The Transcendence of Virtue Ethics Over Utilitarianism and Deontology in Bioethics and Medicine: Lessons from South Africa.

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Abstract

The field of biomedical ethics navigates complex moral landscapes, applying ethical principles and frameworks to inform decision-making in healthcare and research settings. At the forefront of this field are two influential ethical theories: utilitarianism and deontology. The interplay between these two theories significantly shapes ethical decision-making. However, reconciling their principles can be challenging, particularly when they yield conflicting courses of action. Resolving ethical dilemmas in bioethics and medical contexts demands thoughtful analysis, balancing competing values and principles to yield decisions that respect the autonomy and dignity of patients while promoting their well-being and safety. This paper evaluates three approaches – utilitarian, deontological and virtue ethics – using examples from South Africa. However, it argues in favour of virtue ethics for the following reasons: in contrast to utilitarian and deontological approaches, which focus on what *I ought to do* in various circumstances, emphasising actions and looking particularly to their consequences, the central questions of virtue ethics are: *what is the good life* for me as a human being; *what kind of person* should I want to become? Because moral actions entail more than just calculating outcomes, virtue ethics also transcends the focus on consequences.

Keywords: utilitarian, deontology, consequences, virtue ethics, autonomy, dignity, wellbeing.

Introduction

The field of biomedical ethics navigates complex moral landscapes, applying ethical principles and frameworks to inform decision-making in healthcare and research settings. At the forefront of this field are two influential ethical theories: utilitarianism and deontology. According to utilitarian theory, as developed by John Stuart Mill [1879] and Jeremy Bentham [1907], actions are morally justified by their capacity to maximise overall well-being and promote the greater good. This consequentialist approach prioritises actions that maximise well-being, measured in terms of pleasure, happiness, welfare, and preference satisfaction [Beauchamp and Childress 1994:361]. In contrast, deontological ethics, as formulated by Immanuel Kant in his *Groundwork for the Metaphysics of Morals*, emphasises the importance of adhering to universal moral duties and principles, irrespective of their consequences [Kant 2002]. Rooted in reason [Kant 2015] rather than intuition, deontology is grounded in respect for autonomy and the inherent dignity of individuals [Beauchamp and Childress 1994:361]. It also focuses on the 'action or the motive' [Stewart 2009:12].

The interplay between these two theories significantly shapes ethical decision-making in clinical and research settings. However, reconciling these principles can be challenging, particularly when they yield conflicting courses of action. Resolving ethical dilemmas in biomedical contexts and traditional professions like medicine demands thoughtful analysis, balancing competing values and principles to yield decisions that respect the autonomy and dignity of patients while promoting their well-being and safety. However, relying

on the two approaches, one sees a difficulty in which a moral agent or acting person is stuck midway, not knowing which of the rival rules is the right one.

This paper will assess the strengths and limitations of both utilitarian and deontological approaches and argue in favour of virtue ethics. Whilst showing how utilitarianism and deontology approaches offer a framework for moral decision–making, this paper will argue and demonstrate the transcendence of virtue ethics in bioethical research and traditional professions like medicine with lessons from a South African context. The paper will further show that virtue ethics is arguably the most holistic approach, as it gets to the source of behaviour by focusing on the 'agent, that is, the person doing the act' [Stewart 2009:12].

1. Utility and Deontology Approaches: Strengths and Limitations

This part provides a brief description of the contents of utilitarianism and deontology. We will then examine the strengths of each approach to demonstrate that they all offer a framework for moral decision-making. However, it will still be determined that each approach presents feasible limitations.

1.1 Utilitarian Approach

According to utilitarian theory, as developed by John Stuart Mill [1879] and Jeremy Bentham [1907], actions are morally justified by their capacity to maximise overall well-being and promote the greater good. Both Mill and Bentham accept that the morality of an action should be assessed based on the utility or how well it serves to advance the general welfare of all or the greatest happiness. Although utilitarianism has always had trouble with its own logic given its diverse understanding, it may perhaps make out the best case for itself by pointing out its own strengths but also exhibiting shortcomings.

1.1.1 Strengths

However, utilitarianism has many strengths that include the acceptance of a significant role in formulating public health policy. According to Chukwuneke and Ezenwugo [2022:23], utilitarianism offers many examples from everyday life. Particularly calculating what should be done by maximising resources and promoting equality in medical care.

1.1.1.1 Maximises Overall Health and Well-being

The utilitarian approach is effective in public health because it prioritises actions that bring the greatest happiness or benefit to the largest number of people. This approach aligns with the goals of public health like disease prevention, health education and large-scale treatment programs. All of which aim to maximise overall happiness or well-being. By focusing on the greater good, utilitarians believe that happiness is the goal, and that actions should be guided by what benefits the most people [Rachels and Rachels 2010:119].

This approach is evident in South Africa's response to HIV, where utilitarian thinking has shaped public health strategies. The South African National Strategic Plan 2007-2011 report has shown, for example, that the 2010 HIV testing and counselling campaign, which aimed to test 15 million people within a year, was a large-scale effort that prioritised the greatest benefit for the greatest number. By doing so, it led to earlier diagnoses, improved access to care, and reduced suffering for individuals, while decreasing community transmission of the disease [South African Government National Strategic Plan 2007-2011]. Other reports have also demonstrated that the approach supports practical public health planning and justifies investments in prevention measures like condom distribution, pre-exposure prophylaxis [PrEP] programs, school-based HIV education and voluntary male circumcision [Statistics South Africa 2025:8; Leigh F Johnson *et al.,* 2022:115-123].

