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 Peter Lucas

QUESTIONS ANSWERED:

Question 1 The definition of public health

ANSWER:
No, I don't agree. 'What we as a society collectively do…' covers many different health measures, some of which are individually targeted, and wouldn't normally be thought of as 'public health' measures. I would have thought that the essence of public health is better captured by saying that it is about collectively TARGETED action to improve health. (That is, public health interventions are practices and policies that intervene at the collective level, rather than simply being examples of collective action.)

Question 2 Factors that influence public health

ANSWER:
No comment

Question 4 Control of infectious disease

ANSWER:
1. Measures such as forced quarantine do seem to me to be justifiable, but only within the kinds of limits referred to in the quoted (p.17) passage from the 2004 Civil Contingencies Act - namely in emergency situations which threaten serious damage to human welfare (for example, a situation in which a disease which is typically fatal or permanently disabling is spreading out of control, and threatening to affect a substantial proportion of the population). 2. In principle these measures could be 'exported' to other jurisdictions. But this would have to involve an acceptance that overriding the customary rights of one's own citizens in their own interests is easier to justify than overriding the rights of citizens of other countries, primarily to benefit one's own citizens. No comment on 3 or 4

Question 3 Prevention of infectious diseases through vaccination

ANSWER:
1. The European Convention on Human Rights and Biomedicine establishes a basic right not to be subject to medical interventions without one's consent. As my answer to the earlier question about quarantine etc indicates, I think this right can be overridden in situations of dire emergency. But for the types of vaccination programmes in question overriding this basic right is not justifiable, since these are not emergency situations posing a severe threat to human welfare (not only are the conditions in question fairly well controlled, they are not normally fatal or permanently disabling). The fact that there are distinct public health benefits to be gained from a high take up doesn't in and of itself justify compulsion. (Incidentally, your presentation of the 'free-rider' problem is seriously misleading. That 'free riding' is morally wrong is by no means a consensus or even a majority view. The free rider

problem arises as a problem for consequentialist moral theories which imply a moral obligation to 'free ride' in certain circumstances. For example, in the vaccination case, an act utilitarian must say that once herd immunity has been achieved, we are under an obligation to ensure that the remaining 10% or whatever of the population do not receive the vaccine, since to vaccinate them in these circumstances would be to expose them to harms for no additional benefit. Even if we consider this to be a serious problem for act Utilitarianism - and some do not - it is a further step to argue that not only is it not obligatory to be a free rider in some circumstances, it is morally wrong to be a free rider. A rational egoist would argue that free-riding where possible is the only rational thing to do. Even if this is morally irresponsible - and it is not an easy thing to show - it remains to be shown that parents who refuse to have their children vaccinated are motivated by egoism. The vast majority of them are not aiming to take advantage of herd immunity, but are opposed to ANY child being given the vaccine. Thus they cannot legitimately be portrayed as rational egoists. Anyone who wants to argue that it is wrong to be a free rider WHATEVER one's motives owes us an explanation of why it is better that we should have 100% vaccine take up than 90% take up, with resulting herd immunity, and with 10% of the population protected from all vaccine-associated harms and risks. 2. The vaccination of children against the wishes of their parents seems to me to be only justifiable in the sorts of cases where it would simultaneously be justifiable to vaccinate the parents against their own wishes - that is, in the above-mentioned cases of dire emergency. A very important distinction overlooked throughout the consultation paper, and highly relevant to this case, is that between benefit and need. From the fact that my child will BENEFIT from a given intervention (and, accordingly, it is in her interests to receive that intervention), it does not follow she NEEDS that intervention. Consequently it does not follow that the NHS is obliged to deliver it(since the NHS was established to address health needs, rather than simply to dispense benefits). Many healthcare decisions already implicitly invoke this distinction. For example, almost everyone would benefit from cosmetic surgery, and accordingly it is in almost everyone's interests to receive cosmetic surgery, but very few people NEED cosmetic surgery, and consequently only serious burns victims etc receive cosmetic surgery on the NHS. When parents make decision about vaccination they ideally take as broad as possible a view of the child's interests. Even if it is the case that the child would benefit from being vaccinated it does not follow that she needs it, or that there is an obligation on the NHS or anyone else to ensure that it takes place.

