New Perspectives on the Theory of Justice: Implications for Physical Therapy Ethics and Clinical Practice

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Recent revisions of physical therapy codes of ethics have included a new emphasis concerning health inequities and social injustice. This emphasis reflects the growing evidence regarding the importance of social determinants of health, epidemiological trends for health service delivery, and the enhanced participation of physical therapists in shaping health care reform in a number of international contexts. This perspective article suggests that there is a "disconnect" between the societal obligations and aspirations expressed in the revised codes and the individualist ethical frameworks that predominantly underpin them. Primary health care is an approach to health care arising from an understanding of the nexus between health and social disadvantage that considers the health needs of patients as expressive of the health needs of the communities of which they are members. It is proposed that re-thinking ethical frameworks expressed in codes of ethics can both inform and underpin practical strategies for working in primary health care. This perspective article provides a new focus on the ethical principle of justice: the ethical principle that arguably remains the least consensually understood and developed in the ethics literature of physical therapy. A relatively recent theory of justice known as the "capability approach to justice" is discussed, along with its potential to assist physical therapy practitioners to further develop moral agency in order to address situations of health inequity and social injustice in clinical practice.

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Since the publication of the first physical therapy code of ethics in 1935,[1] numerous codes of ethics have been developed by national and international professional associations within physical therapy. In describing the evolution of physical therapy ethics, Purtilo[2] identified 3 successive and overlapping periods: self-identity, patient-focused identity, and an "emerging" period of societal identity. Although the earliest physical therapy codes focused primarily on professional identity (1935) and later codes emphasized obligations to patients (1970), the most recent period of ethics focuses on what Purtilo described as self-identity and patient-focused identity nested within societal priorities:

> [A]s our [self-identity] and our patient-focused identity continue to mature today, we are approaching a third season in a seriously shifting social landscape that appears unfamiliar to us who are accustomed to focusing primarily on the physical therapist's relationships with professional teammates or individual patients. I am calling this emerging season physical therapy's *Period of Societal Identity*. In this most recent period, our task will be to establish the moral foundations for a true professional partnering with the larger community of citizens and institutions.[2(p1114)]

Consistent with Purtilo's framework, it appears that current physical therapy codes of ethics[3–9] are increasingly addressing the societal dimensions of our ethical obligations. Table 1 provides sample statements from current physical therapy codes of ethics delineating the individual and collective obligations of physical therapists in reducing health disparities, health inequities, and social injustice. Collectively, these statements reflect an understanding that physical therapists and patients are part of complex social systems that have a profound impact on injury, disease, rehabilitation, and the practice of physical therapy. This new societal emphasis also reflects the growing evidence regarding the importance of social determinants of health, epidemiological trends for health service delivery,[10,11] and the enhanced participation of physical therapists in shaping health care reform in a number of international contexts.

We believe that this broadening of ethical focus from concern for individual patient well-being to include those of a wider societal and global nature, such as social disadvantage and injustice, represents a maturation of the physical therapy profession's sense of moral agency.[2,3,12–15] *Moral agency* refers to the realization of a capacity (as an individual or group) to act morally and for change in a situation.[14,15] In articulating a more comprehensive sense of moral agency, the profession is giving voice to an emerging consensus that its "social contract" extends beyond the treatment encounter between individual therapist and patient and into those broader social and ethical issues that are increasingly recognized as shaping and determining

Table 1.
Sample Statements About Social Responsibilities From Physical Therapy Codes of Ethics

Organization/Document	Sample Statements
American Physical Therapy Association, *Code of Ethics for the Physical Therapist*[4] (2010)	• Principle 8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core value: social responsibility) • 8A. Physical therapists shall provide *pro bono* physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured. • 8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.
Australian Physiotherapy Association (APA), *The Australian Physiotherapy Association Code of Conduct*[5] (approved 2008)	• APA members must strive to contribute to the development and implementation of health service delivery which enhances the health status of the community and promotes social justice. (Principle 8) • Physiotherapists shall participate in the planning and implementation of health service delivery designed to provide equitable access to quality health care and achieve optimal health outcomes for local communities. ("Guidance Point" for principle 8)
Chartered Society of Physiotherapy (United Kingdom) *Proposed Revision of the Code of Members' Professional Values and Behaviour*[7] (November 2010)	• 2.3 Members engage with relevant professional and social contexts. • 2.3.1. Strive to challenge and address health inequalities in how services are delivered.
Canadian Physiotherapy Society, *Code of Ethics and Rules of Conduct*[8]	• Physiotherapists shall recognize their responsibility to improve standards of health care.
World Confederation for Physical Therapy, *Appendix to Ethical Principles*[9]	• Physical therapists are obliged to work toward achieving justice in the provision of health services for all people.

