

Introduction to Public Health Ethics 1: Background

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A public health ethics must begin with recognition of the values at the core of public health, not a modification of values used to guide other kinds of health care interactions (Baylis, Kenny, & Sherwin, 2008, p. 199).

Public health practitioners have long grappled with ethical issues in their practice but, until recently, there have been few relevant ethics frameworks that take into account the values base of public health.¹ Historically, those involved in health care ethics and bioethics more generally have failed to provide public health practitioners with guidance geared to their unique ethical concerns. Until relatively recently, a rights-based deontological approach (Zahner, 2000), or the health care ethics principles of autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 1979), were invoked as the appropriate framework to support ethical public health practice. But, as an examination of the distinct goals and collective orientation of public health shows, health care ethics provides neither an adequate theoretical foundation nor appropriate normative justification for public health practice. This is because health care ethics focuses primarily on individuals, often in clinical settings, whereas public health ethics is concerned primarily with populations, often in community settings.

Public health ethics is a relatively new field of applied ethics (Bayer et al., 2007; Baylis, Kenny, & Sherwin, 2008; Dawson & Verweij, 2007). Although a few writers some years ago proposed the need for an ethics of public health (Beauchamp, 1976; Lappe, 1986), the field of public health ethics has only been claimed and named as a distinct area of scholarship since the late 1990s and into the new millennium (Kass, 2004). In fact, Kass says that the term “public health ethics” was rarely used prior to the year 2000.

This paper, the first of three, defines public health and reviews the history and development of public health ethics, including its philosophical underpinnings. The next papers will use this introduction as its starting point for a more involved exploration of the theoretical and philosophical background to public health ethics, the emerging frameworks for public health ethics, as well as a snapshot of where the field stands and where it may be going.

What is Public Health?

“Public health is a contested concept” (Verweij & Dawson, 2007, p. 13) that has multiple meanings and is often misunderstood. Some understand public health to mean health care provided within the publicly funded health system. This misinterpretation occurs, in part, because public health operates under the radar; people are not aware of it until a crisis strikes and drastic public health measures need to be implemented. The health care system, on the other hand, is highly visible in our lives.

Definitions of public health include the following:

...the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society (Acheson, 1988, p. 1);

...what we, as a society, do collectively to assure the conditions in which people can be healthy (Institute of Medicine, 1988, p. 1);

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...an organized activity of society to promote, protect, improve, and, when necessary, restore the health of individuals, specified groups, or the entire population. It is a combination of sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all the people (Last, 2007, p. 306).

Common elements across all definitions include collective effort, societal responsibility, and attention to social and environmental health determinants. In all of them, the moral aim is to promote the health of the population as a social good that allows people to pursue other valued ends. Population health assessment, health surveillance, health promotion, disease and injury prevention and health protection tend to figure among the main functions pursued by public health (Canadian Institutes of Health Research, 2003). More recently, as evidence of growing health inequities accumulates, a concern with vulnerable and marginalized populations has emerged.

Because public health aims to improve the health of whole communities, the strategies do not focus solely on individuals. Societally oriented interventions, by their very nature, are provided by local governing bodies such as state/provincial governments, municipalities, or regional health authorities. Providing safe water, ensuring a safe and accessible food supply, public sanitation, and taking action to control or prevent communicable diseases are just some of the public health interventions that require collective rather than individual action. The collective nature of these interventions often requires legislative authority and may infringe on the rights of individuals, thus raising distinctive ethical challenges.

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Who is the “Public” in Public Health?

Childress et al. (2002) identify three notions of *public* in public health; the numerical public, the political public, and the communal public. The numerical public is the target population that refers to an aggregate of individuals to which population health measurements refer. The political public refers to what is done collectively through public agencies and governments; it is the legislatively designated responsibility of governments to promote and protect health. Finally, the communal public includes all other forms of social and community action to promote health that extend beyond the practices of public health providers and agencies including non-governmental organizations, private groups and citizens, and other collectives. The Healthy Cities/Communities movement worldwide (Hancock, 1997) is an example of public health action that involves a communal public.

