EDITORIAL

A Code of Ethics for Public Health

The mandate to ensure and protect the health of the public is an inherently moral one. It carries with it an obligation to care for the well-being of communities, and it implies the possession of an element of power to carry out that mandate. The need to exercise power to ensure the health of populations and, at the same time, to avoid abuses of such power are at the crux of public health ethics.

Until recently, the ethical nature of public health has been implicitly assumed rather than explicitly stated. Increasingly, however, society is demanding explicit attention to ethics. This demand arises from technological advances that create new possibilities and, with them, new ethical dilemmas; new challenges to health, such as the advent of HIV; and abuses of power, such as the Tuskegee study of syphilis.

Medical institutions have been more explicit about the ethical elements of their practice than have public health institutions. However, the concerns of public health are not fully consonant with those of medicine. Thus, we cannot simply translate the principles of medical ethics to public health. In contrast to medicine, public health is concerned more with populations than with individuals, and more with prevention than with cure. The need to articulate a distinct ethic for public health has been noted by a number of public health professionals and ethicists.[1–5]

A code of ethics for public health can clarify the distinctive elements of public health and the ethical principles that follow from or respond to those elements. It can make clear to populations and communities the ideals of the public health institutions that serve them, ideals for which the institutions can be held accountable.

THE PROCESS OF WRITING THE CODE

The backgrounds and perspectives of people who identify themselves as public health professionals are as diverse as the multitude of factors affecting the health of populations. Articulating a common ethic for this diverse group is a formidable challenge. In the spring of 2000, the graduating class of the Public Health Leadership Institute chose writing a code of ethics for public health as a group project. The institute provides advanced leadership training to people who are already in leadership roles in public health. Because the fellows bring a wealth of experience from a wide variety of public health institutions, they are uniquely able to represent diverse perspectives and identify ethical issues common in public health.

At the 2000 meeting of the National Association of City and County Health Officers, the group added a non-institute member (J.C. Thomas) and charted a plan for working toward a code. The plan included receiving a formal charge as the code of ethics working group at the annual meeting of the American Public Health Association (APHA); reviewing codes written by other organizations, particularly those within public health (the American College of Epidemiology and the Society of Public Health Education); and balancing open participation with efficiency in writing the code.

The latter aim was achieved by having a small number of people write an initial code, then inviting feedback on it and each successive version from progressively broader audiences. The audiences reacting to the code drafts were (1) the working group itself; (2) an additional 19 ethicists and representatives from various public health agencies gathered in a meeting at the University for Health Sciences in Kansas City to critique the code; and (3) APHA members (via the APHA Web site, where the code was posted and feedback was solicited, and the 2001 annual meeting).

THE CONTENT OF THE CODE

The consensus reached during the review process was that while people outside the public health establishment might find the code useful, it should be directed to those in traditional public health institutions, including public health departments and schools of public health. Similarly, while people working in public health throughout the world may find the code helpful, it was written with the American public health system in mind. Although touching on aspects of research, the focus of the code is principally on public health practice.

While acknowledging the value of a set of principles for individuals, and the fact that institutional policies are often carried out by individuals, the working group wrote the code for institutions. One reason was the definition of

public health first articulated in the Institute of Medicine report *The Future of Public Health* and used in the code: "What we, as a society, do collectively to assure the conditions for people to be healthy."[6] Others have also noted that one of the differences between public health and medicine is that public health is most often delivered by government institutions to a population rather than by one person to another.[3]

The writers of the code aimed for a document that could fit on a single page and be easily posted. This concise statement of 12 ethical principles (box on this page) is accompanied by a series of other documents, including a preamble that explains the purpose of the code; a list of 14 values and beliefs inherent to a public health perspective that underlie the ethical principles; and notes on the ethical principles to more fully explain their intent. (All of the components are posted on the Web, and are available at http://www.apha.org/codeofethics.)

Reviewers of the code preferred positive rather than negative wording of the ethical principles. For example, the principle addressing conflicts of interest (number 12) is worded as an affirmation of collaboration with the proviso that it be done in a way that enhances the public's trust in the institutions.