Table 2.
Primary Health Care Values and Elements[17,18]

Primary Health Care Values	Primary Health Care Elements
1. Equity 2. People centeredness 3. Community participation 4. Self-determination	1. Reducing exclusion and social disparities in health (universal coverage reforms) 2. Organizing health services around people's needs and expectations (service delivery reforms) 3. Integrating health into all sectors (public policy reforms) 4. Pursuing collaborative models of policy dialogue (leadership reforms) 5. Increasing stakeholder participation

health. Although we applaud the societal focus of the emerging model of moral agency, we believe it represents a "paradigm shift"[16] in physical therapy ethical thinking that calls into question current concepts about foundational ethical theory and the nature of clinical practice.

The purpose of this article is to delineate critical questions raised by the societal shift with regard to issues of justice for both clinical practice and ethics in physical therapy. Following an outline of critical questions in both of these areas, we suggest the core values and elements of the primary health care model[17,18] as delineated by the World Health Organization (Tab. 2) as one model to address questions raised for clinical practice.

Throughout the article, we offer the perspective that addressing the 2 interrelated sets of questions requires a more robust foundation in the ethical theory of justice than currently exists within the physical therapy literature. In that regard, a secondary purpose of this article is to invite further discussion of the theoretical foundations for physical therapist practice, the theory of justice, and the relationship of these theories to the practice of physical therapy.

Critical Questions: Theoretical Ethical Foundations

Two distinct but related sets of questions arise from the revisions to codes of ethics described above (Figure). The first set of questions relates to the appropriate theoretical ethical foundations for addressing inequities. In the light of the injunction to widen the scope of practice and address health inequities and social injustice, what is the most appropriate ethical theoretical framework to underpin current physical therapy codes of ethics and, therefore, physical therapist practice? For example, the recently revised codes of ethics continue to predominantly ground their ethical foundations in a dominant form of bioethics known as "principlism" or the 4 ethical principles.[19–21] The 4 principles are: respect for patient autonomy, benef-