When applied equitably, these efforts have significantly improved population health outcomes, demonstrating the effectiveness of utilitarian principles in public health policy formulation and implementation.

1.1.1.2 Promotes Equality

The utilitarian approach is based on the idea that everyone's interest should be considered equally, with not one person's happiness or wellbeing given more importance than another's. This means that decision-makers should aim to treat all individuals fairly and without bias. Focusing on the good for the greatest numbers, utility promotes decisions that benefit the entire population without favouring specific individuals or groups. Matti Häyry's [2021:341] work *Just Better Utilitarianism* encapsulates this affirmation succinctly in the following way: 'Utilitarianism could provide a basis for moral and political decisions and choices in bioethics and elsewhere [professional traditions like medicine].' Häyry [2021:351] points out in particular that decisions made in a variety of fields, including medicine and healthcare, are public. To ensure the survival and satisfaction of the health of one person at the expense of the many, the utility approach, for instance, would question the necessity of foregoing the distribution or allocation of medical and healthcare resources. Häyry argues that in societies with public services 'we do not have to go further than to the cost of some drugs for rare diseases, which can drain local medical and healthcare resources, causing major inconveniences to many.'

As such, in public health, utilitarianism can help make fair healthcare decisions. It considers everyone's needs equally so healthcare policies benefit everyone, not just a few. For example, when resources like vaccines or hospital beds are limited, utilitarianism prioritises strategies that help the most people, like vaccinating vulnerable groups or treating critical patients. This approach benefits society while promoting fair allocation of resources.

1.1.2 Limitations

1.1.2.1 Ignores Individual Autonomy and Dignity

Utilitarianism judges the morality of an action by how well it serves the common good and favours the extreme pleasure of pursuing the greatest happiness of the greatest number. This can come at a cost. Sometimes individual freedom and dignity may be sacrificed for the greater good. This raises concerns about the potential for the majority to override individual rights and compromise personal dignity. Logically, making the noblest acts not good in themselves but only useful means. In a way, when individuals are treated as mere means to achieve a large goal, their autonomy and dignity may be undermined [Beauchamp and Childress 1994].

For example, during the COVID-19 pandemic, South Africa implemented one of the strictest lockdowns in the world starting in March 2020 [South African News 2020]. Movement was highly restricted, businesses were closed, and social gatherings were banned with an aim to reduce transmission and prevent hospitals from being overwhelmed. People entering the country or suspected of having COVID-19 were also forced into state quarantine facilities, and individuals had no choice over where they were quarantined or how long they stayed, sometimes in poor conditions. Citizens were confined to their homes, even for non-threatening activities like outdoor exercise or visiting family.

These measures reflect a utilitarian approach to public health but also raise ethical concerns, particularly about individual rights and freedoms such as the right to freedom of movement, assembly, and economic activity, individual autonomy, and dignity, as individuals had limited choice over their placement and duration of stay. The lockdown measures also disproportionately affected vulnerable populations, including refugees, asylum seekers, and those living in poverty, who may not have had access to adequate healthcare, sanitation, or economic support.

1.1.2.2 May not Prioritise the Vulnerable or Minority Groups

Beauchamp and Childress [1994:360] intone that utilitarianism can result in the tyranny of the majority, where the interests of the majority are prioritised over the vulnerable or those of minority groups. This means that utilitarianism can lead to the oppression of minority groups, where the needs and desires of the majority

override those of smaller groups, potentially leading to unfair treatment and disregard for their rights. They go further to expose the limitation of utilitarian ethics. They assert that it began with a focus on 'using time and resources efficiently in healthcare, without initially considering the broader public good.' However, 'it lacks mechanisms to address or prevent unfair social distribution' [Beauchamp and Childress:1994:360]. In effect, utilitarianism seems to permit the interests of the majority to override the rights of the minorities and, therefore, cannot adequately disavow unjust social distributions [Chukwuneke and Ezenwugo 2022:23].

For example, when the South African government implemented lockdowns during the COVID-19 pandemic to reduce transmission and protect public health, these measures had significant economic impacts. As can be noticed in the *Equality Research Brief* by the South African Human Rights Commission [2021:13], the adverse effects of lockdowns affected small businesses and vulnerable populations particularly. The report states that, 'in the context of economic hardship brought about by the pandemic and lockdown restrictions, accessing credit became crucial for the survival of minority-owned businesses.' The research also found that minority group entrepreneurs or small business owners were forced to close their businesses or significantly reduce operations, low-income workers were retrenched or faced reduced hours, and vulnerable populations struggled to access essential services or support like medical care [Human Rights Commission 2021:13]. From a utilitarian perspective, the measures of lockdowns might be justified if they reduce overall harm and save lives. This approach might prioritise the health of the majority over the economic well-being of marginalised groups.

