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.

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We are pleased to have the opportunity to comment on the above **consultation paper**. We are an academic centre that carries out research, teaching and support to health services in medical ethics and law. The Centre is multi-disciplinary and includes researchers with backgrounds in: philosophy; law; social science; and clinical medicine (Appendix 1). The focus of our responses is on the ethical framework.

1. We welcome this report. Public Health raises a large number of difficult ethical issues and yet it is a relatively under-developed area of health-care ethics.

Scope of report

2. We note that the 2007 Report focus is to offer "advice that is primarily relevant to UK policy and practice" (page 8) and with special emphasis on the NHS. Many of the major ethical issues in public health relate to global issues and, in particular, to the relationships between rich and poor countries. Furthermore many of the issues that arise within the UK context also have impact more globally. For example, cycling is mentioned a couple of times in the report. Policies affecting transport in the UK affect global climate change which affects global health. The consequences of public health measures and therefore the ethical issues cannot be limited to the UK.

We recommend therefore that the Report clearly recognises the relationship between public health ethics within the UK and the broader global issues.

Even with a focus on the UK we believe that the scope is rather narrow. There is little mention of poverty, and other social issues that have major effects on public health. We are also struck by the prominence given to individual responsibility and the 'punishing' of individuals for 'lifestyle choices'. This is seen in the third bullet point of the section on the responsibilities of government on page 7 where the question is immediately posed as to whether those in low socio-economic groups should be held responsible for their health problems, and again in the third bullet point of the section on the responsibilities of individuals. Although these are legitimate questions to consider we believe that the balance of the document in this introductory section comes across as somewhat insensitive to the difficulties faced by disadvantaged members of society. In a document on public health ethics we believe that there should be greater emphasis on the social conditions that help to maintain poor health and on the limits to individual choice for many members of our society.

The ethical principles

3. The way in which ethical principles are dealt with in this report is, we believe, somewhat inconsistent, confusing, and idiosyncratic.

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4. It is inconsistent, for example, in that on page 11 (point 9) six 'principles' are enumerated (autonomy; solidarity; fair reciprocity; harm principle; consent; and trust). On pages 37 *et.seq.* four 'principles' are discussed (autonomy; solidarity; fair reciprocity; and harm principle). Consent and trust are presented (on page 39) not as principles but as aspects that are important in addressing challenges.

5. There are, we believe, good reasons for considering consent and trust as something other than principles. We find the presentation of principles confusing partly because the six, or even the four, examples given play very different roles in ethical reasoning. In our view, for example, both respecting autonomy, and avoiding harm, are principles that can inform ethical judgments in public health. Trust, on the other hand, is a condition, or requirement, if (particular) public health measures are to be followed, or enforced, within a democratic society. Solidarity again might be seen either as a condition, or as underpinning a particular approach to ethics, but it is not a principle. It might underpin a principle of justice, but it is not a principle in itself. This can be seen in the attempt to explain the concept. No general explication of the 'principle' is given; rather specific examples are given of what might follow from the 'principle'.

6. The presentation is also confusing because the explanations of some of the 'principles' are unclear and confusing. This is particularly the case with 'fair reciprocity'. Two examples of what it might 'entail' are given but there is no coherent account of the concept.

7. The final choice of four principles as: autonomy; solidarity; fair reciprocity; and the 'harm principle' is idiosyncratic. It reads to us as though the committee wanted to fall over backwards to avoid using the widely identified, and extensively analysed, 'four principles of bioethics' (respect for autonomy; maximising benefit; avoiding harm; and justice/fairness). The result is that the four 'principles' proposed lack clarity and two of them (solidarity and fair reciprocity) are ill-defined.

The report may have avoided using the conventional four principles on the grounds that they have been developed with the paradigm of individual patient care in mind rather than public health. It is true, we believe, that the balancing of ethical considerations is often rather different in the public health setting compared with the clinical setting (see also point 9 below). There is often a particular tension, in the public health setting, between broadly utilitarian considerations and more duty-based approaches. To a considerable extent public health starts with considerations of what is best for society and clinical care starts with the question of what is in the best interests of an individual patient. This distinction, however, can be exaggerated. The good of 'society' or of a population is still grounded in the good of individuals, and utilitarianism is concerned with the good of individuals. In our view, therefore, although the judgements about how to apply different ethical principles and broader ethical theories may often be rather different in the public health setting compared with clinical care, the principles and theories that need to be considered are the same.

