This paper examines the differences between clinical and public health ethics and provides several examples of contemporary public health challenges that pose ethical questions. The relations among ethics, rights and obligations are explored, because public health philosophers propose these as different ways for public health to align its activities to what we value. Resources for education in relation to the ethics of public health are identified.

Paul Komesaroff, the editor of this occasional series on ethics, gave me a choice: write about either the ethics of senior management in a university or the ethics of public health. For 6 years, I was dean of the University of Sydney medical faculty and, for longer, a Fellow of the university senate. Remembering my behaviour when occupying those positions, I invoked the Fifth Amendment, and chose to write about the ethics of public health. That may have been unwise of me. The ethics of public health is not a straightforward or simple matter. Be it understood, if it is not immediately apparent from what follows, that my expertise is in public health and not in ethics. I note with admiration what ethicists have written. I am aware of ethical problems in public health. However, it is not in my professional capacity to solve them. The best I can do is point to places in the published ethics literature where I consider answers may lie.
medicine is, appropriately, concentrated on the encounter between a doctor and an individual patient. Since the 1970s, clinical ethics has been obsessed with patient autonomy.

The fiduciary duty of a doctor to his or her patient overrides concerns about the allocation of health-care resources and notions of social justice, achieving the greatest good for the greatest number and much else that traditionally, rightly or wrongly, has been part of public health. The clinician treats patients who seek care for their illness and who expect professional skill, understanding, no prejudice, honesty, unselfish concern, confidentiality, and information and space for choice. They want the doctor to call them by their name and to listen when they speak. They want the doctor to be their unswerving advocate. There is no counterpart in public health to the seeking patient. Nevertheless, public health is concerned about individuals and clinical practice mediates many public health measures, especially prevention, so the distinctions between the two brands of practice and their ethics are not watertight. Indeed, Calman and Howie, in their extensive chapter on the ethics of public health in the *Oxford Textbook of Public Health*, establish the utility of the principles used in classical clinical ethics: to do no harm, to be beneficent and generous to public health. 1

But in public health beside these principles there is coercion, which in clinical practice is anathema. However, life in a community involves some coercion, an element of political philosophy and practice. This is why Onora O'Neill in an elegant essay, argues that public health should ‘engage as fully with political philosophy as we do with (medical) ethics, and to set aside, or rather relegate to their proper context, exaggerated views of the importance of individual autonomy’. 2 O'Neill continues:

In starting with political philosophy, we must make it explicit that just health provision has to be based on a reasoned view of the limits of justified compulsion, and hence on the limits of possible coercion, not only in transferring resources but also in maintaining and enforcing public health policies … It would, for example, be quite arbitrary to assume that health policies can do entirely without compulsion, and the possibility of coercion.

On the contrary, any society and any world that seeks to limit coercion will have to permit some coercion – for example, the forms of coercion needed to enforce just laws …[J]ust [public health] policies should not proceed by coercion when it is avoidable. Equally, however, they have no reason to assign such priority to demands for individual independence and autonomy that they impede or fail to support action that is indispensable for basic public health. 2

Beside coercion, consensus-seeking compromise is another element in public health, and this process is vital to success for a public health professional operating in a pluralistic democracy. Much public health action is taken on behalf of a faceless, anonymous, collective known only by the name public, for reasons that may not be made clear to them and over which they exercise no choice. Not always is all of the truth disclosed: occasionally public health politely keeps silent and at times for what appear to be excellent reasons. At other times the silence of public health is far from golden. The following two examples illustrate coercion, secrecy and politics at work in public health.

**EXAMPLES OF PUBLIC HEALTH PRACTICE THAT POSE ETHICAL QUESTIONS**

**Fluoride**

More than 10 years ago, the New South Wales State Government told the City of the Blue Mountains that it would fluoridate their drinking water. The Blue Mountains community prides itself on its quirky green credentials. Outrage followed the fluoridation announcement. The Blue Mountains City Council in Katoomba organised a public meeting for Friday evening. No one from the State government agreed to attend. The organisers invited me, as a public health professional and resident. I had recently participated in a civilised public meeting in the same hall on electromagnetic radiation from power lines. So I thought, why not?
The meeting was rowdy, packed and well lubricated. When the meeting chair introduced me, a man at the back called out, ‘Who pays your salary?’ I told him, ‘Universities are paid by the government! This man’s a government stooge!’ he shouted, and everyone agreed raucously. Later, rather more amusingly, an older man stood and asked me why, as he had no teeth, the government should fluoridate his drinking water.