The above scenario illustrates the trade-off between individual and collective interests and the complexity of decision-making in crises. The South African government faced difficult choices between protecting public health and mitigating economic harm, highlighting the need for nuanced and context-dependent decision-making. It also highlights the need to consider how benefits and burdens are distributed among different groups, ensuring that marginalised populations are not unfairly disadvantaged.

1.1.2.3 Can be used to Justify Harmful Actions

While utilitarianism aims to promote overall well-being, its potential to justify harmful actions raises significant ethical concerns. Utilitarians argue that rules allowing actions like euthanasia or withholding treatment should only be supported if they lead to the most beneficial overall outcomes. For example, the *trolley problem*, a classic thought experiment, illustrates the dilemma of diverting a runaway trolley from killing the "many" people onto a track where it will kill one person. For Beauchamp and Childress [1994], utilitarianism may justify sacrificing the one person to save the "many" people.

During Covid-19 epidemic, South Africa, like many other countries, faced significant healthcare challenges, including a shortage of ICU beds. This shortage became even more critical, forcing healthcare professionals to make difficult decisions about who receives care. The shortage of ICU beds, ventilators, and other essential medical equipment limited the ability to provide adequate care. Consequently, healthcare professionals had to make triage decisions, prioritising patients based on their 'likelihood of survival with acceptable quality of life and the most quality adjusted life year' [Morrow *et al*., 2020:1177]. Given these circumstances, Beauchamp and Childress [1994] argue that utilitarians may justify their actions of sacrificing the 'one person to save the many,' where the main criteria for such action would relate to 'function and comorbid conditions' [Morrow *et al*., 2020:1177].

While utilitarianism provides a clear principle to maximise overall happiness or minimise suffering often proves extremely difficult to apply in real-world situations due to difficulty in predicting outcomes. This means it would be hard to predict the outcomes of different actions and determine which one will lead to the greatest happiness. Based on this, Beauchamp and Childress [1994] argue that the policy or decision makers often lack complete information about the needs, preferences and circumstances of all individuals affected. They argue that utilitarianism is premised on two difficult conditions: Firstly, making value judgements about what constitutes happiness or well-being, which can be subjective and contentious. Secondly, requires sacrificing the individuals' rights or dignity for the greater good, which can be morally problematic.

1.2 Deontological Approach

Unlike the situation with utilitarianism, which starts with pain and pleasure and considers the consequences in deciding how to act morally, the point of departure for deontology – Kant's theory- is rather what your moral duty is [Kant 2002]. That is, to act morally, 'it is the rules that tell you what motive to act from and what you ought to do' [Stewart 2009:35].

1.2.1 Strengths

1.2.1.1 Respect for Autonomy and Dignity

Noel Stewart [2009:45] begins by noting that Kant's deontological approach has made it enduringly popular due to its benefits. 'It explains and justifies many of our ordinary moral thought processes, such as our tendency, when confronted by wrongdoing, to challenge the culprit by asking, what if everybody did that?' The universality test does a great job of capturing this typical response. As Stewart [2009:45] avows, Kant's assertion on the goodwill explains our intuitive belief that, when it comes to evaluating an action's moral worth, 'it is the thought that counts.' Furthermore, deontology 'is strong on respect for autonomy, human rights and human dignity' [Stewart 2009:45]. Respect for autonomy means recognising the individual's right to make decisions about their own lives and healthcare. While respect for dignity means treating individuals with dignity and worth, regardless of circumstances [Stewart 2009:45].

Unlike Utilitarianism, deontology prioritises respect for individual autonomy and dignity, safeguarding patients' rights and interests. It opposes, point-blank, sacrificing the rights of an individual in the name of promoting societal happiness. Its unwavering assertiveness to justice resonates deeply within everyone because justice is not negotiable and rules must not be bent to get a happy result [Stewart 2009:45]. Deontological ethics shines through in its insistence on the importance of informed decision making and consent to treat individuals as ends in themselves, rather than mere means to an end, promoting unconditional respect regardless of outcomes [Rachels and Rachels 2010:146].

A clear example is the case of informed consent in cancer treatment. Bansanta Kumar Nayak [2024:94] argues in the article *Deontological Approach to Resolve Problem in Medical Ethics* that in order for healthcare practitioners to make moral decisions, they need to adhere to certain obligations and rules. If healthcare practitioners are confronted with a particular case, where, for instance, a patient is diagnosed with cancer, the healthcare provider [oncologist] should consider discussing the available medical options with the patient to direct their decision-making process to necessitate a thorough examination of the principles of autonomy. The doctor should provide details about surgery, chemotherapy, radiation and potential side effects. Medical practitioners discuss potential outcomes, success rates and potential complications with the patient. The patient decides on a treatment plan that aligns with one's values and preferences, exercising autonomy. A medical practitioner respects patients' autonomy by supporting the patients' chosen plan. This entails a 'strict commitment to prioritise the significance of upholding individuals' autonomy and their entitlement to make decisions regarding their own health … and mandates healthcare practitioners to uphold patients' confidentiality and refrain from deliberately causing injury' [Nayak 2024:94-97].

Informed decision-making and consent process exemplifies respect for autonomy and dignity. Informed consent empowers individuals to make informed decisions about their health and access to treatment, which can significantly improve and protect the health outcomes and quality of life of most vulnerable populations.

