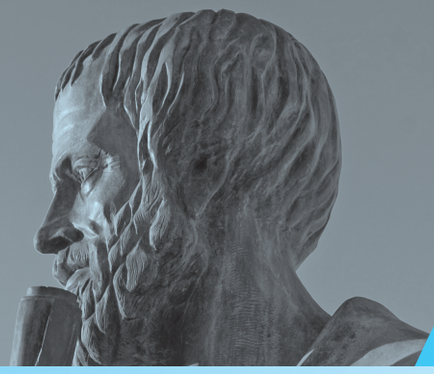
PART I

Foundations



CHAPTER 1

Introduction: A Framework for Public Health Ethics

by James F. Childress and Ruth Gaare Bernheim

Learning Objectives

By the end of this chapter, the reader will be able to:

- understand public health ethics in the context of public philosophy in the U.S.
- identify several moral norms applicable to public health
- interpret and assess three approaches to ethical conflicts and dilemmas in public health (absolutist, contextualist, and presumptivist)
- utilize justificatory conditions for overriding moral norms in some conflict situations
- appreciate the importance of the process of public justification in public health ethics
- use a set of questions for analyzing ethical dimensions and issues in particular situations
- understand how metaphors shape reflection on ends and means in public health

INTRODUCTION: PUBLIC HEALTH ETHICS: A PRELIMINARY ANALYSIS

This chapter provides an introduction to public health ethics and develops a framework of ethical analysis, deliberation, and justification for public health interventions. Public health officials face myriad decisions as they seek to protect the public's health, prevent illness, disease, injury, and death, and promote the health of the population. Public health is an ethical enterprise, resting on moral foundations, yet some public health interventions appear to threaten or compromise other moral norms, such as liberty, privacy, and confidentiality. Hence public health decisions are sometimes ethically fraught.

Ethical issues may arise on different levels. On the one hand, governmental officials such as legislators, judges, executives, regulators, and health officials frequently recommend or put into place laws and policies regarding public health. For instance, these laws and policies may set the conditions under which it is permissible to impose a quarantine to prevent the spread of a communicable disease, or to notify a person's sexual partners that they are at risk for a sexually transmitted disease. On the other hand, public health officials often must make their own decisions about which goals to pursue and which measures and interventions to undertake, because these laws and policies are usually indeterminate and often authorize actions without prescribing them. Ethical questions and issues arise at both the level of setting laws and policies and the level of deciding what to do where those are indeterminate. For example: Which law or policy regarding justifiable breaches of confidentiality would best protect both the public health and the rights of persons with communicable diseases? And, if the law or policy permits, but does not require, a breach of confidentiality by mandating the disclosure of information to third parties such as sexual partners under certain conditions, what is the ethically justifiable course of action for public health officials? Which ethical and other factors are relevant to these decisions? On what ethical grounds can the public health official justify his or her decisions?

What Is Public Health Ethics?

What, then, is *public health ethics*? About a decade ago, some of the authors of this volume collaborated in an effort to map the terrain of public health ethics.[1] It was not—and is not—an easy task, because of variations in meanings of the terms "public health," "ethics," and the two in combination.

In general, *ethics* refers to the reflective task of interpreting what constitutes moral life and moral actions. We will here concentrate on and engage in normative[a] ethics.[2] In its general sense, normative ethics involves identifying and justifying moral norms regarding right and wrong, good and bad, and determining the meaning, range, and strength of those moral norms for purposes of guiding human action. In its practical or applied mode, normative ethics interprets and guides various domains of life and action, such as business, politics, or public health, in light of moral considerations. Drawing a rough but useful distinction, we can say that *morality* refers more to a social institution or practice—what people believe, value, and do—while *ethics* refers more to the reflective task of interpreting, understanding, and criticizing morality. By contrast, the terms *ethical* and *moral* are often used interchangeably.

The meaning of *public health* may appear to be obvious, but here, too, there are complexities and confusions. According to the now classic definition from the the Institute of Medicine (IOM), public health "is what we, as a society, do collectively to assure the conditions in which people can be healthy."[3] This definition points to a collective activity, but it also refers to the goal of the collective activity—"assur[ing] the conditions in which people can be healthy." We will start with the activity, but our discussion will inevitably incorporate public health goals, such as enabling "healthy people in healthy communities."[3]

Two authors of this book have written elsewhere:[4b]

> … public health involves not only traditional government action to protect the public from imminent threats, but also, at a more fundamental level, cooperative behavior and relationships of trust in communities, as well as a far-reaching agenda to address complex social, behavioral and/or environmental conditions that affect health.

As a political undertaking, public health includes, at minimum, government's central role, grounded in its police power, to protect the public's health and to provide public goods that would not otherwise be available from individual action alone. Law, with its foundation in a society's political philosophy, provides the framework for the powers and duties of the government to protect public health; sets boundaries on state power to limit individual rights and private interests in order to promote health; and creates incentives and disincentives for individual or organizational activities that affect health.

Government public health actions present at least two types of ethical/political challenges.[5] One set of challenges focuses on the *scope* of public health, e.g., does government have a public health duty to prevent chronic disease by addressing behavioral (sedentary lifestyle) or socioeconomic (poverty) risk factors? Another set of ethical issues involves the appropriate *means* of public health intervention, e.g., should government outlaw risk-taking behavior such as riding a bicycle without a helmet? When is the state justified in isolating a noncompliant patient with tuberculosis? The state's use of its police power, particularly in paternalistic or coercive policies, raises important ethical questions for a liberal, pluralistic democracy and requires moral justification that the public—in whose name the policies are carried out—could reasonably be expected to accept.

As a social endeavor, public health includes many forms of social and community action and increasingly involves overlapping networks of individuals and organizations, including governmental and private agencies, for-profit and nonprofit stakeholders, professionals from many disciplines, and citizens, all working together over time to improve the population's health and the living conditions in the community. Relationship building, whether between public health officials and the public they serve or among community partners, is not merely instrumental, but rather is part of the substance of public health work. Particularly at the local community level, public health interventions, e.g., those that focus on socioeconomic or

---

[a] Normative ethics is contrasted with both meta-ethics and descriptive ethics. The former analyzes the language, concepts, and methods of ethical reasoning, while the latter studies how people reason and how they act. See Reference 2.

[b] The next four paragraphs are from Childress JF, Bernheim RG. Public health ethics: Public justification and public trust. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz* 2008;51(2):158–163.

behavioral risk factors, tend to be multidimensional, sustained over months or years, and context-dependent. Community public health campaigns to reduce youth tobacco use are examples of complex, multifaceted programs that depend on community coalition-building and partnerships, as well as numerous social institutions such as the public education system, in order to effect changes in social norms and behaviors related to teen smoking. Ethical analysis in this sphere of public health extends beyond the political to include professional, institutional, and civic duties as well.

Public Philosophy

Public health ethics thus draws on the overlapping domains of formal political, social, and moral philosophy. However, we mainly appeal to an informal or de facto "public philosophy," to use Michael Sandel's language, which refers to "the political theory implicit in our practice, the assumptions about citizenship and freedom that inform our public life."[6] This public philosophy provides an ethical foundation for—and sets limits on—public health laws, policies, and practices and on social institutions and organizations engaged in public health activities. As a normative enterprise, public health ethics can provide a framework to explore the fundamental ethical values that define the relationships of the individual, the state, and social institutions in public health activities aimed at public health goals. It can also provide ways to reason about the conflicts that arise among those ethical values—for instance, in the selection of public health interventions.

