This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

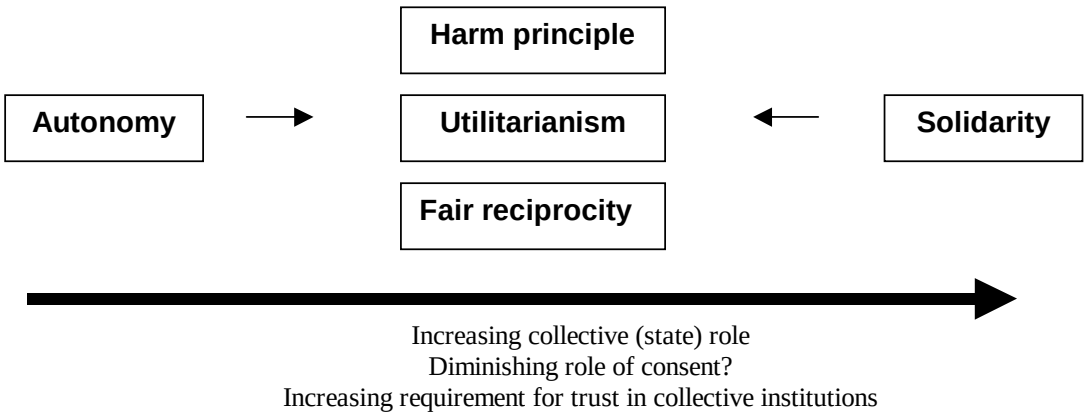
Dr David S Gordon

I found this an extremely difficult paper to engage with. The case study approach tended to obscure the overarching principles; by focusing on particular examples the case studies encouraged the contingent and pragmatic thinking that is typically the hallmark of public health ethics in practice. The approach didn't, for me, bring to the fore the bigger issues as it was, no doubt, intended to. Indeed, it would have been much more profitable to have considered and responded to the questions posed rhetorically on pages 7-8. But you chose not to frame the debate in this way.

I fail to understand why the factors that influence public health are being regarded as an ethical issue. Whether your list is correct or not, this is a matter for scientific rather than ethical debate.

Utilitarianism is not included as one of the principles, but is one that (with safeguards for minorities) often underlies public health decisions.

All the principles, including utilitarianism can be applied. Which is the prime principle in a particular issue depends upon the issue, its context, and the perceived motivations of and trust in the actors involved. The principles can only be crudely ranked, and the poles of autonomy and solidarity represent philosophical starting points which one adapts to the reality of a particular situation. This can lead to a varied and probably inconsistent application of principles in real life. Pragmatism is hardly a principle, but it is often a substantial modifier of principle.



On 19 June 1883, Lyon Playfair made a speech in favour of smallpox vaccination in the House of Commons. His conclusion was that it should not be left to the conscience of the individual:
"A man may burn down his house if he injures no-one but himself. If he affects his neighbours we punish him. Likewise smallpox vaccination."

But what, in a welfare state, is the contemporary definition of 'injury'? Injury might extend to not exploiting unreasonably the charity of others - directly or through the state - so perhaps an individual might burn down his house only if he has another place to stay. And, if an action carries some element of risk for the individual, what risk should an individual accept for the common good? And how clearly should that risk be communicated if it leads to self-interested action that, taken overall, produces a net level of population harm? So what starts out as a seemingly simple proposition accepting autonomy in some actions but with the harm principle requiring solidarity for others, becomes less clear as one moves from (abstract) principle to (real world) practice.

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

To the (large) extent that public health is put into practice through the state and its organs, I suspect that views on public health ethics (and particularly the autonomy-solidarity dimension) cannot be very clearly distinguished from views of the state. There is an important difference between voluntary solidarity, about which one can be wholly positive, and solidarity that is imposed upon individuals by the monopoly power of the state, about which I grow increasingly wary.

Indeed, reflecting on my personal stance (which may not always be the same as my professional stance!), probably the greatest change in my principles over my adult life has been my diminishing level of trust in state-sponsored vehicles of solidarity, which I formerly saw in a much more benign light than I now do.

An important consideration in this is that personal positions are rarely arrived at solely as a result of scientific considerations such as evidence, risk and uncertainty. It is perceptions of evidence, risk and uncertainty that matter; and these are very much shaped by perceptions of, and trust in, those providing the information.

This can, and does, lead to clear dissonance on occasion between personal and professional views. Professionally, I know the evidence and can weigh it up and come to a position. Personally, I observe the exploitation and manipulation of the evidence to serve interested parties (as well as genuinely disinterested advocacy for public health) and lack trust while feeling that often lip service, at best, is being paid to my right to consent or withold consent as a free citizen. Power is abused by commercial interests but it is also abused by the state that should serve as the protector of its citizens.

I did not mean this to become a bit of a rant, but that it did so perhaps helps illustrate how public health ethics have become intertwined with views of the wider role of the state given that it is public health's sponsor (?master) in the UK.