

The Steward of the Millian State

Angus Dawson and Marcel Verweij

One important reason why public health ethics is such an exciting area of bioethics is that we are just at the beginning of exploring the relevant conceptual and theoretical issues. There has, of course, been previous work done on these themes, but there are few (if any) well-worked-out ‘theories’ of public health ethics that can either be easily supported or contested. The fairest summary of the present position is to say that we have a number of sketches or suggestions for what such an adequate theoretical position might look like, but there is still plenty of work to do, expanding and refining these ideas. One of the tasks of this journal is to encourage this engagement, and it is very satisfying to see some such work in this issue. We look forward to seeing further developments.

One possible normative framework for public health ethics is offered by the Nuffield Council on Bioethics (NCB) in its recent report *Public Health: Ethical Issues* (2007).

This report is welcome, as an attempt to provide both a systematic approach to public health ethics as well as a discussion of a number of key issues in public health policy (i.e. infectious diseases, obesity, alcohol and tobacco, water fluoridation). One of the things that makes the report of particular interest to anyone looking for a thorough and well-worked-out ‘theory’ of public health ethics, is its discussion of Mill’s liberalism, and its attempt to offer a broader, though still liberal, approach to public health ethics. In bioethics, presentations of John Stuart Mill’s liberalism are often based upon selective reading of *On Liberty* (1859), notably the lines in which the *harm principle* is introduced. The harm principle holds that the only legitimate basis for interfering with a competent individual’s autonomous choices is where such a decision might harm other people. Actions directing at improving the lives of others are likely, on this view, to be held to be unethical (unless they arise after prior informed consent) because they are ‘paternalistic’. Of course there are many issues here that require discussion. The harm principle is not as simple and obvious as it may seem. The notion of ‘harm’ at work here is more complex than is often supposed (Dawson, 2007; Verweij, forthcoming), coercion is not an unproblematic concept (Wertheimer, 1987) and there is a tendency to be rather hasty in just

assuming that paternalism is a bad thing (Garrard and Dawson, 2005).

The NCB, however, avoids this simplistic reading of Mill, and briefly refers to a section of *On Liberty* that makes it clear that Mill was not solely preoccupied with this very narrow conception of harm. It is often forgotten that according to Mill, it is possible to justify the compulsion of individuals to ensure that each ‘bear[s] his fair share in the common defence, or in any other joint work necessary to the interest of the society of which he enjoys the protection’ (1859). This provides an opening for focusing on the provision and maintenance of at least some public goods, and the NCB report proceeds in that direction. The NCB presents what they call, a ‘stewardship model’ for public health ethics, which they claim expands the liberal framework in such a way that it includes obligations to reduce health inequalities, and supports policies that aim at securing goods that are essentially collective.

This attempt to develop a broader normative basis for public health ethics is laudable. However, in what follows we address a series of questions that arise in relation to the development of these ideas. What is ‘stewardship’? Can it be clearly distinguished from the strict (and simplistic) ‘Millian’ paradigm that it aims to avoid? Why is the report so concerned about the issue of paternalism? Is it possible to both oppose paternalism and have a robust and adequate public health ethics? In the end, we argue that the NCB is too timid and conservative in its approach. Public health ethics awaits further theoretical development, and it is not clear that the model (or even the metaphor) of stewardship provides enough substantive content to ground a public health ethics.

So, what is ‘stewardship’? It is hard to answer this question, as little detail is given about what exactly constitutes this view and how it might be justified. The report concentrates mainly on setting forth a set of policy goals (2007: 26) that it holds are justified by a ‘stewardship’ approach, rather than providing a clear account of what this view is or how it might be justified. Although the specified goals are highly normative (and we are told that public health programmes ‘should’ be concerned with them (2007: 26)) there is little attempt to support these

goals and say how they relate to a 'stewardship model', rather than any other alternative approach. There is no real attempt to outline and defend a particular theoretical account of public health ethics. Two references are given in the report to previous articulations of a stewardship view, but one is just a passing mention in a WHO report (2000) and the other, although a worthy attempt to fill out the metaphor, is hardly philosophically robust (Jochelson, 2005). Given the claims made on behalf of the view, and the lack of a literature providing a satisfactory basis for it, it seems odd that so little space is devoted to exploring what is meant by 'stewardship'.

A key part of the development of their modified liberal view is the attempt to distinguish the stewardship model from what they call 'paternalism'. They claim that the 'difference between paternalism and our stewardship model is that the latter is less likely to support highly coercive universal measures' (2007: 26). There are a number of problems with this. First, paternalism is a concept, not a normative position. Usually, and certainly in Gerald Dworkin's (2005) definition, the term paternalism is used to describe specific types of action, performed for specific reasons. It is not a model, theory or view in any sense parallel to the stewardship model. Second, whilst, paternalistic actions may involve coercion, it seems a category mistake to claim that paternalism *supports* coercion, and therefore very odd to claim that it implies acceptance of 'highly coercive' measures. Paternalism is a particular feature of acts motivated by beneficence: in essence it is wanting to do good for another person. The proposed intervention may be coercive (or it may not). There is certainly no reason why such acts are by definition 'highly coercive'. Third, even if it makes sense to talk of public health interventions as being paternalistic (and this may be doubted (Nys, 2008)), there is certainly no obvious reason why such proposals cannot also receive democratic oversight along exactly the same lines as those proposed for the supposedly morally superior stewardship model (2007: 26).