MORAL NORMS

Moral Considerations in Public Health

Several moral considerations play important roles in the analysis and assessment of public health activities, including both ends and means. Rather than appearing in a simple code, they emerge from a variety of sources. Some are embedded in our society's public philosophy, as expressed in our laws, policies, practices, and the like. They also appear in the kinds of moral appeals that public health agents make in deliberating about and justifying their actions, as well as in public debates about moral issues in public health. **Table 1.1** captures these "moral considerations in public health."

We recognize that these general moral considerations, which we will often call moral norms—but also values, principles, rules, and the like—may have different labels or names and may be interpreted differently in different ethical frameworks. Some frameworks may locate one or more of the above concepts under others. Nevertheless, we contend that the moral content of public health ethics is largely, if not completely, captured by these moral norms. They represent the ethical essentials of public health.

TABLE 1.1 Moral Considerations in Public Health

1.	Producing benefits
2.	Avoiding, preventing, and removing harms
3.	Producing the maximal balance of benefits over harms and other costs (often called utility)
4.	Distributing benefits and burdens fairly (distributive justice) and ensuring public participation, including the participation of affected parties (procedural justice)
5.	Respecting autonomous choices and actions, including liberty of action
6.	Protecting privacy and confidentiality
7.	Keeping promises and commitments
8.	Disclosing information as well as speaking honestly and truthfully (often grouped under transparency)
9.	Building and maintaining trust

Data from Childress JF, Faden RR, Gaare RD, et al. Public health ethics: mapping the terrain. *Journal of Law, Medicine, & Ethics* 2002;30(2):169–177.

Relations Between Moral Norms and Public Health

Moral norms function in various ways in relation to public health goals and interventions. Several provide warrants for the moral enterprise of public health. Particularly relevant are the norms of benefiting others, preventing and removing harms, utility, and justice. At minimum, "public health" points to a broad and important social benefit that governments and societies generally should and do seek. Public health is both an intrinsic and an instrumental social good; that is, it is good both in itself and for what it enables the society to do. Public health is an intrinsic good because, other things being equal, a healthy society is preferable to an unhealthy one. Public health is an instrumental good because it enables the society to realize other goods it values. For instance, a healthy society is more productive, needs fewer economic resources for health care, and can defend itself better from external threats.

Several norms thus support the enterprise of public health, rendering its achievement an important ideal (but not the only one) and its pursuit an important obligation (within limits). Public health thus falls under the broad

norm of beneficence (of producing good), which we have above broken down into (1) producing benefits, (2) avoiding, preventing, and removing harms, and (3) producing the maximal balance of benefits over harms and other costs, the last of which is often referred to as *utility*. This involves governmental and social activities to *protect* the public's health, to *prevent* its ill health, and to *promote* its good health. Justice is also important, because the fair distribution of benefits and burdens in the society requires attention to persons' special vulnerabilities to illness, disease, and injury.

Some general moral norms for societies and governments support at least some public health activities. However, this broad benefit of public health will need to be specified in various ways in different contexts. At this point, we have not indicated exactly how much weight public health goods and goals should have in general and in specific contexts, especially when they conflict with other moral norms. For now, we can affirm that public health is an important value, but not an overarching benefit that always trumps all other goods and norms.

Beyond supporting the governmental and societal pursuit of public health, some norms, as implemented, may actually be a means to or even a precondition for the achievement of public health. There is strong evidence, for instance, that conditions of social injustice contribute significantly to ill health, and that violations of human rights "have adverse effects on physical, mental, and social well-being."[7]

Despite the links between moral norms, including human rights, and public health, conflicts sometimes do emerge in deliberation about whether, to what extent, and how to pursue some specific public health goals. For instance, debates may erupt over how much money should go into public health versus other societal goods when budgets are limited, and about whether the costs or risks of a potentially effective public health intervention are too great to warrant the intervention. In specific contexts, some moral norms, including human rights, may limit and constrain what the state and society may do in pursuit of public health.

If and when moral norms come into conflict, how can we resolve those conflicts? In the remainder of this chapter, we will sketch a framework for resolving ethical conflicts in public health.

ADDRESSING ETHICAL CONFLICTS AND DILEMMAS IN PUBLIC HEALTH

Should the law mandate children's vaccination for certain diseases even against parents' religiously based objections to vaccinations? In seeking to resolve such ethical conflicts and dilemmas—whether in public health or in other domains—we need to attend to two dimensions of ethical norms. One dimension is their range or scope, the other their weight or strength. Reasoning through conflicts and dilemmas requires attention to both dimensions. Sometimes, it may be possible to specify one norm in order to eliminate its conflict with another norm; this occurs by specifying that norm's range or scope of applicability.[2,8] For instance, we might specify the range or scope of privacy, both to make it more concrete for real-life situations and, in the process, to reduce its conflict with some public health pursuits.

However, some conflicts are not amenable to resolution through specification. In such cases, it will be necessary to determine the relative weights or strength of the conflicting norms.[2] In putting forward a framework to address and resolve ethical conflicts and dilemmas in public health, we will first analyze and assess different approaches to determining the weight or strength of conflicting norms and propose justificatory conditions for overriding norms in some situations; then we will focus on a process of public justification.

Absolutist and Contextualist Approaches

There are three basic approaches to formulating the relative weight and strength of conflicting moral norms, and we will seek to determine which approach, or approaches, are the most adequate for deliberating about public health policy and practice in a liberal, pluralistic, democratic society. The first approach is *absolutist*. It asserts that one norm is superior to and always triumphs over all other norms or, in a rank order, over certain other norms. There is general agreement that some norms are absolute—for instance, prohibitions of murder, rape, and cruelty—but few, if any, other norms qualify as absolute. It is implausible to hold that norms such as liberty, privacy, and confidentiality that sometimes conflict with the pursuit of public health are absolute. Absolutist approaches encounter devastating counterexamples and are unable to address ethical complexities in the real world. Consider the following absolutist claims: (1) "liberty (privacy, confidentiality, etc.) should never be sacrificed for public health," or (2) "public health always trumps liberty (privacy, confidentiality, etc.)." Neither absolutist claim is defensible. We can easily think of cases in which individuals' liberties should be overridden to protect the public health—mandatory quarantine in a serious epidemic is a good example. On the other hand, in many cases public health goals may not be clear, specific, or strong enough to override individuals' liberties, or can be realized without compromising those liberties.

At the opposite end of the spectrum from absolutist approaches, we can place contextualist approaches. Contextualist approaches proceed by balancing all relevant

factors, including all applicable norms, in a particular context. For instance, officials may balance public health goals against rules of privacy in order to determine which is weightier *in a specific situation*. Advantages of this approach include its flexibility as well as its attention to the particularities of different situations; one disadvantage is its possible arbitrariness and unpredictability. The process of balancing, by itself, seems to make our judgments too intuitive, less reasoned.

