor being contrary for the sake of contrariness. This caution can be interpreted as an indication that the best way for the boundary debates to avoid partisanship is for inquirers to eschew ideology when engaged in debate.

I will not develop a comprehensive account of the intellectual virtues (either generally or specific to public health and epidemiology), here. Rather, I merely wish to establish that if some contentious aspects of the boundary are to be resolved, it is those engaged in debate that will need to lead the way, in part by building coalitions rather than solely seeking to find fault with the opposition's view. Such a position endorses the notion that virtues are not only those traits that help agents to achieve their goals, but also those attributes that sustain and foster the communities and practices that set the stage for individual and collective goal-directed endeavors.[245]

### 4.4.4 What are the desired outcomes of discourse?

Lastly, those considering the boundary problem need to be explicit about what they desire to obtain from discussion. Is the objective of discourse a definition of public health (the good and the bad), an account of *governmental* public health responsibilities, an articulation of the

243 James A. Montmarquet, "Epistemic Virtue," *Mind* 96, no. 384 (1987): 482–97.
244 Salmieri, "Aristotle's Non-'Dialectical' Methodology," 321.
245 I have in mind here Montmarquet's view that virtues are sometimes self-directed, and sometimes other-directed. Montmarquet, "Epistemic Virtue."

common values shared by the entire discipline, or a set of values to guide public health policies and action?[246] Sometimes what professionals seek from an ethics of public health are not only a set of normative considerations characteristic of public health, but also some way of using these values to shape allocation schemes, or even develop justificatory conditions for initiating interventions.[247] To summarize points a) through c), Salmieri observes that there are "three fundamental questions we can ask about a method of inquiry: "What are its *starting-points*? What are its *goal(s)*? and What is the *process* by which we progress from the starting-points to the goal(s)."[248] Until those engaged in disputes around the boundary problem become clear about the answers to these questions, they are as likely to speak past each other, as to speak to each others' legitimate concerns.

## 4.5 Professional flourishing

It is noteworthy that much of the debate regarding the boundary problem, on both sides, stems from a professional feeling that getting the answers wrong entails a moral failure on the part of public health professionals. This driving concern indicates a sense of professional dissatisfaction, even uneasiness, with the current state of affairs in public health practice in the

246 Gostin refers to the distinction between the penultimate and ultimate questions as the difference between an ethics of public health and ethics in public health, "Public health, ethics, and human rights," 125–6.

247 In addition, it is worth noting that the results of one inquiry may be that starting points for further inquiry, as noted by Sarah Broadie in Aristotle, "Nicomachean Ethics," 279. Those engaged in discourse on the boundary problem would also do well to follow Aristotle's lead by recognizing that an inquiry that raises more questions is not futile – the articulation of questions themselves may be part of what it means to be a good public health professional if they, too, generate better understanding.

248 Salmieri, "Aristotle's Non-'Dialectical' Methodology."

absence of adequate moral guidance for the profession. I claim that such discomfort illustrates the aptness of a virtue ethics approach. For, it is an advantage of a virtue ethics approach to public health that it captures the ways in which professional life contributes to our assessment of a life as a whole.

Aristotle's notion of a good life indicates that success or flourishing includes a temporal element: "For a single swallow does not make spring, nor does a single day, in the same way, neither does a single day, or a short time, make a man blessed and happy." (*NE* 1.7 1098a17-21) This aspect of *completeness* has its parallel in a professional ideal; a professional career that ends in disgrace is one that is perhaps more tragic precisely because of the good that may have preceded a downfall, and our suspicion that such a career had, until the crucial point, been exemplary. One might also imagine that contemporary public health angst over the indeterminate nature of the profession, and its foundational values, indicates that the profession is lost, perhaps lacking the virtues needed to clarify both individual vision and sustain a coherent community. However, I think that to the contrary, it is *because* public health professionals have deeply personal moral commitment to serving that community that advocates of both broad and narrow approaches are so invested in engaging in, and determined to find greater understanding as a result of, inquiry into the nature of public health. Thus, just public health professionals (on both sides) are frustrated by the current state of affairs in public health precisely because they believe there is more to be done and they feel unable to do it. While gaining clarity on why such insights are justified - and what recommendations for action follow – will help, we ought not to take confusion in public health philosophy and ethics as a sign of the absence of professional virtue. On the contrary, the concern with which professionals have engaged in debate ought to

be interpreted as a signal that virtue is present, and perhaps even accountable for both the changing nature of public health, and desire to preserve what is virtuous in traditional public health practice.[249]