8. Our recommendation is threefold:

a) That it be made clear that in analysing ethical issues there are many different approaches (e.g. use of principles; exploration of more general ethical theory; and case comparison). Application of principles is often valuable but it is neither the only method of analysis nor is it always sufficient (principles clash, or a principle might be interpreted in different ways for a given situation, for example).

b) In so far as the report discusses key ethical principles we recommend that these should be the widely advocated 'four principles' rather than using two of them and using two others. The conventional principles have the advantage of having been developed and analysed in great detail, of being clear and coherent, and of being widely understood. The principle of justice, for example, is we believe much clearer, and has been subject to much greater analysis, than 'fair reciprocity'. The points that are raised under 'solidarity' and 'fair reciprocity' could be discussed (with more coherence) under the principle of justice.

c) That, having identified and explained the key principles, the report should go on to highlight issues that are important if good public health policies are to be devised and carried out. In making practical decisions on an ethical basis it is important to combine principles with facts about the world, including the fact that we, as individuals, are interdependent and that therefore trust, solidarity and mutual obligations are important concepts. Trust (by the population in policy makers and health professionals), for example, is important for many policies to be effective (but it is not a principle in itself). Indeed, solidarity, trust and reciprocity are aspects of the relationships between people that help to facilitate agreement over public health measures rather than principles. The discussion of 'consent' seems to us best dealt with in part as an analysis of respect for autonomy (e.g. that the principle implies that individuals are properly informed) and in part framed within a discussion of how different principles conflict (e.g. avoiding harm to some people, or maximising benefit – as with fluoridation of water – where the benefit to most clashes with respecting individual autonomy).

Hierarchy of principles

9. We believe that there is no hierarchy of principles and that judgment is inescapable when faced with situations in which different principles would lead to different actions. In the public health setting the principles will typically be weighed in different ways compared with clinical situations. This is because public health measures normally affect many people whereas the focus of clinical situations is often on the interests of an individual. Considerations of justice are often more salient in the public health setting. Different public health situations, however, will require different approaches to the judgments to be made, and respect for individual autonomy is important even when considering interventions at the level of a large population.

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Specific responses to your questions

10 Compulsory vaccination

There are three grounds in favour of compulsion:

a) For the health and safety of others (i.e. the herd immunity issue). Respecting individual autonomy puts others at risk and on the principles of avoiding harm and maximising benefit (as well as justice) compulsion can be justified.

b) On the principle of justice alone: that allowing 'free riders' is unjust. In fact we would not worry much about the free rider issue except where it leads to more harm (thus if in fact sufficient numbers of people are vaccinated voluntarily to give herd immunity we do not think that compulsion would be justified simply because of the unfairness of allowing free riders).

c) In individual best interests (e.g. where it would overall be better for this child to be vaccinated against whooping cough: this provides grounds, based on the child's best interests, for overriding parental refusal).

11. Control of infectious diseases

Again an infringement of civil liberties (autonomy) can be justified on grounds of preventing harm. However we would only find compulsory quarantine acceptable if other less coercive measures (e.g. education) had been used first.

12. Obesity

We do not believe that it is acceptable to make NHS services dependent on individuals losing weight, for two reasons: first, the degree of control that individuals have (given their individual histories, their socio-economic situation, and their genetics) is not clear and probably much less than is often assumed; and second, in a society where there are so many ways in which individuals are encouraged to become obese (advertising; food industry products) it is then unfair to penalise those affected by these encouragements.

13.Smoking

Do smokers in fact cost more over their life-time? Again, given all the social pressures, and lack of control that many people will have (e.g. because addicted from a young age) we do not believe that smokers should be at lower priority for services.

14. Supplementation of water

This can be justified for maximising benefit (and preventing harm). The concern here is whether the long term effects will turn out to be worse so the key here is the degree of evidence that such measures are in the long term in the best interests of the population.

15 Cycling

We believe that cycling should not be used as an example of where a person has irresponsibly brought trauma on themselves (pages 7 and 15). This is for three reasons:

a) There is evidence that, overall, cycling reduces mortality and morbidity (because it is good exercise).

b) If someone is cycling rather than driving then they are at less risk of harming others (so this is not an example of someone doing something that increases their own risk but has no other relevant consequences).

c) There are strong environmental reasons (and hence public health reasons) for encouraging cycling. Cyclists are perhaps a group who should be given higher priority than others for health care since they reduce morbidity and mortality for others!