A Presumptivist Approach

Falling between absolutist and contextualist approaches is a *presumptivist* approach. It is closer to a contextualist approach in attending to particular circumstances and examining all relevant norms and data, but it also finds bare balancing too unstructured and intuitive to be sufficient. Moreover, in any genuine conflict between the society and the individual, the society tends to win in the process of balancing. Hence, in thinking about *means* to achieve public health goals in a liberal, pluralistic, democratic society, it is important to put more initial weight on the liberty (privacy, confidentiality, etc.) end of the scale, at least to the extent of placing the burden of proof on proponents of policies and actions that infringe upon these personal interests. This also implies a tentative (but nonabsolute) priority for interventions that do not violate liberty and related norms unless necessary and unless other conditions are met. Our "public philosophy" entails this approach. Its presumptions, often expressed in the legal-like language of burden of proof, serve to structure moral deliberation and justificatory arguments in situations of uncertainty and indeterminate norms.[9]

As we have previously argued elsewhere,

> … a presumptivist framework best structures public health ethics in a liberal, pluralistic, democratic society. A presumptivist framework sets presumptions about means and interventions, but also views these presumptions as rebuttable and identifies the conditions for their rebuttal. Hence, it avoids certain deficiencies of both the absolutist and the contextualist approaches. On the one hand, it is clearly nonabsolutist, since either liberty or public health can take priority in some situations. On the other hand, it moves beyond the contextualist approach's metaphorical balancing by admitting presumptions, burdens of proof, starting points, initial tentative weights, or heuristics in the selection of means to achieve the goal of public health. The presumptions emerge from a society's core values, as expressed and embodied in its constitution, laws, policies, and practices, as well as in its myths and stories, all making up the society's public philosophy. They structure, and should structure, without absolutely determining, the selection of public health interventions.[4]

Interlude: Summary

To summarize and set the stage for a discussion of justificatory conditions, we are focusing on the public philosophy of liberal, pluralistic, democratic societies, a public philosophy that characterizes legal and ethical norms and discourse in the U.S. In addition to the ends of public health that it includes and emphasizes, this public philosophy also attends to means. Following the identification of a public health problem or need that warrants governmental and societal action, the selection of means or modes of intervention becomes crucial. This selection should not treat all potentially effective means, or even all means that would probably produce a net benefit, as equally meritorious, subject only to determining their probable success and balance of good over bad effects. The ends justify the means—what else could?—but not all potentially effective means that would probably produce a net balance of good over bad effects in the particular circumstances. This public philosophy establishes presumptions in favor of means or interventions that respect liberty, privacy, confidentiality, and the like. Hence, our ethical analysis should start with these presumptions. But, as we have argued, these presumptions are nonabsolute and can be rebutted—overridden or outweighed—under certain conditions. Hence, we need to identify rebuttal conditions, what we are here calling "justificatory conditions," that indicate when the presumption in question can be justifiably rebutted.[2,4,10]

JUSTIFICATORY CONDITIONS FOR OVERRIDING NORMS IN CONFLICT SITUATIONS

We now turn our attention to several conditions for justifying infringements of norms such as liberty, privacy, and confidentiality in the selection of public health interventions, as means to achieve public health goals. These conditions can also be viewed as rebuttal conditions because they indicate when the presumption against infringing such norms can be rebutted.

We will explore these several justificatory conditions in part by examining a specific liberty-limiting intervention: mandatory, forcible quarantine. In attempting to slow or

TABLE 1.2 Justificatory Conditions

Effectiveness: Is the action likely to accomplish the public health goal?
Necessity: Is the action necessary to override the conflicting ethical claims to achieve the public health goal?
Least infringement: Is the action the least restrictive and least intrusive?
Proportionality: Will the probable benefits of the action outweigh the infringed moral norms and any negative effects?
Impartiality: Are all potentially affected stakeholders treated impartially?
Public justification: Can public health officials offer public justification that citizens, and in particular those most affected, could find acceptable in principle?

Data from: Childress JF, Faden RR, Bernheim RG, et al. Public Health Ethics: Mapping the Terrain. Journal of Law, Medicine, & Ethics 2002;30(2):169–177, at 172 and Childress JF and Bernheim RG. Public Health Ethics: Public Justification and Public Trust. Bundesgesundheitsblatt: Gesundheitsforschung, Gesundheitsschutz 2008;51(2):158–163.

stop an outbreak of a serious contagious disease, such as Severe Acute Respiratory Syndrome (SARS), avian influenza, or active tuberculosis (all of which involve airborne transmission), quarantine is recognized as a legitimate public health measure. We will examine forcible quarantine in detail elsewhere; for now, we will use this intervention as a way to illustrate how justificatory conditions work.[10c]

Effectiveness in the Protection or Promotion of Public Health

If there is no reason to believe that a quarantine would be an effective public health measure, then it would be a mistake to impose it. Indeed, not only would forcible quarantine under those circumstances be unwise, it would also be ethically unjustified. Interventions that infringe important social values must have a reasonable prospect of success in order to be justified.

Necessity

Even if forcible quarantine would probably be effective in some cases, it might not be necessary or essential. It might be possible, for instance, to secure voluntary compliance with quarantine requests without resort to the threat or use of force. Liberty and other presumptive values require a search for alternatives before they can be justifiably overridden. In short, a public policy that can accomplish its goals through voluntary cooperation has priority over threat or use of force.

This justificatory condition has implications for different strategies to ensure that persons with, for example, active tuberculosis will complete their treatment until cured, in order to reduce the likelihood of long-term risks to others, particularly from tuberculosis strains that are resistant to multiple drugs. Other things being equal, persuading persons with tuberculosis to complete their treatment until cured, even through the use of financial or other incentives, should have priority over forcible detention. In such a case, proponents of forcible strategies bear the moral burden of proof: They must be able to provide strong reasons for their belief that a coercive approach is necessary and essential.

Least Infringement of Presumptive Value

Suppose that forcible quarantine would satisfy the first two conditions in a particular set of circumstances. Public health officials should still seek the custody alternatives—e.g., confinement at home, admission to a hospital or similar facility, or protective custody in a jail—that are least restrictive and intrusive, yet consistent with obtaining the end that is sought. For some analysts, the condition of least restrictive or intrusive means is a corollary of necessity, in that coercive measures should be necessary in degree as well as in kind. However, it is also helpful to view this condition as a specific requirement to minimize infringements of presumptive values. To take another example, even if it is justifiable to breach privacy or confidentiality in particular circumstances, this third condition places limits on the scope of the infringement, in terms of both the information that is disclosed and the parties to whom it is disclosed.

Proportionality

Some ethicists would fold the previous justificatory conditions into a broader conception of proportionality: If a specific quarantine measure would satisfy the three prior conditions, then it would be a proportionate response to the threat.[11] However, we view proportionality as a separate requirement, because it involves balancing broader considerations. After determining that a proposed coercive intervention such as quarantine would satisfy the first three conditions, we still must ask whether the probable benefits (in risk reduction), minus any probable negative effects, are sufficient to rebut the presumption in favor of freedom from governmental coercion.

[c] The following six paragraphs in the text are from Childress JF, Bernheim RG. Public health ethics: Public justification and public trust. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz* 2008;51(2):158–163.