Jennings (2007) provides a more evocative notion of public as “a community of individuals, intertwined through complicated institutional and cultural systems in (and through) which they act and carry out their lives” (p. 36). He sees *public* as a normative concept “that provides an account of how that system should be structured and how our lives in common ought to be composed and lived” (p. 36). Thus, the public is much more than an aggregate of individuals. It is a complex system comprising a network of interacting and interrelated elements. As a whole, it has properties that are not reflected in its individual components. A simplistic view of a population as an aggregate of atomistic elements is rejected. Instead, Jennings argues, drawing on Harré (1998), that an understanding of ethical conduct must encompass notions and concepts that “reflect the relational nature of the human self or actor and the contextual social nature of the actor’s meaningful, symbolically mediated relationships with others” (p. 37). As we shall discuss in the next paper, these ideas about the meaning of *public* and the relational nature of persons undergird emerging perspectives in both public health and feminist ethics. It is in this relational, social sense underlying the concept of *public* that we find a key inspiration for public health ethics, and in which the distinction between public health ethics and traditional health care ethics is most clear.

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What is Public Health Ethics?

Gostin (2001) proposes three analytic perspectives on public health ethics: the ethics *of* public health, ethics *in* public health, and ethics *for* public health. Callaghan and Jennings (2002) add a fourth type, which they name *critical public health ethics*.

Professional ethics, or the ethics *of* public health, relates to the mission of public health to protect and promote health and focuses on the virtues or professional character of public health practitioners who hold themselves accountable to standards or codes of ethics. The Public Health Leadership Society (2002) in the U.S. has developed a code of ethics to guide public health practitioners but there is no such code in Canada. In the ethics *of* public health questions include, To whom do public health professionals owe a duty of loyalty? Is it individual clients/patients, the community at large or both? How do professionals know what actions are morally acceptable? How would an ethical public health practitioner serve the community interest? (Gostin, 2001).

Applied ethics, or ethics *in* public health, seeks to develop general principles that can be applied to practical situations to guide ethical practice. It is situation-specific in that it “seeks to identify morally appropriate decisions in concrete cases” (Gostin, 2001, p. 125). However, the principles that should be applied to decision making in concrete public health situations are open to debate and many have been identified (Kenny, Melynychuk, & Asada, 2006);

there is no consensus on what these principles should be, which should have priority, or how trade-offs among them should be determined when there are conflicts. It is generally agreed that the principles of health care ethics (autonomy, beneficence, non-maleficence, and justice) are not always a good fit for the ethical issues that arise in public health (Kass, 2001) because of their individualistic and clients-rights orientation, to the exclusion of the common good. Several authors have attempted to lay out a set of principles more relevant to the moral aims of public health, including solidarity, relational autonomy, social justice and reciprocity, to name a few (Baylis, Kenny, & Sherwin, 2008; Upshur, 2002).

Advocacy ethics, or ethics *for* public health, is a less theoretical approach and probably represents the most pervasive ethical orientation in practice. Public health practitioners clearly see themselves as advocates. Advocacy ethics involves taking a stand for the goals, interventions, and reforms that are most likely to achieve the moral aims of public health. There is a strong orientation to social justice and equity primarily from a distributive justice and contractarian ethics perspective. Ethics for public health reflects a “populist ethic” (Gostin, 2001) to serve the interests of populations, but in particular, the needs and interests of the marginalized and disadvantaged, and thus needs to account for more than distributive concerns (Rogers, 2006; Young, 1990). One concern with advocacy ethics is that public health practitioners may be constrained by their positions within public health units or departments and thus their loyalties may be divided. Advocacy can be seen as “biting the hand that feeds you.” Jennings (2003) suggests that advocacy ethics is limited in its ability to provide a critical perspective on taken-for-granted professional norms or orientations and that we need a perspective that is critical of powerful interests.