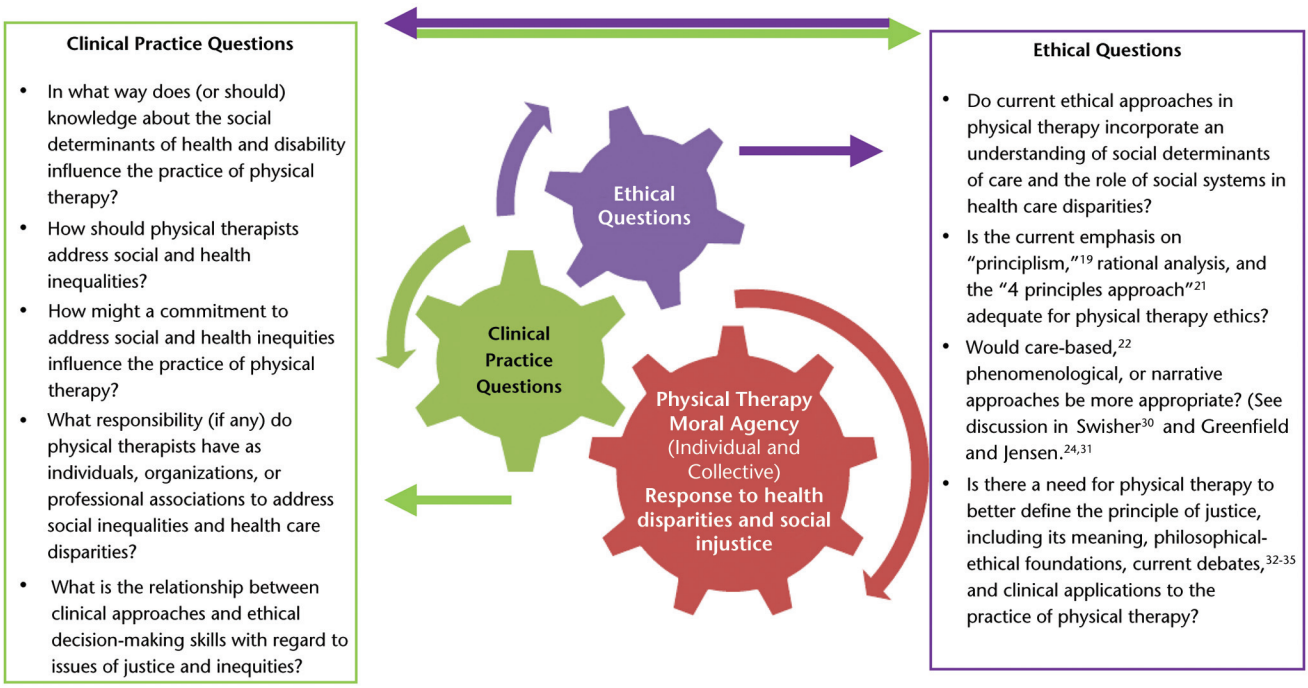

Figure.
Ethical and clinical practice questions related to health disparities and social injustice.

icence (promote the interests of the patient), nonmaleficence (cause no harm), and justice (act fairly).[21] Although the principles approach reflects the Western liberal, individualist culture from which it has emerged and may arguably be well suited to clinical decision making at the practitioner-patient level,[19] it has been criticized for its reliance on deductive, rationalist, and normative forms of thinking and logic at the expense of other, more relationally oriented ethical processes.[20,22–24] Given that paradigms or frameworks of practice can either implicitly or explicitly influence the nature of decision making and action in clinical practice,[25–27] we suggest that there is a need to question the apparent "disconnect" between the societal obligations and aspirations expressed in the revised codes and the individualist ethical framework that predominantly underpins them. It is timely, therefore, to consider what ethical approaches best underpin physical therapist practice (via codes of ethics). Just as the World Health Organization's *International Classification of Functioning, Disability and Health*[25] (ICF), with its biopsychosocial foundation, has been universally adopted as a framework and language for physical therapist practice, we need to ask whether there is an equivalent biopsychosocial "breadth" underpinning the ethical approaches used in physical therapy. Table 3 provides a summary of definitions for concepts used in this article.

Critical Questions: Ethics in Clinical Practice

The second set of questions (Figure) arising from the revisions to codes described above derive from an overarching question: "How does a profession that has been traditionally situated in secondary and tertiary health care settings, and practicing largely in a one-to-one therapist patient relationship,[36] address health

Table 3.
Definition of Concepts Related to Health Inequity and Ethics

Concept	Definition
Ethical theory	An *ethical theory* is an overarching account of morality that puts forward an explanation of the nature of doing right and wrong and the conditions by which morality can be facilitated. An *ethical approach* does not propose to be a complete theory or model and may complement or add an element to an ethical theory (eg, narrative ethics). An *ethical framework* is a set of ideas, principles, agreements, or rules that provides the basis or outline for something intended to be more fully developed.
Health disparity[a]	*Health disparities* refer to inequalities of health that may be related to events such as access, utilization, and quality of health care or a particular health "outcome" that deserves scrutiny. "Health disparity," a term that is used more commonly in the United States, connotes that "what is unequal is not necessarily inequitable."[28]
Health inequity[a]	*Health inequities* are inequalities of health that are the result of unjust conditions or failures of identifiable duties. The term "inequity" signifies an ethical judgment.[29]
Justice	*Justice* is the principle that people should be treated fairly. *Distributive justice* is concerned with equitable resource allocation (eg, health services). *Contractarianism* is an approach to justice where the notion of a social contract is developed "in which rational people get together, for mutual advantage." Rawls' "justice as fairness" approach emphasizes the scrutiny of process and procedure in the formation of just institutions and in the distribution of resources.[70] *Utilitarianism* is an approach to justice in health care that seeks an outcome that arrives at the maximum benefit or utility for the greatest number of people. The *capability approach to justice* shares an Aristotelian view that resources such as income or wealth are an inadequate way of judging advantage. In this approach, not only is health seen as central to our well-being, but the exercise of choice and capability is dependent on our health achievements (or status).
Moral agency	*Moral agency* refers to the realization of a capacity (of an individual or group) to act morally and for change in a situation.
Narrative approach to ethics	*Narrative ethics* offers an alternative approach to normative ethical approaches in that an inductive understanding of another person's perspective or experience, rather than a deductive application of universal principles, values, or ethical "rules," is central to any analysis and resultant decision making (also called "descriptive ethics").
Normative ethics	*Normative ethics* is concerned with deciding which general moral norms best guide and evaluate conduct and why.
Primary health care	*Primary health care* is an approach to health care arising from an understanding of the nexus between health and social disadvantage that, in a preventative sense, considers the health needs of patients as expressive of the health needs of the communities or populations of which they are members.
The 4 ethical principles	• Respect for patient autonomy • Beneficence (promote the interests of the patient) • Nonmaleficence (cause no harm) • Justice (act fairly)

