

Overhauling medical ethics in face of emerging moral problems stemming from public health management

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Abstract

The choice between attending to the obligations of public health and individual patient care (rights accorded to individuals under civil liberty cannot be denounced) always give rise to ethical questions. Not resolving these questions by leadership, management, and administration of public health systems can make public health more coercive than consensual. The research aims a discourse which could lead the government-led interventions ranging from either the use of epidemiological data for population surveillance of disease or to issue health warnings may look to have worked in the interest of public without undermining individual liberty.

Introduction

The public health as an organized discipline, with its focus on mass healthcare, fraught with concerns with regard to appropriation of its outreach programme. Among its moral dilemmas, or so called the ethical questions, are the catalogue of activities curtailing individual liberties. The challenges for better public healthcare practices are the ways and means that must be found to come to terms with these moral dilemmas.

The collective action to promote and protect public health, which occurs at national and global level through largely government-led interventions in service of population, may range from use of epidemiological data for population surveillance of disease to government health warnings applying restrictions on certain way of life that likely to infringe on civil liberties.

The public health ethics dealing with the moral underpinnings and justifications for public health may arise out of scarcity of resources for promoting health to the increasing tension between mass benefit to individual liberty, hence the decision to privilege one over the other.

The question what do we mean by the term 'public progresses? An explanation to this regard is that the public is a discrete unit that corresponds to state boundaries, or so called the population within this geographical containment.

The public health challenges, the contours of its outreach always perceived to be nation-state boundaries, certainly must not be regarded as region or nation specific problem. For example, the communicable diseases, which spread beyond the national boundaries, ask for preventive measures targeting multiple countries. Hence, ethical questions about justice and equity account for geographies beyond the nation-state or hence, the rich nations obligations to attend to the public health of poor.

In recent years there is a perceptible shift of bioethics' focus on ethical issues in clinical medicine and medical technology to public health. With emerging public health problems and societal responses to the same, sometimes the public health comes in collision course with civil liberty or well-being of individuals or raise questions about justice in relation to health resource allocations according to the hierarchy of needs, or in the view of other considerations that can be extremely complicated.

Kass (2001) suggests that in order to advance traditional public health goals while maximizing individual liberties and furthering social justice, public health interventions should reduce morbidity or mortality; data must substantiate that a program (or the series of programs of which a program is a part) will reduce morbidity or mortality; burdens of the program must be identified and minimized; the program must be implemented fairly and must, at times, minimize pre-existing social injustices; and fair procedures must be used to determine which burdens are acceptable to a community.

Conflict between Public Health Policy and Individual Liberty

Ideally there should not be any conflict between public health and caring for individual patient since the 'public' is an aggregation of 'individuals' and public health, hence, should be understood as the sum of the health of all those people. But in practice the conflicts occur where the interest of the 'individuals' are preferred over 'public' undermining the concept of equitable distribution of healthcare resources as and when the public health management system strives to come to terms with public funding, effective treatment, duties, rights and preferences with regard to specific areas such as epidemiology, health systems research, disaster preparedness and relief, infectious disease control, mass screening, and health awareness and promotion campaigns that have the potential to reduce the burden of disease within populations.

As always the Nuremberg Code, a set of research ethics principles for human experimentation laid down as a result of the Subsequent Nuremberg Trials (also known as Doctors' Trial) at the end of the World War II. The rights of individual underpinning tenets such as 'informed consent', 'absence of coercion' and 'beneficence towards experiment participants' took the primacy over the larger public interest.

The protection of research subjects followed the appalling Nazi human experimentation by giving assent to external constraints such as 'legal frameworks' and 'research ethics committees' to prevent any mistreatment of research subjects placed enormous responsibility on clinicians and physicians. Since public health required a larger spread after the War the National Health Service (NSH) in UK is a template-example, it required a little shift in balance softening absolute position adopted in Nuremberg Code in DoH. Thus, the DoH did not require children to vaccinate or immunise children against diseases or on incompetent or 'captive' populations, such as prisoners and military personnel.