Critical public health ethics sheds light on issues that may be obscured from view by traditional ways of thinking or acting (Nixon, 2006). Critical ethics is historically informed, practically oriented, and considers social values and trends in analyzing and understanding both the public health situation at hand and the moral problems it raises (Callaghan & Jennings, 2002). Public health problems are influenced by, among other things, “institutional arrangements and prevailing structures of cultural attitudes and social power” (p. 172). This perspective calls for policies or interventions to be

“genuinely public or civic endeavours” and suggests the need for “meaningful participation, open deliberation, and civic problem solving and capacity building” (p. 172). This commitment to participation is a long-standing tradition within public health and is also consistent with a range of philosophical perspectives, including feminist and communitarian perspectives, and deliberative democracy.

Nixon (2006) goes further to suggest that a critical lens “prompts us to question the taken-for-granted and think about the ways in which power relations are represented” (p. 33) in particular public health concerns. We need to uncover the assumptions underlying our positions and perspectives and interrogate these critically, asking “Why?” and “Whose interests are served?” Through a critical public health ethic we are asked that we remember our social justice roots, recalling that public health is social justice (Beauchamp, 1976). Jennings (2003, p. 165) argues that “the development of work in critical ethics is the most important priority within the normative study of public health at the present.”

Four perspectives on public health ethics

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HOW DOES PUBLIC HEALTH ETHICS DIFFER FROM HEALTH CARE ETHICS?

The difference between health care ethics and public health ethics lies in the distinction between public health and health care. Health care and its ethics are focused on the needs, interests, and concerns of individual patients as they interact with and receive care from practitioners and the health care system for their illnesses. Public health and its ethics, on the other hand, focus on the health of the population, made up of large numbers of people in the settings of their daily lives, particularly as they are affected by social and political structures and environmental conditions. Although concerned with the entire population, there is also a concern with equity in health and the health of those who are disadvantaged, oppressed, or marginalized.

Daniels (2006) says that the early bioethics focused on (1) the relationships between patients and physicians or other health care providers (i.e., health care ethics) and between researchers and subjects (i.e., research ethics) and (2) the issues and challenges arising out of new medical technologies. The problem, according to Daniels, is that bioethics has largely ignored the broader institutional settings and policies that affect and mediate population health and has not addressed the context in which these relationships develop and play out in practice. He further suggests that the focus on “exotic technologies” has blinded bioethics to the broader determinants of health that are of primary concern in public health. This has led bioethics away from concerns with health inequities and issues of social justice. Others have also argued that bioethics has not typically demonstrated a concern with the social determinants of health (Baylis, Kenny, & Sherwin, 2008; Pauly, 2008).

Three features of public health create specific moral concerns (Dawson & Verweij, 2007). First, in public health, the initiative comes from the professional, not the patient. Classic public health strategies, like case finding and contact tracing, mean that the professional seeks out the patient and may have to use either persuasion or coercion to ensure essential care for protecting the public. In health care, patients voluntarily seek out professionals. Second, because interventions are aimed at populations, the benefits for any individual may be negligible—this is the classic “prevention paradox” (Rose, 1985). Some interventions that will benefit the community as a whole may not benefit the

individual in any significant way, or may even inflict harm. Third, public health interventions are potentially pervasive such that it is difficult for individuals to refuse participation. Examples include fluoridation of water, seat belt legislation, drinking and driving laws, and mandatory immunization. These distinct foci create very different demands for ethical analysis and each raises its own unique ethical challenges.

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The overarching concern in health care for the individual patient is not comparable to the concern for the health of the population. Upshur (2002) points out that there is no clear analogy in public health to the fiduciary role of health care providers in terms of their therapeutic contract with the patient, which is legitimized by informed consent (Nixon et al., 2005). By contrast, the population focus of public health implies a contract with society at large that is legitimized in governmental policies and public health legislation.

