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Mr David Algie, Senior Policy Executive, British Medical Association

Thank you for the opportunity to submit comments on the Council's consultation document on ethical issues in public health. This has been considered by the BMA and we have provided responses to the questions outlined in the document below:

***Question 1:**: Do you agree with the definition of public health introduced above ("What we as a society, collectively do to assure the conditions for people to be healthy")? If not, please explain why. What alternative definition would you propose?*

There are of course a number of definitions of 'public health' in circulation. The consultation paper uses the influential definition provided by the American Institute of Medicine. The *Oxford Handbook of Public Health Practice* defines it as "the science and art of improving the population's health through the organized efforts of society, using the techniques of disease prevention, health protection, and health promotion."[1] Another similar and widespread definition, quoted in *The New Dictionary of Medical Ethics* is "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society."[2]

Public health incorporates a large variety of activities, and the limits to what constitute legitimate activity in the field is sometimes contested. While few would dispute, for example, that the control of infectious diseases forms a legitimate part of public health activity, the extent to which public health professionals should take action to modify the underlying socio-economic determinants of health is the subject of disagreement. The boundary between public health and political activity can be uncertain. On the other hand, the distinction between public health activities and the direct provision of health services to individual patients can also be unclear. While the development of vaccination programmes is undoubtedly a public health responsibility, the delivery of vaccines to individual patients is often undertaken by primary health care staff.

Arguably this lack of conceptual clarity has contributed to the comparative lack of attention paid to ethical issues raised by public health practice. As the discipline of medical ethics has developed, it has tended to focus on value conflicts arising in the doctor-patient relationship. Partly as a result, any discussion of medical ethics tends to place issues such as autonomy, consent and confidentiality at the centre of interest. The search for conceptual clarity in public health might be thought to stem in part from a desire to attract more serious attention to the undoubtedly complex, serious and demanding ethical issues encountered by public health practice.

Given the potential scope of public health activity however, any definition is likely to be either so broad as to risk vagueness – which may be the case with the definition given in the consultation – or so narrow that legitimate areas of activity might be excluded, which may be the case with the aforementioned definition in the *Oxford Handbook of Public Health Practice*.

From an ethical perspective, it might be useful to concentrate on those aspects of public health that give rise to dilemmas that are significantly distinct from those encountered in ordinary health care practice. Public health:

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[1] Pencheon D, Guest C et al (eds). *The Oxford Handbook of Public Health Practice*. Oxford: Oxford University Press, 2002. xviii.

[2] Boyd K, Higgs R, Pinching AJ (eds). *The New Dictionary of Medical Ethics*. London: BMJ Books, 1997.

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- focuses on the health status of the group, community or population, not the individual patient
- seeks aggregate or statistical improvements in health status
- is interested in the underlying conditions and determinants of population health, not with individual experiences of illness or disease
- uses epidemiological and statistical tools looking at rates or incidences of ill health across populations
- has traditionally focussed on preventing the occurrence of ill health, where primary health care has concentrated on the development of curative techniques

It might then be possible to work back from these primary features to a definition. One interesting possibility is a less restrictive version of the definition that appears in the Oxford handbook: "the science and art of improving the population's health through the organized efforts of society".

***Question 2**: Do you agree that interactions between the following five factors are the main influences affecting public health: the environment, social and economic factors, lifestyle, genetic background, preventive and curative health services? If so, do you think that some are more important than others? If so, what are they?*

These factors seem comprehensive, although in the consultation document, little mention is made of the prevalence of infectious disease agents in the environment. The prevalence, for example, of tuberculosis, pandemic flu agents or the HIV virus is presumably itself a public health issue. This may of course come under the heading 'environment' but it could perhaps be developed slightly.

