Ethical dilemmas in public health

SIR

Public health officials, like physicians, should observe wherever possible the Hippocratic maxim – 'Do no harm'. Because most public health measures are preventive, they would appear less likely to harm than the physician's diagnostic and curative interventions. But the history of three twentieth-century, public-health campaigns shows that preventive measures are not without their adverse effects.

1. Sanitation: Rapid strides in the provision of modern water and sanitation services to the American public during the first half of this century occasioned a marked decline in typhoid, cholera, hookworm and other water-borne and excreta-related diseases. But during this same period the incidence of clinical poliomyelitis increased, reaching epidemic proportions during the 1950s prior to the advent of a safe and effective vaccine. Epidemiologists now attribute the epidemic of the 1950s to the improved sanitary conditions enjoyed by the American population (1).

Poliomyelitis is spread by the faecal-water-oral route. In earlier times it was contracted very early in life when it rarely has serious paralytic complications. Improved sanitation and cleanliness postponed the age at which children were first exposed to the virus. Since paralysis is much more frequent when school-age children or adults contract the infection, the disease became more common even as the infection was becoming less common.

2. Rubella vaccination: Rubella vaccination has not eradicated the disease. Instead it has raised the average age at which the disease it acquired. Rubella vaccine is an unusual immunisation in that it is prescribed not for the benefit of the recipient (rubella being a very mild illness in children and adults) but to protect the fetuses borne by the recipient population. The serious congenital rubella syndrome occurs in the offspring of women who acquire the infection in the first trimester of pregnancy. Knox has shown how some vaccination programmes may actually increase the incidence of congenital rubella syndrome by raising the age at which females contract rubella (2).

3. Malaria control: Until recently most malariologists have believed that malaria control efforts even when successful or temporary (as in pilot projects) have bestowed an unqualified benefit of increased health upon those who live in endemic malaria regions. The costs of malaria control were believed to entail only the money, labour and material expended. Such perceptions, however, have been too optimistic because they neglected to consider the effect that malaria control would have on the acquired immunity of adults living in endemic regions.

In endemic regions adults suffer far less morbidity and mortality from malaria than children owing to the effect of immunity acquired over a lifetime of exposure to the parasite. It has been well established that this acquired immunity can only be maintained by repeated antigenic stimulation provided by the biting parasite-inoculating *Anopheles* mosquito vector. Temporary malaria control in endemic regions diminishes transmission and consequently acquired immunity. This would not be a problem if malaria control could be continued forever, but the experience of the last 30 years has demonstrated all too clearly that control programmes are likely to fail from time to time for political, economic, technical or biological reasons. When malaria transmission resumes the formerly immune adults may now be subject to malaria disease as well as infection. Empirical data from the Garki Project (3) and the theoretical models of Aron and May (4) support this jaundiced assessment of temporary malaria control in endemic regions: ie that it constitutes the deprivation of acquired immunity without consent.

Medical ethics as a discipline has concentrated on the ethical dilemmas of the physician-patient relationship. The ethical dilemmas faced by public health officials, while less apparent, may be more important insofar as the potential for public good or harm is far greater. The ethical dimensions of the preceding examples could bear serious investigation by medical ethicists.

RICHARD B JOHNSON MD MPH
Cambridge, Mass;
USA

References


Physicians’ strikes – second thoughts

SIR

What brings me to comment this time is not the unquestionable importance of the issue of doctors’ strikes but rather the uneasy feeling I have that a tremendous gap separates the ideas expressed last year as well as presently...
in this journal from what is actually happening outside in the real world. Just a month ago Israeli physicians staged a one-day strike to protest a delay in receiving their wages. Yesterday the nurses' union decided at the last moment to postpone a threatened general strike in which our 20,000 nurses would have abandoned all the hospitals and clinics in the nation.

On re-reading Dr Glick's (1) pure and sincere (but a bit naive perhaps) desire that doctors can have no moral justification for going on strike, or Brecher's (2) response in this issue in which he deals more with Glick than with the question itself, or our own paper (3) which in retrospect seems to be written too gingerly and in a lukewarm way, I doubt that any of these can bring forth a solution to the problem.

To the first question - is a doctors' strike a good thing? - a negative answer would be agreeable to all of us because a doctors' strike in any form brings immediate suffering and in some cases even death.

The next question is: is there any difference between a doctors' strike and a nurses' (or other health workers') strike? I believe that in essence there is no difference because the end result is the same. The only distinction I see is that the harm to the patients comes more immediately if it is the physicians who withhold care. On moral or theoretical grounds I find similarities between strike action by health service workers and by other public sectors. In both, pressure is brought by the strikers causing suffering or harm to the public whom you may wish to call innocent bystanders or, alternatively, active bystanders who can vote in the decision-making process in a democratic society.

The third question must be: does the exclusive responsibility for choosing the drastic step of strike or walkout or collective resignation (all the same in my opinion) rest solely upon the shoulders of doctors or of health workers? The answer, of course, is no. In order to analyse this issue let us compare how the Hippocratic Oath was fulfilled in days past with how it is carried out nowadays. The Oath goes into great detail on the day-to-day applications of the holistic principles of total concern for the patient, unquestioned commitment to the sick and to the colleague who is ill, and even the obligation to take care of the orphaned son of a colleague so that he might continue his study of the Art of Medicine. Are these commitments honoured today?

Hippocrates's positive moral imperatives were easier to follow when doctor-patient relations were simpler. The doctor's judgement and decision-making prerogative were exercised within the confines of a bi-directional relationship. Social development has brought a more complex medical-care structure in which each angle of a doctor-patient-society triangle is pulling its weight; and the proportional, or disproportional, weight taken by society as expressed by the political establishment is increasing steadily. While society's decision-making power is growing, I am not at all sure that there is parallel growth in society's willingness to assume responsibility.

Thus a conflict situation has arisen in which responsibility continues to lie squarely on the physicians and other medical workers while at the same time the decision-making process is not totally in their hands. This contradiction has already caused two extreme forms of response in the medical community: a) a shrugging off of answerability and a passivity rooted in despair and b) putting the strike weapon into action even for the most trivial disputes.

If on the one hand the strike tactic is inappropriate and unacceptable in the medical workers' sector because of its immediate fatal results, and on the other hand we would not like to strip the doctors of their responsibilities and power of decision-making because symmetry must continue between the two conditions, then the only conclusion is that in this interplay of health workers and political establishment we must be given an alternative to the strike. This option can be an arbitration committee agreed upon by both sides or any other body or process whose decision would be binding.

My immediate concern is not the moral justification nor the ethical grounds for a doctors' strike but rather the pressing need to create a setting in which the outbreak of a strike would simply not be possible - for the good of the patients, of society, and of the doctors.

MOSHE GARTY, MD  
Head of Clinical Pharmacology Unit  
and Deputy Chief of Department of Internal Medicine 'C', Belinson Medical Center and Tel Aviv University Sackler School of Medicine, Petah Tikva, Israel:

References

