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Mapping the Issues: Public Health, Law and Ethics

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Public Health, Law and Ethics

in

PUBLIC HEALTH LAW AND ETHICS: A READER
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Introduction

Mapping the Issues:
Public Health, Law and Ethics

The issues and questions presented in the theory and practice of public health are not resolved solely through scientific inquiry; rather, law and ethics, along with the public health sciences, guide our inquiries. Despite the integral nature of the interplay between public health, law, and ethics, each of these three fields has its separate identity, and the three have rarely cross-fertilized. For the most part, each of these fields has adopted its own terminologies and forms of reasoning. To the extent that scholars and practitioners in the fields of law and ethics have engaged in sustained examinations of issues in health, they have focused principally on medical care. This introductory chapter maps the important features of, and issues in, law and ethics as they pertain to the theory and practice of public health.

I. PUBLIC HEALTH

In thinking about the application of ethics or law to problems in public health, it is important first to understand what we mean by public health. How is the field defined and what is its content—its mission, functions, and services? Who engages in the practice of public health—government, the private sector, charities, or community-based organizations? What are the principal methods or techniques of public health practitioners (Novak 1996; Turnock 2001)? In truth, finding answers to these fundamental questions is not easy because the field of public health is highly eclectic and conflicted (Beaglehole and Bonita 1997). For a summary of the definition, mission, functions, and jurisdiction of public health, see Table 1.

Table 1
PUBLIC HEALTH

<table>
<thead>
<tr>
<th>Definition</th>
<th>Society’s obligation to assure the conditions for people’s health</th>
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<tbody>
<tr>
<td>Mission</td>
<td>Promote physical and mental health; prevent disease, injury, and disability</td>
</tr>
<tr>
<td>Functions</td>
<td>Assessment—assemble and analyze community health needs</td>
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<td></td>
<td>Policy development—informed through scientific knowledge</td>
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<td></td>
<td>Assurance—services necessary for community health</td>
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<tr>
<td>Jurisdiction/Domain</td>
<td>Narrow focus—proximal risk factors (e.g., infectious disease control)</td>
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Definitions of public health vary widely, ranging from the World Health Organization’s (1946) utopian conception of an ideal state of physical and mental health to a more concrete listing of public health practices. Charles-Edward A. Winslow (1920, 30), for example, defined public health as “the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, and the organization of medical and nursing service for the early diagnosis and preventive treatment of disease.” More recent definitions focus on “positive health,” emphasizing a person’s complete well-being. Definitions of positive health include at least four constructs: a healthy body, high-quality personal relationships, a sense of purpose in life, and self-regard and resilience.

The Institute of Medicine (IOM) (1988, 19), in its landmark report *The Future of Public Health*, proposed one of the most influential contemporary definitions: “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.” The IOM’s definition can be appreciated by examining its constituent parts. The emphasis on cooperative and mutually shared obligation (“we, as a society”) reinforces that collective entities (e.g., governments and communities) take responsibility for healthy populations. Individuals can do a great deal to safeguard their health, particularly if they have the economic means to do so. They can purchase housing, clothing, food, and medical care. Each person can also behave in ways that promote health and safety by eating healthy foods, exercising, using safety equipment (e.g., seatbelts, motorcycle helmets, and smoke detectors), and by refraining from smoking, using illicit drugs, or drinking alcoholic beverages excessively. Yet there is a great deal that individuals cannot do to secure their health, and therefore these individuals need to organize and collaborate on building infrastructure and developing shared resources. Acting alone, people cannot achieve environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. Each of these collective goods, and many more, are achievable only through organized and sustained community activities.

The IOM definition also makes clear that even the most organized and socially conscious society cannot guarantee complete physical and mental well-being. There will always be a certain amount of injury and disease in the population that is beyond the reach of individuals or government. The role of public health, therefore, is to assure the conditions for people to be healthy. These conditions include a variety of educational, economic, social, and environmental factors that are necessary for good health.
Most definitions share the premise that the subject of public health is the health of populations—rather than the health of individuals—and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few. The field of public health is concerned with health promotion and disease prevention throughout society. Consequently, public health is interested in devising broad strategies to prevent or ameliorate injury and disease, and to promote longevity and wellbeing.