I presented to the meeting a review of the evidence of the general benefits associated with fluoridation. Another academic gave an opposing view, sticking to the facts.

The coup de grace came when my principal opponent thumped down on the speakers’ table a huge canister labelled Rat Poison and growled at the audience, ‘Do you know what’s in that?’ ‘No!’ they shouted back on cue. ‘FLUORIDE!’ he thundered. The meeting ended in uproar, enthusiasts leaving to picket the house of a politician. Still, come the next week, the water was fluoridated.

Did I do the right thing sticking my academic water pistol (so to speak) up against such heavy artillery? I do anger well but not roaring and thunder, so another person with these skills might have been a better match for the man with the rat poison. Then, maybe the politicians and bureaucrats were right to stay home. Given the way the State government had made the fluoridation announcement, perhaps I should not have participated in the meeting. Maybe by doing so it seemed that I approved of that process.

Food

Recently a petitioner asked me to support a statement to go to the World Health Organization (WHO) calling for a ban on the advertising of junk food to children. The world is facing a pandemic of obesity, and prima facie, the petition made good sense. After seeking advice from a public health nutritionist, I wrote back to the petitioner saying yes, I would support the petition, and adding:

Energy-dense, nutrient-poor food is a better term than junk food when talking with the food industry. Objective criteria for classifying foods in this category would also be useful, if not already developed: so that it includes only the things at the top of the healthy foods pyramid that people should eat only occasionally (or, as discussed in the Australian Guide to Healthy Eating, things that are termed extra foods). Banning the foods is not the aim; banning the advertisements that make kids want the foods more than occasionally is the aim.

The petitioner replied:

I completely agree that ‘energy-dense, nutrient-poor’ is a useful way of explaining what we mean to industry, and that the ultimate aim is not to ban foods but to ban advertising of junk food to children. Regarding objective criteria – these, too, are obviously important. But the debate at WHO is happening at a much more elemental and elementary level. Basically, the international sugar industry, Coca-Cola, Cadbury Schweppes, ConAgra, General Mills et al. are doing all that they can to weaken or block the WHO global strategy for nutrition and physical exercise. Right now, this is a contest of raw political power. We hope to, if we are successful, begin to define the objective criteria, as you suggest. However, we are not at that point yet.

The ‘contest of raw political power’ of which the petitioner writes is a bloody arena in which to expect to see ethical reasoning operating. What are you or am I as professionals to do about the aggressive, profit-motivated actions of governments and private enterprise that are damaging human health, either directly (tobacco) or indirectly (pollution and over-nutrition)? Even if the behaviour of polluters, tobacco companies or food manufacturers is inimical to public health, does this permit us to play eye-for-an-eye with them? Is this part of our professional responsibility? Do we sleep well at night, as public health professionals, if we have fought fire with fire? How much fire?
A wonderfully creative New York advertising executive said to me recently, when we were discussing the global epidemic of obesity, ‘Remember this, Steve! P-lease! The bad guys are in control everywhere’. I must learn, he said, that the sentence is no longer the unit of communication. It is the sound bite. The language of advertising, the headline, text messaging, Hollywood and spin is what a person hears and sees today and from which he or she obtains his or her information. If I had a message about obesity for the world, I must learn the language in which to speak it, or the world will ignore me, he warned me. Where, he left me wondering, does rationality fit, if at all, in this new language? and what of ethics?

What does one do with food companies that buy the favour of politicians so that they do not have to account for practices like advertising their sugar and fat wares during cartoon time to hungry children? Was BUGA UP, an Australian campaign that began in the late 1970s to disfigure billboard posters advertising cigarettes, ethical or criminal? Would public health wish to own it or disown it? It may wish to own it now, but did it then?