Question 5 Obesity

ANSWER:
1. This is an odd question. Why would anyone think that attempts to influence people's eating habits were PARTICULARLY intrusive? If we confine ourselves to the promotion of healthy eating, and (potentially) to legislation aimed at food manufacturers to design and market their products responsibilty, I don't think there are any special sensitivities connected with food to be taken into account. 2. No comment. 3. It is pretty much a given in this area that there should be a mismatch between parental attitudes and behaviours and government/NHS guidance - that is

primarily why the guidance is there. However it is surely scandalous if there is an enduring mismatch between school food provision (including, but of course not limited to, the routine distribution of sweets by teachers as rewards for good work or behaviour), and government guidance. The production and marketing by the food industry of products specifically aimed at children is also susceptible to direct government interventon through legislation. Consequently, I expect schools and the food industry to be brought into line first, with the aim of setting an example to parents. 4. It is not in my view acceptable to make obesity as such a criterion in resource allocation decisions. However insofar as obesity is inevitably linked to the likely effectivness of any treatment, it is hard to see how the pursuit of cost-effectiveness can avoid the establishment of what amounts to a triage system that systematically disadvantages seriously obese patients.

Question 6 Smoking

ANSWER:
1. No comment. 2. I think legal action against tobacco companies would be desirable, not necessarily to prosecute for past crimes, but to prevent future sales. The most effective and consistent line might be to challenge the safety of the products in their intended use. The vast majority of tobacco products are clearly aimed at 'smokers' (and potential 'smokers'). That is, they are intended to be used habitually, and marketed as such. If they are not safe to use habitually - and they surely are not - then they are not safe for their intended use. I believe that the promotion and sale of chewing tobacco - under the trade name 'Skoal Bandit' - was successfully challenged on this basis during the nineteen eighties. 3. Your figures reveal that smokers already contribute through tax far more than they absorb through additional health care costs. It therefore seems prudent not to go down the road of asking for further contributions. I'm not aware of any evidence showing that accidents connected with extreme sports absorb a significant proportion of the NHS budget. Incidentally, it seems bizarre to describe cycling in major cities as a risky activity without addressing what makes it risky, namely DRIVING in big cities (and elsewhere). Surely THAT is the relevant public health concern? 4. Virtually everyone agrees that the state is entitled to intervene in cases of serious self-harm. Whether smoking in and of itself amounts to such a case is a moot point. However, pursuing the line that tobacco products are not safe for their intended use could result in their sale being prohibited, without directly raising that question - you are free to smoke, but you are not free to manufacture and sell tobacco products. It is hard to see how the state can prevent children and teenagers having access to tobacco products without imposing severe general restrictions on their manufacture and/or sale.

Question 7 Alcohol

ANSWER:
1. Comprehensive measures to prevent harm from alcohol have quite properly 'lagged behind' measures to control tobacco products because the rational case for such measures is much weaker. Alcohol products are not intended for habitual use in the way that tobacco products are, and there is therefore a reasonable case for

saying that the social and health problems associated with alcohol arise from its misuse, rather than from its intended use. 2. The above answer is not of course intended to suggest that alcohol misuse isn't common. I certainly think that manufacturers and retailers should be compelled to ensure that their marketing promotes responsible use.