[a] Both terms are used in this article.

inequities and social injustice?" The answer lies, in part at least, in the tenets and practices of primary health care, which is an approach to health care arising from an understanding of the nexus between health and social disadvantage and which, in a preventative sense, considers the health needs of patients as expressive of the health needs of the communities or populations of which they are members.[17,18]

In this article and in our companion article[37] in this issue, we address these critical questions by identifying both conceptual/theoretical ethics and practice-based frameworks to provide guidelines to help physical therapists recognize and respond to situations involving health inequity and social injustice. We begin our discussion with the implications of further adopting primary health care as a health care model in physical therapy. A primary health care model of health care delivery emphasizes social determinants of health and has explicit links with the ethical principle of justice. We highlight that adopting primary health care principles in physical therapist practice would require some questioning and redefining of underpinning values and goals of core clinical activities, including methods, scope of assessment, and treatment. We then focus on the principle of justice by reviewing its development within physical therapy ethics and practice literature. In this discussion, we review the broad development and focus of the physical therapy ethics discourse. We then narrow our focus to theories of justice.

Justice is fundamental to primary health care models of health care and is the primary theme of this article. We suggest that the determination of how physical therapists can most effectively engage with health inequities and social injustice requires a new focus on the ethical principle of justice. Since Purtilo's early studies of physical therapists' perceptions about justice,[38,39] there has been little dialogue within the profession about the principle of justice. In that regard, justice remains the least understood and developed principle in the ethics literature of physical therapy. We discuss contemporary theories of justice, highlighting the "capability approach to justice," which can inform physical therapists' ethical decision making. As a full-scale theoretical analysis and application of the ethical principle of justice is beyond the scope of a single article, this article will focus on theoretical perspectives that underpin and provide conceptual explanations for primary health care and physical therapy clinical practice. Our companion article[37] in this issue will address the application of these perspectives to clinical practice.

Primary Health Care as a Clinical Model for Addressing Health Inequity and Socially Patterned Disease

Inequities of health, disease, and disability are well recognized[10,17,29,40] and have been identified as "systematic, socially produced and unfair,"[41(p1)] prompting the World Health Organization to state: "Social justice is a 'matter of life and death.'"[41(p1)] Patients who present for physical therapy are people whose life "chances" (ie, their chances of staying well or being ill, of living a long life or having their life cut short), and share of resources, are influenced by being members of various communities or populations, often with multiple, complex health and social needs and various combinations of them.[10] While acknowledging the complexity of addressing this core inequality, some authors contend that health care practitioners have a central role in narrowing the health divide and that potentially primary health care is positioned to effectively reduce inequalities in populations.[10,42]

Primary health care is associated with better health and a more even distribution of health care both across and within nations.[10,42] Although health care practitioners are well placed to recognize health inequities and needs in communities, the opportunity to offer appropriate care, which is targeted toward goals of building trust, security, and well-being, often is hampered by the challenges of dealing with social conditions and inadequate health policy.[41]

There are few or no data indicating how physical therapists respond to health inequities in clinical practice.[43] Consider the following scenario. "Toby" visits a physical therapist for management of his ongoing low back pain. Toby also has a recent diagnosis of type 2 diabetes and has been advised by his general practitioner to lose weight and get fit, with little success. Toby has an unskilled job as a process worker at a local factory. He is married with 3 children and lives in a run-down part of the city. His wife has recently lost her job in the global recession, and they are now under financial stress in relation to house and car payments. The physical therapist acknowledges the medical complexity of Toby's case, with its multiple morbidities, which may be more likely in populations with lower socioeconomic status.[44] In doing so, the therapist recognizes that attending to the back pain, with its immediate consequences of pain, incapacity, and reduced quality of life, also will require addressing the weight and fitness issues and an ongoing self-management program.[41] Toby appears to display a lack of motivation and some disengagement with the therapist's discussion of goals related to improving his health and well-being. The therapist is aware of

evidence demonstrating that limited access to resources, together with material and economic constraints, may hamper Toby's capability to engage in self-management actions.[45,46] Similarly, evidence links the capacity to attain physical fitness with access to appropriate facilities and environments.[47,48] Furthermore, access to healthy foods such as fresh fruit and vegetables and unhealthy fast foods is related to the socioeconomic status of the neighborhood.[49,50] The therapist faces a quandary: how best to support Toby within the constraints of health insurance, the therapist's own practice constraints of finance and time, and the social conditions and priorities of the patient.