Scholars and practitioners are conflicted about the “reach,” or domain, of public health. Some prefer a narrow focus on the proximal risk factors for injury and disease (Epstein 2003). The role of public health agencies, according to this perspective, is to identify risks or harms and intervene to prevent or reduce them. This has been the traditional role of public health—exercising discrete powers such as surveillance (e.g., screening and reporting), injury prevention (e.g., safe consumer products), and infectious disease control (e.g., vaccination, partner notification, and quarantine).

Others prefer a broad focus on the socioeconomic foundations of health (Gostin and Bloche 2003). Those favoring this position see public health as an all-embracing enterprise united by the common value of societal well-being. They claim that the jurisdiction of public health reaches “social ills rooted in distal social structures” (Meyer and Schwartz 2000, 1189). Ultimately, the field is interested in the equitable distribution of social and economic resources because social status, race, and wealth are important influences on the health of populations (Marmot and Wilkinson 1999). Similarly, the field is interested in “social capital” because social networks of family and friends, as well as associations with religious and civic organizations, are important factors in individual wellbeing and community functioning.

This inclusive direction for public health is gaining popularity. Figure 1 illustrates the determinants of health according to the Department of Health and Human Services: physical environment, behavior and biology, and social environment. Using this vision, public health researchers and practitioners have ventured into areas of general social policy, ranging from city planning, safe housing, and diet and exercise to violence, war, and discrimination.

The expansive view of public health may well be justified by the importance of culture, poverty, and powerlessness on the health of populations. Social epidemiologists have found an association between these factors and increased morbidity and premature mortality. Yet to many, this all-embracing notion is troublesome. First, there is the problem of excessive breadth. Almost everything human beings undertake impacts the population’s health, but this does not justify an overly inclusive definition of public health. The field of public health appears less credible if it overreaches.

Second, there is the problem of expertise. Admittedly, the public health professions incorporate a wide variety of disciplines (e.g., occupational health, health education, epidemiology, laboratory technology, and nursing), with different skills and functions. But public health professionals do not possess all the skills necessary to intervene on
behavioral, social, physical, and environmental levels (e.g., competence in behavioral and social sciences, economics, and engineering).

Finally, there is the problem of political and public support (Burris 1997). By espousing controversial issues of economic redistribution and social restructuring, the field risks losing its legitimacy. Public health gains credibility from its adherence to science, and if the field strays too far into political advocacy, it may lose the appearance of objectivity.

If public health has such a broad meaning, then who engages in the work of public health? The IOM’s (2003) sequel to its first report, The Future of the Public’s Health in the 21st Century, stressed the importance of a public health “system,” comprising a wide array of public and private entities—government, industry, academia, charities, and community-based organizations. At the governmental level, public health has a significant jurisdictional problem. Even the most powerful public health agency cannot exercise direct authority over the full range of activities that affect health. Many of the determinants of health are normally the province of other agencies (e.g., agencies concerned with education, agriculture, transportation, housing, child welfare, and criminal justice). Furthermore, much of the behavior that public health agencies try to change (e.g., exercise and diet) is not subject to direct legal regulation at all. At the same time, many of the institutions that affect the public’s health are outside government, such as managed care organizations, business and labor, community-based groups, and academic institutions.

The breadth and variety of public health actors is a relevant practical and theoretical consideration. It matters a great deal in law and ethics to understand who is acting, with what authority, and with what resources. For example, society is prepared to allow government to wield powers to coerce (e.g., tax, inspect, license, and quarantine) that would be unacceptable in the private sector.

What are the principal methodologies of public health practitioners? Because of the field’s broad sweep, the techniques of public health are highly diverse. For example, public health practitioners monitor health status, which calls for skills in epidemiology and biostatistics; inform and educate the public, which calls for skills in education and communication; and create health policy and enforce laws, which calls for legal, political, and leadership skills. This description does not account for the many subjects in the field of public health requiring expertise in domains such as infectious diseases (e.g., virology and bacteriology), the environment (e.g., toxicology), and injuries (e.g., behavioral and social sciences). As the IOM (1988, 40) has observed, “Public health’s subject matter . . . necessitate[s] the involvement of a broad spectrum of professional disciplines. In fact, . . . public health is a coalition of professions united by their shared mission.”