The accusation of paternalism is aimed at cases where individuals are either not consulted or are 'coerced' (presumably this is used in a very wide sense to cover the continuum of cases of force, pressure, encouragement and education) into particular types of behaviour by public health officials. However, it is important to see that such 'coercive' public health policies are not arbitrary, but are often motivated by the need to create or preserve important common goods or vital features of community life. Indeed, the NCB report itself is committed to the importance of just such community concerns. So are such actions paternalistic (but justified)? If so, this seems incompatible with their support for Dworkin's (2005)

definition of paternalism. Or if they are legitimate (perhaps because of the intention behind them) then we are owed an account of why such acts do not count as paternalism in the relevant sense. Even if we assume we ought to frame our discussions of public health policies in terms of the dyad of individual and community (and it might be argued this is unhelpful), it is surely appropriate to value community to the extent that individuals may be 'coerced' on at least some occasions (and, as we have already made clear, Mill certainly thought so). Or, alternatively, perhaps the NCB actually think that autonomy and liberty take priority over other values after all? Stewardship is held to be 'a revised liberal framework' (2007: 25), but it looks as though there is a real danger that it will just collapse into simplistic 'Millian' liberalism after all. Some further observations support this concern.

First, if we look at the proposed answers to the case studies that are discussed in the report, one thing that strikes the reader is that the answers provided are very conventional and differ little from those that the 'Millian' would defend. For example, in relation to tackling obesity, any intervention that might infringe the liberty of adults is just ruled out as unjustified. The ethical solution is held to be one based on information provision about the need to change our diets and exercise more. The fact that such an approach has failed to halt or even slow down the rise of obesity in the developed world is ignored. Second, much of the discussion in the report focuses on when (if ever) restrictions on individual liberty are justified. This is apparent in the outline of the so-called 'intervention ladder' (2007: 41–43): a view that holds that we ought to frame our policy choices to ensure that they minimise the restriction to individual freedom. Unless, like the simplistic 'Millian', we are already committed to the idea that freedom is the key value, it is hard to see why we should accept this way of framing the issues. For example, an alternative approach could frame policy options in terms of a plural set of values reflecting the importance of improving the public's health. Such a view might help to explain the conflicts *and* connections between public health, welfare and autonomy. Third, the general conclusions of the report suggest that we indeed ought to understand the stewardship account as primarily supporting the values of freedom and autonomy. At this point, the NCB identifies three principles that they claim are of special importance to the ethical evaluation of public health interventions (2007: 144): (i) the harm principle, (ii) caring for the vulnerable, and (iii) autonomy and consent. This is a remarkable mixture of very different types of principles. More importantly, not only the third principle, but all three give a central

place to autonomy. The harm principle specifies which constraints on freedom can be legitimate in a way that is fully consistent with the supreme value of autonomy. And the obligation to protect the vulnerable also emphasises autonomy, in the sense that ‘vulnerable persons’ are the ones who lack capacity to make informed judgments for themselves or otherwise face circumstances that contribute to a lack of autonomy. In an ethical framework for public health, one would expect a somewhat larger role for concerns about the common good and the welfare of individuals and society.

Ironically, the basis for just such a view is present in *On Liberty*. Whilst the NCB seem to recognise this early in their report, they quickly forget it and it plays no substantive role in the sketch of stewardship that they provide. We agree with the NCB that we need more than the harm principle, especially if we are concerned (as we ought to be) about health inequalities and collective goods. However, in developing a robust public health ethics, we need something more radical and theoretically grounded than the rather muddled metaphor of the steward.

Some of the papers in this issue of *Public Health Ethics* could be used to provide the basis for a different approach. In particular, the paper by Baylis *et al.* provides the beginnings of what they term a ‘relational’ perspective upon public health ethics. This grows out of a particular feminist tradition that calls attention to existing power relationships in society and related injustice, as well as the need for a socially grounded view of ethical issues. They argue that this approach will provide a basis for a more substantive justification for ideas, such as the common good, that they hold are central to the idea of public health practice (and hence public health ethics). One of the examples that they use to ground their argument is a discussion of ethical issues in relation to pandemics. One aspect of this is taken up in the second paper by Parmet. She explores the issue of quarantine from a legal perspective, demonstrating the influence of the ‘Millian’ paradigm in the area of law, but suggesting that the justification of such laws are a function of the broader social sphere. Lee *et al.* continue the discussion of pandemics, but are interested in the issue of access to information and the impact this feature of pandemic planning may have upon equity in general. Edmund *et al.* are also interested in ethical issues relating to infection control, but their focus is on hospital transmission and our responsibilities to combat such infections. Buchanan *et al.* explore an

important theoretical and practical issue in research ethics, namely how communities are to be engaged in medical research. They argue that thinking about the problems in present practice and the requirements for reform require a radical re-alignment of research ethics towards a population perspective. Farrelly takes up the importance of theoretical perspectives when it comes to key policy issues such as, in this case, how to think about the place of human ageing research within a set of priorities for public health. Farrelly explores utilitarian and contractualist approaches to this issue and suggests that we ought to think of ageing as an, or even the most, important public health issue.

Of course, none of these papers will be the last word on any of these questions. We would like to encourage our readers to engage with these issues both in further volumes of this journal and elsewhere.

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