Reinforcing the reality of the challenges facing the therapist *and* patient above, Townsend and colleagues' qualitative study investigating patient experiences of early rheumatoid arthritis, in a medical context, revealed gaps between policy guidelines and practice.[51] They found that patient accounts of their experiences pinpointed contradictions of policy (eg, patient-centered care, shared decision making) and personal experience (eg, feeling disempowered in the medical encounter). Thus, tensions between normative ethics (what should happen in the medical encounter) and relational ethics (patient experiences of the medical encounter) arose (Tab. 3).[51]

If primary health care is to play a role in reducing health inequities, its value commitments of equity, people-centeredness, community participation, and self-determination (Tab. 2)[11,17,41,52] must be matched with a commitment to practical strategies grounded in these same values. Some practical strategies for physical therapists include: collaboration with other professionals; targeted health promotion with patient input; prevention, screening, risk management, and triage; assessment and treatment modified for community settings; knowledge of particular needs and priorities (eg, self-management models that respect patient autonomy and social setting); advocacy; and community development.[11,53–58]

Applied to Toby, the goals of physical therapy treatment need to encompass not only manual treatment and exercise advice, but also strategies that might enhance his capacity to seek and access suitable health and fitness programs or assist him in connecting with employment agencies or similar community organizations.

The challenge for physical therapy in engaging with primary health care lies not only in embracing new strategies or methods of service delivery but in being able to situate the contribution and best deployment (or adaptation) of physical therapy skills and values in a continuum of individual (patient-therapist) *and* social (community or population based) forms of practice. A key question to arise from this challenge is: How should the physical therapy profession develop its sense of professional moral identity and evolving "social contract" with society? To answer this question, we begin with a review of ethics and values underpinning physical therapist practice.

The Moral Basis of Clinical Practice

There has been considerable debate about the moral basis of clinical practice in health and the question of what, in a moral sense, deserves our ultimate focus of attention as practitioners. Pellegrino[59] took a phenomenological approach (that is, one that recognizes the importance of experiencing a phenomenon to generate meaning and understanding) and argued for the primacy of the individual patient-practitioner relationship. This approach holds that ethical understanding is generated in and through the meaning-based relationship between patients and their physicians[24] and, in turn, determines its own "internal morality" and set of ethical obligations.[59] Wildes, however, argued that health care is fundamentally a social practice and that Pellegrino's focus is too narrow:

> The phenomenological approach has no way to take into account those who are not present. For example, those who are systematically excluded (eg, from access to health care) . . . for reasons of race or economic standing.[60(p79)]

Both views proclaim truths that in some way represent the moral tension facing physical therapy in seeking to build ethical frameworks and knowledge that maintain and enhance the traditional and familiar patient-therapist–focused ethical understanding of practice, which also encompasses a more inclusive ethics that takes into account those larger, more socially determined health inequities and injustices.

Ethics Discourses in Physical Therapy

The recent focus of ethics debate in physical therapy is well summarized by 2 review articles. In 2002, Swisher[34] provided a comprehensive, retrospective analysis of physical therapy ethics knowledge from 90 English language articles published between 1970 and 2000. In 2008, Carpenter and Richardson[61] identified a further 27 peer-reviewed articles about physical therapy ethics published in the period 2000 to 2007. Swisher grouped the ethics literature according to 3 overall categories: establishing the role of the physical therapist as an ethical decision maker, applying philosophical principles to ethical problems, and examining the evolving relationship between physical therapists and

patients. Carpenter and Richardson highlighted advances in knowledge and research about unique ethical issues in physical therapy and an increased emphasis on moral agency and types of moral reasoning.

More recently, in an article emphasizing the moral agency of physical therapists, Delany et al[14] proposed practical, clinic-based strategies by which practitioners can be assisted to recognize and respond to not only the moral dimensions within the patient-therapist encounter but also the impact of social, economic, and cultural factors that shape a person's illness experience. In a parallel debate, Greenfield and Jensen[24] advocated less emphasis on the use of normative ethics in physical therapy by outlining how physical therapists might be assisted to recognize and respond to the moral dimensions of a person's disability through a phenomenological understanding of the meanings of the individual's stories and lived experience. Their conception of phenomenology includes an acknowledgment of the broader social factors that each patient might experience, including loss of his or her social role and loss of ability to participate in his or her vocation and other activities.