In summary, it appears that there is a deep divide between the commitments of health care ethics and the values that inform public health ethics (Bayer & Fairchild, 2004). "The core values and practices of public health, which often entail the subordination of the individual for the common good, seem to stand as a rebuke to the ideological impulses of bioethics" (p. 474); therefore, the standards for guiding public health ethics cannot be derived from the assumptions of bioethics in which individualism is dominant and the principle of autonomy has pride of place. The second paper in this series will discuss perspectives on the philosophical basis of public health ethics, and frameworks that have been proposed to guide ethical public health policy and practice.

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WHAT IS THE HISTORY OF PUBLIC HEALTH ETHICS?

Canada has lagged behind the U.S. and the U.K. in the development of a focus on public health ethics, although increasingly Canadian ethicists have recognized the need for a "robust, coherent and meaningful ethic of public health" (Kenny, Melynchuk, & Asada, 2006, p. 402). Recent theoretical work by feminist ethicists in Canada position us to contribute meaningfully to the broader development of public health ethics, notably by explicitly drawing "a relational understanding of persons" into the mix to reflect and affirm the ways in which we are social and interdependent (Baylis, Kenny, & Sherwin, 2008; Kenny, Sherwin, & Baylis, 2010, p. 10).

Kass (2004) describes three stages of public health ethics development. In Stage I, during the 1970s and 1980s, health promotion and HIV/AIDS came on the scene to contribute foundational ideas for the later articulation of public health ethics. Stage II saw the development of frameworks for public health ethics, an emerging consensus that the field of public health ethics was distinct from that of health care ethics, and proposals for philosophical and political foundations as alternatives to the classical utilitarian and contractarian theories. Stage III is the future, which Kass suggests will focus on global and environmental justice and public health research ethics.

Stage I began with the emergence of health promotion as a new focus within public health. Because public health ethics had not been named as such, nor had its philosophical basis been proposed and debated, ethical analysis of health promotion drew primarily from liberal philosophy and bioethics that privileged the principle of autonomy (Bayer & Fairchild, 2004). Challenges emerged to the legitimacy of state or professional interventions to change individual voluntary behaviour (e.g., diet, exercise, smoking) because such interventions based on education and persuasion could stray dangerously close to coercion and thus violate individual autonomy. Even if coercion was not overtly involved, the ethics of persuading people to

change their personal preferences, desires, and behaviours, particularly if there was no harm to others, was viewed as a violation of individual liberty and autonomy.

A number of authors, including ethicists and health promoters, weighed in on the ethics of health promotion (Faden & Faden, 1978; McLeroy, Gottlieb, & Burdine, 1987; Minkler, 1978; Wickler, 1978a, 1978b, 1987). Both the challenges and the ethical analyses were, however, based on an individually focused and uniquely American definition of health promotion that has been challenged by many authors (Hancock, 1985, 1994; Labonte & Penfold, 1981; MacDonald, 2002; Pederson, O'Neill, & Rootman, 1994) since the release of the Ottawa Charter for Health Promotion (World Health Organization, 1986). Then, the emphasis shifted from individual behaviour change to social and community change to promote health with a focus on social determinants of health and healthy public policy. This raised a different set of concerns that called on ethicists to grapple with the inherent paternalism of healthy public policy. In health care ethics, paternalism is a dirty word and public health has struggled to deal with this given that much public health policy is indeed paternalistic. Recent work in public health ethics has led to a reconceptualization, perhaps even reclaiming, of the notion of paternalism within the context of relational ethics, drawing implicitly or explicitly on communitarian thinking (Beauchamp, 1985; Gostin & Gostin, 2009; Jennings, 2009; Jones & Bayer, 2007).