In order to establish an optimal relationship between public health and individual health is considered to be a major ethical challenge for healthcare system. Hence, Williams (2008)'s attaches priority to resolving the conflict between 'individual' and 'public' health in the view of ethics of research on humans. The World Medical Association (WMA)'s Declaration of Helsinki (DoH) accepts the fact that while concern for the individual has predominated over the needs of public health since World War II in recent time there has been efforts towards redressing this recognised imbalance.

The DoH with the aim to provide guidance to physicians participating in clinical research implies at the responsibilities of researchers for the protection of research topics while at the same time upholds the virtues and necessity of public health subordinated to the individual research.

Research Inquiry

There are two prevailing views such as regarding moral foundation of public health as an injunction to maximize welfare (health as an element of welfare)¹ as opposed to characterising the moral foundation of public health as social justice (secure a sufficient level of

health for all and narrow unjust inequalities). One view cannot be completely denounced at the cost of the other, hence, it calls for the continuous concern for balancing both commitments.

In public health, the unease tautness is always between the injunction to do as much good as possible with 'scarce resources' and the injunction to rescue identifiable individuals in immediate peril, regardless of cost, known as the "Rule of Rescue" which needs to be taken to taken forward.

The ethical questions from this alleged friction between two conflicting priorities pose immense challenges for health care personnel and public policy makers as they come to terms with decisions with regard to public resource allocation and giving accent to new drugs and surgeries. Should they need to deem practical approaches to operationalising the 'Rule of Rescue' before allowing the individual moral imperatives weighing into this debate with regard to the making of public policy?

Addressing to the above concern, Cookson, R. et al (2008) put forward the view that whilst public policy makers should facilitate exceptional departures from a cost effectiveness norm in clinical decisions about identified individuals it is not so obvious that they should, as a matter of national public policy, exempt any one group of unidentified individuals within society from the rules of opportunity cost at the expense of all other.

There are handful of questions. How the cases for 'exceptional departures' in clinical decisions are made? Why these exceptions cannot be made as precedence to allow for more exceptions of similar kind? And further, what is the moral basis of privileging 'unidentified individuals' over 'identified individuals' or vice versa? Why the cost of an alternative must be forgone in order to pursue a certain action (for example the choice to keep a terminally ill under palliative care rather than moving the person to an old age home with basic life-sustaining support)? In which cases a choice needs to be made between several mutually exclusive alternatives given limited public health resources? Like in the situation of a general economic activity it is difficult to establish the basic relationship between scarcity and choice in public health practices, thus providing for the utility gained or lost can never be known.

The inevitable questions about justice in relation to priority setting sets out Verweij and Dawson (2013) to uncover specific reasons to their unique approach to biomedical ethics: public health interventions are generally aimed at populations rather than individuals, and therefore cannot easily be tailored to individual choice. Hence, whereas "autonomy" and "informed consent" are seen as core elements of clinical bioethics, their role in public health ethics is less clear. It certainly seems to a plausible line of enquiry.

Identification of Specific Ethical Questions

Who would prevail in the case of apparent disagreement between patients/families and health care professionals about treatment decisions or should the public health officials combat the growing 'waiting list' by allocating lesser resources for some of the terminally ill patients or mentally ill or those aged under the care of geriatrics. The medical errors, a common sight today, do not in themselves represent an ethical challenge *per se*, but raise ethical questions as if, under what circumstances, and how medical errors should be disclosed to patients and/or families. Further, behind the curtain of medical error the ethical question may be raised on the appropriate prescription of pain medication in the terminally or chronically ill patients, and those declared to be in the last leg of their lives with no hope of recovery yet have been kept under palliative care.

The challenge of balancing benefits and risks of the research in the health care setting and issues riveting patient privacy and confidentiality can always have its set of ethical questions.

The ethical challenge of obtaining informed consent in the health care setting, either cannot read or do not read leading consent to be more procedural formality than a genuine agreement, Flory and Emanuel (2004) aptly point out at the consent discussions and capacity assessments that are largely superficial and hurried due to time constraints contributing to staff not employing interpreters with patients whose first language is other than English. Thus, the health care staff subject patients to medical interventions without providing properly informed consent in violation of patient autonomy based on doctrine of informed consent.