1.2.1.2 Protection of Vulnerable Populations

Deontological ethics emphasises the importance of respecting human dignity, particularly for vulnerable populations, and prioritises the protection of vulnerable populations from harm, exploitation, and abuse. This means every person has inherent dignity and moral worth, regardless of their status, abilities, or situation. This includes vulnerable groups like children, the elderly, people with disabilities, or marginalised communities. It also argues that we have a moral duty to protect vulnerable populations, ensuring their safety and well-being, and these moral duties are universal and non-negotiable, so they apply equally to

everyone [Beauchamp and Childress 1994].

This implies that we are obligated to treat vulnerable individuals with the same level of respect, honesty, and fairness as anyone else by ensuring assent is obtained from parents or guardians before medical treatment for young children, that elderly people's autonomy and dignity are respected in care facilities and accessible healthcare services and accommodations for people with disabilities. By prioritising respect, dignity, and accessibility in care, healthcare providers can promote the well-being and quality of life of vulnerable populations.

If we take an example of a young child in South Africa who requires medical treatment for a serious illness. The child's parents are concerned about the treatment options and potential side effects. Healthcare providers ensure the parents understand the treatment options. The healthcare provider obtains assent from parents or guardians before medical treatment of a child. The healthcare provider prioritises the child's needs and comfort. This scenario demonstrates the importance of respecting the dignity and autonomy of children and their families in healthcare decision-making.

1.2.2 Limitations

Though the deontological approach seems attractive and good in that it acts as an antidote to hedonism with its serious and strict claims of duty, it exhibits certain difficulties, especially concerning three points: [1] Overemphasising law underemphasises relationships [2] the lack of regard for consequences, and [3] the limited consideration for culture and social context.

1.2.2.1 Problem of Overemphasising Law Over Relationships

Kant's moral theory focuses on obligations derived from universal moral principles and agreements and duties based on rational consent, and may not be the best approach for understanding moral relationships, particularly in personal and intimate contexts. This has been criticised for overemphasising rules and obligations while failing to capture the nuances and complexities of personal relationships. It has also been criticised for neglecting the importance of emotions, empathy, and care in relationships [Beauchamp & Childress 1994].

An example can be drawn from a scenario where a doctor has a close family member who is hospitalised in the same hospital where he works. According to Kant's moral theory, the doctor might prioritise their professional obligations and treat their family member with strict adherence to medical protocols. However, this approach might overlook the nuances of their personal relationship and the emotional needs of their family member. This example illustrates how deontological theory might not fully capture the complexities of personal relationships in healthcare, where emotional connections and individualised care can be essential.

1.2.2.2 Lack of Regard for Consequences

Beauchamp and Childress [1994] argue that deontology's focus on moral rules and principles can lead to a lack of consideration for the consequences of actions, which can result in harm or unintended consequences. According to Beauchamp and Childress, deontology judges actions based on whether they follow moral rules or duties, not on what happens as a result. This means an action can be considered morally "right" even if it leads to harmful or tragic consequences. In practice, consequences often matter deeply, especially in fields like medicine, law, or public policy. Ignoring outcomes can lead to rigid decisions that cause more harm than good, even when intentions are pure.

Austin Fagothey [1976:129] contends that it is unnatural and inhuman to base all morality on the motivation of duty. For him, Kant never claims that an action performed out of duty is immoral; rather, he merely states it is nonmoral. He also does not assert that an action must be performed out of pure duty to be moral. Summarising Kant's ideas, Fagothey notes 'unless the motive of duty is present, it cannot be moral, and if it is done from both duty and inclination, it is the motive of duty that gives it its morality.' Even this remark, according to Fagothey [1976:129], overplays the role of duty. Does the mother's commitment stem from her sense of duty or her love for her child? According to Fagothey, 'a sense of duty will be present in such a case, but love is always esteemed as a higher motive than mere duty and gives the act a greater mo-

ral worth. We fall back on duty only when other motives fail. Duty is rather the last bulwark against wrong acting than the highest motive for right acting.'

How may heroic acts like [1] telling the truth to following public health narrative can be explained by the deontological approach? David Misselbrook [medical doctor] [2013:211] explains, 'as the patient starts to drift off under anaesthetic to repair his critically ruptured aneurysm, he asks me, "will I be ok, doc?" Or the relative asks me, "did he suffer that much at the end?" Must I always tell nothing but the truth?' Misselbrook sees deontology as useless at triage. It cannot guarantee him which duties to prioritise over others, as all his duties are absolute. Or [2] giving one's life for one's friend. An example can be drawn from Wendy Lipworthy's article *Beyond Duty–Medical Heroes and the Covid-19 Pandemic*. Lipworthy [2020:723-727] explains that as soon as Covid-19 emerged, a narrative in the media appeared that stated, 'healthcare workers are marching to the "frontline" in the "war" against the virus and, in doing so, putting themselves at considerable risk' for the sake of saving other people's lives. These heroic healthcare workers everywhere in the world are now the subject of coordinated public applause. These acts are always thought to be the noblest and best precisely because they go beyond the call of duty, as in Lipworthy's assertion.

