THINKING ETHICALLY IN PUBLIC HEALTH

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Singapore faces a convergence for the perfect storm: an ageing population, increasing prevalence of chronic diseases, escalating healthcare costs, and ongoing reforms on the delivery of health and social care. While the last is largely a response to the first three, it also creates its own set of challenges. These reforms, Public Health interventions in one form or another, seek to better the health of people and the population, and at the same time conserve and better deploy limited resources and improve the efficiency and effectiveness of the healthcare system.

Public Health interventions

Public Health interventions are by nature complex affairs. They involve many diverse stakeholders: the patients and their families, the professionals who care for them, the providers that structure and deliver care, the payers who seek better returns for their expenditure, the community who must now play a larger role in the care of the elderly and the sick, the populace, and the politicians.

Unlike medical technology and pharmaceuticals, Public Health interventions are inherently less amenable to traditional research modalities like randomised controlled trials. It is rarely pragmatically possible to randomise people in the community into study groups for comparison, not just on ethical grounds if it means withholding needed services, but because people are not devices or drugs and will not obey the segregation. In a health education programme, for example, subjects who are in the non-education branch might nevertheless read up on their own, if for no other reason that they have been introduced to the very topic of study by the informed consent process!

The common question is whether we achieve the results promised – clinically, socially, financially, operationally or even politically. Is what we do worth the time, attention, effort and resources? These are utilitarian and consequential perspectives. We should also ask if what we are doing is *right*, which highlights our values around what we consider to be right.

The four principles

From first principles, one can argue that a good Public Health intervention must at least:

- Deliver benefits and desired outcomes.
- Not harm patients and others in the process.
- Balance between individual rights and community rights.
- Efficiently allocate and conserve limited resources.

The astute reader would note immediately the parallels to Beauchamp and Childress' four principles of medical ethical behaviour, viz. beneficence, non-maleficence, respect for autonomy and justice. Their four principles go beyond the strictly utilitarian or consequential, and suggest that the principles for determining Public Health rightness must likewise do the same.

Clinical judgement is needed in making decisions in the ward and clinic. The medically indicated best option may be opposed by the patient (or a family member), lead to unintended larger consequences, or be inhibited by the circumstances of the time. Are decisions in Public Health similar in that pros and cons have to be weighed or are such considerations unnecessary in what we do?

Design principles

Nancy Kass' questions (listed below) are a good start for such thinking.[1] They help in the design of good programmes that indeed balance much of the four principles above. The very first principle is a good reminder to state upfront and clearly the goals of the programme, a practice often missed in our haste to leap into action.

1. What are the Public Health goals of the proposed programme?
2. How effective is the programme in achieving its stated goals?
3. What are the known or potential burdens of the programme?
4. Can burdens be minimised? Are there alternative approaches?
5. Is the programme implemented fairly?
6. How can the benefits and burdens of a programme be fairly balanced?

The questions, however, are only a checklist of thinking steps in the design of good programmes. If the programme is not effective or if burdens are not minimised, what happens then? Do we leave well alone, despite the troubles already out there? This is the equivalent of the clinician's therapeutic dilemma where treatment and non-treatment both hold risks.

Not implementing programmes necessarily means leaving our constituencies in the undesirable situation they are in. Unfortunately, in Public Health, the patient is not writhing in pain in front of our eyes and discussions on the merits and otherwise of programmes are not done by the bedside but in comfortable air-conditioned meeting rooms far from the patient's suffering.

Public Health interventions, just like clinical care, must be timely. Delaying a programme in order to clarify some fine detail (or to complete some administrative niceties) means that people continue to suffer the lack of sorely needed services. Programmes have been set back for months and years because a bureaucrat

insisted on a particular mantra being more lustily sung. The clinical context requires a decision to be made, even if the decision is to actively wait. A deferred Public Health decision likewise has real consequences for the people and the population.

The four-box approach

One useful instrument in the toolbox of the clinical ethicist (or the ethical clinician) that can be adapted for Public Health interventions is the well-known four-box approach.[2,3] This approach, when used in the clinical context, helps ensure a comprehensive assessment of the case that connects circumstances to the underlying ethical principles. The four boxes are, in sequence:

1. Medical indications
2. Patient preferences
3. Consequences and quality of life
4. Contextual features

When applying the logic from the clinical context to a Public Health intervention, we should firstly be clear that the proposed intervention is necessary and likely to produce the desired outcomes, that there are no better alternatives, and that the timing is appropriate. Rather than assuming that it should work, we need to establish the evidentiary basis for the intervention.

This needs to go beyond showing that there is some evidence in support of a policy to weighing the balance of all available evidence; in a nutshell, the difference between evidence-based policy and policy-based evidence ("tell me what you want and I'll find the supporting research"). If there is a paucity of evidence, that should be admitted and the programme should be more carefully structured to protect the interests of the beneficiaries and the community.

Public Health is hard. While drugs may vary somewhat depending on demography and pathology, Public Health interventions are majorly influenced by technology, socio-economics, politics, financing and a host of other factors. What works in one locality is not guaranteed to achieve the same success elsewhere. No self-respecting clinician would institute a treatment, especially one with less than certain results across boundaries, without intentionally instituting close follow-up and monitoring. By this analogy, Public Health practitioners may be startled to realise that launching Public Health interventions without upfront and clear evaluation plans amounts to unethical practice.

The second box reminds us that Public Health interventions are not simply interventions *on* or even *for* the population, but that the community we serve must have a voice and a part in the implementation. This means going beyond what we think they need to what they tell us they want. How often do we seek the views of those we serve? In the UK, an organisation called National Voices reframed the goals of care integration in the words of the recipient which we would do well to consider.[4] There has also been increasing recent concern about the justification for Public Health interventions on the basis of paternalism.[5]

The third box prompts us to think beyond the immediate impact of the programme. Other than the intended outcome, what are the other consequences both to the individual and the community? If the programme succeeds for the patients, does it come at a significant cost to their families? Can the programme be sustained? A successful Public Health implementation that cannot be maintained is like a successful surgery in which the patient dies. Can the programme be scaled to other communities? Any programme called a "pilot" which is not intentionally designed for wider implementation is a contradiction in terms.

Finally, the fourth box – the catch-all for everything else – considers the larger consequences of delivering the programme from the perspective of healthcare providers, financiers, policy-makers, perhaps in some cases law makers and enforcers, and the families and community. These are all important considerations, but patients and the population must come first.

For example, the bed crunch that plagues our public healthcare institutions is a critical national problem, but that cannot be the starting premise for Public Health interventions. We must first be sure that the proposed interventions will actually work for the holistic betterment of the patients, that the patients and their families have their voice, and that the outcomes are sustainable and scalable.

Conclusion

Public Health is a traditionally low-profile specialty whose time has come. The greatest challenges and efforts today must involve all clinicians in a concerted response to the upcoming storm. Like it or not, all doctors have a part to play in Public Health, and must apply their clinical ethical judgement to Public Health issues and interventions. ◆

References

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