The bewildering challenge of acceptance of substitute decision making in the situation when the patient himself or herself fails or not capable of opting for a particular healthcare choice can have the most problematic ethical questions, and these become more convoluted as the jurisdiction may impose a particular legal hierarchy of decision makers not consistent with health care consent legislation.

Further, the prescription of new drugs and innovative surgical techniques, which may be considered as part of the routine process of perfecting surgical techniques but yet cause potential damages through this experiment on human bodies, all these issues bring up questions pertaining to ethics.

The conflicting value-system between the public health personnel and patients and families subject to public health can pose ethical problems, as decision either way can potentially lead to life-altering decisions in the health care setting.

Now, more recently the randomised controlled trials require the participants to give up their own interests benefitting future patients. As the scientific rationale for conducting a trial of this kind rests in collective equipoise, as the best treatment always remains elusive, it raises several ethical questions. The key point, however, is that future patients benefit at no cost to participants, provided that participants are in personal equipoise and give informed consent on this basis. In these circumstances, the trial arms are an equally good bet prospectively.

Public health Challenges

The public health ethics' questions can be sharpened as long the contours of public health ethics are marked and their overlapping with ethics of clinical practice or the ethics of biomedical science are clearly pointed out. These questions mostly need to be organised around the definition of public health and hence the derived ethics such as what is public good, how it needs to be promoted involving a laser focus on prevention, how the government and other agencies need perform the health interventions and how public health involves an intrinsic outcome-orientation.

Since public health concerns itself with people at large, not individuals, but the apparent benefits of a public, communal good, cannot discount an individual. The result is an individual who cannot readily be individuated from those to another, though its burdens and benefits the public healthcare system reflecting unevenly on different sub-groups of the population at large. Such wheels-within-wheels logic engenders a particular set of justificatory challenges which public health ethics must come to terms with: Public health good is meant for whom? Whose health are the public health must care about, and what sacrifices can be asked from individuals in order to achieve 'public health good' that can be termed acceptable? The perceptive difference between public health and population health? And why is public health a good can justifiably be promoted?

To arrive at a plausible answer to any of the above questions must not discount the fact that the public health measures are largely based on prospective benefits as opposed to immediately securable benefits.

Since much of the discussion surrounding public health focuses primarily on this preventive aspect (commitment to the prevention of disease and injury) how the public health agencies and services dealing with diagnosis and treatment of illnesses prioritise their delivery with all the attendant clinical services that those activities require. The preventive functions and the delivery of personal medical services within national health systems of a country, for example NHS in UK, are integrated under a common political or administrative structure, sometime inseparable like a conjoined twin. Public health's commitment to prevention may come in the wake of immediate healthcare challenges eliminating or mitigating the existing or suddenly surfaced harm or other times public health may choose to commit itself to avoid a long-term health disaster of greater magnitude. To set out the priority in terms of resource allocation with regard choosing one over the other always would invite ethical questions. Should preventive public health interventions be given primacy over than medical treatment challenges in hand with regard to funding and public support? There is no definite answer, largely the force of the event decides the course public policy.

The most difficult task is how ethical questions can ever be formed without knowing the 'unknown' – for examples, the benefits of prevention can never be known until the event occurs, and the costs and burdens of preventive interventions if were to be expended on medical treatment or removing the existing harm. How the benefits of these would come to bear upon the overall public good in long term? This cannot be found with certainty. There can only be probabilistic measures, opinions and perspectives, and the individuals who are known and others who unknown.

The preventive interventions designed to produce results in the future, largely have individuals from the population whose identities cannot be known, hence they currently account for in the probabilistic terms. Such anonymization of individuals in statistical estimate raise questions about how the public health personnel should reflect on the statistical and unidentified individuals, and direct their current course of action to the prevention policies and programs in definite terms. Even the public health personnel manage to get all these tasks right they still will not know whether health gains in the future should be treated as worth less than health gains in the present. This is a trump card question which answer can never be known, or even trying to find answer to this, will raise serious ethical questions.