Impartiality

Basic standards of fairness apply across public health interventions. More specifically, they require that coercive public health measures, such as quarantine, be imposed impartially. Even though this condition might seem to be unnecessary and even useless, a quick glance at serious outbreaks of infectious disease in the past reveals that victims have been singled out for blame along with others in such broad categories as race, ethnic background, socioeconomic class, or geographical location, and have been subjected to stigmatization and discrimination. Far from being relegated to the past, stigmatization and discrimination occurred in the SARS outbreak in several places, including, for example, in Toronto against the Chinese.[12]

We will examine the sixth condition, public justification, separately because it focuses on the context of justification, indicating to whom the justification must be made as well as the procedures and processes of engagement for creating the social basis for justification.

PUBLIC JUSTIFICATION IN CONTEXT

In making difficult choices in public health that involve important social, cultural, and political norms and values, decision makers at all levels should attempt to act "in ways that preserve the moral foundations of social collaboration" that are at the core of public health.[13] A presumptivist approach for public health ethics, which sets out core moral values and norms as starting points for deliberation, can provide a foundation for social collaboration and for enduring relationships of trust in public health. An explicit acknowledgement of shared core values and common goals and needs in public health can engender trust and support for collective action and even build a community of stakeholders by educating and enabling individuals and entities to see themselves as connected through health.

In a democratic political order, engagement of the public in public health deliberation is an indispensable part of a presumptivist approach because members of society are political and social stakeholders—they themselves have a stake in the ongoing protection of fundamental values such as liberty and privacy that are displayed, embodied, and sometimes overridden for their benefit. Real-time public health decisions are socially situated within particular communities; hence, accountability to and transparency with the public requires that reasons, justifications, and explanations for practices such as quarantine be provided to ensure the public can support such actions. Even forcible quarantine requires considerable voluntary cooperation to be successful. At minimum, justification requires that officials state, "We are choosing to impose quarantine in this context because ..."

Context here includes the particular social, political, and institutional settings in which an action takes place. It also includes such factors as socioeconomic, cultural or demographic features of the population as well as the strength and quality of political and social relationships and discourse in the community. The need for public support directs our attention to relationships—"support from whom to whom for what?"—including, in the case of quarantine, the relationship between public health professionals and community members. Thus, relationships, built on common understandings, developed over time, of roles, obligations, and collaborations, frame the meanings of and justifications for public health decisions and engender the public's trust and willingness to support those decisions.

It is our contention that public health relationships provide a significant context for a framework of core values, presumptions, and justificatory/rebuttal conditions. Because public health is both a political and a social undertaking, we believe public health ethics must include both a framework for deliberation, such as we have proposed, and an explication of the professional and civic roles and relationships that provide the context for public health policies and actions.

The primary public health relationship is between community members (with a background understanding of reciprocal civic obligations of membership in that community) and public health professionals (with their understanding of their authority as government officials established by law, as well as their understanding of their role as health professionals in society). This relationship is complex in that it pulls together many perspectives, languages, and cultures. It includes on the one hand government officials, who are professionals with particular expertise and professional values, and on the other community members with their numerous and simultaneous memberships in diverse groups, families, cultures, and religions.

In addition, the relationship between public health officials and community members is unique: public health officials act as both government agents with police powers, and as health professionals with responsibility for population health, a public good. In a democracy, public health officials might be thought of as physicians to the community, and the process of justification shares some features of a consent process between doctor and patient—one that is framed as a partnership based on voluntary action, with a strong presumption against any "unconsented to" action. Particularly in times of need and vulnerability, health professionals usually are approached as trustworthy because of general societal beliefs about and expectations of health professionals who have ethical commitments to act in the

individual's or public's best interests. For instance, a public health code of ethics entitled *Principles of the Ethical Practice of Public Health* that has been adopted by a number of public health professional organizations in the United States explicitly states in Principle 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."[14] In a similar vein, the recent IOM report, *The Future of the Public's Health in the 21st Century*, emphasizes the multisectoral dimensions of community health and suggests that a goal of public health is to collaborate with and facilitate the contributions of many community entities: "All partners who can contribute to action as a public health system should be encouraged to assess their roles and responsibilities, consider changes, and devise ways to better collaborate with other partners. They can transform the way they 'do business' to better act to achieve a healthy population on their own and position themselves to be part of an effective partnership in assuring the health of the population. Health policy should create incentives to makes these partnerships easier."[15 (p. 32)]

Public health's emergency preparedness activities illustrate the ways that relationships provide the context for public health ethics. Emergency preparedness, as a community process, requires public health officials to take an active role in building a community of stakeholders prepared to act when an infectious disease or terrorist threat occurs, and in generating community discussions of and deliberations about such policies as rationing scarce resources in an emergency. The fire department metaphor for public health illuminates this role, because fire officials "teach and practice prevention at the same time that they maintain readiness to take on emergencies."[16 (p. 40)] Drills are important not only as instructive devices for practicing activities (such as "know the nearest exit"), but also because, in the context of bio-preparedness, we need to "prepare" our civic responses when challenged as a community. The purpose of public debate is not merely to reach a consensus on any one course of action based on fair procedures, but also to build and strengthen our civic commitment to continued cooperation.

Consider, for example, the possible role of the local public health official in preparing a community for hospital triage or quarantine during a public health emergency. At minimum, this role could and should include convening stakeholders such as hospital administrators, community physicians, and community representatives and sponsoring forums for public deliberation to develop and forge professional, institutional, and public support for ethical guidelines. Forms of public engagement and consent could range from providing mere notice to the public through the media, to organizing town hall meetings, to conducting community focus groups and surveys about public values, to establishing an ethics board of community leaders and public representatives. Public health professionals should address which option for community engagement is appropriate, based on contextual factors such as community cohesiveness, expectations, and values. One aim of this activity is to create, over time, a public that cooperates with and trusts each other. The relationships this activity engenders provide the important social context for public deliberation and public justification when public health authorities believe that it is necessary to use liberty-limiting state power, such as forcible quarantine, or must adopt a rationing program because the vaccine supply is limited.

Whatever the governmental public health action—whether the collection of population data during a disease outbreak, or forcible quarantine, or the allocation of scarce vaccines, or an ongoing community program to change social norms—a primary goal should be the development and maintenance of relationships of trust, defined in a report from the IOM as "the belief that those with whom one interacts will take one's interests into account, even in situations in which one is not in a position to recognize, evaluate, or thwart a potentially negative course of action by those trusted."[16,10,d]

ETHICAL CONFLICTS: PERVASIVE OR OCCASIONAL?

Ethical analyses in public health, and elsewhere, often focus on conflicts, dilemmas, and quandaries for obvious reasons: Their difficulties and our perplexities require thoughtful, disciplined, and imaginative responses, as public health officials seek to determine what they should do in such cases. Can they find a way to navigate an apparent conflict, or must they sacrifice some norm or right in order to protect the public's health? For instance, should officials seek a court authorization to confine a recalcitrant tuberculosis patient who refuses to take the medication necessary to achieve a cure in order to protect others?

Ethical Dimensions of Public Health Decisions

While it would be a mistake to ignore such conflicts, it would also be a mistake to reduce public health ethics to these conflicts—public health decisions have ethical

[d] The preceding seven paragraphs in the text are from Childress JF, Bernheim RG. Public health ethics: Public justification and public trust. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz* 2008;51(2):158–163.

dimensions even if no such difficult conflicts arise. Public health officials often have to determine how best to realize all applicable norms in pursuing public health goals. Their decisions may concern what they should recommend about laws, policies, or regulations on public health or what to do when laws, policies, and regulations permit a range of actions but do not require a specific action. Where indeterminacy and uncertainty exist, decisions have to be made that address the full range of relevant values, including but not limited to public health.