As illustrated in Figure 2, the field of public health is caught in a dilemma. If it conceives itself too narrowly, then public health will be accused of lacking vision. It will fail to tackle the root causes of ill health and fail to utilize a broad range of social, economic, and behavioral tools necessary to achieve healthier populations. At the same
time, if it conceives itself too expansively, then public health will be accused of
overreaching and invading a sphere reserved for politics, not science. It will lose the
ability to explain its mission and functions in comprehensible terms and, consequently, to
sell public health in the marketplace of politics and priorities.

There may be a deeper level of tension here. Public health is an arm of the state and a
profession of public service. It must work within the bounds of the law and respect the
judgments of elected officials. Yet, public health professionals often function as a voice
of social conscience and a champion for the disadvantaged who disproportionately suffer
from injury, disability, and disease. It is not always easy for public health officials to
“speak truth to power.” Balance, however, can be achieved by those who understand the
myriad political and economic considerations that underlie public policy judgments and
the numerous entry points in the democratic process that create opportunities to draw
attention to relevant scientific evidence and public health values.

II. PUBLIC HEALTH LAW

As we have just seen, the question “What is public health?” is much more difficult than it
first appears. Despite the lack of conceptual clarity, it is important to study carefully the
legal foundations of public health, as well as its ethical dimensions. Public health law has
long taken a back seat to health care law, which examines primarily the financing,
organization, and delivery of personal medical services. But important scholarly studies
of public health law are becoming more salient in the United States (Goodman et al.
2003; Gostin 2008; Grad 1990; Wing 2003;) and internationally (Bailey et al. 2005;
Reynolds 2004; Martin and Johnson 2001). The emergence of the field is underscored by
a public health law program at the Centers for Disease Control and Prevention (CDC), a
public health law association, and numerous academic centers and institutes devoted to
this subject.

The preservation of the public’s health is among the most important goals of
government. The enactment and enforcement of law, moreover, is a primary means by
which government creates the conditions for people to lead healthier and safer lives. Law
creates a mission for public health officials, assigns their functions, and specifies the
manner in which they may exercise their power. The law is a tool that is used to influence
norms for healthy behavior, identify and respond to health threats, and set and enforce
health and safety standards. The most important social debates about public health take
place in legal fora—legislatures, courts, and administrative agencies—and in the law’s
language of rights, duties, and justice. It is no exaggeration to say that “the field of public
health . . . could not long exist in the manner in which we know it today except for its
sound legal basis” (Grad 1990, 4).

In the companion text, I define public health law as “the study of the legal powers and
duties of the state, in collaboration with its partners (e.g., health care, business, the
community, the media, and academe), to ensure the conditions for people to be healthy
and of the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals."

Public health law scholars, therefore, are interested in government authority to prevent injury and disease and to promote the public’s health, as well as in the constraints on state action to protect individual freedom. Government has ample authority to act for the common good, with “police powers” to safeguard the health, safety, and morals of the population. But the state must exercise that power within the constraints of the Constitution.

Law can be an effective tool to achieve the goal of improved health for the population. Law, regulation, and litigation, like other public health prevention strategies, intervene at a variety of levels, each designed to secure safer and healthier populations. First, government interventions are aimed at individual behavior through education (e.g., health communication campaigns), incentives and disincentives (e.g., taxing and spending powers), and deterrence (e.g., civil and criminal penalties for risky behaviors). Second, the law regulates the agents of behavior change by requiring safer product design (e.g., safety standards and indirect regulation through the tort system). Finally, the law alters the informational (e.g., advertising restraints), physical (e.g., city planning and housing codes), and business (e.g., inspections and licenses) environments.