Since public health calls upon government action, many public health measures are coercive or forced upon by the law, the state will have to address tensions among justice, security, and the scope of legal restrictions. The justificatory questions surrounding the paternalistic state's public health intervention curtailing individual actions and services can bring up a litany of ethical questions stemming from the trade-off between personal freedom and collective action.

The consequentialist orientation of public health, as with all utilitarian or consequentialist schemes, that is viewed as the moral justification and foundation of public health and, can sit at an odd with deontological ethics, and justice-related concerns such as the fair distribution of burdens (Childress et al. 2002²; Kass 2001³).

Should the public health be allowed to override the rights of the individual? This is always 'subjective' or a case-specific opinion, but largely the physicians or clinicians are likely to pledge their primary duty to the care of 'individual' patients while the public health personnel are likely to emphasize on the needs of the community over those of individuals.⁴

The focus on the relation of 'individual' and the 'collective rights' of 'public', which bedevils public personnel, can progress to arrive at public-health ethics independently from traditional health-care ethics that concentrates on 'individual.' Negotiating with the conflicts between the two schools of thought the legitimate goals of public-health interventions must not deny the needs of individuals. Williams (2008) aptly guards the public healthcare system against such an approach that he terms can be 'both unnecessarily conflictual and counter-productive.' Williams (2008) insists on an alternative approach that can have considerations of public-health ethics underpinning the longstanding experience and wide body of literature of traditional health-care ethics recognizing the truth that the traditional ethics is evolving towards a more inclusive system concerning larger number of people.

The WMA's International Code of Medical Ethics, which went through revision in recent years, has received flaks for its restrictions on medical research as well as the disregard to ethics in favour of commerce. An alternative public-health research ethics needs to be consistent with, not dismissive of, traditional health-care ethics (Williams 2008). Such a thing can promote openness to the entire framework of debate on public-health research ethics together with the need to uphold the legitimate rights of individuals. In the evolving human social structure, the body of thought regarding their methodologies and practices adopted by the individuals responsible for the healthcare or the people at the receiving end of these services relate to the societal institution of healthcare that are the fountainhead of ethical questions.

Nearly every decision in health care space that is made to bear out on ethical implications - concerns the patients, providers and other stakeholders in healthcare at large. The science and art of preventing disease, prolonging life and promoting health through organized efforts of society may not be easy in practice as they sound, hence the public health of protecting and improving the health of communities always fraught with choices, contradictory viewpoints and actions, competing claims and counterclaims, predictions that may go either way.

The clarity over concepts, structure of methods, and contours of boundaries of public health ethics are largely remain amorphous (or perhaps continuously being defined). But upon knowing that public health is about the entire populace than a few individuals certainly narrows down the ethical perspective to inclusion. The ethical questions arising out of medicine focuses on the treatment and cure of individuals whereas public health concerns itself to improving the disease and disability in a population at large. Medicinal practices can be understood as the doctor-patient relationship that is at the heart of this social transaction whereas the public health relates itself to interactions and relationships among multiple social actors responsible for development, implementation and assessment of healthcare interventions.

In order to have a definite engagement with moral problems in public health the latter can follow the suggestion of Childress *et al* (2002): Public health system consists of all the people and actions, including laws, policies, practices, and activities, that have the primary purpose of protecting and improving the health of the public. Childress *et al* (2002) guard us against the myth that public health is always tightly structured or centrally directed but to acknowledge the role of a cross-section of social actors from government and non-governmental organisations including charities.

The public health in the hand of government confirms to the principles of distributive justice (socially just allocation of goods or resources) than individuals in the control of the same independent of the state. The principles of distributive justice can always confront with choices that how the available quantum of resources can be made available following certain processes and more importantly, can the state always be guided by the utilitarian principle that distributive justice must always concentrate on outcomes (maximum benefits for maximum

numbers) or deontological principle that ways and means by which these distribution of resources going to take place (normative ethics).