Virtue ethics claims not only that the virtues are instrumental to achieving one's goals, but also constitutive of *eudaimonia,* or human flourishing. The professional equivalent of this implies that professional virtues are both instrumental to attaining professional goals, but also constitutive of professional flourishing – or professional satisfaction, as we might be more likely to call it. This does not mean that the virtues will necessarily grant professionals the capacity to achieve every promotion or recognition of good service desired. Rather, such achievements are as contingent upon the merits of those who do the valuing and promoting. In contrast, professional flourishing is the satisfaction that derives from enacting and completing one's own understanding of a job not just well done, but *excellently* done. Only in such a career can professionals access what MacIntyre calls these internal goods of a practice.[250]

Such goods are independent of the outcome of public health interventions. Reductions in morbidity and mortality achieved at the expense of the virtues will give those with the right sensibilities a sense of profound inadequacy, despite the outcomes. In contrast, when nothing else can be done to protect public vulnerability to harm, virtuous action lends the professionals the inadequate but sweet solace of having done everything they could, even if it could not forestall tragedy. Given the increasing connection between modern choices of vocation and

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249 For a discussion of how virtues are dependent on historical context, see Ludwieg Siep, "Virtues, Values, and Moral Objectivity," in *Virtue, Norms, and Objectivity: Issues in Ancient and Modern Ethics,* ed. Christopher Gill (Oxford: Oxford University Press, 2005), Chapter 4.
250 MacIntyre, "After Virtue," 191.

personal identity, it is not surprising that our professions are one arena that prompts us to ask the ancient question of what *kind* of life we ought to live, one remaining domain of life which calls upon us to reflect on a whole life, if not "from every aspect an all the way down," then from the long and significant segment that now constitutes a modern career.[251]

251 Williams, "Ethics and the Limits of Philosophy," 5.

# CONCLUSION

I mentioned in the introduction that professional ethics are necessarily truncated. One way that philosophers have handled this with respect to other professions is by a drawing bright line between the goals of a profession and the more general goals of a good life. I have conducted my investigations here with an eye toward the impossibility of such compartmentalization. I contend that a virtue approach to public health ethics cannot be isolated in this way from virtue ethics more broadly due to two insufficiencies that result: (1) inadequate guidance for public health practice, and (2) inadequate guidance for public health professionals. I then consider some avenues for further development of a virtue approach to public health ethics.

(1) In Chapter 1 I examined the role of public health professionals in cultivating civic friendship. I have neglected until now to note that Aristotle primarily believed that such alliances would be formed based on shared understandings of the minimal requirements of a just society. I did this in part because such friendships can be motivated by what I have called "civility," or a kind of general amiability or concern for others that can be distinguished from justice. However, that Aristotle conceived of civic friendship as centrally connected to matters of justice is a reflection of his view that moral and political matters both fall under the umbrella of practical action. As such, for Aristotle, the moral is political. A virtue ethics of public health, then, will not be complete without an account of justice as a virtue, but also in terms of a political philosophy. I have made some references to justice throughout the dissertation, but this more comprehensive account requires far more than can be accomplished within the limits of this project. My analysis here suggests that this more complete virtue approach to public

health ethics will see public health professionals as fulfilling two roles. The first is educational, as exhibited by the process of imaginative engagement initiated from the synoptic perspective characteristic of all public leaders. Such engagement goes beyond the professional virtues because it involves such professionals in the process of articulating a societal understanding of the good life. In this way, public health practice will be a generative force for the civic virtues and their place in individual and communal views of the good life. Secondly, while part of what public health professionals do is create and sustain community, they are also implementers of political legislation. Thus, public health professionals will need an account of political philosophy in order to attend to this aspect of their work, which covers both the virtuous and the non-virtuous members of society. The need for an account of justice ought not to come as a surprise to those working in public health ethics given the way in which social justice has come to be a prominent topic of discussion in recent years.[252] The account I have provided here is therefore consistent with the current emphasis public health ethics is placing on developing ethical resources for just public health practice.

