

Ethics in public health practice

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The approach to ethical medical practice is easy to define. It rests on the premise that the doctor's primary ethical commitment is to his/her patient. The doctor is supposed to spare no effort to see that everything is done in the best interests of the patient, for his/her survival or well being. The physician is also exhorted not to divulge any secret s/he might learn about the patient to a third party under any circumstance. The ethics of public health practice, on the other hand, do not furnish such a black and white picture. In fact, it has so many shades of gray that one can be forgiven for not recognising the picture.

Unlike the practising physician, public health protagonists, by definition, must have the interests of society at large. Their conflict also starts with this definition. What is the society that they owe his allegiance to? Is it the community which sustains them? Is it the larger state or nation? Or are they supposed to hold close to their heart the interests of mankind as a whole? Though the ideal public health doctor would be one who conforms to the last description, such a one would be difficult to find. This may not matter in everyday practice, as long as practitioners can see beyond the individual to include the larger community as their clients. This may, however, be a real problem when narrow, patriotic interests clash with larger, humanistic ideals in the mind of the doctor. Are we for instance, to condone spending on nuclear armaments in the larger interests of national defence?

Ethics and public health practice

Modern technological development has contributed quite a bit to ethical conflicts in medicine. A large share of this is in the sphere of public health. Technology, for instance, has provided the means to examine previously

inaccessible organs and tissues of the human body and to intervene creatively in many situations. This, however, has come at great cost. It is one of the dilemmas that third-world nations are facing every day: who will pay for the new sophisticated technology that has become part of routine medical care, such as the CAT scan, MRI scan, interventional cardiology, and the new reproductive technology? In a country which is struggling to provide essential drugs to most of its population, where most health service facilities lack the basic infrastructure, a section of the public demands that they should have access to these sophisticated modes of care and treatment free of cost. What is an ethical stand in this? It cannot be denied that making such machines more accessible may, indeed, save many lives. What about the thousands of other lives that might have been saved by simpler interventions like safe drinking water or sanitation? Who decides which lives are to be saved? On the other hand, would it be ethical to put a ban on all technological progress, to say that till such time as everyone has access to a reasonable level of care, we will not let anyone use more sophisticated technology? Would this amount to penalising people for what could be argued is a folly of policy makers?

Such questions are indeed hard to answer. We can, in theory, say that any health technology should be socially acceptable. The trouble, however, is in instituting a process that judges social acceptability. Democratic societies are notoriously weak in these matters. In situations that are less than life threatening, things may be a bit easier. We can always say that public money should not be used for subsidising cosmetic surgery. In more sophisticated cultures, some of the ethical dilemmas concern modern developments in reproductive and organ transplant technologies. Foetal tissue is a much valued medical commodity these days because of its potential in curing some chronic conditions, after transplantation into the adult body.

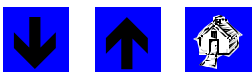
Does this justify women getting pregnant so that they can abort the foetus, sell it, and earn money? In many western countries, transplants from cadavers are legally permitted. This has perhaps led to many young accident victims being artificially maintained on life support systems so that they can be 'declared brain dead' at the appropriate time for harvesting their organs. Are these practices ethical?

Public health practice and conflicts in the Third World

Not so long ago, there was a scandal in India about kidneys being 'stolen' from unsuspecting victims who were hospitalised on some pretext. This led to widespread demands for banning unrelated donor transplants. The other side of the story is presented by some youngsters who argued that a man who fully understands the consequences of his action should be entirely at liberty to sell one of his kidneys, because he can survive on the remaining one organ. In the case of many poor people, the ban on such organ donation would be depriving some people of their legitimate earnings, and perhaps a means to a livelihood. Does society, which has done nothing to provide them with opportunities to earn a daily living, have any right to shut off this door?

Many of the ethical concerns in public health practice revolve around public policy issues. A classical question which has been discussed by generations of doctors in India is: do Indian doctors have an ethical obligation to serve in India, especially considering the fact that in most cases, their training costs have been heavily subsidised by taxes? Though the question remains relevant to this day, it might seem too abstract to the present generation of medical students, who look upon emigration as their birth right. To some extent they cannot be blamed, for the same arguments could be raised in the case of all higher education. Yet, the government positively encourages Indian software and engineering graduates to work

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abroad. Why should doctors be singled out for a higher level of social commitment? After subsidising medical education to thousands of urban middle-class people who have used this easy route to success and material glory, now the governments of the states seem intent on starting institutions which cater only to the rich, in the name of cutting subsidies in higher education. The ethics of public policy would have demanded that most doctors who trained with subsidised funds be obliged to serve Indian communities.