Kant will be relevant in this discourse: "Nothing in the world—indeed nothing even beyond the world—can possibly be conceived which could be called good without qualification except a good will."

"The good will is not the only intrinsic good as such; rather, it is the only intrinsic good that is morally good in all circumstances."

As the healthcare professionals continually strive to improve, mend, and alter the overall nature and quality of lives under their care there can be many interpretation of ethical questions, either the way they are constructed or pre-exist as some would argue, there is certainly a sense of public liberalisation associated to it as the way ethical questions are apprehended as the foundational good, a pre-requisite for public life, as Levin (Summer 2012) frames it.

For example, balancing care quality and efficiency within the remit of available resources or providing access to healthcare for the same reason will have many possibilities varying from one reason to another, hence, the ethical questions will also seek their context. If the healthcare access always be given immediate primacy over the 'care quality and efficiency' the spreading out of the healthcare resources may come to a point it could not sustain the lives as many as it would have done in the first place. Yet it does not morally sound good as we cannot consider the lives of some individuals more precious and deserving than the other 'have-nots'. If the country is facing an epidemic or a resource scarcity the exercises of these choices become more difficult.

Some of the contemporary ethical questions may stem from the pursuit of promotion of health and the prevention of disease and disability may force the participating agents in the collection and use of epidemiology data, population surveillance, snooping, and other forms of empirical quantitative assessment. Hence, developing effective interventions in healthcare system as recognition of the multidimensional nature of the determinants of health and an emphasis on the complex interactions of many factors --- biological, behavioural, social, economic and environmental -- may augment the dimension of ethical questions.

There would be no denial of the fact that the philosophy of healthcare relates to ethics, processes, and individuals which constitute the maintenance of health for human beings at large.

Health care management in NHS

The NHS reforms in early 90s with the internal market within the organisation started gaining ground, the conflict between public health and individual liberty (patient care) assumed a new importance in the discourse of health care management. The NHS comprised of providers and purchasers -- providers include hospital trusts competing among themselves in order to secure contracts from purchasers, such as general practices -- the organisational complexity reached new levels calling upon specialist management skills to balance between public health and individual patient care. The new changes in organisational structure lead to effectiveness and economics targeted in exposing the NHS to market forces that now called upon certain managerial skills.

The NHS in late 90s put forward the opinion that it must knock down the internal market in order to replace the competition by collaboration and a system laying emphasis on the needs of patients. What could concern here forth the public health -- although the reforms would certainly have an effect on what health service personnel perform and who they were -- the fundamentals of health care decisions about how best to use resources for patient care remain unchanged: 'health care decisions best made by those who treat patients'.

Combating the Challenges

1. *Creating policies for health care institutions, delivery partners, etc.*

How these institutions must develop their policies on cases of disagreement consistent with social conventions or value-system, judicial systems, best practices of the industry including any suggestion to this regard that has been made by national accreditation organizations and World Health Organisation (WHO). Since the health care institutions are required to have mechanisms in place to address ethical issues facing patients, family members, and healthcare personnel stemming out of the disagreements over treatment decisions (any issue such as informed consent to substitute decision making) the policy development always must happen through a process of consultation involving all stakeholders with diverse value systems than imposing the top-down approach.

2. *Close-look at patient's viewpoint:*

Until the dissension between patients or their substitute decision makers and health care personnel do not take public health forward, hence, the need to engage with the alternative viewpoints such as 'end-of-life' issues or treatment decisions from the patients and their substitute decision makers remain a key indulgence of bioethicists to patients themselves.

3. *Reporting to the public*

The systematic effort to keep the public informed of public health research and diverse initiatives towards the formulation of policies or guidelines will remain a continuous challenge.

4. *Educating & Training of health care personnel:*

The emphasis always has been imbibing the health care personnel with technical knowledge with communication skills, but rarely the art of negotiation and mediation skills to resolve the disagreements between public health prescription and patients or their family members. Cribb (2005) argues that the biomedical ethics should draw upon public health values and ethics paving the way for the sharing of responsibility for health, thus, promoting greater health equality.