The emerging public health discipline of health advocacy unpacks the tricks ‘the bad guys’ use in winning public support. Should public health train a commando force to go and do likewise in the cause of good health? Australian health promotion leader Colin Sindall offers a thoughtful review of ethical discussions in health promotion, one of the effector arms of public health especially useful when confronting social structural impediments to good health, in a recent editorial in Health Promotion International. 4 I commend it as an excellent summary of the state of the art. Sindall, as reviews editor of that journal, concluded with a call for papers to launch a debate about the ethics of health promotion. He has received no submissions, nor has the journal editor, John Catford (personal communications). This is not necessarily a field that is attracting much attention, despite the ethical challenges health promotion and public health pose. However, encouragingly, two excellent articles on the ethics of public health have appeared recently in the Australian and New Zealand Journal of Public Health, one by the eminent Lawrence O. Gostin. 5,6

**ETHICS, HUMAN RIGHTS OR OBLIGATIONS?**

In Arcadia, there would be no need for public health. However, we live in a world that is more Faustian than Arcadian. Ethics are soft and warm. Maybe public health needs rules of action that are tougher. It is then little wonder that the debate about what to do in contemporary public health should contain in it an element that we do not confront often in clinical care: human rights. Ron Bayer, of whom I spoke earlier, offers the view that rights have dominated in the USA because ‘in the US there is no alternative discourse such as solidarity. This is part of the USA's intense individualism’. The big difference between human rights and ethics is that rights ultimately are laws. Ethics are not. Both rights and ethics can derive from, and refer to, values, defined by Jennings from the Hastings Center and the Yale University School of Medicine as ‘names for states of affairs that conform to what is ethically right and that further the human good or the good of all beings’ 7 but they are not the same.

The rights people assert that unless you have permanent and universally accepted definitions of the entitlement of people to good health, you will be debating well past sunrise. Get real, they urge: you cannot have only ethics in society where dictators crush justice, where men treat women terribly, and where majorities flagrantly exert prejudice against minorities. However, you can have universally agreed human rights and hammer them home, using international pressure (backed presumably with rewards and sanctions) to ensure a better deal for people who dictators would otherwise abuse with their excess and greed.

Critics of the rights-based approach point to many occasions when human rights overlap or even conflict: the right to privacy versus the right of public to environmental safety for example. How, the critics ask, can you resolve such conflicts unless you adduce ethical evidence and principles, turn the matter around in debate, and then punt for what appears to be the wisest course of action? O'Neill writes:

> A common problem with rights-based approaches is that rights are usually [ambiguous] phrases such as “right to life” or “right to health” “right to development” and “right to work”…
phrases which have multiple interpretations: they cannot [be rendered unambiguous] without sorting out who has to do what for whom— in short by specifying which obligations correspond to various more specific interpretations of each supposed right. Taking rights as basic to ethics, including health ethics, does not get close enough to the action. 2

O'Neill suggests that developing a systematic account of obligations sheeted home to an understanding of who has to do what for whom makes it easier to pick incoherence:

For example, it is easy and rather fetching to talk about a universal “right to health” but plain enough when one considers who has to do what for whom that universal health cannot be provided, so that there can be no such right. 2

Failing countries cannot secure justice or just health care for their citizens and ‘may make it hard for others to step into the breach’. We then have obligations to do things for those for whom we can. This seems far more realistic. For those with a philosophical bent, as O'Neill points out, the arguments here are ‘minimalist Kantian’ in style.

The late Jonathan Mann of Harvard, a brilliant, passionate public health physician whose work in HIV in the early days of the epidemic through the WHO was legendary, was a major proponent of a human rights-based approach to public health. In looking widely, he saw the great need to protect people, especially in the developing world, through rights if they were to have a chance at health. 8 Mann’s legacy is powerful and the debate rages. For an example, I direct you to a paper by Nancy Kass from the Department of Health Policy and Management at Johns Hopkins University 9 and to a response to it from Sofia Gruskin from the International Health and Human Rights Program in Boston. 10

Lawrence O. Gostin, a professor of law at Georgetown University in Washington DC, and a professor of public health at Johns Hopkins University, is an outstanding (lonely) figure in the field of public health ethics, values and rights. Gostin argues that the fields of public health, human rights and ethics need to use words carefully. 11 They should follow Confucius’ dictum: ‘First, rectify the language’. One should not think, as a public health person, that one has automatic familiarity with the concepts of rights or ethics. Take care, he urges, with one another’s concepts.