Government engages in the work of public health through three separate branches: legislative, executive, and judicial. The Constitution provides a system of checks and balances so that no single branch of government can act without some degree of oversight and control by another. Separation of powers is essential to public health, for each branch of government possesses a distinct, albeit overlapping, constitutional authority: (1) legislatures create health policy and allocate the resources necessary to effect it; (2) executive agencies implement health policy, promulgate health regulations, and enforce regulatory standards; and (3) courts interpret laws and resolve legal disputes. As a society, we forgo the possibility of bold public health governance by any single branch in exchange for constitutional checks and balances that prevent government from overreaching and ensure political accountability.

In practice, public health agencies in the modern state go beyond traditional executive branch functions of implementation and enforcement. Certainly, the legislature assigns the responsibilities and activities of public health agencies. But beyond that, public health agencies can, in a sense, create law through administrative regulations, and interpret law through the regulatory process and their own practices. They can also adjudicate disputes, such as when a business has violated a safety standard or when a professional is eligible for a license.

Public health law is concerned with the tradeoffs entailed in the exercise of government power. Under what circumstances should government be permitted to act to achieve a public good when the consequence of that act is to invade a sphere of personal or economic liberty? This is the kind of question that intrigues scholars interested in law
and the public’s health. Rather than using ethical discourse to resolve these conflicts, the law uses the language of duties, powers, and rights.

It is clear from the foregoing description that public health law is a vast field incorporating thinking from a variety of legal subspecialties—constitutional, administrative, and tort law. The Constitution affords the federal government certain powers and limits the authority of governments at every level in order to protect a sphere of freedom. Administrative law is concerned with the body of statutes and regulations that set health and safety standards, together with agency powers to interpret and enforce those standards. Tort law provides a method of indirect regulation through the courts. By levying damages for certain kinds of harm, tort law can provide powerful disincentives to risk behaviors (e.g., litigation against cigarette and firearm manufacturers). A fourth body of law—international law—is becoming increasingly relevant as infectious and even chronic diseases transcend national borders. International law includes a wide array of treaties in health, trade, human rights, arms control, and the environment. These legal dimensions will be explored further as the Reader unfolds, particularly in Part II on the Legal Foundations of Public Health.

III. PUBLIC HEALTH ETHICS

The fields of bioethics and medical ethics have richly informed the development and use of biotechnologies, the practice of medicine, and the allocation of health care resources. Ethicists have not devoted the same sustained attention to problems in public health, but this is beginning to change with interesting and important scholarship in public health ethics. The Association of Schools of Public Health, for example, has developed a model curriculum for courses in public health ethics that includes materials on the traditions and values of public health, as well as on the ethical issues raised by infectious disease control, environmental health, and health care reform.

Public health ethics seeks to understand and clarify principles and values that guide public health actions, offering a framework for decision-making and a means of justifying decisions. Because public health actions are directed to populations, the principles and values of the field can differ from those that guide actions in biology and clinical medicine (bioethics and medical ethics) which are more patient or individual-centered.

This discussion raises a critical unanswered question: What are the features that distinguish public health ethics from conventional medical ethics or bioethics? Are ethical principles and values, or the methods of ethical analysis, materially different when applied to populations than when applied to individuals? In thinking about this question it will be helpful to consider public health ethics from at least two perspectives: the ethics of public health professionals (professional ethics) and ethics in public health theory and practice (applied ethics). See Table 2.
Table 2
PUBLIC HEALTH ETHICS

<table>
<thead>
<tr>
<th>Branches of Public Health Ethics</th>
<th>Principal Concerns</th>
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| Ethics of Public Health (i.e., Professional Ethics) | Ethical dimensions of professionalism  
Moral trust society bestows on professionals to act for the common good |
| Ethics in Public Health (i.e., Applied Ethics: Situation or Case Oriented) | Ethical dimensions of public health enterprise  
Moral standing of population’s health  
Tradeoffs between collective goods and individual interests  
Social justice: equitable allocation of benefits and burdens |
| Advocacy Ethics (i.e., Goal-Oriented, Populist Ethic) | Overriding value of healthy communities  
Serves interests of populations, particularly powerless and oppressed  
Methods: pragmatic and political |

Source: Hastings Center Project on Ethics and Public Health.