Question 8 Supplementation of food and water

ANSWER:
1. The reasons why fluoridation quite reasonably meets resistance are broadly as follows: Fluoridation of public water supplies is not an example of of 'supplementation'. The three examples of supplemetation discussed in the consultation document (restoration of nutrients, addition of nutrients in 'substitute' foods, addition of nutrients to breakfast cereals etc) all seek to address dietary deficiencies; and all of these cases concern substances that can reasonably be characterised as NUTRIENTS - as the wording of your own discussion reveals. Fluoride is not a nutrient. Fluoride at the relevant levels is not a necessary or even a desirable component of a healthy human diet (nor is it a naturally-occuring component of the typical human diet). The fluoridation of public water supplies cannot therefore reasonably be presented as an attempt to address a dietary deficiency. What it is is an attempt to deliver a medical intervention by dietary means. The European Convention on Human Rights and Biomedicine recognises a basic right not to be subjected to medical interventions without consent. As my earlier answers indicate, I think this right is overridable in cases of dire emergency. But the control of dental caries is very far from being such a case. Many many people, perhaps a majority, do not want this intervention, and the majority do not NEED it. In my earlier answer on the topic of vaccination I referred to the key distinction between benefit and need. Proponents of fluoridation systematically overlook this distinction, pointing out that the majority of people would benefit from fluoridation. But 'benefit' is not what is most important here. The vast majority of sufferers from dental caries can control their condition without any additional help. For the small number of severe cases, who arguably do need additional fluoride, fluoridating the public water supply is completely inappropriate as a delivery method. Fluoridating soft drinks would make a lot more sense, and would enable those who neither need nor want additional fluoride to exercise some choice. But the evident absurdity of this suggestion serves to highlight the real issue: severe dental caries is caused by an excessively sugar-rich diet, not by some mythical 'deficiency' of fluoride. No doubt efforts to address the problem by encouraging peoople to eat a balanced diet are making frustratingly slow progress, and hopefully that situation will change soon (on the positive side, any progress that does occur in this area simultaneously brings progress in other areas, such as the control of obesity). But in the meantime it would be absolutely wrong to override the basic rights of the majority who neither need nor want the relevant medical intervention in order to address a comparatively minor health problem which is properly tackled by education and a change of diet (and perhaps by government measures to control the sale and marketing of sugar-rich foods, particularly those aimed at young children). 2. I fail to

see how any democratic instrument can justify a policy that would involve overriding a basic human right for relatively trivial reasons. 3. As with my answer on childhood vaccinations: consistency requires that we only override parental consent in respect of an intervention involving their children in circumstances that would warrant overriding their consent in respect of an intervention involving the parents themselves. These would be the aforementioned cases of dire emergency. To repeat: that health benefits are obtainable by certain public health measures does not entitle us to override the basic right not to be subjected to a health intervention without consent except in emergency cases, to address severe needs. I don't think ANYTHING justifies subjecting someone to a medical intervention they neither need nor want when alternative delivery methods that would avoid such violations of basic rights are easily available.

Question 9 Ethical issues

ANSWER:
1, 2 & 3. On my reading of the consultation document only the first four of these principles are presented as 'guiding principles concerning the way we behave toward others'. These four principles parallel the globally well-established four principles of biomedical ethics, and I see no reason to depart from the standard view that none of them is automatically privileged. However, I would argue that an ethical framework primarily designed for the professional context is not appropriate for discussing the responsibilities of parents vis a vis their children. Parents have particular duties involving reasonable partiality in respect of their own children (for example, privileging the needs of their own children over others, if faced with a choice). These cannot be accommodated within the deliberately neutral professionally-oriented schema. I would suggest that a principle of familial care/loyalty be added, which is distinguished from more general 'solidarity', and professional duties of care, and which will potentially legitimate the actions of parents who are concerned to jealously protect the perceived interests of their own children in the face of recommendations by health professional who do not and cannot have the same kinds of duties to protect the interest of those particular children. it is on the basis of this idea of familial care/loyalty that parents make judgements about the interests and needs of their own children. This principle would incidentally also potentially cover a grown-up child's decisions concerning the care of their aged parents. On consent: documents such as the European Convention on Human Rights and Biomedicine give a central place to consent. As a very general point I think we should be suspicious of any moves to undermine that role in public health contexts, excepting situations of dire emergency. On trust: the important point here is surely professional trustworthiness. As commentators such as Chomsky and Herman have emphasised, trust is hard to earn, but relatively easy to manufacture. Those involved in public health need to pay attention to earning trust - for example by being candid about the fact that fluoridation is mass medication - instead of devoting themselves to manufacturing it.