At certain periods, ethical conflicts may seem more salient and unavoidable, depending on the social and political context and the nature and seriousness of public health problems and needs. For instance, since the September 11, 2001 terrorist attack, many in the U.S. have emphasized the strongly felt conflict between public health and liberty as well as between political security and liberty. Liberty is not the only potentially limiting and constraining norm, but we will focus, for illustrative purposes, on the conflict between public health and liberty—or, better, liberties—while keeping in mind and later discussing conflicts between public health, on the one hand, and privacy, confidentiality, private property, and so forth, on the other hand.

Competing Claims about Ethical Trade-offs in Public Health

For some interpreters of public health law and ethics, conflicts between public health and norms protecting individual liberties are not only common, but also inevitable. It is harmony that is atypical and exceptional.[17,18] For other interpreters, such conflicts are unusual and generally avoidable; trade-offs are not usually necessary.[7] For instance, lawyer/bioethicist George Annas denies that "in a public health emergency, there must be a trade-off between effective public health measures and civil rights."[19,20] Public health, in this view, does not typically conflict with norms protecting individual liberties but generally presupposes those norms in the effective pursuit of its ends and goals. Indeed, respecting the relevant norms and presumptions regarding public health interventions will generally provide a basis for public trust and cooperation, which are essential for the success of most public health activities.

Scope of Societal Values: Inclusion of Personal Values

In addressing this debate, it is important not to view "ethical problems" in public health policy and practice only in terms of conflicts between the individual on the one hand, and the state or society on the other—or put another way, between collective interests and individual interests. Such formulations are unsatisfactory, flawed, and indefensible. A society or state may have a strong commitment to the values associated with individuals and their lives and activities. These include individuals' liberties, privacy, confidentiality, and other rights. In the U.S., the society and the state have such high regard for these individual values that they are, in fact, social values; they are embedded in our de facto public philosophy, represented in the constitution, laws, judicial decisions, professional codes, public discourse, and the like—all important points of reference. It is thus a mistake simply to set unspecified collective interests over against individual interests.

Those individual values are shared social values that are embodied in American myths and narratives that feature individuals and their actions. They are constitutive values that shape and express our national identity. If civil liberties and rights are values and norms within our communal identity, and even partially constitutive of that identity, then they represent collective interests too, just as public health does. This leads to an important shift in perspective: Trade-offs occur not simply *between* individual interests and collective interests, as though only the latter really constitute societal identity, but rather *within* and *among* our social values. Our collective interests, properly understood, include civil liberties and rights as well as public health, among other values.

Historical Perspective on Conflicts in Public Health

Historical perspective may be useful. It is plausible to view the conflict between liberty and public health as common in public health law and policy until the last 60 years or so. Two co-authors of this volume have sometimes taught a course entitled *Confronting Plagues: Historical and Contemporary Responses to Epidemics*. In doing so, they have observed recurrent conflicts during major outbreaks of diseases such as plague, cholera, tuberculosis, and sexually transmitted diseases. In part because of limited scientific knowledge (at least in some of these outbreaks) and human tendencies to seek scapegoats in crises, individual liberties commonly have been sacrificed. The last half of the 20th century saw a clearer and firmer legal recognition in the U.S. of rights to liberty, privacy, and due process, in general and in relation to health and health care. These rights were increasingly recognized in legislation and judicial opinions regarding contraception, abortion, life-sustaining treatment, and the detention and treatment of persons with mental illness.

Another development helped to alter the overall perspective on conflicts between public health and liberty: By the last third of the 20th century, to many observers the major threats from contagious diseases appeared to be largely under control. Major achievements included vaccines for several contagious diseases, such as polio, and effective treatments for such contagious diseases as tuberculosis. In some ways, public health itself languished for a time because it was deemed to be less necessary and less important in view of these achievements.

Then came acquired immunodeficiency syndrome (AIDS), caused by human immunodeficiency virus (HIV) infection, in the early 1980s, followed over subsequent years by threats from other infectious and communicable agents, such as avian influenza, and from possible terrorist attacks that might use biological agents (e.g., anthrax) as well as other weapons of mass destruction. When HIV/AIDS emerged, the structure of civil rights and liberties, the modes of transmission of HIV/AIDS, the social groups in which these infections first appeared led to what some call "AIDS exceptionalism."[21] This phrase suggests that HIV/AIDS was largely exempted from some traditional public health measures such as named reporting and quarantine. HIV's mode of transmission was certainly a factor in such exemptions: HIV was soon understood to be transmitted only through the exchange of bodily fluids, either directly or indirectly, through sexual contact, sharing needles and syringes, or contaminated transfused blood or blood products. In the context of and as a result of this experience, claims of harmony between public health and liberty, and other norms and rights, became even more dominant. According to Ronald Bayer and James Colgrove, both major figures in public health ethics,

> Given the unique biological, epidemiological, and political factors that shaped the public policy discussion, it became possible to assert that there was no tension between public health and civil liberties, that policies that protected the latter [civil liberties] would foster the former [public health], and that policies that intruded on rights would subvert the public health.[22]

To take one example: Since HIV-infected patients' voluntary cooperation was needed to identify and notify at-risk sexual partners, assurance of the protection of their privacy and confidentiality was deemed important to public health.

From this perspective, then, conflicts between public health and individual liberties and rights generally do not erupt, though exceptional and difficult cases flare up on occasion. For the most part, effective public health measures and civil liberties and rights can and do coexist. On the one hand, as previously suggested, civil liberties and rights—as well as human rights more broadly—contribute to public health and, in some cases, are indispensable to the effective pursuit of public health, as the above example indicates. On the other hand, it is usually possible to find—and certainly important to seek—methods, measures, and interventions that are effective and, at the same time, that do not infringe these rights and liberties. Hence, it is important to reject two extremes—either (1) that trade-offs between public health and various liberties and rights are omnipresent and inevitable, or (2) that protecting liberties and rights will never impede effective public health measures. Instead, it is essential to examine particular situations and cases to determine whether there is a conflict, whether it can be avoided or mitigated, and so forth. Take the following example: if public health officials can persuade individuals who have active tuberculosis to undergo directly observed treatment until cured, no individual liberties are violated, whether the effective persuasion comes through rational appeals about individuals' health and the health of others or through incentives for compliance. In either case, liberty is not compromised.

ANALYZING ETHICAL ISSUES IN PARTICULAR SITUATIONS

Policy makers and public health officials have to analyze ethical issues in particular situations, whether in making decisions

TABLE 1.3 Analyzing Ethical Issues in Public Health

What public health problems, needs, concerns are at issue?
What are appropriate public health goals in this context?
What is the source and scope of legal authority, if any, and which laws and regulations are relevant?
What are the relevant norms and claims of stakeholders in the situation and how strong or weighty are they?
Are there relevant precedent legal and ethical cases?
Which features of the social-cultural-historical context are relevant?
Do professional codes of ethics provide guidance?