Some state governments have declared their intention of restricting population growth by enacting legislation denying many subsidies to families with more than two children. They will not be eligible for subsidised food grains through the public distribution system. They may also be denied many other rights. While agreeing that restricting population growth is a laudable policy objective in India, can we condone such practices as ethical? China has drastically reduced its population growth through policies that are equally restrictive. For ts has also received great encomiums from the world community, which has chosen to remain practically silent on the coercive practices used. Ethics, however, cannot be decided on public approval.

The advent of the HIV epidemic has introduced new ethical challenges in public health. The establishment view in public health is that everyone has the right to confidentiality and cannot be forced to undergo HIV testing. Once tested, the status also can not be revealed without consent from the subject. This is flouted by many national governments who insist on testing all entrants, and they also deny visas to those who test positive. There are many clinicians in India who feel that they have a right to know the HIV status of their patients, especially those on whom they plan interventional procedures. They consider themselves to be at high risk, and think that knowing the HIV status of patients would enable them to take extra precautions. It is well known that universal precautions, if taken diligently in all cases, could protect

against HIV infection. Perhaps they forget that the patient has an equal right to know the HIV status of their health practitioner, since it is a well known route of spread.

There are many epidemiological studies and trials in the country which are organised on a massive basis. This involves interviewing and testing thousands of people in the community. Most of them are initiated by western universities or agencies, with funding from international agencies. Very few have been started with the explicit consent of the local communities. There is no process of discussion with the community leaders, or of asking them if they think the study will benefit them. Is this ethical? Would this be tolerated in any of the donor countries? The answer is no. Many such studies are deliberately planned in third world countries since they would not receive ethical clearance in the countries of their origin. The guideline seems to be that such studies need get clearance from only the recipient country. This is because the donors know that many of these countries have lax mechanisms for policing scientific investigations and they would be able to do what they would not dare present to their own national authorities.

Ethics and the public good

How does one decide the right approach in this complex milieu? At first glance it may seem difficult or impossible. The ethics of public health practice is decided by the ethics of the public good: what is right is what benefits the largest number of people to the greatest extent. There is, however, one caveat: such actions should not deny basic human rights to anyone. No one should put their stamp of approval on any action which they would not agree to be directed to themselves in similar circumstances. Mechanisms to ensure this need to be strengthened, especially in this era of market friendliness. It remains the first duty of the state to protect the rights of citizens: this should form the cornerstone of all ethical dialogue in public health.

Rene Favaloro : R.I.P.

The suicide of 77-year-old Rene Favaloro, pioneering Argentine cardiac surgeon, who championed the cause of universal health care in his country, was not from depression but distress at the consequences of globalisation on the poor. The Favaloro Foundation set up in 1992 offered the best of treatment to rich and poor alike, conducting ground-breaking research, sophisticated organ transplants and coronary surgeries, and training more than 400 doctors in the region. Market reforms forced a slash in government subsidies to his foundation even as millions of Argentines lost health care coverage along with their jobs. Favaloro did not turn back uninsured patients but his institution was on the brink of financial ruin. He said free-market reforms were "better referred to as a neo-feudalism that is bringing this world toward a social disaster where the rich are getting richer and the poor are getting poorer."

"Rene had fought hard to give his patients equal treatment," said Mariano Favaloro, the foundation's chief of surgery. "He felt this new world we live in could no longer permit it, and he ended his life."

Favaloro's suicide has deeply affected Argentina, causing soul-searching about the rise in poverty and the collapse of social services as the role of government has diminished, corruption has soared and state companies have been sold off.

His death also has reverberated internationally, underscoring one of the biggest challenges of globalisation: providing quality health care in developing countries. For years, most Argentines received their health care from any of 296 union-related cooperatives. But today, 80 percent of those co-ops are in dire financial straits—collectively \$2.6 billion in debt—as their clients have lost their jobs and been unable to pay their dues. Public hospitals, relied upon by about 44 percent of Argentines compared with 37 percent two years ago, are overburdened.

Anthony Faiola: Doctor's suicide strikes at heart of Argentina's health care crisis. Washington Post, August 25, 2000.

