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EDITORIAL

Biomedical ethics, public health ethics, and bioethics: Identifying the interrelationships between three distinct fields☆

Éthique biomédicale, éthique en santé publique et bioéthique : identifier les relations entre trois domaines distincts

English version

Steven Miles contributes an article to this collection with his co-author Laar. Miles and Laar challenge what many take to be the dominant paradigm in bioethics, often called ''principlism'' [1]. Such challenges to ''principlism'' go back at least to an article by Toulmin in 1981 [2]. Though the bioethics framework of principles has become the dominant one, there are other equally good ethical frameworks, such as the human rights framework and international legal conventions. Both approaches are widely used, but thinking of them as alternative approaches to bioethics is original, and testing them for their global perspective is provocative. Public health ethics has been willing to use both ''human rights'' and ''principles'' without seeing them as competing approaches. A prosaic way to put the same point is that two of the leading schools of public health in the U.S. have degree programs in ethics; at Johns Hopkins' Bloomberg School, it is called the Program in Bioethics, while at Harvard's Chan School, it is called the Program in Ethics and Human Rights.

☆ This special issue of the *Journal of Ethics, Medicine, and Public Health* discusses the interactions between public health and bioethics. Included are six articles that represent frontiers in public health ethics in the US. They represent a range of concerns and methods, and together give readers an excellent idea of current issues in the field.

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In contrast to Miles and Laar, my contribution explains why I find the approach of using mid-level principles useful, and why it has been so successful in biomedical ethics. Thus, one might read Miles and my contributions as a pair to compare and contrast our differing evaluations of the principles approach. I understand and find common ground with many critics of the principles by acknowledging that many people, both in the US and around the world, mistakenly call them ''principles of bioethics'' instead of ''principles of biomedical ethics.'' In other words, the principles were written to help create an intelligible ethical framework for medicine and the doctor-patient relationship. They do not (and were not intended to) extend automatically to all other fields of bioethics, such as global bioethics, environmental ethics, or. . .most relevant here. . .public health ethics. Thus my contribution proposes a more fitting set of principles for public health ethics and for environmental ethics.

Stephen Linder contributes a philosophical discussion of how to reconcile differences in ethics between different professions. There has recently been a surge of interest in inter-professional education, and Linder's contribution is a timely discussion of how ethics can become more inter-professional [3]. Linder's article raises important questions about the Codes of Ethics of different professions, and what to do if they conflict or appear to conflict to members of different professions. He proposes a range of possible solutions, comparing the ethical theories of Rawls, Scanlon, and Habermas on how they might propose to handle these conflicts, wrestling with how to maintain pluralism without resorting to either relativism or authoritarianism. This can relate to both the earlier contributions: how might one reconcile the principles of public health ethics and biomedical ethics, for example, or principles and Human Rights.

Lisa Lee describes the different organizations in the United States concerned with accrediting both public health educational institutions and public health departments. She proposes several different values or concepts, which she clusters into two groups: liberal (concerned with individual's rights and human rights) and collective (concerned with communities and populations). Lee's article also focuses on identifying a decision-making process, a process of deliberation that must include input from both experts and the public, i.e., evidence from both science and lived-experience. Then, there must be a participatory process (what I called a ''just process'') that leads to actionable recommendations that we subsequently act on. Thus, there must be attention to three important and distinct elements: ethical content, ethical process, and ethical action.

In an example of a county public health department trying to implement an ethical process for decision-making, Dirksen et al. describe how they helped institute the use of geographical information systems (GIS) in Oregon to create ''health zones''. They found guidance from Codes of ethics from the American Public Health Association (APHA), the Centers for Disease Control (CDC), and from National Association of County and City Health Officials (NACCHO). Their example shows how a process that began in biomedical ethics, the formation of hospital ethics committees to review complex and potentially controversial cases, can be extended to public health departments. It is an empirical example, then, of the proposal that Lee suggests. Thus, these two articles together form a very practical combination to lend guidance to any public health department trying to implement an ethical decision-making process.

Since all public health departments in the U.S. are now expected to have an ethics deliberation mechanism in order to be accredited, Dirksen's account can be helpful to many departments. It will be interesting for health departments in other countries to reflect on how they identify, analyze, and handle ethics issues in their own policies. One will need to find some ethics experts, choose committee members with the right interests and skills, and have some training program for staff. Dirksen's article quickly lists well over a dozen common topics that involve ethical issues, demonstrating that ethics is not some rare or exotic problem, but everywhere in healthcare. This is the same lesson that we learned in medicine: ethics is not confined to the rare ''dilemma''; every instance of doctor-patient interaction has ethical implications that will be better served once explicitly recognized and treated as ethical in nature.

Bondi describes an initiative to improve the number and effectiveness of advance directives. This includes living wills and ''durable power of attorney for healthcare'', wherein patients choose their proxy rather than relying on a surrogate list specified by local or national laws, and giving patients input into medical orders at the end of life such as DNR. What is most relevant to public health in her effort is that, in order to succeed, she needed to have community involvement or ''buy-in'', by using a participatory process very much like that proposed by Lee. So while Bondi is describing a biomedical ethics initiative, for it to succeed for a population required using a public health ethics process.

The distinction between biomedical ethics and public health ethics is one that many people might overlook. But in preparing this issue of a bi-lingual and bi-cultural journal, it occurred to me that the distinction itself might be something of a cultural artifact. For example, the English and French titles for the journal are not the same. The French name refers to ''public policy'' rather than ''public health''. Perhaps in a country with universal healthcare, the line between the doctor-patient relationship and national health policy is blurred, while it seems like a comparatively bright line in a country like the US where not everyone can afford a doctor (and if you can, it might feel like they work for you rather than the public). If so, this may help explain both why American-style biomedical ethics seems a little foreign in some countries, and why public health ethics feels like it always takes the back seat to biomedical ethics in the U.S.

Disclosure of interest

The author declares that he has no competing interest.

Version française

Ce numéro spécial du *Journal d'Éthique, Médecine et Politiques Publiques* traite des interactions entre la santé publique et la bioéthique. Ce numéro est composé, entre autres, de six articles représentants les frontières de la

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