The ethics of public health are concerned with the ethical dimensions of professionalism and the moral trust that society bestows on public health professionals to act for the common welfare. This form of ethical discourse stresses the professionalism among public health students and practitioners. It instills in professionals a sense of public duty and trust. Professional ethics are role oriented, helping practitioners to act in virtuous ways as they undertake their functions.

Many professional groups, such as physicians, nurses, and attorneys, hold themselves accountable through a set of ethical guidelines, but public health professionals have no official code of ethics. Perhaps the explanation is that there is no single public health profession, but rather a variety of different disciplines. Indeed, some public health disciplines have their own ethical codes—for example, epidemiologists, health educators, and health services researchers.

A code of ethics, or at least a well-articulated values statement, could be helpful to the field. A code could give the profession a moral compass, providing concrete guidelines to help clarify distinctive ethical dilemmas. Public health professionals work in a field of considerable moral ambiguity where guidance could be instructive. A code could also give moral credibility to the field and a higher professional status. The Public Health Leadership Society developed an unofficial code of ethics after a systematic consultative process, which is reproduced in table XX.
Table 3. Principles of the Ethical Practice of Public Health
(Source: Public Health Leadership Society 2002)

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.

2. Public health should achieve community health in a way that respects the rights of individuals in the community.

3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.

4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.

5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.

6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community’s consent for their implementation.

7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.

8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.

9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.

10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.

11. Public health institutions should ensure the professional competence of their employees.

12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public’s trust and the institution’s effectiveness.

A salient issue in the ethics of public health professionals involves fiduciary duties. To whom do public health professionals owe a duty of loyalty, and how can these professionals know what actions are morally acceptable? Physicians, attorneys, and accountants have a fiduciary duty to their clients that informs their moral world. For example, client-centered professions usually adhere to the principle that the professional serves the client, advises the client fully and honestly, takes instructions from the client, and avoids acting against the client’s best interests.
In the context of public health, the community might be regarded as the “client.” The problem is that it is unclear what constitutes a “community”; the notion is often vague and fragmented. In any given situation, different groups may claim to represent community interests. If the community’s wants and needs are not easily ascertained, should public health professionals make their own judgments about communal interests? Public health professionals may, at times, coerce some members of the community to take actions that are not necessarily in the individual’s best interests but are in the interests of others. In thinking about public health’s complex relationship to populations, is the concept of fiduciary duty helpful as an ethical value?

Do public health professionals have a duty to tell the full truth and, if so, under what standard should they be judged? Public health professionals may earnestly believe that their mission requires vigorous interventions to prevent risk behaviors (e.g., smoking and illicit drug use) or encourage health-promoting behaviors (e.g., exercise and a healthy diet). To achieve these beneficent objectives, public health professionals may exaggerate the risks or benefits or make claims that are insufficiently grounded in science. Suppose public health professionals know that the risk of sexual transmission of HIV in a middle-class, rural neighborhood is relatively low. Are they obliged to disclose this fact when advising men to wear condoms? How would an ethical code address the nuanced question of “truth telling” by public health professionals?

A second form of public health ethics might be called ethics in public health theory and practice. Ethics in public health are concerned not so much with the character of professionals as with the ethical dimensions of the public health enterprise itself. Here, scholars study the philosophical knowledge and analytic reasoning necessary for careful thinking and decision making in creating and implementing public health policy. This kind of “applied” ethics is situation or case oriented, seeking to understand morally appropriate decisions in concrete cases. Scholars can make significant contributions to this area by applying general ethical theory and detached analytical reasoning to the societal debates common in public health. Public health ethicists could identify and clarify the ethical dilemma posed; describe the benefits and burdens; specify the alternative courses of action; and offer guidance about an ethically appropriate intervention.

