Clinical and public health ethics: conflicting or complementary?

The Milroy Lecture 1993

As an epidemiologist whose working life has been spent largely in universities, I am acutely aware that to embark on an analysis of the ethics of what clinicians and public health doctors do in the Health Service may well be to 'rush in where angels fear to tread'. My interest in the subject was largely kindled by a rather unlikely spark: a passage in an address by the World Medical Association to the Pope. The passage said:

'Medical ethics are threatened by events. Two major but radically opposed trends now prevail. First, the Christian thesis, which is defended by the vast majority of members of the World Medical Association and which sees the physician as being at the service of the individual, the person, the human being; and second, the socialist thesis, which thinks that he should be at the service of the State—that is, of the community, the material and moral interests of which increasingly are in serious competition with those of the sick', [1]

I said that this quotation kindled my interest, but it might have been more honest to say that it kindled my indignation, because as a Christian with socialist leanings I do not accept either that Christianity and socialism are antithetical or that the practice of community medicine, as it used to be called, is any less Christian than the practice of individual medicine. Had I been a non-Christian clinician I might well have been equally indignant at the suggestion that the ethic of individual medicine was Christian in origin—indignant, first because the command, 'love your neighbour as yourself', which provides biblical authority for this ethic, was in the Hebrew Torah before it was in the New Testament; and second because as a matter of history the ethical codes of individual medicine did not evolve primarily from either of these sources but from the Hippocratic Oath, which begins by invoking the gods and goddesses of classical Greece!

However, the quotation’s misuse of the word ‘Christian’ is really a side issue. The important question to consider is whether the quotation is right to see the ‘thesis’ that doctors should serve the individual as ‘radically opposed’ to the ‘thesis’ that doctors should serve the community. To explore this question it is necessary to consider first, the types of ethical theories that appear to underlie these two theses; second, the ethical principles that appear to be shared by those who practise individual medicine and those who practise community medicine—in other words by clinicians and public health doctors; and third, the rules found in medical ethical codes such as the Hippocratic oath. These codes largely reflect clinical rather than public health thinking and experience; indeed, one academic in the public health field has said that ‘public health medicine is not governed by any ethical code’ [2].

After recalling the rules of clinical ethics, we shall look at examples of situations in which the application of these rules appears to conflict with the concerns of public health doctors. These examples will be drawn from three major fields: epidemiological research and surveillance, National Health Service practice, and Third World health. From these examples we shall try to decide whether conflict between the ethical perspectives of clinical and public health practice is inevitable, or whether these perspectives are at least potentially complementary.

Ethical theories

The two main types of ethical theories are the deontological and the consequentialist types. Deontological theories state that there are certain absolute moral rules which it is our duty to obey in all circumstances—the word ‘deontological’ starts with the Greek word for duty, ‘deon’. Consequentialist theories state that actions should be judged right or wrong purely on the basis of their consequences. The World Medical Association’s address to the Pope seems to imply that the ethics of individual-centred medicine—clinical practice—are deontological, and that the ethics of community-centred medicine—public health practice—are consequentialist.

Deontological ethics

By tradition, the great religions of the West have been deontological in their ethics. They have taught that certain moral rules or commandments are God-given and should always be obeyed, whatever the consequences; and I suspect that when, in effect, the World Medical Association applied the word ‘Christian’ to clinical practice it was with the idea in mind that Chris-
tianity and clinical practice both had books of rules and that these rule books had a lot in common. In reality, however, it is not so simple. Not all Christians accept this deontological approach; some believe in 'situational ethics', which are more consequentialist. Nor do all deontological theories start from belief in a divine lawgiver. One which does not, and which seems to provide as good a rationale as any for the ethics of clinical practice, is that of Immanuel Kant. He argued that each person—or each 'rational agent', to use his term—had an absolute moral value. This meant that a person should never be used as just a means to an end, but should always be respected as an end in herself or himself. It meant that we should deal with every person in accordance with universally applicable principles, and therefore in accordance with principles which we would think it right for others to apply in their dealings with us if our roles were reversed.

When as patients we go to a clinician, we hope that he will deal with us like this—that he will regard us as having absolute moral value, and that his first consideration in dealing with us will be to promote our own personal welfare rather than to use us as a means to any end outside ourselves, even an end as worthy as the health of other people. (I use 'he' and 'his' not because I mean to be sexist but because, rather than repeating 'he or she' whenever I use the third person singular, I am referring to clinicians as masculine and public health doctors as feminine throughout this lecture.) The hopes we place in the clinician when we are patients correspond to the expectations of the medical ethical codes, and both for this reason and because of the other rules which these codes lay down—on respect for life and respect for secrecy, for example—we can accept the idea that the ethics of clinical practice have a deontological basis.