(2) A virtue approach to public health ethics is a version of role morality, and as such it exhibits the limitations of all role morality. Virtues and their specifications in public health practice are not the only expressions of virtue, and while one can be professionally virtuous, this is not sufficient for providing individuals who happen to be public health professionals with guidance for how they should act *all things considered.* What one ought to do *qua* professional vs. *qua* person can be a challenging determination for public health professionals to make because they cannot artificially separate their professional expertise from their public (or

252 See note 241.

personal) personas. For example, as public figures, it will be difficult for public health professionals to speak out publicly and distinguish this act as one not performed in a professional capacity. This may be in part what is happening in public health at the moment. Given the injustices public health professionals are increasingly aware of, the boundary problem is in part an expression of struggles to determine what is required of them as professionals, and what is required of them as members of a society responsible for such injustices, in order to respond to such injustice appropriately. One way of thinking about the relationship between public health ethics and ethics *simipliciter* is to assume that role morality is subject to being overruled by more general moral considerations.[253] Thus, a public health professional may conclude that while her professional obligations do not require her to speak out about injustices she has witnessed in a professional capacity, other moral obligations do.

Another way of considering this relationship, however, is to consider whether a particular role is in the midst of being renegotiated. On this view, role morality is an instance of ordinary morality, and the content of the role is constantly negotiated both internally by those who take on a role, but also externally by those whom are served by the role.[254] Again, the boundary problem discussion is explained by this view. In making a professional commitment to society, different professionals may "hear different promises being made," and furthermore

253 Norman E. Bowie, "'Role' as a Moral Concept in Health Care," *The Journal of Medicine and Philosophy* 7, no. 1 (1982): 57–63.
254 Judith Andre, "Role Morality as a Complex Instance of Ordinary Morality," *American Philosophical Quarterly* 28, no. 1 (1991): 77.

the public may have heard a different set of promises as well. On this view, the boundary problem is a discussion about the content of this professional promise.[255]

In conclusion, the view I have presented here provides an initial glimpse of what a virtue approach to public health ethics has to contribute; as I have noted, such discussions have no small bearing on the future of bioethics more broadly. I would like to highlight two features of the arguments presented here that suggest some considerations for further development of a virtue approach to public health ethics.

The first consideration is the need to understand the nature of the relationship between institutions and virtue. Developing such an account will be important to public health ethics, but also a great deal else in professional ethics, suggesting important overlap with organizational ethics. Because public health is a collective and public practice, I believe it more immediately suggests the need to develop accounts of ethics within institutions. Possibilities include acknowledging the limits of the virtues, and exploring their capacity to complement principled approaches, or perhaps an account of the intellectual virtues of organizational deliberative processes. I believe that such discussions will have important bearing on public health ethics pedagogy as well as clinical ethics, where such matters have been sorely neglected.

The arguments laid out here also highlight the interdependent nature of the virtues, and how an understanding of them changes how we can discuss what ought to be done. I have argued that an understanding of courage can contribute to risk discourse, including with the public, which means that such conversations are a form of imaginative engagement that fosters

255 Andre, "Role Morality," p. 77

civic friendship as well as civic courage. In turn, the ability of public health professionals to foster civic friendship is highly dependent on how much they are trusted. Given the disconnect between being trusted and being trustworthy, this means that public health professionals may also be highly invested in cultivating civic trust more generally (i.e., trust in other citizens), insofar as this is possible, especially as the capacity for trust in society may be at an all-time low. The implication of these connections is that if and when a virtue ethics approach to public health practice is combined with casuistry, bioethicists would do well to think in terms of many virtues, rather than assuming that certain public health challenges fall under the domain of a single virtue.

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