Ann Ist Super Sanità 2012 | Vol. 48, No. 1: 1-4
DOI: 10.4415/ANN_12_01_01

Commentary

Person: centre both of clinical ethics and of public health ethics

Carlo Petrini
Unità di Bioetica, Presidenza, Istituto Superiore di Sanità, Rome, Italy

Summary. The "public health" perspective is different from the "patient-centred" clinical perspective for various reasons. Tensions between collective and individual interests are unavoidable in public health. Intersections between public health ethics and clinical bioethics can be traced to a set of duties which derive from respect of the person. Human rights and solidarity are "person-centred" cornerstones of both clinical and public health ethics.

Key words: ethics, medical ethics, personhood, public health.

"PERSON-CENTRED" MEDICINE IN THE HISTORY OF THE PATIENT-PHYSICIAN RELATIONSHIP

The notion of "person-centred" medicine is frequently encountered in the literature on medical ethics and deontology [1], where the expression refers mainly to the patient-physician relationship [2].

From Hippocrates and Galen to the modern age, the patient-physician relationship has passed through the centuries with a mostly paternalistic stance [3]. This approach is found in a large body of literature: "Comprehensive treaties on ethical questions have been in existence ever since antiquity. Besides those, one can find short versions, reduced to enumerations of rules. Concerning medical practice, such rules have existed in the form of oaths, covenants, and prayers since antiquity, as ecclesiastic dogmas and laws since the Middle ages, and as professional rules since the nineteenth century. For some time now, the concept of "ethics code" has been established to name these shortened documents. Their number has increased enormously since the Nuremberg code (1947), especially over the last two decades, since they were considered to provide the means of orientation and self-representation. In terms of their content these codes typically thematize the qualities of a "good doctor", the healer- or physican-patient relationship and basic questions of medical practice" [4].

ARE THE TRADITIONAL CLINICAL ETHICS ALSO SUITABLE FOR PUBLIC HEALTH ETHICS?

The "public health" perspective is different from the "patient-centred" clinical perspective for various reasons. In particular: public health deals with populations, whereas clinical practice deals with individuals; public health deals largely with prevention as well as with treatment; public health objectives are long-term goals; decisions on public health issues involve institutions as opposed to individual doctors [5].

Apart from situations in which one or more individuals can threaten the health of a community (*e.g.* in the case of a particularly severe infectious disease), public health is not (at least directly) interested in individual health. Public health focuses on populations: as Marcus Tullius Cicero wrote in *De legibus "ollis salus populi suprema lex esti"* [6].

Tensions between individual and collective interests are unavoidable in public health. Public health organisations/institutions often address these tensions through a utilitarian approach. In most cases the utilitarian approach does not correspond to the basic values of clinical bioethics: utilitarian theories seem to be an effective way of maximizing benefits for the greatest number of people, but do not consider how those benefits are distributed among individuals [7]. According to Charlton there is "a sharp difference between the ethics which govern public health compared with those appropriate for clinical specialities" [8]. Likewise, according to Bayer and Fairchild "bioethics cannot serve as a basis for thinking about the balances required in the defence of public health. As we commence the process of shaping an ethics of public health, it is clear that bioethics is the wrong place to start" [9]. The same authors underline that clinical ethics and public health ethics are grounded on different values: "Those involved in the practice of public

Address for correspondence: Carlo Petrini, Unità di Bioetica, Presidenza, Istituto Superiore di Sanità, Via Giano della Bella 34, 00162 Rome, Italy. E-mail: carlo.petrini@iss.it.

health embrace a set of values that are often, if not always, in conflict with the autonomy-centred values of those who take an individualistic and anti-paternalistic stance". Public health surveillance is a typical case in which a few pillars of clinical ethics (*e.g.* informed consent) are often overridden by collective interests: "Public health surveillance by necessity occurs without explicit patient consent" [10].

The tensions between individual and public interests may lead public health to favour groups and to neglect individuals. This is one of the most relevant ethical problems in public health; one that is again often addressed using a utilitarian approach: "In public health the personal choices and preferences of some will be overridden by a greater concern for the well being of a whole population" [11].

Nevertheless, the widespread opinion "that public health ethics is based entirely on a particular type of consequentialism (...) [or] "health utilitarianism" is "oversimplified" [12], and "the conflicts that arise when attempting to actually implement this oversimplified version of public health ethics are stark reminders of its inadequacy for practice" [12].