Data from Bernheim RG, Nieburg P, Bonnie RJ. Ethics and the practice of public health. In Goodman RA (ed): *Law in Public Health Practice*, 2nd edn. New York: Oxford University Press, 2007.

or recommendations about laws and policies, or about courses of action when laws and policies are indeterminate. In either of these situations, the previous table provides helpful questions for rigorously and imaginatively analyzing ethical issues in public health.

We will use this analytic framework to examine a range of problems and cases in subsequent chapters. We will start with an examination of legal authority for public health in its protective, preventive, and promotive modes. Then we will examine several clusters of moral norms related to utility, justice, and respect for personal liberties and other interests; in the process we will consider more closely how both to specify and to weight these norms in order to guide public health decisions. Subsequently, we will turn to a series of public health interventions, using case studies to open up the range of ethical issues. This analytic framework will be used to illuminate these issues and to reach ethically defensible decisions, in light of the justificatory conditions previously explicated.

THE ROLE OF THE PUBLIC HEALTH CODE OF ETHICS

We now turn to the *Public Health Code of Ethics* and its dozen principles of the ethical practice of public health.[23] This code was developed in 2002, under the auspices of the Public Health Leadership Society, with input from representatives of several organizations involved in public health. The aim, indicated by the Preamble, was to "highlight the ethical principles that follow from the distinctive characteristics of public health." Hence, it was not intended to be novel or to exhaust the content of public health ethics. Underlying several of the code's ethical principles is a fundamental belief in human interdependence as "the essence of community." This belief is expressed in the public health effort "to assure the health of whole communities," but also in recognition of the inextricable tie between individual health and communal life.

The authors of the code intended it primarily "for public and other institutions in the United States that have an explicit public health mission" but also stressed that it could be pertinent and helpful to institutions and individuals whose work has effects on the health of the community even though they do not have an "explicit public health mission." As we will see, physicians and other health professionals outside the conventional public health structure often have a role, sometimes even legally mandated, in public health—for instance, to report certain conditions to public health authorities.

The following table presents the 12 principles of the code.

TABLE 1.4 Principles of the Ethical Practice of Public Health (Public Health Leadership Society)

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/evaluated with community members' input.
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/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 based on the high likelihood of significant harm to the individual or others.
11	Public health institutions should ensure their employees' professional competence.
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.

Reproduced from: Public Health Leadership Society (2002). *Principles of the ethical practice of public health* version 2.2. New Orleans, LA. PHLS.

These principles operate on several levels. Some of them specify the broad ethical values and norms we have already. Hence, there is substantial overlap between our framework and the ethical principles articulated in the code. Some of

them are much more specific as befits a professional code—for example, #11: "Public health institutions should ensure their employees' professional competence." This is obviously a precondition of the ethical practice of public health but is not something we will discuss here.

As we proceed, we will note the overlap, convergence, and interaction between the principles stated in this code and the clusters of ethical values and norms that we present, and we will at times show how the code's principles apply to particular cases. However, an appeal to the code by itself—"This is what the code says"—will not provide a sufficient public justification for public health policies and practices. Such justifications will come from appeal to broad, shared ethical values and norms, embedded in the society's institutions including the law, as well as in the code's ethical principles. However, the ethical principles in the code provide helpful guidance in practical decision making in public health.

METAPHORS IN PUBLIC HEALTH ETHICS

In this final section we consider the role of metaphors in public health ethics.[24,25,e] Metaphors involve seeing something as something else—for example, seeing human beings as wolves or life as a journey. "The essence of metaphor," according to George Lakoff and Mark Johnson in *Metaphors We Live By* (p. 5), "is understanding and experiencing one thing through another."[26]

Metaphors are unavoidable, and they frame and shape what we see and experience even when we are not consciously aware of them. They are sometimes dismissed as merely decorative when they are noticed at all. However, they do have cognitive significance, and attending to them may enable us to make better ethical judgments about policies, practices, and actions in public health. Some metaphors may even be "generative metaphors" that produce significant ethical insights into situations we confront and relevant norms.[27] For instance, the metaphor of the ladder in the Intervention Ladder proves to be an illuminating way to think through various public health interventions in relation to respect for autonomous choices and liberties. Earlier we suggested that the metaphor of fire officials illuminates public health's dual roles in prevention and in preparation for emergencies

We can evaluate metaphors not only by their decorative and rhetorical significance—for instance, how they stir people's emotions—but also by how well they illuminate what is going on and what should go on. These are the descriptive and prescriptive uses of metaphor. The metaphor of the parent-child relationship in the model of paternalism accurately describes some public health practices, but elsewhere we test its adequacy for ethical guidance in public health. In addition, we will consider the metaphor or analogy of the lifeboat when we examine the ethics of rationing or triage, and several other metaphors when we consider public health surveillance.

Evaluating metaphors' descriptive function (helping us see what is going on) requires attention to accuracy and adequacy. Evaluating their prescriptive function, their adequacy to guide and motivate policies and actions in public health, requires attention to the ethical principles and values they highlight and hide. Which do they illuminate and which do they obscure? Do they adequately account for the full range of general moral considerations for the analysis and assessment of public health policies and actions? This, for instance, is what we will do in our examination of paternalism. For now, we will focus on two current metaphors for public health: public health as warfare and public health as stewardship.

Public Health as Warfare

We often think of policies and actions, even nonmilitary ones, through metaphors of warfare. This has been particularly true in medicine and public health, at least since the emergence in the late 19th century of the germ theory of disease, which identified biological agents that invade the human body and threaten its defenses. Our conversations and debates in both medicine and public health frequently resort to military metaphors, which both illuminate and distort descriptions of and ethical guidance in medicine and public health. Our language tips us off to the prevalence of military metaphors, even when we are not fully aware that we are using them because they seem so natural to us. Childress points to several war-related metaphors in written and oral descriptions of modern biomedicine:

> The physician as the captain leads the battle against disease; orders a battery of tests; develops a plan of attack; calls on the armamentarium or arsenal of medicine; directs allied health personnel; treats aggressively; and expects compliance. Good patients are those who fight vigorously and refuse to give up. Victory is sought; defeat is feared. Sometimes there is even hope for a "magic bullet" or a "silver bullet."[24]

[e] Metaphors and analogies have substantial overlap. Analogies focus on similarities between two entities, such as a lifeboat situation and the intensive care unit. There is a rough consensus that, while metaphors presuppose some similarities, they also enable us to see similarities in entities that appear to be dissimilar.