Taking the contributions above and Wildes' observation[60] regarding the need for an ethical framework with a "wider phenomenology" to include the social dimensions of health, the critical question becomes: How can the wider social influences and phenomenological perspectives about a person's health be incorporated into an ethical framework for physical therapist practice? At present, the answer remains relatively untheorized within ethics discourses in physical therapy.

An Understanding of Justice in Physical Therapy

Justice (or fairness) is perhaps the most multidimensional and complex of the 4 major ethical principles. There has been a dearth of theory and research concerning justice in the physical therapy literature in the 3 decades since Purtilo's early studies. Nevertheless, many of society's needs, if not always its priorities, continue to be expressed in physical therapy literature as encounters with various health inequities and social injustices by physical therapists in the course of their practice.[43,54–58,62] Associated with this diverse literature are repeated calls for further education concerning the role of physical therapists and the profession,[11,12,43,56,63–66] for enhanced clinical practice assessment and management skills together with innovative service delivery strategies,[43,53,55–58,67] and for further development of health policies and regulations,[11,12,47,56,63] all related to enacting justice and working toward ameliorating health inequities and social injustice.

The seeking of justice, therefore, for the inequities and injustices suffered by individuals and communities continues to be an important issue expressed by practitioners at a clinical level and relevant for the profession at large. What remains is for the reaching of some consensus as a profession, as suggested by Purtilo,[38,39] regarding the nature of justice as a foundation for further determining the role of physical therapy practitioners and the profession in enacting justice. We contend that further developing the moral foundations of the profession to engage with these social issues cannot take place without equipping practitioners with an ethical decision-making framework for clinical practice (the focus of our companion article[37] in this issue) that is inclusive of issues beyond the immediate patient-therapist encounter in physical therapy and based on a broader understanding and conceptualization of justice in health care.

Theoretical Approaches to Justice: Contractarianism and Utilitarianism

In the Western tradition, issuing from the period of the Enlightenment, 2 broad approaches to social justice can be identified.[33] One approach, in the tradition of thinkers such as Kant, Locke, and Rousseau, focuses on defining the nature of a just society (including its institutions) and prescribing the conditions under which people are able to freely exercise choice in upholding both their rights and obligations in society.[33,68,69] This tradition has become known as *contractarianism*, and, as its name suggests, the notion of a social contract is developed "in which rational people get together, for mutual advantage, deciding to leave the state of nature (ie, a survival of the fittest) and to govern themselves by law."[68(p2ff)] The influence of this tradition on the shaping of the political democracy that many of us enjoy is evident.

More recently in this tradition, Rawls, in his influential theory of justice (ie, justice as fairness), specified the terms of social cooperation that free and equal citizens can accept as fair.[70(p11)] These terms include an index of so-called primary social goods, which Rawls saw as the most important resources required by people and which include things such as "rights, liberties and opportunities, income and wealth, and the social bases of self-respect."[70(pp60–65)]

Rawls did not specifically address issues of health inequity.[28] Indeed, Rawls described health (like intelligence) as a "natural good" rather than as a social good.[35] Daniels, however, building on Rawls' "justice as

fairness" approach, argued that an understanding of the breadth of factors that affect levels of population health and its distribution (ie, the social determinants of health) creates a strong argument that health *is* indeed a primary social good and that "failing to promote health in a population, that is, failing to promote normal functioning in it, fails to protect the opportunity or capability of people to function as free and equal citizens."[35(pp14–15)] Nevertheless, Daniels' interpretation of the justice as fairness approach in relation to equity in health raises difficult questions. First, regarding Rawls' "difference principle,"[70(p75)] which allows for inequalities providing those inequalities are made to work in favor of the least well-off in society: How does one account for tradeoffs between health and other social goods? For example, a person may choose (or feel forced by circumstance) to risk his or her health by placing himself or herself in a high-risk but well-paid job.[29(p588)] Second, how does one set limits in relation to the allocation of resources to health care and other goods, and in prioritizing between patients?[29,71] Daniels' response, known as "accountability for reasonableness," was that in the absence of any agreed-upon set of principles for distributive justice, "the question becomes one of procedural justice: under what conditions are rationing decisions legitimate?"[29(p588)] To this end, Daniels followed Rawls' notion of "pure procedural justice" in which the correct procedure defines the correct outcome.[70(p85)] It is this emphasis on "procedure" as opposed to "outcome" that distinguishes the contractarian approach from the second main approach to justice: the utilitarian approach.