PUBLIC HEALTH ETHICS AND CLINICAL ETHICS: SOME COMMON VALUES

Several codes of ethics affirm that public health need not be only utilitarian (*e.g.* the *Public Health Code of Ethics* by the Public Health Leadership Society [13]) and can help public health ethics and clinical ethics to move closer together.

Public health interventions can be ethically sound if they simultaneously meet the challenge of being respectful of each individual (not utilitarian) and practically effective. In this perspective, several "checklists" against which to evaluate the quality of public health interventions have been proposed. Three examples are given here.

According to Childress *et al.*, "regardless of the ethical theories taken as reference, the relevant moral considerations [in public health decisions] include" [14]:

- producing benefits;
- avoiding, preventing and removing harm;
- producing the maximal balance of benefits over harm and other costs (often called utility);
- distributing benefits and burdens fairly (distributive justice) and ensuring public participation, including that of affected parties (procedural justice);
- respecting autonomous choices and actions, including liberty of action;
- protecting privacy and confidentiality;
- keeping promises and commitments;
- disclosing information as well as speaking honestly and truthfully;
- building and maintaining trust.

The same authors suggest the following "conditions intended to help determine whether promoting public health warrants overriding such values as individual liberty or justice in particular cases":

- effectiveness;
- proportionality;
- necessity;
- least infringement;
- public justification.

According to Kass "an ethics framework for public health" can be built by asking and answering the following questions [15]:

- what are the public health goals of the proposed programme?
- how effective is the programme in achieving its stated goals?
- what are the known or potential burdens of the programme?
- can burdens be minimized? Are there alternative approaches?
- is the programme implemented fairly?
- how can the benefits and burdens of a programme be fairly balanced?

According to Gostin *et al.* "coercive measures, which violate individual rights, are acceptable when" [16]:

- the risk to public health is demonstrable;
- the intervention is likely to be effective, cost-effective, not overly invasive, fairly distributed;
- the process for pursuing intervention is just and publicly transparent.

PUBLIC HEALTH ETHICS AND CLINICAL ETHICS: A FEW COMMON HISTORICAL ROOTS

Other intersections between clinical bioethics and public health ethics (that also show how both should be "person-centred", though in different ways) can be traced to the medical issues that led in the 1970's to the birth of bioethics as a new and independent branch of learning (the term "bioethics" first appeared in a widely read article published in 1970 by Van Rensellaer Potter [17] and was developed the following year in a book [18] by the same author).

Many scholars (*e.g.* Baker and McCullough [19]) have emphasised that most of the problems that in the sixties raised the ethical issues at the origin of bioethics are typically of a clinical nature. The principal issues can be divided for convenience into five areas: human experimentation, genetics and genetic engineering, organ and tissue transplantation, the end of life, procreation.

Nonetheless, these problems are not only clinical; nor are they extraneous to public health.

The issues surrounding death and organ transplantation, for example, are numerous and heterogeneous and include, among others, the allocation of scarce resources and scarce interventions. Allocation is another problem that typically is also encountered in public health. Organ allocation for transplantation is an emblematic example of conflicts between the interests of individuals. At about the same time that the novel technique of organ transplantation was posing new ethical questions (the first kidney transplantation was performed in 1954 by Joseph Murray at the Birmingham Hospital in Boston), other new procedures, such as dialysis, were generating similar problems. On March 9th, 1960, in Seattle, thirty-nine-year old engine-driver, Clyde Shields, who was close to dying of kidney damage, was connected through a cannula to a new instrument that had been invented the preceding month by the nephrologist Belding H. Scribner and the engineer William Quentin. The new technique immediately triggered problems of allocation: only nine beds were available at the Seattle Kidney Center, while 20 000 patients were potential candidates to receive dialysis, and the costs were very high (about $ 10 000/year). An Admissions and Policy Committee (whose seven members were protected by anonymity) was established with the extremely difficult task of selecting candidates. As the decisions taken by this Committee were a matter of life or death for the potential candidates it became known as the "God Committee" [20].

However, the problem of allocation is typical not only of contemporary health care: it has accompanied the entire history of medicine and public health. Back in the nineteenth century, when William Henry Duncan's pioneering work in the slums of Liverpool led to the 1846 "Liverpool Sanitary Act", difficulties in resource allocation were immediately evident. Nevertheless, Duncan's reply to Edwin Chadwick's inquiry about his resource base was lapidary: "Which of the Ten Commandments is optional?" [21].

This response illustrates that the allocation of scarce resources is not only a problem of funds and capitals: it is, first of all, a problem of values.