The question of whether any of the factors listed is more important than others is always going to depend upon context. For example, in the United Kingdom, some of the earliest and most successful public health interventions were environmental, focussing on clean water supplies and the provision of basic sanitation. Currently however some of the most pressing public health issues in the UK, and in many other developed countries are related to lifestyle choices and their underlying socio-economic determinants. Obesity, cigarette and alcohol consumption and lack of exercise are all significant concerns, and they are distributed differently according to geographical and socio-economic background. In developing countries, however, environmental issues, and the enormous burden of infectious disease, including tuberculosis and HIV/AIDS remain pressing problems. In addition, while some factors may have an important bearing on population health status, influencing them may require sophisticated and expensive resources – genetic background is an obvious example. In developing countries, for example, while genetic background may strongly influence overall health status, lack of resources may mean that it cannot become a focus of public health policy. Other cultural or national variables that are likely to influence priorities will include the extent to which Governments have legal powers to regulate powerful free market actors such as cigarette manufacturers.

***Question 3**: Some countries have a compulsory rather than a voluntary system of vaccination. On what basis can such policies be justified to achieve herd immunity? Should they be considered in the UK?*

Compulsory vaccination constitutes a significant invasion of individual freedom and bodily integrity. Vaccination also carries with it a small but recognised risk of adverse events. In the UK, the compulsory treatment of competent adults is only permitted where (a) the individual is suffering from a mental disorder, and (b) he or she presents a risk of harm to him or herself or to others. In Scotland, before compulsory treatment is lawful, the presence of the mental disorder must also be allied to an impairment of decision-making capacity.

Another significant issue here is the so called 'prevention paradox'.[3] Measures such as vaccination aimed at generating population immunity that are of enormous potential importance to the community as a whole can offer very little in the way of benefit to the individual, particularly in the short term. Compulsory vaccination thus entails significant infringement of fundamental rights or liberties, allied to a risk of harm, without being able to offer much in the way of significant immediate benefit. Whilst some coercive public health policies, such as the enforced wearing of motorcycle helmets, have been broadly accepted, these are in part aimed at coercing individuals in their own interest. Compulsory treatment in the interest of others, or of 'the population' may well be less palatable and could meet with public resistance.

Legally and ethically, any significant invasion of personal freedoms or bodily integrity must be proportionate to the desired aim. In the UK, voluntary vaccination programmes, supported by vigorous public health education and promoted by family doctors have proved successful. Clearly where voluntary vaccination programmes can achieve the desired goal, there can be no justification for compulsion. The effect of public concern about the safety of the MMR vaccination has raised concerns about a loss of population immunity and the possibility of epidemics, but currently the numbers refusing MMR seem quite restricted. Again, where public fears are raised about a particular vaccine, any move toward compulsion is likely to be strongly resisted.

In practice it is more likely that smaller groups of individuals who may be exposed to particular threats will be either compulsory vaccinated or put under pressure to consent. During war, for example, the requirement for consent to vaccination against biological and chemical weapons might be waived. Certainly combatants in Operation Desert Storm were given a relatively untested anthrax vaccine that some studies suggest might have been responsible for the subsequent emergence of Gulf War Syndrome.[4]

In the context of most liberal democracies, where great weight is given to individual autonomy, the use of compulsory vaccination would ordinarily therefore need to be linked both to a very serious threat that can be effectively dealt with by a vaccination programme, and to the failure of voluntary schemes to provide sufficient protection to the population. Apart from more extreme conditions such as during war, it is difficult to envisage a situation where compulsory vaccination programmes for the whole population would be justifiable.

***Question 4**: For childhood vaccinations, parents make decisions on behalf of their children. Are there cases where the vaccination of children against the wishes of their parents could be justified? If so, what are they?*

Ordinarily, until children develop the understanding and maturity necessary to make decisions on their own behalf, parents are deemed to be the best judges of their interests and it is appropriate that they make decisions relating to vaccination and other health interventions. Legally and ethically it is clear however, that parental rights to choose on behalf of their child stem from duties to protect and promote the child's interests. Where parents make choices that seem to be seriously at odds with the child's interests, legally and ethically such choices can be overridden. The courts have shown themselves willing to intervene to consent or refuse treatment on behalf of a child, even in the face of concerted parental opposition. Such cases have usually involved potential serious harm, and in relation to vaccination in the face of parental refusal, a risk of serious harm would have to be demonstrated. In these circumstances the BMA would advise that doctors and other healthcare professionals seek legal advice.