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With the emergence of AIDS, many ethical issues became apparent and debates regarding policy responses were spawned. In addressing the moral challenges raised by HIV/AIDS, as with health promotion, health care ethicists were initially guided by the same principles and values that had shaped the development of their field (Bayer & Fairchild, 2004). When AIDS arrived, public health already had a set of well-established practices related to screening, surveillance, reporting, and notification for infectious diseases that had proven effective in controlling epidemics (Burr, 1999). HIV/AIDS, however, was understood to be very different from

other infectious diseases; this led to a response that came to be known as “AIDS exceptionalism” (Bayer, 1991; Smith & Whiteside, 2010), defined as “departures from standard public health practice and prevention priorities in favour of alternative approaches to prevention that emphasize individual rights at the expense of public health protection” (Fisher, Kohut, & Fisher, 2009, p. 45). In retrospect, Burr (1999) and others (Bayer, 1991) questioned whether AIDS exceptionalism had its intended effects—to gain the cooperation of those affected and reduce the spread of the disease—or whether it contributed to a worsening of the problem. The contribution of HIV/AIDS to the development of public health ethics is a long and complicated story that cannot easily be summarized here. What is important is that HIV/AIDS raised many issues related to the dilemma of attending to individual human rights while protecting the health of the population.

In Stage II, from about the year 2000, public health ethics frameworks were proposed and theoretical work intensified to articulate an appropriate philosophical basis, including perspectives that went beyond the traditional liberal orientation. A journal dedicated solely to public health ethics was launched in 2008 (Dawson & Verweij, 2008). A parallel track of development in feminist and nursing ethics that drew on some of the same concepts and principles (e.g., relational autonomy and solidarity, social justice) was also developing. These ideas were applied to specific public health problems (e.g., harm reduction, violence against women) within a health care ethics context but without consideration as to how ethical analysis for these public health problems might help to articulate a broader public health ethics (Pauly, 2008; Varcoe, 2004).

It was in Stage II that public health ethics came into the limelight in Canada in the wake of SARS, which spurred efforts to renew the public health system and its infrastructure to be better prepared for the next public health crisis. SARS demonstrated that Canada was ill-prepared to deal with the ethical issues raised by serious epidemics (Singer et al., 2003). Some critics suggest, however, that the work on the ethics of pandemic planning in Canada has reflected a traditional bioethics perspective with a “too heavy reliance on an ethic of individual rights” (Baylis, Kenny, & Sherwin, 2008, p. 196) and limited recognition that the burdens of a pandemic are most likely to affect disadvantaged groups.

Stage III captures what Kass saw, in 2004, as the future of public health ethics, which revolves around three areas of potential concern: 1) environmental justice; 2) public health research; and 3) global justice. Environmental justice deals with the fair distribution of benefits, risks and consequences of environmental exposures. Since public health is concerned with both health equity and environmental health, it was surprising to Kass that public health ethics had not already drawn from and contributed to the field; so it was likely to do so in the near future. Kass also perceived the need to better define the specificities of public health research, and to assess whether public health research raised particular ethical issues that would justify having a branch of research ethics dedicated to public health research. Finally, Kass saw a need for a global justice focus in public health ethics which she believed would require “a shift toward *global* issues,” in which the “relationship between inequity and health is even more pronounced” than it is at local, state and national levels (Kass, 2004, p. 237).

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Conclusion

From this brief survey of the field through the questions, What is public health? Who is the public in public health? and What is public health ethics? (and particularly by considering how public health ethics is very distinct from health care ethics) we can see that public health ethics is (1) at a stage in which it is drawing on new ideas and resources from different disciplines that are helping to realize more diverse aims, and (2) is rapidly developing, with different schools of thought emerging as new dimensions are being explored. We can also start to discern some of the complexities that public health ethics is likely to confront, in part because there are competing definitions of “public health.” In other words, public health may refer to a grouping of practices that are not monolithic and easily unified. Public health ethics will have to find a way to speak to this diversity while it continues to highlight different aspects of these practices (e.g., professional, applied, advocacy, critical). Nevertheless, the relatively early stage of development combined with the remarkable amount of interest and work that is being put into public health ethics are promising signs.

The next papers, currently in development, will delve into some of these complexities by focusing on more normative concerns like the theoretical and philosophical underpinnings on which the claims of public health ethics are justified, frameworks that have been developed that may be relevant or useful for public health ethics, and on future directions and key issues for the field as it develops in the coming years.

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