The application of ethical principles and values to public health decisions can be complex and controversial. Problems in public health often involve numerous risk factors, multiple stakeholders, and diverse perspectives on matters of individual liberty and population wellbeing. Since a principle aim of public health is to achieve the greatest health benefits for the greatest number of people, it draws from the traditions of consequentialism, which judges the rightness of an action on the consequences, effects, or outcomes that are produced. Utilitarianism, one of the most influential illustrations of consequentialist ethical theory, holds that actions are justified insofar as they promote the greatest happiness of the greatest number of people.

The “public health model” of ethical reasoning, argue Allen Buchanan and others, uncritically assumes that the appropriate mode of evaluating options is some form of
cost-benefit (or cost-effectiveness) calculation—the aggregation of goods and bads (benefits and costs) across individuals. Public health, according to this view, appears to permit, or even require, that the most fundamental interests of individuals be sacrificed in order to produce the best overall outcome.

This characterization is based on a misunderstanding or, at least, an oversimplified understanding of the public health approach. The field of public health is certainly interested in securing the greatest benefits for the most people. And public health officials, as part of government, must concern themselves with efficiencies, benefits, and costs. But public health does not simply aggregate benefits and burdens, choosing the policy that produces the most good and the least harm. Rather, the overwhelming majority of public health interventions are intended to benefit the whole population without knowingly harming individuals or groups. When public health authorities work in the areas of tobacco control, the environment, and occupational safety, for example, their belief is that everyone will benefit from smoking cessation, clean air, and safe workplaces.

Certainly, public health focuses almost exclusively on one vision of the “common good” (health, not wealth or prosperity). And public health action can diminish personal and economic freedoms such as privacy or free enterprise. But, such individual sacrifices are not the salient characteristics of public health ethics. The field rarely sacrifices fundamental interests to produce the best overall outcome, except perhaps when individual behavior threatens the equally fundamental interests of others to live in health and safety—e.g., isolation of persons with multi-drug resistant tuberculosis. At the very least, when a public health action pits one fundamental interest against another, public health ethics should facilitate vigorous debate, and the action should be subject to legal oversight.

The public health approach, of course, does follow a version of the harm principle. Thus, public health authorities regulate individuals or businesses that endanger the community. The objective is to prevent unreasonable risks that jeopardize the public’s health and safety—for example, polluting a stream, exposing others to infectious disease, or selling dangerous toys for children. When public health officials regulate to curtail activities that harm others, they are acting squarely within a widely accepted Western liberal tradition.

More controversially, public health officials at times recommend and undertake paternalistic interventions, such as mandating motorcycle helmets or banning trans fat in foods. Public health officials reason that the sacrifice asked of individuals is relatively minimal and the communal benefits are substantial. Few public health experts advocate denial of truly fundamental individual liberties in the name of paternalism. In the public health model, individual interests in autonomy, privacy, liberty, and property are taken seriously, but they do not invariably trump community health benefits.

The public health approach, therefore, differs from modern liberalism primarily in the balancing of interests; public health places greater weight on community benefits,
whereas liberalism favors liberty interests. Characterizing public health as a utilitarian sacrifice of fundamental personal interests is as unfair as characterizing liberalism as an individualistic sacrifice of vital communal interests. Both traditions would deny this kind of oversimplification.

Scholars in medical ethics and bioethics have demonstrated convincingly the power and importance of individual freedom. However, until recently they have given insufficient attention to the equally strong values of partnership, citizenship, and community (Beauchamp 1998). As members of a society in which we have a common bond, we also have an obligation to protect and defend the community against threats to health, safety, and security. Members of society owe a duty—one to another—to promote the common good. A new public health ethic should advance the idea that individuals benefit from being part of a well-regulated society that reduces risks that all members share.

There remains much work to do in public health ethics. What is the moral standing that should be attached to the collective good? Does the health of a community have a moral standing that is independent of the health of individuals within that population? Under what circumstances should individual interests yield to achieve an aggregate benefit for the population? And, importantly, what counts as a “harm” or “benefit”? Must the person’s behavior pose a risk to others or can public health officials justifiably restrict self-regarding behavior?