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[3] Rose G. Sick individuals and sick populations. *International Journal of Epidemiology*. 14 (1985) 32-38.
[4] http://en.wikipedia.org/wiki/Gulf_War_Syndrome.

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***Question 5**: Control measures for specific diseases depend on how infectious a disease is and how it is transmitted. For infections that are directly transmitted from person to person, what justification would be required to render interventions such as forced quarantine, which helped to control the outbreak of Severe Acute Respiratory Syndrome (SARS) in Asia, in countries such as the UK where such measures may be considered to infringe civil liberties? If you think such measures cannot be justified, what are the principal reasons?*

The ethics of a response will to a large extent be determined by the scientific understanding of the epidemiology of the disease, its means of transmission and its morbidity and mortality. A relevant question will be the extent to which forced quarantine can actually control the outbreak. It is estimated that globally seasonal flu outbreaks kill between 500,000 and one million people annually.[5] Even if it were possible to contain these outbreaks by large-scale quarantine, it is unlikely that there would be support for the deprivation of liberties required. Where quarantine might be effective in controlling a future new pandemic flu, particularly if it proved to be as virulent as the 'Spanish Flu' of 1918, enforced quarantine may be justifiable. Once again the nature of the threat posed to the community as a whole would need to be balanced against the corresponding requirement to limit personal freedoms. What is in part in question here, as with so many decisions in public health, is a political judgement about the meaning of community and the balance that must be struck between the protection of individual liberties and the promotion of the collective interest – what is a society and what goals should it promote? Currently under the Public Health (Control of Diseases) Act 1984 for England and Wales, the Secretary of State has powers to make such regulations as are needed to respond to an immediate disease threat. The Act also permits detention in hospital by order of a Justice on the application by a health authority where medical evidence identifies an infectious disease risk to the public health. Additionally, under the Public Health (Infectious Diseases) Regulations 1988, a Justice of the Peace can order the continued detention of a person with AIDS if he has reason to believe that he or she will fail to take proper precautions as to the spread of the disease on release. Such public health legislation should not be read however as justification for wholesale utilitarian state intervention to control infectious diseases. As Mason and Laurie write:

> *…robust health protection programmes should always require the state to justify every measure and intervention; secondly the interventions should be minimal and 'necessary' in the circumstance – that is no other reasonable means are available to achieve the same ends; and, thirdly, there should be full respect for other individual rights that are not implicated in the immediate health threat…*[6]

***Question 6**: In general, the earlier that an outbreak of disease is detected, the easier it will be to control. What would be suitable criteria to determine in what circumstances, and to what extent, the state should provide more resources to develop methods of preventing outbreaks of serious epidemics in other countries?*

The factors to consider in this are the effectiveness or otherwise of current international surveillance systems, prevailing conditions for the generation and transmission of infectious diseases – such as the current extremely widespread outbreak of avian flu – and geopolitical issues, such as the ability to monitor outbreaks of disease in failed states or countries that are the site of civil war.

Given the interest that the global commons has in the detection and control of infectious diseases, there is clearly a strong argument from mutual self-interest that robust surveillance

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[5] Chief Medical Officer. *Explaining pandemic flu*. DH 2002. 19.
[6] Mason JK, Laurie GT. *Law and Medical Ethics*. Oxford: OUP, 2006. 30.

and prevention systems are put in place in areas where there is a high risk of emergent infectious diseases. For example, in developing countries, humans and animals often live very close together and conditions can be conducive to the development and spread of zoonotic infections such as pandemic flu. Given that, broadly, these are the countries least able to afford sophisticated surveillance methods, and also least likely to be able effectively to control diseases once they are established, there is a strong justification for ensuring that resources are made available by the international community to strengthen these systems.