Gostin explores the nature of public health, human rights and ethics. Public health is ‘what we, as a society, do collectively to assure the conditions for people to be healthy’ says the US Institute of Medicine. 12 While there is much that individuals can do to promote their own health – eating well, exercising, not smoking – there are things that society must do through government and collective action to ensure environmental safety, hygiene, sanitation, clean air and water, safe roads and cars, well planned cities, recreational space and control of infectious disease. These collective goods, as Gostin calls them, are achieved only by organised and sustained community activities. 11

In relation to the ethics of public health, Gostin dismisses the claim that public health cares not a toss for individuals. ‘In the public health model’, he writes, ‘individual interests in autonomy, privacy, liberty, and property are taken seriously, but they do not invariably trump community health benefits’. 11 Gostin agrees that there remains much to do in public health ethics:

What is the moral standing that should be attached to the collective good? Does the health of the community have a moral standing that is independent of the health of individuals within that population? Under what circumstances should individual interests yield to achieve an aggregate benefit for the population?’. 11

Gostin concludes by identifying four areas where ethics can assist public health in its mission: 11 (i) helping define the meaning of public health professionalism and the ethical practice of the profession; (ii) guiding discussion on the moral weight and value of the community’s health and well-being; (iii) addressing the recurring themes of the field and the dilemmas.
faced in everyday public health practice and (iv) guiding the use of advocacy to achieve the goal of safer and healthier populations.

As noted, Mann emphasised the role of human rights in the attainment of better health. Unless women in Africa at risk of HIV are free of physical and emotional abuse by their husbands through the rule of laws against domestic violence, they are powerless to use knowledge and skills to assist them in preventing HIV. Human rights operate best by being enshrined in laws, including the Universal Declaration of Human Rights. Ethicists by contrast ‘seldom refer to international law doctrine’ and instead ‘employ philosophical reasoning and argumentation’. Confusion may occur, then, when ethicists speak of human rights, because to an ethicist, justice may be a philosophical concept whereas to a human rights person it derives from the operation of a law. Much work also remains in the field of rights for it to achieve all it can offer to public health.

Relevant to these concerns is another philosophical debate that has been running in different forms since John Rawls, the late twentieth century's most influential moral philosopher, published A Theory of Justice in 1971. That debate is between those who value community concepts and traditions and those who elevate individualism. The former include communitarians, the latter liberals. The former elevate connectedness through social formation and the latter value the power of the market. It is obvious that these philosophical positions will take a different view of public health and advance different ethical principles and processes by which to transact its business. This is a huge topic and I suggest, as an introduction, an entry in the Stanford Encyclopedia of Philosophy as a starting point for those interested in pursuing this debate.

EDUCATION RESOURCES FOR ETHICS IN PUBLIC HEALTH

How are those of us who are public health educators to handle this topic? What resources can we use? Ronald Bayer, professor of public health at the Joseph L Mailman School of Public Health at Columbia University (my lunch partner to whom I have referred twice already), has provided two thoughtful modules about the ethics of infectious disease control and health promotion, for a model curriculum in ethics and public health developed under the aegis of the Hastings Center in New York for the US Association of Schools of Public Health. I commend these two modules (and the rest of the curriculum) to fellow educators.

The American Public Health Leadership Society sponsored the development of a code of ethics for public health in 2000–2001 and published it in 2002. The code may be useful to public health educators in provoking debate among students. It defines a series of behavioural virtues that one might hope to see expressed in the professional conduct of public health practitioners. The principles underlying the code of ethics include public health addressing the fundamental causes of illness, respecting the rights of individuals, policies developed in consultation with the community, institutions reacting in a timely way to the information available to them and so on. Being a document from the USA, the authors found that the principle relating to ‘enhanced physical and social environments’ had no essential public health service committed to its achievement. A consensus process was used to identify these principles and so they reflect common understanding among a vast and impressive array of participating public health organisations.

CONCLUSION

To summarise, there are different approaches available to public health ethics. It can be a matter of discussion and philosophical debate accepting as given a set of ethical principles or values (beneficence, etc.) or using an approach that seeks to unravel and judge the likely consequences of different courses of action. Hence we can use the different notions of ethical goodness and the methods that we invoke when we discuss difficult clinical problems. However, even here, it is important to see beyond valuing the individual to value society as an organic entity requiring preservation through actions that may not sit comfortably with a valorised notion of individuality. Alternatively, one can reach out for a progressively codified
set of human rights, located in international law, and seek to enact them through casuistic exposition and interpretation and political action.

Finally, one might seek to discern what one's obligation is in any ethically challenging situation, using reason to assess the proposed course of action for coherence and not reaching for an impossible ideal.

REFERENCES


2 O'Neill O. Public health or clinical ethics: thinking beyond borders. Ethics Int Affairs 2002; 16: 35–45. [Context Link]


4 Sindall C. Does health promotion need a code of ethics? Health Promot Int 2002; 17: 201–3. [Context Link]


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