Conclusion

Since clinical bioethicists may limit their role to clinical trials of drugs and their prescriptions the ethical questions do not need to create its specialist community of interpreters. The stakeholders in this entire process keep their own perspective of this subject matter, which enable them to develop their own ethical point of view. The most common trigger for ethics consultations has been a proclivity for helping to resolve a conflict in hand arising from a particular situation. The most commonly witnessed ethical problems arise out of disagreements that occur in the intensive care unit. The context of such disagreement can be very wide-ranging from questions pertaining to palliative care and rehabilitation to surgery and alternative medicine.

References

- Childress, J. F., et al (2002) Public Health Ethics: Mapping the Terrain. *The Journal of Law, Medicine & Ethics*, Issue 2, Vol 30 (London: Wiley) pp 170-178
- Coleman C.H, et al (2007) How should ethics be incorporated into public health policy and practice? *Bull World Health Organ*, Vol 85, Issue 504
- Cookson, R. et al (2008) Public healthcare resource allocation and the Rule of Rescue, *Journal of Medical Ethics*, Issue 34 (London: BMJ Publishing Group Ltd & Institute of Medical Ethics) pp 540-544

- Cribb, Alan (2005) *Health and the Good Society: Setting Healthcare Ethics in Social Context* (Oxford: OUP)
- Edwards, Sarah, J., L., et al, (1988) Ethical issues in the design and conduct of randomised controlled trials. *Health Technology Assessment*. In: Edwards, Sarah, J., L., (31 Oct, 1988) *The ethics of randomised controlled trials from the perspectives of patients, the public, and healthcare professionals*, *BMJ*, 317 (7167): 1209–1212.
- Flory, J., and Emanuel, E., (2004) Interventions to Improve Research Participants' Understanding in Informed Consent for Research: A Systematic Review. *JAMA*, 292:1593-160
- Kass, Nancy, E. (Nov 2001) An Ethics Framework for Public Health. *American Journal of Public Health* (Washington, D.C.: American Public Health Association) Vol. 91, Issue No. 11, pp. 1776-1782.
- Kant, Immanuel (1785) "First Section: Transition from the Common Rational Knowledge of Morals to the Philosophical", *Groundwork of the Metaphysics of Morals*.
- Kohn L.T., et al (eds.) *To Err is Human: Building a Better Health System*. Institute of Medicine, Committee on Quality of Health Care in America
- Lederer S.E. (2007) Research without borders: the origins of the Declaration of Helsinki. In: Schmidt U, Frewer A, eds. *History and theory of human experimentation: the Declaration of Helsinki and modern medical ethics* (Stuttgart: Franz Steiner Verlag) pp. 155-6
- Lilford, R., J., and Jackson, J., C., (1995) Equipose and the ethics of randomisation. *J R Soc Med*. 88:552–559 In: Edwards, Sarah, J., L., (31 Oct, 1988) *The ethics of randomised controlled*
- Powers, M. and R. Faden (2006) *Social Justice* (NY: Oxford University Press)
- The new NHS modern dependable (8 Dec 1997) NHS White Paper <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf> Accessed 30 Nov 2015
- Verweij, Marcel and Dawson, Angus (1 Feb 2013) *Public Health Ethics*, *The International Encyclopaedia of Ethics* (London: Wiley)
- Williams, John R (Aug 2008) *The Declaration of Helsinki and public health*, *Public Health Classics* (Geneva: Bulletin of the World Health Organisation) SciELO Public Health <www.scielosp.org/scielo.php?pid=S0042-96862008000800022&script=sci_arttext> Accessed 29 Nov 2015
- Wolinsky, H. (2006) *The battle of Helsinki*. *EMBO Report* 7, pp 670-2.
- Yuval Levin (Summer 2012) 'Putting Health in Perspective,' *The New Atlantis*, Number 36, (Washington, D.C.: The Center for the Study of Technology and Society, The Ethics and Public Policy Centre, The Witherspoon Institute) pp. 23-36.
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