In addition to arguments from mutual self-interest, and given the likelihood that the greatest burden of infectious diseases will continue to fall upon the poorest countries of the world, this question also raises issues of global distributive justice. It is a requirement of justice that wealthy nations consider how best to transfer resources to developing countries to reduce extreme inequalities of health outcome. Strengthening disease surveillance and control systems in those countries is an important part of this wider undertaking.

The question is a very broad one and makes no mention of existing systems for disease surveillance and control. Clearly this work is undertaken in large part by the World Health Organisation, and it is from this organisation presumably that an understanding of the adequacy or otherwise of international surveillance systems should be sought. The WHO would presumably be best placed to comment on what additional resources are required to ensure an adequate international standard.

Question 7: *Travel and trade are key factors in the spread of infectious diseases. Global travel and exchange of goods are increasing rapidly. Each day, two million people travel across borders, including around one million per week between developing and developed countries. Disease-causing organisms and vectors can therefore spread quickly around the world, Are new measures needed to monitor and control the spread of infectious diseases? If so, what would be promising strategies?*

A promising strategy would be to define essential and non essential travel in times of serious outbreaks and to ensure that permits are obtained for essential travel. In such circumstances people would be required to register their intention to travel with the health service before booking their ticket. Governments could be asked to develop systems to be accredited by the WHO. Individuals who suffer materially from travel restrictions should be eligible for compensation in recognition of the contribution they have made to the commonweal.

Question 8: *Under which circumstances, if any, would mandatory testing for highly infectious and life-threatening diseases such as tuberculosis or HIV/AIDS be justified?*

As already mentioned, western liberal democracies place a very high value on individual freedom. In a health context this is most obviously expressed by the legal and ethical principle of informed consent – that competent adults retain the right to choose whether or not to undergo a particular health intervention. Currently in the UK the only exception relates to compulsory treatment for mental disorder where individuals present a threat either to themselves or to others. Although in certain circumstances public health law permits the incarceration of individuals who pose a public health threat, the law does not extend to authorising compulsory treatment.

When considering the use of compulsion, a number of factors must be addressed. Where such a deprivation of fundamental liberties is being contemplated, the intervention must be proportionate to the risk or threat. In the case of compulsory testing, given the seriousness of the invasion into personal freedom, the disease being tested for must present a very high risk to the community. Also, testing must be an appropriate method for managing the risk

presented by the organism. Compulsory testing would also have to be the least restrictive alternative, that is no effective method of managing the threat that is less restrictive of fundamental liberties can reasonably be identified. The use of compulsion must also be cost-effective and undertaken in a fair and non-discriminatory manner.[7]

In addition to these underlying principles, the likely effect of using compulsion on the intended outcome of compulsory screening will need to be considered. Although Coker points out that between 1981 and 1989 compulsory testing was introduced in 30 countries, and that in China, Cuba and Japan quarantine or prison on the basis of HIV was introduced, the UK experience in managing the HIV/AIDS epidemic suggests that a co-operative approach, particularly where it is essential that long-term compliance with drug regimes or life-long changes in behaviour are required, is likely to be far more effective than coercion.[8] Coercion, particularly where it is related to diseases that carry significant stigma and are associated with marginal or vulnerable population groups, will often result in infected individuals either denying their status or avoiding the providers of health care services.

Although it currently seems unlikely that there will be a move towards community-wide compulsory screening in the UK, there may be some justification for the use of compulsory screening for infectious diseases among specific groups, such as health care workers. Here again, ethically, any policy must be effective, proportionate and undertaken without unfair discrimination.

