Dr I M Jessiman

In this consultation the most important matter on which I should like to comment is the ethics section. I shall deal with this first.

Part B Section 5. Ethical issues.

It seems to me that the ethical basis offered in the consultation document is inadequate. The foundations of society, as such, are much more basic than just autonomy and solidarity. The 'common good' of a society is derived from the individual humanity or 'human nature' of the individuals composing it. We are all human beings and as such have an innate relationship with other human beings. On this is based the rights and duties of all the members of the race.

Autonomy cannot be totally unrestrained or unrestricted in any society if that society is to survive. Our individual autonomies interrelate and must therefore be limited by the autonomies of others. The autonomy of one individual cannot 'claim' precedence over that of another. If this is not to be so, and everyone can simply do what they like, then society becomes impossible. Judgements under the present 'human rights legislation' are showing that one-sided emphasis on the rights of the individual can be destructive of the rights of the group. If by nothing else, individual autonomy must be limited by the 'common good' or harmonious co-existence becomes impossible. My autonomy does not give me the right to ignore or overlook the rights of others.

Solidarity, then, is an inadequate concept to explain the mutual rights and duties in society. It would suggest that an individual's autonomy is restricted only by his/her voluntary surrender of some part of it, insofar as he/she recognises that others have needs. This seems to carry no sense of obligation to others except that which is voluntarily adopted after becoming aware of a need. Such a minimal obligation would not be enough to maintain a unified society (at any level) nor even co-operation between individuals.

As a technical description of relationships in a mutual 'insurance' scheme 'solidarity' has a particular connotation, but this is a practical description, not an ethical principle.

Fair reciprocity is also even less convincing as a reason for individuals to act together. However, in the same context as mentioned for solidarity it describes an alternative scheme of mutual relationships.

The harm principle is entailed in the idea of an obligation to the common good and to the individuals who compose it. But the concept could only carry weight as part of an over-riding obligation to society as a whole.

Consent. Because any society, as a whole, has certain independent 'rights' and authority, as against the autonomy of individuals who compose it, it can, for a sufficient reason, override the autonomy of an individual or minority in favour of that of the majority. But this is a power that any society should only exercise when is imperative that things cannot be left uncontrolled and as they are.

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.

Trust has little to do with autonomy or even the ethical bases for action, but refers to the willingness of individuals or a group to trust the guidance or decisions of others, in this connection particularly those in authority.

Science and knowledge progress by debate. This requires the postulation of a theory and its subsequent confirmation or rebuttal by others. Nowadays the media, probably for reasons of circulation rather than mere ignorance, will take any postulate and publish it as 'accepted fact' before it has been adequately assessed and debated by others in that field. This is making it difficult for science to advance without emotional factors (from the media or the general public) coming into play.

Part A. *Questions 9*. Ethical issues.

As explained above I do not think any of the principles quoted provides an adequate basis for exploring the ethical issues. Insofar as the principles can be listed in order, following after the basic obligation to the common good (or to humanity as a whole), I would suggest consent (which, of course, implies autonomy), autonomy, trust, solidarity, fair reciprocity and the harm principle.

In the application of ethics to the cases quoted I would argue that a Government, or by devolution a local authority, has the right and power to prevent an individual doing harm to others or to society as a whole, but has no prima facie right to prevent individuals doing things which may harm only themselves.

In a society such as ours, where we have taken over the responsibility for treating all members of our society (NHS), there could be grounds for claiming the power to restrain individuals from doing things which would be harmful to society purely in terms of the cost to the NHS. To invoke such a power there would have to be incontrovertible grounds for believing such things were related as cause and effect, and not merely 'likely to be' or 'probably' connected. There may be other factors to consider as if, for example, something were to be banned and people would then turn to something even more harmful.

Questions 2. Factors that influence public health.

I agree that these encompass all the main factors and would list them, in order of importance, as genetic factors, environment (including climate, etc), social and economic factors, lifestyle, and preventative and curative health services.

Questions 3. Prevention of infectious disease through vaccination.

For a policy of compulsory vaccination there would need to be very compelling reasons, which do not pertain in this country at present. Such policies were introduced in USA when Polio was a common and very grave threat to the life and subsequent health of many. It might apply now in the face of an acute lethal epidemic.