In contrast to the contractarian tradition, a number of other Enlightenment philosophers (eg, Smith, Wollstonecraft, Bentham, and John Stuart Mill) developed a diversity of approaches that "shared a common interest in making comparisons between the different ways in which people's lives may be led, influenced by institutions but also by people's actual behaviour, social interactions and other significant determinants."[33(p xvi)] Out of this tradition, with its emphasis on comparative evaluations of the welfare of individuals, has emerged the approach to justice known as *utilitarianism*. Utilitarianism, therefore, has both a welfarist and a consequentialist orientation, namely, that the moral justification of an action is found in its outcome as opposed to the intrinsic nature of the act or, indeed, its fairness by process (as for contractarians).[71]

The dominant place of utilitarianism as an approach to justice in health care can be understood as the imperative to derive, from existing and often limited resources, maximum benefit or utility for the greatest number of people.[33,68,71] The term "utility" in the utilitarian approach refers to notions of satisfaction, happiness, or preference and, therefore, the distribution of economic benefits or, in the context of health, resources such as access to health care services to maximize such entities in an aggregate manner across a population.[71] Cost utility analysis is the primary evaluation of health policy in the utilitarian approach; therefore, measures or indexes such as quality-adjusted life years combine preference for length of life with those for quality of life.[29,69]

We take up 2 criticisms of utilitarianism here. The first concerns its focus on the total or average utility of a population, as measured by expressions of satisfaction, and how this focus raises the issue of (diminished) respect for the separate person.[33,68,71] In order to produce the largest social total (or average), it encourages tradeoffs between some goods (eg, economic well-being, health, education) and others (eg, freedom, choice, opportunity); therefore, there is no notion of a "single experiential entity," and thus some people suffer or are sacrificed so that others may gain.[68,71] Given its focus on group outcomes, utilitarianism may not safeguard duties, values, and rights that are given priority status within other ethical frameworks. Nussbaum further observed that utilitarianism's commitment to aggregated measures of satisfaction does not allow for adequate consideration of the needs of marginalized or deprived people:

> . . . we also want to know what they are actually able to do and to be. People adjust their preferences to what they think they achieve, and also to what their society tells them a suitable achievement is for someone like them. Women and other deprived people frequently exhibit such "adaptive preferences" formed under unjust background conditions.[68(p73)]

This discussion leads to the second criticism of utilitarianism, which is that the agency of people (or their realization of a capacity to act for change in a situation) is largely extinguished.[33,68] Sen noted that the capacity "to reason and choose is a significant aspect of human life" and that human lives should be seen more "inclusively rather than ignoring everything other than the pleasures or utilities they end up having."[33(p19)] The interests of justice, therefore, would suggest that it is not enough to provide health care without accompanying efforts to expand individuals' agency, including their "ability to engage with and navigate the health system and their environment."[69(p9)]

The Capability Approach to Justice

The capability approach to justice was conceived by Sen (in the field of economics) and further developed by Nussbaum (in the field of philosophy) as a response to argued short-

comings of both contractarian and utilitarian approaches. The capability approach is a "theory of justice that can serve as the basis of practical reasoning" and focuses on "ways of judging how to reduce injustice and advance justice, rather than aiming only at the characterization of perfectly just societies."[33(p ix)]

Both Nussbaum and Sen emphasize freedom and the value of choice and opportunity for individuals to live the life they choose in the context of their personal and social circumstances.[69] In this approach, not only is health central to our well-being but the exercise of choice and capability is dependent on our health achievements (or status). Equity in health, therefore, is central to social justice rather than being "a fortunate side effect of implementing 'justice as fairness.'"[29(p588)]

The capability approach shares an Aristotelian view that resources such as income or wealth are an inadequate way of judging advantage.[33] Nussbaum observed that people have different needs and uses for resources:

> . . . and also varying abilities to convert resources into functioning. Thus, two people with similar quantities of resources may actually differ greatly in the ways that matter most for social justice.[68(p75)]