As Richard Coker points out, "internationally, compulsory screening has been used to screen sex offenders, commercial sex workers, pregnant women and prison inmates."[9] Alternatively however states may apply conditional screening where certain privileges, such as rights of residency, may be conditional upon accepting the offer of screening. In 2002 46 countries required an HIV test before immigration was permitted. [10]Clearly in these contexts any consent may have been subject to fairly coercive pressures – an asylum seeker who has made a hazardous journey to the host country, for example will not be in a good position to refuse screening on these terms. In these circumstances, consideration would need to be given to the kinds of benefits, in relation to counselling and treatment, that would be given where an individual is diagnosed as suffering from the index disease.

Question 9*: Food is closely linked with individual satisfaction and lifestyle. This means that any strategy that seeks to change people's behaviour is likely to be perceived as particularly intrusive. How should this sensitivity be considered in devising policies that seek to achieve a reduction in obesity?*

One of the paradoxes and tensions that rises in ethical reflection on public health interventions lies in the disputed area of individual choice. While, on the one hand, decisions about food consumption, exercise uptake and the use of cigarettes and alcohol are to a large extent personal, it is clear from population-wide data, that factors to a greater or lesser extent outside an individual's control – such as socio-economic status, gender and geographical location – influence the likelihood that individuals will make lifestyle choices that harm their health. Consideration of the need to be sensitive to individual preferences – a respect for the autonomy of individual citizens – must therefore be balanced against the requirements of distributive justice, the need to ensure that as much of the population as possible is able to maximise health outcomes.

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[7] See Coker R. *Migration, public health and compulsory screening*. London: IPPR, 2003.
[8] Ibid 9.
[9] Ibid. 7.
[10] Ibid. 9

Obesity is also an outcome with a variety of complex causes, including increasingly sedentary lifestyles, cheap and available fast food, changes in family structures, patterns of female employment, relative affluence, methods of industrial food production etc, as well as personal lifestyle choices. In addition to these complex causal factors, the extent to which

state-sponsored public health interventions aimed at influencing personal choices are a legitimate sphere of activity is contested. What is at stake here is a fundamentally political question about the proper relationship between both individuals and the state, and, in relation to issues like food, alcohol and tobacco, the extent to which the state should regulate powerful non-governmental actors such as large corporations. Where powerful corporations are investing huge resources in promoting food that has very high levels of saturated fat or salt, is there any obligation on government's to counteract or to balance this advertising with the provision of information about healthy eating or about the health risks of excessive reliance on these foods?

As Gostin points out, however,[11] human behaviour may be highly complex, and influenced by a variety of social and environmental factors, but information is a prerequisite for change. People must be aware of the health consequences of their choices before they can make an informed decision. Whilst it is therefore clear that, as an absolute minimum, information both about the kinds of choices that lead to obesity, and the health impact of obesity must be made available, the extent to which more intrusive or coercive measures are justified is unclear. Whilst food products that can lead to obesity if overused are aggressively marketed, obesity is not. Aspirational advertising relentlessly promotes idealised views of extremely slim bodies, and this itself is thought to lead to psychological health problems, particularly but not exclusively among young women, including a variety of eating disorders. Interventions here have to be judged with sensitivity. Individuals who have difficulty controlling their eating may be blamed for any subsequent illnesses, be subject to stigmatisation, and exposed to ridicule. Returning as well to the points in the earlier paragraphs, while ordinary health interventions are, by and large, governed by consent, public health interventions , which often aim to change what Gostin calls "the information environment" are non-consensual – by and large we do not ask to be subject to commercial and state-sponsored advertising. Public health interventions are therefore sometimes criticised for excessive paternalism – if adults choose to drink, smoke or eat fatty foods, then what is the justification for trying to dissuade them?