Social justice is one of the most basic and commonly understood aspects of public health ethics. Justice requires fairness or reasonableness, especially in the way people are treated or decisions are made. It stresses the importance of fair disbursement of common advantages and the sharing of common burdens. Does an otherwise effective policy become unfair if it disproportionately disadvantages a racial, ethnic, or religious group? For example, public health professionals often advocate primary enforcement of seatbelt laws so that police can stop a driver simply for failure to comply with the law. But what if primary seatbelt laws are enforced disproportionately against African Americans, as appears to be the case?

Social justice, of course, encompasses not only fair distribution of resources, but also requires the preservation of human dignity and the showing of equal respect for the interests of all members of the community. As Hurricane Katrina taught us, a failure to act expeditiously and with equal concern for all citizens, including the poor and less powerful, erodes public trust and undermines social cohesion. It signals to the disadvantaged and to everyone else that the basic human needs of some matter less than those of others, and it thereby fails to show the respect due to all members of the community.

In addition to “professional” and “applied” ethics, it is possible to think of an “advocacy” ethic informed by the single overriding value of a healthy community. Under this rationale, public health authorities perceive of themselves as knowing what is ethically appropriate and understand their function as advocating for that social goal. This
populist ethic serves the interests of populations, particularly the powerless and oppressed, and its methods are principally pragmatic and political. Public health professionals strive to convince the public and its representative political bodies that healthy populations and reduced inequalities are the preferred social responses.

The language and concepts of human rights are often invoked when advancing an advocacy ethic, and with good reason. Human rights, part of a body of international law, afford individuals rights against state interference. These include civil and political rights, such as autonomy, bodily integrity, privacy, and nondiscrimination. Human rights, moreover, impose affirmative duties on states to act for the welfare of society. Economic, social, and cultural rights include the rights to social security, education, work, and to share in scientific advancement and its benefits.

Most importantly, human rights require governments to recognize “the right of everyone to the highest attainable standard of physical and mental health” (International Covenant on Economic, Social, and Cultural Rights, art. 12). Critics point to the vagaries of the right to health, such as its lack of definable standards and enforcement mechanisms. Although this critique has force, the Committee on Economic, Social and Cultural Rights and a Special Reporter have offered more detailed guidance on the meaning and implementation of the right to health. Public health advocates often invoke this right when seeking improved health conditions, reduction of socioeconomic disparities, and universal access to health care.

Public health ethics, therefore, can illuminate the field of public health in several ways. Ethics can offer guidance on (1) the meaning of public health professionalism and the ethical practice of the profession, (2) the moral weight and value of the community’s health and well-being, (3) the recurring themes of the field and the dilemmas faced in everyday public health practice, and (4) the role of advocacy to achieve the goal of safer and healthier populations, and the importance of the human right to health.

There needs to be a much more sustained, sophisticated discussion of ethics among students, practitioners, and scholars in public health. For example, ethics instruction in schools of public health is scarce and targeted primarily to biomedical or medical ethics, but this too may be changing as the Association of Schools of Public Health’s model curriculum illustrates. Further, few public health employers in the public and private sectors offer continuing education that includes ethical issues. Government and academic institutions should consider the value of including ethics in accreditation of schools, credentialing of professionals, and the promotion of public health research.

IV. CONCLUSION

Assuring and improving population health requires consideration of broad and divergent issues, from the philosophical to the economic and jurisprudential. Traditionally, these dimensions of public health theory and practice have been analyzed independently by
public health practitioners, lawyers, and ethicists, who each apply the distinct terminology and analytical methods of their respective fields. The divergence between these approaches is not inherently problematic; members of each field bring their own richly diverse expertise to the theory and practice of public health. But the key to analyzing and practicing public health in a coherent way is the integration of these methodologies into a unified framework. In pursuit of this goal, the Reader seeks to integrate and foster dialogue between the fields of public health, law, and ethics.

**Recommended Readings**


- Gostin, Lawrence O., and M. Gregg Bloche. 2003. The politics of public health: a response to Epstein. *Perspectives in Biology and Medicine* 46: 160-175. (Contends that public health must be understood to have a wider scope that encompasses non-communicable diseases and social determinants of health)