TWO MILESTONES: HUMAN RIGHTS AND SOLIDARITY

To conclude these brief remarks identifying some of the links between clinical ethics and public health ethics, it is worthwhile recalling two cornerstones of both clinical and public health ethics.

The first is human rights. As Wynia observes: "There is strong evidence that attention to human rights is critical to good community health, as well as individual health" [12].

The second is solidarity. The report *Solidarity. Reflections on an emerging concept in bioethics* published by the Nuffield Council on Bioethics [22] confirms that solidarity is a value that not only has accompanied the development of a large part of human thinking and culture, but also provides sound roots for contemporary bioethics.

Acknowledgements

This Commentary is partially based on a paper presented by the author at the Congress "Complessità emergente in medicina: la centralità della persona nelle frontiere etiche e scientifiche. Un concorso di idee", held in Rome, Istituto Superiore di Sanità, on December 14th, 2011.

Conflict of interest statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

Accepted on 5 January 2012.

References

1. Sledziewski ÉG. Une éthique pour l'homme et le citoyen. In: Hirsh E (Ed.). *Éthique, Médecine et société. Comprendre, réfléchir, décider*. Pris: Vuibert; 2007. p. 51-8.
2. Lagrée J. Patient. In: Lecourt D (Ed.). *Dictionnaire de la pensée médicale*. Paris: Presses Universitaires de France; 2004. p. 845-51.
3. Carrick P. *Medical ethics in the ancient world.* Washington DC: Georgetown University Press; 2001.
4. Tröhler U, Reiter-Theil S. Introduction of the Editors. In: Tröhler U, Reiter-Theil S (Eds.). *Ethics codes in medicine.* Aldershot: Ashgate; 1998; p. xii-xiv.
5. Schneider D, Lilenfeld DE (Eds.). *Public health. The development of a discipline. Vol. 2. Twentieth-century challenges.* New Brunswick: Rutgers University; 2011.
6. Marcus Tullius Cicero. *De Legibus.* Vol. III.
7. Lyon D. Utilitarianism. In: Becker L, Becker C (Eds.). *Encyclopedia of ethics. Vol. 3.* New York: Routledge -Taylor & Francis; 2001. p. 1737-44.
8. Charlton BG. Public health medicine – a different kind of ethics? *J Royal Soc Med* 1993;86(4):194-5.
9. Bayer R, Fairchild ALR The genesis of public health ethics. *Bioethics* 2004;18(6):473-92.
10. Lee LM, Heiligh CM, White A. Ethical justification for conducting public health surveillance without patient consent. *Am J Public Health* 2012;102(1):38-44.
11. Thomas JC. Teaching ethics in schools of public health. *Public Health Reports* 2003;118:279-86.
12. Wynia MK. Oversimplifications II: public health ignores individual rights. *Am J Bioeth* 2005;5(5):6-8.

13. Public Health Leadership Society (PHLS) and American Public Health Association (APHA). *Public health code of ethics.* 2002-2004. Available from: www.apha.org/codeofethics/ethics.htm.
14. Childress JF, Faden RR, Gaare RD, Gostin LO, Kahn J, Bonnie RJ, Kass NE, Mastroianni AC, Moreno JD, Nieburg P. Public health ethics: mapping the terrain. *J Law Med Ethics* 2002;30(2):170-8.
15. Kass NE. An ethics framework for public health. *Am J Public Health* 2001;91(11):1776-82.
16. Gostin LO, Bayer R, Fairchild Amy L. Ethical and legal challenges posed by Severe Acute Respiratory Syndrome. *JAMA* 2003;290(24):3229-37.
17. Potter VR. Bioethics: the science of survival. *Perspect Biol Med* 1970;1:127-53.
18. Potter VR. *Bioethics, bridge to the future.* Englewood Cliffs, NJ: Prentice-Hall Inc.; 1971.
19. Baker RB, McCullough D. *The Cambridge world history of medical ethics.* Cambridge University Press: New York and Cambridge; 2009.
20. Durand G, Duplantie A, Laroche Y, Laudy D. *Histoire de l'éthique médicale et infirmière.* Montréal: Les Presss Universitaires de Montréal; 2000.
21. Ashton JR. The following is my entire establishment... your servant, William Henry Duncan. *J Epidemiol Community Health* 2004;58(8):717.
22. Nuffield Council on Bioethics. *Solidarity. Reflections on an emerging concept in bioethics.* 30 November 2011. Available from: www.nuffieldbioethics.org/sites/default/files/Solidarity_report_FOR_WEB.pdf.