Ethically there is a tension here between autonomy, understood as a respect for individual preferences and broader issues of social justice. Recognising that there are underlying socio-economic determinants of unequal health outcomes, the state may be required, on the basis of justice, to intervene to try and make outcomes more equitable. In doing so they may use public health campaigns aimed at changing individual lifestyle choices. Such campaigns are paternalistic in relation to their target groups, and are consequently are arguably less-respectful of the autonomy of individuals in these groups. One possible way of reducing conflicts arising in this area is through the involvement and participation of those communities that are the focus of the campaigns.

In relation to obesity, as the sources are multi-factorial, public health campaigns that focus on issues such as the labelling of processed foods, the development of a salt, sugar or fat tax on prepared foods, the positive promotion of the benefits of regular exercise, a reduction in excessive reliance on cars, particularly for short journeys – all of these are likely to influence outcomes without necessarily being seen as aggravating negative stereotyping in relation to people who are overweight.

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[11] Gostin LO (Ed). *Public Health Law and Ethics: A Reader*. Berkeley: University of California Press, 2002. 335.

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***Question 10**: while there is clear evidence about the extent and scale of obesity, there is far less clarity about what measures should be adopted by the government and other stakeholders to prevent it. In view of this uncertainty, what would be suitable criteria for developing appropriate policy?*

As with the majority of public health interventions, the obvious list of criteria will include factors such as effectiveness, cost-effectiveness, equality and non-discrimination, public participation and a respect for autonomy. From an ethical perspective however, there is a prior question about what would constitute success in this area. While it is tempting to say that the only worthwhile and measurable outcome would be a decline in overall levels of obesity, given that the justifiable limits to state-intervention in individual choices is contested, notions of success could be restricted, for example, to ensuring that sufficient good quality information is made available to ensure that lifestyle choices are properly informed. State intervention in terms of clear, consistent and universal food labelling and healthy eating policies in schools and hospitals could be promoted

***Question 11**: What are the appropriate roles and obligations of parents, the food industry, schools, school-food providers and the government in tackling the problem of childhood obesity.*

It is doubtful whether this question can be given a meaningful answer. The question is complex and compound. Each of the groups nominated will have different responsibilities in relation to childhood obesity, and the precise scope of these responsibilities will be subject to national and cultural variation. It is, for example, universally accepted that parents have a moral obligation to promote the best interests of their children. Acceptable levels of body weight are however subject to cultural variation. State schools are a direct agency of the government, and are charged with direct responsibility for promoting the wellbeing of children. It is appropriate that schools should both disseminate information about healthy eating and exercise, and reinforce these messages through their own provision of foods, and by ensuring that exercise is a fundamental part of the curriculum. The extent to which commercial entities, such as food producers, have a direct responsibility in relation to obesity is more controversial. Limited companies have a primary legal responsibility to their shareholders, and the extent to which they have a responsibility in relation to obesity will depend upon factors such as the requirements of the regulatory environment. If they fail to sell their products in a competitive market however then they will not survive. While large corporations have the marketing power to influence consumer tastes in relation to healthy foods, they also have to be responsive to consumer demand which may limit their effectiveness.

***Question 12:** Is it acceptable to make the provision of NHS services dependent on whether a person is obese or not?*

In the BMA's view the provision of health care should be dependent on need, not on value judgements about a person's lifestyle and whether or not they 'deserve' treatment. There are occasions when a person's weight is likely to be clinically relevant to the likelihood of a positive outcome, and these factors need to be weighed alongside all other relevant clinical factors.

***Question 13**: The effects of smoking have been known for a very long time. Comprehensive measures by governments to prevent harm to the population are relatively recent. In your view, what are the reasons for this delayed response? Are there any lessons that can be learned from other countries, or from strategies pursued in other areas of health?*

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The reasons for the delayed response are that governments were reluctant to sacrifice tax income revenue from cigarette sales. In addition, politicians were likely to have been influenced by the lobbying of the tobacco industry and those in receipt of sponsorship from the industry. There was clearly a resistance within government to accept the medical evidence concerning passive smoking and support for the arguments of personal choice.