We fight against illness, disease, and trauma as immediate enemies and against death as our ultimate enemy. Practicing medicine requires being "on the firing lines" or "in the trenches," and practitioners often have "war stories" to share. Moreover, the lens of military training and hierarchy can illuminate demanding medical training and structures of authority in medicine.[28] Furthermore, "[a]s medicine wages war against germs that invade the body and threaten its defenses, so the society itself may also declare war on cancer or on AIDS under the leadership of its chief medical officer, who in the United States is the Surgeon General."[24] Susan Sontag's point applies directly to public health: "Where once it was the physician who waged *bellum contra morbum*, the war against disease, now it's the whole society."[29]

The complex of military metaphors has positive, negative, and ambiguous implications in medicine, health care, and public health. On a personal level it can empower resistance and support courageous, vigorous efforts to combat disease and death.[28] However, it can also lead to futile and counterproductive actions. Some persons coping with chronic, debilitating diseases have found military metaphors unhelpful and even harmful, and as a result, have resorted to other metaphors—for instance, one young patient found a better life in viewing diabetes as a *teacher* rather than, as previously, an *enemy* to be conquered.[30]

Following are some common practical implications of the military metaphor. These are tendencies in ethical interpretation and application rather than necessary implications. First, the metaphor of medicine as warfare tends to underwrite overtreatment, even in the face of imminent death, since death is the ultimate enemy. Second, military metaphors tend to frame the society's healthcare budget as a defense budget in the war against morbidity and mortality. These metaphors may support a larger allocation of funds for the societal defense represented by medicine, health care, and public health than might otherwise be warranted. And, within health care, they suggest a set of priorities: critical care over preventive and chronic care; lethal diseases, such as some forms of cancer, over chronic diseases; acute technological interventions, such as intensive-care units, over less technological modes of care.[24]

Some of the negative or ambiguous implications of military metaphors could be corrected, at least partially, if we understood and conducted warfare in health care and public health not as a total war, but rather in line with the "just-war" or "limited-war" traditions, which stress limited objectives and limited means. In the just-war tradition, for example, waging a war is not ethically justifiable unless there is a reasonable prospect of success, the probable positive effects of the intervention outweigh the risks, the distinction between enemy combatants and noncombatants is maintained, and so forth.

The military metaphor has been sharply challenged in medicine and health care, but it has continued to flourish in public health, in part because of its function in describing and guiding society's responses to contagious diseases that threaten the public's health. This is not surprising because, after all, the spread of severe infectious diseases across borders can pose threats to a state's stability and security as much as military aggression across those borders.[31] Hence, as Mark Hall notes, "[t]he metaphors of public health strategy are war-like."[32]

In our sociocultural context, the metaphor of war is almost expected when a serious threat to a large number of residents requires the mobilization of societal resources, particularly when that threat comes from biological organisms that attack the body. It provides a way to galvanize the society and to marshal its resources for an effective counterattack. The ambiguous and negative implications previously noted need resistance and correction in this context too. Furthermore, the war metaphor is perhaps even more dangerous, both rhetorically and practically, when the war on terror becomes the model for the war on infectious diseases.[33] Limits are even more difficult to maintain in such a war.

Another serious ethical ambiguity in society's war against contagious diseases emerges in the identification of the enemy, such as a threatening virus. This process of identification is an important and necessary part of the battle. Once this occurs, it is possible to identify human vectors who may "harbor" the virus, "infect" others, and even become public "enemies." When AIDS appeared in the early 1980s, the society undertook what was described as a "war against AIDS." As part of this war, researchers vigorously sought to pinpoint the responsible biological agent, soon identified as HIV. Once tests were developed to detect the virus—the immediate "enemy"—in human beings, it was possible to identify individuals who were "carriers" of the virus, who "harbored" the virus, and who supposedly endangered others. Not surprisingly—but nonetheless problematically—many proposed draconian policies to identify HIV-infected individuals, perhaps even through mandatory screening and testing. Such "carriers" tended to become "enemies" in social discourse and practice as much as the virus itself.[34] Despite warnings by the Surgeon General and others that the war against HIV was not a war against people with HIV, this distinction was too subtle for many.

As already noted, military metaphors would be less problematic if the society followed the constraints of the

just-war tradition in waging war, by pursuing limited objectives and using limited means, rather than being tempted by a total war or crusade stoked by rampant and often uninformed or ill-informed fears. Since we are not likely to eliminate the war metaphor in public health—nor should we try to do so—it is important that we use it selectively, when the situation warrants, and with due regard to ethical limits.

Public Health as Stewardship

A creative proposal to interpret and even reorient public health appeared in the Nuffield Council on Bioethics' 2007 report *Public Health: Ethical Issues*, which proposed the metaphor of *stewardship*. The report argues that a state, guided by the metaphor or model of stewardship, should act as a steward—an agent or overseer—of the health of its population. It stresses the state's duty to "look after" the population's important needs, including their individual and collective health needs. Even if the state views the public's health as an intrinsic value, a value in and of itself, it can also protect and promote the public's health as a "primary asset" because "higher levels of health are associated with greater overall well-being and productivity."[35] Its obligations include providing the conditions that permit people to be healthy and taking steps to reduce health inequalities, with special attention to disadvantaged and vulnerable groups. In emphasizing the state's stewardship of public and population health, the report does not assign sole responsibility to the state or preclude various public-private collaborations. Far from it—there are also corporate responsibilities for public health. According to the report, several goals and constraints flow from the stewardship model, as indicated in the following two tables.

Critics of the stewardship metaphor make several points. A main criticism—one we share—is that it is difficult to see how these several goals and constraints, as important as they are in public health, are systematically related to the metaphor itself. At most this very broad metaphor provides a general orientation for public health rather than operational guidance. According to critics, it is a "rather muddled metaphor," one that is inadequately explored in the report.[36] As a result, its substantive content is limited. Some developers of the stewardship model insist in response that it provides "an explicitly value-rich framework against which policy makers and others can assess existing policy, and develop new policy, by determining to what degree they achieve its goals, while minimizing unnecessary burdens and constraints."[37]

What is more crucial than finding the best possible metaphor for public health is recognizing that our views about public health goals and means, as well as the situations in which we have to make decisions, are often shaped by metaphors that we may not explicitly recognize and that may have positive, negative, or ambiguous implications we fail to see. We need to attend to those metaphors (whether they are functioning descriptively or prescriptively), assess their adequacy, and correct, constrain, and supplement them as needed. Public health officials may not be able to decisively

TABLE 1.5 The Stewardship Model: Goals of Public Health Programs

Aim to reduce the risks of ill health that people might impose on each other.
Aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food, and appropriate housing.
Pay special attention to the health of children and other vulnerable people.
Promote health not only by providing information and advice, but also by programs to help people overcome addictions and other unhealthy behaviors.
Aim to ensure that it is easy for people to lead a healthy life, for example, by providing convenient and safe opportunities for exercise.
Ensure that people have appropriate access to medical services.
Aim to reduce health inequalities.

Modified from the Nuffield Council on Bioethics. Public health: ethical issues (November 2007), published by the Nuffield Council on Bioethics, London, England. Available at: http://www.nuffieldbioethics.org/sites/default/files/Public%20health%20-%20ethical%20issues.pdf (accessed May 3, 2013).

TABLE 1.6 The Stewardship Model: Constraints on Public Health Programs

Not attempt to coerce adults to lead healthy lives.
Minimize interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate.
Seek to minimize interventions that are perceived as unduly intrusive and in conflict with important personal values.

Modified from Nuffield Council on Bioethics, *Public Health: Ethical Issues* (November 2007), published by the Nuffield Council on Bioethics, London, England. Available at: http://www.nuffieldbioethics.org/sites/default/files/Public%20health%20-%20ethical%20issues.pdf (accessed May 3, 2013).

shape or reshape the systems of metaphors that guide the society's response to public health needs and threats. Those metaphorical systems may be too deeply embedded in the society and culture to allow significant alterations. Despite such barriers, it is important, in public communication and public engagement, to attend to those embedded metaphors and address their positive, negative, and ambiguous implications, sometimes by invoking alternative metaphors. (See our discussion of health communication in Chapter 9.)