Deontology is then faced with this dilemma: either it must deny that heroic acts are moral, thus putting the best of human acts outside the pale of moral goodness; or it must make heroic acts a duty, thus putting a burden on human nature that it cannot bear and robbing these acts of the very quality that makes them heroic. These scenarios highlight the complexities of applying deontological principles, where adherence to moral rules or law can have significant consequences.

1.2.2.3 Limited Consideration for Culture and Social Context

Deontology's moral rules and principles can be limited in their consideration for cultural and social context, which can lead to difficulties in applying them in diverse settings. Deontological ethics emphasises universal moral laws that apply to all people, always, regardless of context. This, according to Chukwuneke and Ezenwugo [2022:21], can make it insensitive to cultural differences, traditions, or values that shape people's moral views in diverse societies.

In real life, people's decisions are often shaped by social roles, relationships, economic conditions, and historical context. Deontology's emphasis on abstract duties may overlook the impact of these lived experiences, especially for marginalised or oppressed groups. Diverse cultures may value different virtues or duties such as loyalty, honour, or community welfare, which might not align neatly with rigid deontological rules. Therefore, the lack of cultural flexibility can make deontology less practical or inclusive in global or multicultural contexts.

South Africa's emphasis on confidentiality in HIV testing may conflict with cultural practices that prioritise disclosure to family or community members. In some cultures, family or community members may be involved in healthcare decisions, including disclosure of HIV status or may prioritise collective well-being over individual autonomy, which may lead to disclosure of HIV status to family or community members. In this case, healthcare providers may need to balance individual rights to confidentiality with cultural practices that prioritise disclosure. Therefore, healthcare providers should strive to provide culturally sensitive care that respects individual rights while acknowledging cultural differences [Beachamp and Childress 1994].

2. Evaluating Virtue Ethics Against Utility and Deontology

2.1 Virtue Ethics in Theory

One approach to transcending the opposition between utilitarianism and deontology is to adopt a more nuanced and context-dependent approach to bioethics and medicine to achieve excellent ends. The word "excellence", which is translated as "virtue," is defined by Aristotle [2000:1106a] as 'the state of character or disposition… that brings both that of which it is the virtue into a good condition and causes the work be-

longing to that thing to be done well.' Aristotle [2000:1107a] further clarifies that 'virtue is a characteristic marked by choice, residing in the mean relative to us, a characteristic defined by reason and as the prudent person would define it.' In simpler terms, Thomas Aquinas [*Summa Theologiae*, I-II, q. 59, art 1] condenses the definition to: 'Virtue is a habit of choosing the mean appointed by reason as a prudent man would appoint it' to discern his actions between the extremes of excess and deficiency in action. For Aristotle, the mean [as already noted above] is not absolute but 'relative to us,' for what is the right amount for one would be too much or too little for another. A generous gift from a poor man would be a stingy one from a rich man. But how then do we attain the good?

The standard by which the mean of the moral virtues is determined is the intellectual virtue of prudence. Aristotle [2000:1107a] contends that in order to attain good actions, one should be aware that virtues do not naturally proceed from human nature but are built on human nature through training. In consonance with Aristotle's perspective, Koali *et al*. [2024:19] add:

> *human character is developed through repeated acts that transmute into habits that permanently cause a moral agent to act persistently; it is logical to infer that character is a product of voluntary repeated human acts. Those who frequently act or say unjust things often develop unjust character.*

In this instance, an unjust character is not determined, but people deliberately choose to develop such unacceptable characters. Mostly because they believe that their unjust methods are justified by the outcomes. Koali *et al.* [2024:79] demonstrate that 'good judgement emanates from good character… being a good person is not about seeking to follow formal rules but an exhibition of moral character traits.' But what traits of character should individuals be encouraged to possess?

In their book *The Elements of Moral Philosophy,* James Rachels and Stuart Rachels [2010:160-164] provide a partial list of traits*,* including benevolence, conscientiousness, prudence, loyalty to friends and family, justice, courage, and so forth. They argue that while it is one thing to say that we should be benevolent in general, it is quite another to specify what these character traits entail. Nevertheless, they conclude that each of them has unique characteristics and presents unique issues. For example, 'courage is a mean between the extremes of cowardice and foolhardiness; generosity, which is the willingness to expend one's resources to help others, is the mean between stinginess and extravagance…' However, this begs the question of why people should possess virtues. Thomas Aquinas responds as follows:

> *... for the need of putting the order of reason into the passions due to their thwarting reason; and this occurs in two ways. First, when the passions incite to something against reason, and then they need a curb, which we thus call temperance. Second, when the passions withdraw us from following the dictate of reason, for instance, through fear of danger or toil, and then man needs to be strengthened for that which reason dictates, lest he turn back, and to this end there is fortitude [Summa Theologiae, I-II, q. 61, art 2].*

In addition, Rachels and Rachels [2010:165-166] spell out that virtues are important in their own respect. Courage is good for coping with danger; generosity is desirable as there are always people needing help; honesty and not lying are needed to safeguard relations, and loyalty is needed for dependence.

In summary, it may be true that different communities view virtues differently and count certain behaviours as satisfying them. One could argue that the value of the character trait varies from person to person and from society to society. However, it is incorrect to claim that societal norms dictate whether a certain character trait of a person is a virtue. Virtues are required not by custom but by facts about our shared human existence.