Question 14: *What are the responsibilities of companies that make or sell products containing hazardous substances, such as nicotine, that can be addictive? Should they be prosecuted for damaging public health or required to contribute to costs for treatment?*

Ethically this is a complex question. From a pure public health perspective, tobacco is so damaging to health that its reduction or abolition, either through the prosecution of cigarette companies, or through making the companies directly liable for the health costs of their products, is attractive. It is clear however that there is a public demand for both lawful and illicit substances that can be hazardous and addictive. There is a large legal market in alcohol and tobacco, both of which fit these criteria. There is also a significant demand for illegal drugs, the control of which has led to large amounts of criminality. Attempts to regulate, or to ban, substances – alcohol for example – in countries where its use is established, such as during Prohibition in America, have led to serious and unintended adverse effects, including criminality and a loss of confidence in certain aspects of the law. As with so many issues in public health, this also raises the question of the legitimate scope of state interference with the private preferences of individuals. If adults choose to undertake health risks, then, provided they have sufficient information on which to base their decision, to what extent is the state justified in intervening? The difficult question in relation to addictive substances however is that they tend to undermine the autonomy that, in this argument, the state should be respecting. Also, as mentioned before, marketing by powerful commercial organisations can have a strong influence in relation to consumer preferences. Where the substances are addictive, a decision to start their use can be much easier than a subsequent decision to stop.

Where the justification for regulating the behaviour of large corporations selling hazardous products stems from a desire to promote overall autonomy, then particular attention would need to be paid to the effect of marketing and retail activity on children and young people, that is to those whose autonomy is most obviously developing and in need of protection.

The consumption of hazardous and addictive substances has direct health costs. Not only does it lead to an increase in the use of health services by the individual consuming them, it can also have collateral effects: passive smoking, the effect of alcohol use on road traffic accidents and violent assault all lead to increased health costs. To this extent there is some argument to suggest that private companies have some responsibility to incur some of these costs. Once again, however, the extent to which the activities of private companies are, or should be, regulated in the interests of public health is part of a broader political argument about the proper relationship between private actors and the state.

Question 15: *Should smokers be entitled to higher than average resources from the public healthcare system, or should they be asked for increased contributions? Would similar charges be justified for other groups of people who deliberately or negligently increase their chances of requiring public health resources, such as people engaging in adventure sports?*

This is a version of the question as to whether the provision of NHS resources should be dependent upon obesity. The BMA supports the underlying principle that NHS treatment should be available free of charge on the basis of need.

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Question 16: *Smokers argue that they choose to smoke. What rights does the state have to impose sanctions to prevent them from smoking? Does the state have the right to prevent the sale of tobacco, which is known to be addictive and highly dangerous? How vigorously is it reasonable for the state act to prevent children and teenagers from smoking?*

Please note the answer to question 14.

Question 17: *The effects of excessive consumption of alcohol on the health of individuals and society have been known for a very long time. It can be argued that in view of the significant harm to individuals and society, comprehensive measures by governments to prevent harm are lagging behind those for tobacco. In your view, what are the reasons for this?*

The reasons to explain this are the resources and lobbying influence that the alcohol industry has as well as the likelihood that government intervention in this area would prove unpopular.

Question 18: *In view of the impact of excessive consumption of alcohol on individuals and society, what are the roles and responsibilities of agents other than the government to limit consumption? Are there different responsibilities for producers and, for example, retailers? If so which?*

It is not easy to see the distinction between this question and the similar questions in relation to obesity and tobacco consumption. See therefore preceding answers.