The code draws upon several ethical concepts. The more individualistic notion of human rights appears in the second principle as a necessary point of tension with the communitarian concern for the well-being of communities. Theories of distributive justice underlie the fourth principle, which speaks of the need for basic resources and conditions necessary for health among the disenfranchised. Duty as an ethical motivation is represented in several of the principles, such as the obligations to provide information in some instances and to protect it in others.

One of the beliefs inherent to a public health perspective is that each person both affects and depends upon others. This interdependence between humans underlies the most fulfilling aspects of relationships and community as well as conflicts between people. Interdependence is the complement to autonomy, a dominant principle in medical ethics. Without denying that individuals have a right to some role in decisions that affect them, a recognition of interdependence serves as a correction to an overly individualistic perspective that is inconsistent with public health's concern with whole communities and populations.

The principle of interdependence between individuals lies behind the preeminence given to the health of communities in the 2nd principle of the code. Interdependence between institutions and the need for collaboration underlies the 12th principle, and the interdependence inherent to ecological systems underlies the 9th principle, which addresses the physical and social environments.

Principles of the Ethical Practice of Public Health

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 and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate for, or work for the empowerment of, disenfranchised community members, ensuring that the basic resources and conditions necessary for health are accessible to all people in the community.
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 and 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 on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
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.

DISSEMINATION AND ADOPTION OF THE CODE

For the code to be truly useful it must be broadly disseminated and adopted by public health institutions. Adoption by key national agencies and organizations will imbue the code with a degree of moral authority that will increase both its utility and the likelihood that it will be adopted and used by national, state, and local institutions. On February 26, 2002, the APHA Executive Board formally adopted the code, making APHA the first national organization to do so. This endorsement provides the code of ethics working group with an important tool for talking about adoption with other organizations and agencies, such as the Centers for Disease Control and Prevention, the National Association of City and County Health Officers, the Association of State and Territorial Health Officials, and the Association of Schools of Public Health. Members of these institutions contributed to the creation of the code, which should help with the next step of adoption.

Once a government agency or professional organization adopts the code, it will need to build these ethical principles into its policies and procedures, to the extent that it has not already done so, and train its employees in ways that ensure the implementation of the principles. Schools of public health should teach the code to their students. Since many public health professionals do not have a formal degree in public health, there will also be a need for continuing education or extension courses that include the code of ethics and how to use it.

For each of these tasks there will be a need for new tools. These might include materials for teaching the code, such as case studies illustrating the application of each of the 12 ethical principles; a workbook that helps

an institution consider how it might build the ethical principles into its policies and practices; and an oath to be recited by individuals as they graduate from a school of public health or as they are hired by a public health institution (the code of ethics working group is now considering writing such an oath).

FUTURE IMPROVEMENTS

The code of ethics, as it now stands, is the first explicit statement of ethical principles inherent to public health. It is a significant step forward, but it is unlikely to be the last step. Although the code was developed with broad input, we will gain new insights about its strengths and weaknesses as it is implemented. Moreover, as the world changes, public health professionals will become sensitized to new ethical issues. We anticipate, then, a time when the code will need to be updated.

To facilitate this process, the code will be posted on the Web in an interactive format that will welcome comments and will allow people to read others' comments. A standing committee of the Public Health Leadership Society will actively engage public health professionals and ethicists in the consideration of periodic updates to the code, which will incorporate lessons learned and comments received over time. In the near future, however, the code should prove to be a useful tool in clarifying the values and purposes of the public health profession and enabling it to more often achieve its high ideals. ■

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This editorial was accepted April 10, 2002.

Acknowledgments

The writing of the code of ethics was funded in part by the Centers for Disease Control and Prevention, both directly and through funding of the Public Health Leadership Society.

The authors thank the other members of the code of ethics working group: Elizabeth Bancroft (Centers for Disease Control and Prevention, Los Angeles County), Kitty Hsu Dana (APHA), Joxel Garcia (Connecticut Department of Health), Kathleen Gensheimer (Maine Department of Health), Teresa Long (Columbus, Ohio, Department of Health), Ann Peterson (Virginia Department of Health), Liz Schwarte (Public Health Leadership Society), Kathy Vincent (Alabama Health Department), and Carol Woltring (Center for Health Leadership and Practice, Oakland, Calif).

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Case Studies in Public Health Ethics

By Steven S. Coughlin, PhD, Colin L. Soskolne, PhD, and Kenneth W. Goodman, PhD

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