Nussbaum applied this point to many who have physical and mental impairments and who have largely still not found full participation as free and equal citizens to enjoy the primary social goods espoused by Rawls.[68] The capability approach as an understanding of justice focuses, therefore, on "a person's actual ability to do the different things that she values doing" and represents a shift "from the means of living (ie, available resources) to the actual opportunities a person has."[33(p253)]

Nussbaum developed a set of central human capabilities that cover diverse areas of human biological and social life and that she argued are minimum thresholds for judging whether justice can be considered to be upheld in a situation.[68(p78)] The capability approach thus provides a broader informational perspective than either "process" or "utility" by which to judge health inequities.[68] The individual capability to achieve valuable "functionings," therefore, becomes the focal variable for social evaluation.[69(p50)] *Functionings* are a person's achievements: what he or she is able to do or be, his or her activities and states of well-being.[69] The capability approach not only considers the importance of well-being but also emphasizes the freedom to pursue well-being.[33]

There is no claim by either Sen or Nussbaum that the capability approach displaces the contribution of either Rawls' justice as fairness model and the importance of just institutions and fair processes or the value of comparative measures of justice, which are seen in the utilitarian tradition. Instead, its concerns are to address shortfalls in these 2 traditions: (1) to consider the actual lives people lead as opposed to a focus on the soundness of institutions and fair processes and (2) to emphasize the role of freedom and personal agency for judging and addressing health inequity.

Implications for Physical Therapy and the Social Contract

The capability approach to justice provides a conceptualization of assessing injustice and acting for just change that is naturally allied with the identity of physical therapy. The aims of the capability approach echo the mandate of physical therapy, which is to assist our patients (whoever they may be) to improve function and with it their level of choice and opportunity for greater freedoms. The language of capability found in terms such as "functioning," "achievements," "opportunity," and "exercise of freedom" (albeit as a language of moral justice) is closely related to the language of physical therapy. Terms in the ICF,[25] which have a clinical purpose such as "activity capability" and "participation restriction," express both part of the informational and management-oriented action of physical therapists and moral notions of capability.

The capability approach to justice, therefore, offers physical therapy practitioners a conception of justice that is grounded in the language and aspirations of clinical practice and expands on both the analyses and solutions offered by the other 2 traditions. However, for the physical therapy profession to address health inequity and social injustice, there must be action at the level of professional bodies in relation to advocacy for change and improvement of health regulations and policies and, at the same time, at the level of its members, the clinical practitioners, who frequently encounter the diverse forms of inequity and injustice in their practices. Each party, association and member practitioner, should be able to share conceptions of justice in the context of physical therapy even if their particular roles within those conceptions are different.

The elements of capability such as freedom, choice, and opportunity are related to the notion of personal agency. It is our contention, expressed in this article and in our companion article[37] in this issue, that both a professional association and its members or practitioners can contribute to the agency of the other in this endeavor and ultimately strengthen the social contract earlier envisaged by Purtilo.

Conclusion

Recent revisions of physical therapy codes of ethics have contained a new emphasis on the role of physical therapists and the physical therapy profession in addressing health inequity and social injustice. This new emphasis represents both a maturation of the social contract of the profession with the society it serves and an acknowledgment of the multiple (and social) determinants of health. However, taking up this challenge of enacting justice is not necessarily easy or straightforward. It is contingent, on the one hand, on the profession having a knowledge of the social determinants of health and its role in models of primary and social health and, on the other hand, on physical therapy practitioners (and the profession) having adequate ethical frameworks by which to underpin this widened scope of practice and, in particular, a clearer conception of justice and its ethical obligations for enacting justice in clinical practice.

Justice in health care has largely been manifested in one or a combination of 2 traditions: contractarianism (and in particular Rawls' justice as fairness approach) and utilitarianism. In order to achieve equity in health, contractarianism focuses on fair procedures in the distribution of resources, whereas utilitarianism focuses on maximizing the utility or benefit across a population. In this article we have presented a newer perspective on justice in the form of the capability approach, which focuses on the actual lives and situation of people and emphasizes opportunity, choice, and agency. The capability approach to justice offers practitioners a means of becoming active in enacting justice within clinical practice situations, understanding inequity and injustice in more inclusive and relational terms compared with the more normatively oriented outcome-based or procedurally based forms of justice.

In our companion article[37] in this issue, we examine, in the context of actual clinical practice, how the development of moral agency is related (for both therapist and patient) to the ability to reason and learn. We outline a practical reasoning and learning process, in the context of the capability approach, that we propose will facilitate moral agency on the part of both practitioners and patients, leading to enacted justice.

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