Question 19: *Fortification of some food stuffs such as flour, margarine and breakfast cereals have been accepted for some time. Why has the fluoridation of water met with more resistance? What are the reasons behind international differences in the acceptance of fluoridation of water? What criteria are there that determine acceptance?*

The BMA supports the fluoridation of the mains water supply, believing it to be a safe, equitable, effective and cost-effective method of reducing dental caries. Opposition to this policy is based on arguments and evidence that the BMA does not find convincing. These include:

- Concerns about the toxicity of fluoride in mains water
- Resistance to what is seen as 'compulsory medication'
- The environmental impact of fluoridation – including increased use of bottled waters by those who do not want to drink water with added fluoride
- Ethical opposition to 'paternalistic' government interventions

Question 20: *Achieving population benefits of fluoridation means restricting choice of individuals. Children benefit the most from fluoridation. However, as with vaccinations, adults, rather than children, are making decisions about whether or not to receive the intervention. Under what circumstances is it acceptable to restrict the choice of individuals in order to protect the health of children?*

In relation to fluoridation, the only obvious choice that is restricted is the freedom not to have fluoride levels altered in the mains water supply. Where mains water is fluoridated, it does not follow that individuals have to drink the mains water – many people prefer to drink bottled water irrespective of fluoride levels, although this does entail some additional financial cost. In the absence of evidence that there are harms involved in fluoridation, the freedom that is being restricted would seem to be quite a trivial one. Good dental health however confers a significant benefit on individuals throughout life. Where such a

substantial benefit is offset by such a trivial apparent harm, it is difficult to see the justification for not raising levels of fluoride in mains water.

The question seems to imply that the interests of children and the interests of adults are in some way meaningfully opposed in relation to fluoridation – that the freedom of adults is restricted to benefit the interests of children, and that such an opposition is ethically problematic. Can the interests of adults and of children be realistically separated in this way? The interests of those who are unable fully to promote their own wellbeing, such as children, will presumably always be subject to special protection.

***Question 21**: In your view, is there one of the following principles that is generally more important than the others: autonomy, solidarity, fair reciprocity, harm principle, consent, trust? If so, which one and why? Are there any other important principles that need to be considered?*

We have no comments to make

***Question 22:** Can these principles be ordered in a hierarchy of importance? If so, how would such an order relate to the five case studies? Would the order have to be refined for each new case study? Are there particular principles that are of particular importance to some case studies?*

In relation to mainstream medical ethics, the BMA has not adopted an underlying stance based upon what has come to be known as 'the four-principle' approach. While such an approach can help identify relevant ethical issues that are engaged in any particular dilemma, in unsophisticated hands it can lead to rigid, slightly formulaic decision-making.

In relation to the principles identified in the consultation document, it would be useful to have more detail about the background justification for their inclusion. Whilst it is clear that, as the document indicates, ethical questions in public health engage deep-seated questions in political philosophy, it is less clear that action guiding principles in public health can be drawn straight from political philosophy. Solidarity, fair reciprocity and the harm principle are all significant principles employed when discussing ideas of political community, but their utility in identifying sound public health policies is less clear. While consent is clearly a vital principle in conventional medical ethics its relevance to public health policy is less sharp as the majority of public health interventions are focussed on populations or communities. To this extent 'consent' might be less useful than something like 'participation', or 'representation'. Principles such as 'solidarity' and 'trust' seem also be of a different order to 'autonomy' and 'consent', which are closely related to respecting individual choices.

Both questions ask whether one or other of the principles are more 'important'. It is difficult to see what this question means in this context. Consent is closely related to autonomy, as is the harm principle, which describes, in a Millian perspective, legitimate restrictions to the exercise of personal choice. Solidarity and trust resemble background values that make individual action within a community possible. Without a background of trust and solidarity, individual actions can be costly. It may therefore not be helpful to rank these principles, but to acknowledge that public health interventions, which simultaneously affect both individuals and communities, have complex ethical implications.

***Question 23:** In cases such as vaccinations or fluoridation parents decide on behalf of their children. Which ideas or principles should guide parents in their decisions.*

Where children or young people lack sufficient maturity to decide on their own behalf, legally and ethically parents should make decisions on the basis of their best interests, making

every effort to involve the children, to the extent of their ability and willingness, in the decision to be made.

I hope you find these comments helpful.