Parents must decide what is in the best interests of their child. Generally the state must not presume to know better and may not override their decision. <u>Rarely</u> it might deem it sufficiently urgent or serious to intervene.

Questions 4. Control of infectious disease…

Forced quarantine might be appropriate for an individual carrying a very serious infective disease, but it would hardly be possible (practical) in this day and age to quarantine a group of people or an area.

Assistance to other countries would need to be on a voluntary basis.

Monitoring. It is desirable for co-operation beyond national boundaries to monitor or control serious infectious disease.

Mandatory testing could well be justified where someone might be carrying a disease which was a serious threat to the public good. This would be more easily justified in the case of would-be immigrants. I believe that it would be in order for someone with open TB which they refused to have treated, to be placed in protective (preventative) detention (for the protection of others).

Question 5. Obesity

Education must be the primary approach.

Control of the 'sales side' by labelling and price inducement.

Education, starting with the school population, and by ensuring the provision of proper healthy diet at schools. It is to be hoped this may lead to improved diets for the next generation.

In general terms it is not acceptable to limit the NHS services which are available to those who are obese. Doctors, in parallel with the GMC guidance (page 14, footnote), must always act in the best interests of the individual patient who is in front of them. This is part of their professionalism and code of practice. Where remediable obesity will counteract the expected benefit of treatment (eg. joint surgery) or is actually causing the problem there may be grounds for deferring treatment.

Question 6. Smoking.

The delayed response probably results from concern over loss of taxation revenue and over loss of jobs for those working in the tobacco industry.

Companies should act responsibly in publicising the risks of smoking, but the government needs to forbid advertising to increase sales (especially to young people). After this I am not in favour of any particular liability for the firms concerned.

No system of risk-related financial liability for particular groups of people is justified. Not all smokers develop cancer or other smoking related diseases. It could be argued that society bears some responsibility for failing to alleviate the underlying causes of their resorting to smoking (or drinking) in the first place (both transiently stress-relieving but eventually addictive).

I do not believe the state can impose sanctions to prevent smoking other than by increase in price (by taxation). Smokers are commonly addicted after a few years and they may then have great difficulty in giving up (which needs help). On the other hand this gives an important reason for trying to prevent younger people starting to smoke by way of forbidding advertising and sale of tobacco to under 18s.

Question 7. Alcohol.

The reason for the delay in tackling this problem is the 'selective' nature of the addiction, probably based on genetic make-up, so that some become more easily or more quickly addicted than others. This means that many see it as relatively harmless.

As with smoking there is a clash between the need to increase sales, and a responsibility not to do harm to others. The retailer has the greatest responsibility in limiting promotional gimmicks ('happy hours') and ensuring that under age 'clients' cannot get alcohol.

Question 8. Supplementation…

The biggest reason why some forms of supplementation were more easily introduced than others is, largely, the change in public outlook on such matters. When fortification of bread was introduced in wartime the government view was accepted without question and there were more important things to worry about. It was usual, for example, at that time, to give school children in some parts of Canada Iodine supplements in tablet form. This appears to have been accepted without cavil. In any case such matters were for the avoidance of actual ill health and not merely, as with fluoridation, to prevent possible dental caries some time in the future.

Nowadays public consultation is unavoidable and any such proposal will always provoke some opposition. Such episodes as BSE and even Foot-&-Mouth have shown that official advice may sometimes to be seriously flawed. Reluctant assent might be achievable if it could be shown that there is an indisputable benefit for the vast majority. One reason for the non acceptance of MMR has been the claim that it has no harmful side effects, when all that can truly be said is that 'we have no evidence, at this stage, of serious side effects'. The public can recognise the difference and would have been more receptive if the limitations of the evidence had been honestly declared from the outset.

I believe only Parliament would be seen, nowadays, as having the necessary authority – even if the implementation were to be dependent on local agencies.

The right of adults to choose on behalf of their children is limited to choosing only what is in their best interests. However, it must be absolutely clear what is in the children's best interests before anyone else (state, agency or individual) can intervene. In my opinion the balance of clear benefit of fluoridation in areas where this is deficient, and with virtually no harmful side effects, is much more convincing than the balance of arguments put forward in favour of MMR (see above).

Question 9. Ethical Issues.

See above.

I Jessiman