2.2 Arguments Against Virtue Ethics

Virtues, according to critics, are a subject better suited for novelists than ethicists. For instance, Bonnie Steinbock [2013:36] contends that there is no way to organise and categorise the various, unspecified, and potentially contradicting virtues. Beyond claims that virtues lack independent action-guiding content, their limited specificity raises concerns about their ability to influence actions. In the same line, Justin Oakley

[1994:94] claims that, 'a virtue ethics criterion of rightness is less precisely specifiable and less easily applicable' than certain other approaches. According to Robert Louden [1984:229],

> *we would anticipate 'a very limited amount of advice on moral dilemmas… from the virtue-oriented approach due to the intrinsic nature of virtue. Naturally, we ought to do what the virtuous person would do, yet it is not always easy to fathom what the hypothetical moral exemplar would do if he were in our position.*

Another critique levelled against virtue ethics is that good or virtuous people can act wrongly and do bad things [Oakley 1998]. According to Steinbock [2013:36], 'neither a settled motivational structure nor guidance from the virtues themselves, including prudence, may be sufficient to preclude wrong actions.' Steinbock [2013:36] continues, 'indeed even if an agent's motivation is virtuous, certain dominant virtues may lead him or her to act wrongly. For example, a caregiver's virtue of benevolence may lead her to find active euthanasia acceptable for a particular patient, even though that patient is not able to speak completely for himself.'

2.3 Applicability of Virtue Ethics in Bioethics and Medicine

Questions are raised concerning whether virtue ethics is sufficiently comprehensive and a viable substitute approach in bioethics and in professional traditions like medicine. Is it possible that virtue ethics can guide actions given their limited specificability?

Firstly, proponents of virtue ethics would characterise it as 'an integrated whole and unity' [Steinbock 2013:37]. This suggests that virtue ethics may include elements from both utilitarianism and deontology. By integrating consequentialist aspects from utilitarianism, it recognises the importance of promoting overall well-being and happiness. Meanwhile, incorporating deontological principles emphasises the necessity of upholding moral rules and principles, such as autonomy and non-maleficence [Rachels and Rachels 2010:181]. Virtue ethics can prioritise promoting the common good, recognising the interconnectedness of individuals and communities. Virtues can also help balance individual interests with collective interests, promoting a more equitable and just society.

Unlike utilitarianism and deontology approaches, whose central question is what "I ought to do" in various circumstances, focusing on actions and looking particularly at consequences of actions, the central questions of virtue ethics are: 'What is the good life for me as a human being… what kind of person should I want to become… and how do I achieve both of these goals?' [Stewart 2009:57]. Virtues posited as 'dispositions' [Aristotle 2000:1105b–1106b] are important because they focus on cultivating positive character traits like compassion and fairness. They enable agents to adhere to moral principles instead of just following rules or considering the outcome of actions. Such that, 'whatever deeds arise in accord with the virtues are not done justly or moderately if they are merely in a certain state, but only if one who does those deeds is in a certain state as well' [Aristotle 2000: 1105a–1105b]. William Frankena [1973:36], therefore, concludes that 'principles without virtues are impotent.'

Virtues also transcend the focus on consequences, considering that moral decisions involve more than just calculating outcomes. According to Edmund Pellegrino [1995:266], virtue ethics can integrate care ethics to provide a more comprehensive moral framework. He asserts that 'professional ethics offers the possibility of some agreement on a telos–that is, an end and a good, which, in the case of the relationship between the healthcare professional and the patient, would be the good of the patient.' From the clinical relationship with its telos of healing, Pellegrino develops a list of virtues: fidelity to trust and promise, benevolence, effacement of self-interest, compassion and caring, intellectual honesty, justice, and prudence [Pellegrino 1995:268].

In a clinical scenario, A 75-year-old woman with advanced dementia and a serious infection is hospitalised. She can no longer communicate clearly, and her family members disagree on what treatment approach should be taken. Some family members want to pursue aggressive treatment, while others believe that comfort care is more appropriate. The doctor decides to apply a virtue ethics approach to this complex situation. The doctor prioritises the patient's autonomy and dignity by listening to the patient's values, even though the patient cannot communicate effectively; her family shares her values and preferences with the doctor. The doctor

considers the patient's physical, emotional, and social well-being, including her pain, comfort, and quality of life. The doctor also engages in open and empathetic discussions with the patient's family, acknowledging their concerns and values. This demonstrates the doctor's compassion and empathy towards the patient and her family, recognising the emotional toll of this decision. Through careful and context-dependent decision-making, the doctor works with the patient's family to develop a care plan that prioritises her comfort, dignity, and well-being. They decide to focus on palliative care, ensuring that the patient receives adequate pain management and emotional support. The above scenario demonstrates how virtue ethics can be applied in medical decision-making to prioritise patient autonomy, dignity, and well-being. By engaging in careful and context-dependent decision-making, healthcare professionals can develop care plans that respect patients' values and promote their overall well-being.