CONCLUSIONS

In this chapter, we developed a framework for examining ethical and legal values and norms and for evaluating the use of several tools and interventions in public health. We examined the public philosophy that marks legal and ethical norms and discourse in the U.S. These include attention to the end(s) of public health and also the means, in the form of various tools and interventions, which are used to realize the end(s). Effective means are crucially important but not all potentially effective means can be ethically justified. This public philosophy sets (rebuttable) presumptions in favor of interventions that respect liberty, privacy, confidentiality, and so forth. Hence, our ethical analysis of means should start with these presumptions that can be overridden or outweighed, if certain "justificatory conditions" are met in the process of public justification for public health policies, practices, and actions. We should not exaggerate ethical conflicts and dilemmas in public health because there are often ways to avoid or reduce tensions. One helpful step is to analyze situations and decisions in public health in a systematic way, through a variety of questions, including the ones we identified. Another valuable step is to consider situations and prospective decisions in light of the *Principles of Ethical Practice of Public Health*. Finally, it is also important to attend to the metaphors that often subconsciously guide our reflections about ends and means in public health and to consider their strengths and weaknesses as well as possible alternative metaphors.

Discussion Questions

- What is distinctive about a presumptivist approach to public health ethics (in contrast to contextualist and absolutist approaches)? And what are its advantages and disadvantages?
- Do you believe that public justification is important in public health policies, practices, and actions? Why or why not?
- Suppose a public health policy, such as quarantine, violates individuals' liberty. Do you believe that it must satisfy all of the justificatory conditions identified in this chapter to be ethically acceptable? Why or why not?
- From your perspective, do you believe that conflicts between moral norms and the realization of public health goals are (a) common and unavoidable for the most part, or (b) uncommon and avoidable for the most part? Explain your answer.
- Can you think of other metaphors than the ones discussed in this chapter for guiding reflections about public health goals and means?

REFERENCES

1. Childress JF, Faden RR, Gaare RD, et al. Public health ethics: mapping the terrain. *Journal of Law, Medicine & Ethics* 2002;30(2):169–177.

2. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 7th edition. New York: Oxford University Press, 2013.

3. Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press, 1988.

4. Childress JF, Bernheim RG. Public health ethics: public justification and public trust. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz* 2008;51(2):158–163.

5. Bernheim RG, Nieburg P, Bonnie RJ. Ethics and the practice of public health. In: Goodman RA (ed). *Law in Public Health Practice*, 2nd edition. New York: Oxford University Press, 2007.

6. Sandel MJ. *Democracy's Discontent: America in Search of a Public Philosophy*. Cambridge, MA: Harvard University Press, 1996.

7. Mann JM. Medicine and public health, ethics and human rights. *The Hastings Center Report* 1997;27(May-June):6–13.

8. Richardson HS. Specifying, balancing, and interpreting bioethical principles. *Journal of Medicine and Philosophy* 2000;25:285–307.

9. Gaskins RH. *Burdens of Proof in Modern Discourse*. New Haven, CT: Yale University Press, 1992.

10. Childress JF, Bernheim RG. Beyond the liberal and communitarian impasse: a framework and vision for public health. *Florida Law Review* 2003;55(6):1191–1219.

11. Working Group of the University of Toronto Joint Centre for Bioethics. *Ethics and SARS: Learning Lessons from the Toronto Experience*. Toronto, Canada: The University of Toronto Joint Centre for Bioethics, 2003. This report is available at http://www.yorku.ca/igreene/sars.html (accessed July 31, 2007).

12. Schram J. Personal views: how popular perceptions of risk from SARS are fermenting discrimination. *BMJ* 2003;326(7395):939.

13. Calabresi G, Bobbitt P. *Tragic Choices*. New York: W.W. Norton & Co., 1978.

14. Public Health Leadership Society. *Principles of the Ethical Practice of Public Health*, 2002. http://www.phls.org/home/section/3-26/ (accessed July 31, 2007).

15. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press, 2003.

16. Soto MA, Abel C, Dievler A. *Healthy Communities: New Partnerships for the Future of Public Health: A Report of the First Year of the Committee on Public Health,* Institute of Medicine. Washington, DC: National Academy Press, 1996.

17. Gostin LO. When terrorism threatens health: how far are limitations on personal and economic liberties justified? *Florida Law Review* 2003;55:1105–1170.

18. Gostin LO. Public health law in an age of terrorism: rethinking individual rights and common goods. *Health Affairs* 2002;21(6):79–93

19. Annas GJ. Bioterrorism, public health, and civil liberties. *New England Journal of Medicine* 2002;346:1337–1342.

20. Annas GJ. Bioterrorism, public health, and human rights. *Health Affairs* 2002;21:94–97.

21. Bayer R. Public health policy and the AIDS epidemic: an end to HIV exceptionalism? *New England Journal of Medicine* 1991;324:1500–1504.

22. Bayer R, Colgrove J. Bioterrorism, public health, and the law. *Health Affairs (Project Hope)* 2002;21(6):98–101.

23. Public Health Leadership Society. *Principles of the Ethical Practice of Public Health* 2002. Available at: http://phls.org/CMSuploads/Principles-of-the-Ethical-Practice-of-PH-Version-2.2-68496.pdf (accessed April 15, 2013).

24. Childress JF. Metaphor and analogy. In: Post SG (ed), *Encyclopedia of Bioethics*. New York: Macmillan Reference USA, 2003.

25. Childress JF. Metaphor and Analogy. *Practical Reasoning in Bioethics*. Bloomington, IN: Indiana University Press, 1997.

26. Lakoff G, Johnson M. *Metaphors We Live By,* 2nd edition. Chicago: University of Chicago Press, 2003.

27. Schön DA 1979. Generative metaphor: A perspective on problem-setting in public policy. In: Ortony A (ed), *Metaphor and Thought*. Cambridge, UK: Cambridge University Press, 1979:254–268.

28. Reisfield GM, Wilson GR. Use of metaphor in the discourse on cancer. *Journal of Clinical Oncology* 2004;22(19):4024–4027.

29. Sontag S. *Illness as Metaphor* and *AIDS and Its Metaphors.* New York: Doubleday Anchor Books, 1990.

30. Pray L, Evans, R III. *Journey of a Diabetic*. New York: Simon and Schuster, 1983.

31. De Grandis G. On the analogy between infectious diseases and war: how to use it and not to use it. *Public Health Ethics* 2011;4(1):70–83.

32. Hall MA. The scope and limits of public health law. *Perspectives in Biology and Medicine* 2003;46(Suppl):S199–S209

33. Mongoven A. The war on disease and the war on terror: a dangerous metaphorical nexus? *Cambridge Quarterly of Healthcare Ethics* 2006;15:403–416.

34. Childress JF. Mandatory HIV screening and testing. In: Reamer FG (ed), *AIDS & Ethics.* New York: Columbia University Press, 1991:50–76.

35. Nuffield Council on Bioethics. *Public Health: Ethical Issues.* London: Nuffield Council on Bioethics, 2007. Available at: www.nuffieldbioethics.org (accessed January 17, 2013).

36. Dawson A, Verweij M. The steward of the Millian state. *Public Health Ethics* 2008;1(2):193–195.

37. Baldwin T, Brownsword R, Schmidt H. Stewardship, paternalism and public health: further thoughts. *Public Health Ethics* 2009;2(1):113–116.