Given that there is no virtue corresponding to respect for patients' autonomy, critics would question if Pellegrino's list and, by extension, virtue ethics in general, condones and encourages excessive professional paternalism. Pellegrino's list of virtues, though not all inclusive are 'most essential to the healing purposes of the clinical encounters' [Pellegrino 1995:268]. There is a mutual reciprocal reinforcement among these many virtues. Consequently, if one were compromised, the other would also be compromised, making a priority ranking impossible [Steinbock 2013:37]. An approach based on virtue might address euthanasia, for example, by highlighting the significance of character and particular virtues in relation to the end method acknowledged.

Philippa Foot investigates the moral feasibility of several forms of euthanasia from the perspective of the end of the virtues. He argues that charity, for example, as the virtue of 'attachments to the good of others,' can support the act of euthanasia since, for its very meaning, it seeks 'one's death for his own sake–for his good' [Foot 1977:106]. However, justice as a virtue opposes and sometimes allows euthanasia. Justice, for instance, supports active voluntary euthanasia, may tolerate non-voluntary passive euthanasia, and opposes involuntary active euthanasia [Steinbock 2013:38]. Yet, justice strongly opposes active euthanasia because, according to Aristotle's rationale, justice is 'a complete virtue, not without qualification, but in relation to another person' [Aristotle 2000:1130a]. For Aristotle, it is complete virtue in the fullest sense for two reasons: first of all, it is the 'actual exercise of perfect virtue' – practice what is right – which is not to harm another – therefore not to kill. It is also complete because 'he who possesses it can exercise his virtue in relation to another person' [Aristotle 2000:1130a]. For this reason, virtue ethics is the greatest of the approaches for the end that virtue aims at in another's interest or good.

Secondly, the limited specificity of virtues raises additional concerns about their power to direct behaviours. Proponents of virtue ethics argue that virtue provides more guidance for action than other theorists often recognise. According to Rosalind Hursthouse [2003], a virtue ethicist herself, the assertion that 'virtue ethics does not and cannot provide guidance the way utilitarianism and deontology do' is a significant misunderstanding that dominates much of the current discussions over ethical theory and methodology. Hursthouse counters this misunderstanding, saying;

> *Virtue ethics provides a specification of right actions– as what a virtuous agent [person] would, characteristically, do in the circumstances– and such a specification can be regarded as generating several moral rules or principles [contrary to the usual claim that virtue ethics does not come up with rules or principles]. Each virtue [for example, justice, charity, and so on] generates an instruction– do what is honest or just, do what is charitable, and each vice a prohibition– do not … do what is dishonest, uncharitable [Hursthouse 2001:17].*

In addition to the response to concerns about virtue ethics' capacity for action guidance, Hursthouse further argues that the goal should not be 'to provide a decision procedure which any reasonably clever adolescent could apply [without moral wisdom or discernment].' [Hursthouse 2001:18]. Virtue ethics may try to specify the virtues and to distinguish merely apparent from real dilemmas, a task that presupposes moral wisdom and discernment. Sometimes, however, irresolvable and tragic dilemmas remain. However, Steinbock [2013:36] acknowledges that virtue ethics might illustrate how the agent should react, that is, with suitable attitudes and feelings, such as grief and guilt, even though action direction is impossible in such circumstances.

Considering the discussion above, it can be observed that virtue ethics, unlike utility and deontology, is an essential approach in biomedical ethics research. Being 'an agent–centred moral approach, it disposes of a moral agent [person] to tenaciously exhibit virtuous acts in all morally demanding circumstances… to strive to maintain integrity so that consistency, honesty, and objectivity prevail' [Koali *et al*., 2024:80]. More specifically, virtue ethics seeks to promote and emphasise the development of moral values and character. It is concerned with the doer, the person or agent behind the actions, not so much with the actions themselves. It is not that virtue theorists do not care what actions are performed. It is that they think getting the person right is the most important thing, and once you have done this, good actions will follow automatically. Make the apple tree good, and you will get good apples.

Conclusion

Navigating the complexities of bioethics and medicine requires a deep understanding of competing moral frameworks, including utilitarianism and deontology. Both theories offer valuable insights but also present significant challenges when applied to real-world scenarios. Utilitarianism is praised for its focus on maximising overall happiness and well-being, and its emphasis on equality. However, it is criticised for potentially ignoring individual autonomy and dignity, favouring the majority over minority groups, and not prioritising the most vulnerable populations. Moreover, utilitarianism can justify harmful actions if they lead to a greater good and can be challenging to apply in practice due to difficulties in measuring and comparing individual happiness or well-being. Deontology, on the other hand, is valued for its respect for autonomy and dignity, protection of vulnerable populations, and promotion of trust and integrity. Nonetheless, it faces criticism for overemphasising law over relationships, its lack of consideration for consequences and limited consideration for cultural and social context. Given the limitations of both approaches, a more nuanced and context-dependent approach to biomedical ethics might be necessary. Virtue ethics offers a potential framework for transcending the opposition between utilitarianism and deontology. By focusing on the development of good character traits such as compassion, honesty, and fairness, virtue ethics can help healthcare professionals navigate complex moral situations and balance competing concerns. It integrates elements of both consequentialist and deontological considerations, promoting moral development and growth while recognising the importance of context and relationships.

In conclusion, while both utilitarianism and deontology provide essential insights into biomedical ethics, a balanced approach that incorporates the strengths of both theories and addresses their limitations is crucial. Virtue ethics, with its emphasis on character development and contextual decision-making, offers a promising avenue for achieving this balance and guiding ethical decision-making in healthcare. By adopting a more nuanced and adaptable approach, healthcare professionals can better navigate the complexities of biomedical ethics and make decisions that respect individual dignity, promote overall well-being, and uphold moral principles.

Bibliography

Aquinas, T. 1911–1925. *Summa Theologiae*. Translated by the Fathers of the English Dominican Province. New York: Benziger Brothers.

Aristotle. 2000. *Nicomachean Ethics*, edited by R. Crisp. Cambridge: Cambridge University Press.

Beauchamp, T.L. and J.F. Childress. 1994. *Principles of Biomedical Ethics*. 4th ed. Oxford: Oxford University Press.

Bentham, J. 1907. *An Introduction to the Principles of Morals and Legislation*. Oxford: Clarendon Press.

Chukwuneke, N.F. and C.A. Ezenwugo. 2020. Deontology vs utilitarianism: Understanding the basis for the moral theories in medicine. *International Journal of Medicine and Health Development* 27(1): 19–23. https://doi.

org/10.4103/ijmh.IJMH_57_20.

Fagothey, A. 1976. *Right and Reason: Ethics in Theory and Practice*. Saint Louis: The C.V. Mosby Company.

Foot, P. 1977. Euthanasia. *Philosophy and Public Affairs* 6(2): 85–112. URL: http://www.jstor.org/stable/2264937.

Frankena, W.K. 1973. *Ethics*. 2nd ed. Englewood Cliffs, NJ: Prentice-Hall.

Häyry, M. 2021. Just better utilitarianism. *Cambridge Quarterly of Healthcare Ethics* 30(2): 343–367. https://doi.org/10.1017/S0963180120000882.

Hursthouse, R. 2001. *On Virtue Ethics*. Oxford: Oxford University Press.

_____, 2003. Virtue ethics. In *The Stanford Encyclopedia of Philosophy*, edited by E.N. Zalta. URL: https://plato.stanford.edu/archives/fall2003/entries/ethics-virtue/.

Kant, I. 2002. *Groundwork for the Metaphysics of Morals*, edited by A.W. Wood. New Haven: Yale University Press.

_____, 2015. *Critique of Practical Reason*, translated by M. Gregor. Cambridge: Cambridge University Press.

Koali, S., N. Khasoane and M. Mongenzi. 2024. Promoting research integrity through the lens of virtue ethics and deontological approach. *South African Journal of Bioethics and Law* 17(2): 78–82. https://doi.org/10.7196/SAJBL.2024.v17i2.XXXX.

Leigh, F.J., G. Meyer-Rath, R.E. Dorrington, A. Puren, T. Seathlodi, K. Zuma and A. Ali. 2022. The effects of HIV programs in South Africa on national HIV incidence trends, 2000–2019. *Journal of Acquired Immune Deficiency Syndromes* 90(2): 115–123. https://doi.org/10.1097/QAI.0000000000002927.

Lipworth, W. 2020. Beyond duty: Medical "heroes" and the COVID-19 pandemic. *Journal of Bioethical Inquiry* 17(4): 723–730. https://doi.org/10.1007/s11673-020-10065-0.

Louden, R. 1984. On some vices of virtue ethics. *American Philosophical Quarterly* 21(3): 227–236.

Mill, J.S. 1879. *Utilitarianism*. London: Longmans, Green, and Co.

Misselbrook, D. 2013. Duty, Kant and deontology. *British Journal of General Practice* 63(609): 211. https://doi.org/10.3399/bjgp13X665422.

Morrow, B.M., P.D. Gopalan, I. Joubert, F. Paruk and A. Pope. 2020. Critical care triage during the COVID-19 pandemic in South Africa: A constitutional imperative. *South African Medical Journal* 110(12): 1176–1179.

Nyayak, B.K. 2024. Deontological approach to resolve problem in medical ethics. *International Journal of Creative Research Thoughts* 12(2): 93–98.

Oakley, J. 1998. A virtue ethics approach. In *A Companion to Bioethics*, edited by H. Kuhse and P. Singer, 86–97. Oxford: Blackwell.

Pellegrino, E.D. 1995. Towards a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal* 5(3): 253–277.

Rachels, J. and S. Rachels. 2010. *The Elements of Moral Philosophy*. 6th ed. New York: McGraw-Hill.

South African Government. 2007. *National Strategic Plan for HIV and AIDS and STIs, 2007–2011*. Pretoria: South African Government.

South African Human Rights Commission. 2021. *Left Behind: The Impact of the COVID-19 Pandemic on Vulnerable Groups*. Equality Research Brief. Johannesburg: South African Human Rights Commission.

South African News. 2020. President Ramaphosa announces a nationwide lockdown on 23 March 2020. URL: https://www.sanews.gov.za/south-africa/president-ramaphosa-announces-nationwide-lockdown.

Statistics South Africa. 2025. *Statistical Release P0302: Mid-Year Population Estimates, 2025*. Pretoria: Statistics South Africa.

Steinbock, B., ed. 2013. *The Oxford Handbook of Bioethics*. Oxford: Oxford University Press.

Stewart, N. 2009. *Ethics: An Introduction to Moral Philosophy*. Cambridge: Polity Press.