Consequentialist ethics

The consequentialist approach is to judge actions as right or wrong by their consequences rather than by whether they conform to any absolute moral rules. The main example of the consequentialist approach is utilitarianism. As formulated by Jeremy Bentham, this theory says that actions are right insofar as they promote 'the greatest happiness of the greatest number'. However, many utilitarians have found the word 'happiness' rather too restricted and would sooner talk about the greatest good or welfare or flourishing of the greatest number; and many feel also that human welfare cannot be maximised without giving people fair shares in this welfare and respecting their autonomy. To some extent this bridges the gap between consequentialist and deontological ethics, since if we say that people should have fair shares or autonomy we are behaving deontologically, laying down moral rules.

If utilitarianism is qualified in this way, it does seem to provide an appropriate ethical basis for public health medicine, the aim of which is surely to maximise human welfare in at least one of its aspects, while showing fairness and respect for individual autonomy. I say 'in at least one of its aspects' because I suspect we might not all agree on whether public health doctors should be trying to maximise everything which the World Health Organisation calls health—the whole of 'physical, mental, and social wellbeing'—or whether their efforts should be targeted at just maximising people's life-spans and freedom from physical and mental disease and disability. But all would agree that at least one important aim for public health doctors is to reduce as much as possible the total burden of mortality, morbidity, and disability carried by the people in their communities; and this must surely imply a utilitarian approach, albeit one tempered by fairness and respect for autonomy.

It is not surprising that the World Medical Association, in its address to the Pope, should have described this approach as threatening. Clinicians are, perhaps, bound to see this approach as threatening, given that they can be told by a public health doctor that there are not enough resources to treat their patients in the most effective way. From the deontological standpoint, appropriately adopted by the clinician, these patients are people of absolute moral value, and the public health doctor is treating them as a means to an end when she says that their treatment must be restricted in order to release resources to treat someone else. We shall meet this problem again, when we specifically consider National Health Service practice.

Medical ethical principles

Having considered the two separate sets of ethical theories which appear to underpin clinical and public health practice, we turn to the ethical principles shared by these forms of practice. The main ones are beneficence or doing good, non-maleficence or not doing harm, autonomy or liberty, and justice or fairness.

Doing good and not doing harm

Doing good and not doing harm can be taken together. They are perhaps the most obvious of the principles. There are, of course, situations in both clinical and public health practice in which harm and good are both done, on the grounds that the good is greater than the harm but cannot be done on its own. An example of this in clinical practice would be the saving of a child’s life by the amputation of a leg in which there was a sarcoma. An example from public health practice would be when, because of limited resources, some patients’ treatment suffers to ensure that enough resources are available to treat others. This poses problems for the deontological ethicist. Somewhat similar situations can arise in an individual clinician’s practice, if, for example, several of his patients need organ
transplants of some kind and he cannot secure enough donor organs for them all.

Autonomy

Autonomy has been defined as 'the capacity to think, decide, and act on the basis of such thought and decision freely and independently' [3]. This definition perhaps needs broadening to cover matters such as people's right to know things of importance to them, and to have their privacy and dignity as well as their independence respected insofar as that is possible without interfering unduly with other people's autonomy. The imbalance of power in the doctor-patient relationship means that clinicians ought to take particular care to allow their patients to exercise their autonomy.

The public also has a right to autonomy: to be informed and consulted about its health needs and about what is being done to meet these needs, and to be actively involved in meeting them for itself. Community Health Councils, the media, self-help and pressure groups, and even the annual report of the Director of Public Health have parts to play here, but many public health doctors and others would say that much more is needed. And what is to be done when the clinician's patient or the public health doctor's community lacks the expertise or the wisdom to make what is medically the right decision? The individual patient in this situation may well be happy to hand over the responsibility for decision-making to the doctor; and when, on the other hand, a patient decides to reject the doctor's advice, most ethicists would say that in normal circumstances the doctor must accept that decision. But if the public or their elected representatives reject a public health doctor's advice—if, for example, they refuse to have fluoridated drinking water or to ban all cigarette advertising—this may be ethically more worrying, since it threatens the health even of individuals who have not been party to the refusal. This might, however, still be defended in terms of utilitarian ethics, on the ground that human welfare would not suffer as much as a result of these particular decisions as it would if such matters were not under democratic control.

Justice

Gillon writes [3] that 'some argue that medical ethics should have no truck with justice in the sense of fair adjudication between competing claims. Especially in the context of scarce medical resources they take the view that the proper role of doctors is . . . doing the best they can for each patient. Their patients suffer when doctors start to temper this obligation with any conflicting considerations of fairness or justice'. However, as Gillon himself implies, even the old-style clinician with no budget to worry about can only get through a certain amount of work in a day, and should be concerned to share this work out fairly between his patients; and the public health doctor cannot begin to achieve her aim of reducing the burden of disease and disability without becoming involved in the sharing out of resources on a much bigger scale. It is self-evident that this sharing must be done fairly and justly.

The problem comes when the public health doctor tries to decide what is meant by fair and just. Should she be a simple utilitarian and favour sharing out our limited health-care resources so as to maximise human welfare, perhaps as measured by quality-adjusted life years (QALYs)? This seems to imply valuing patients in proportion to the number of QALYs that medical care can add to their lives, which tends to favour the young at the expense of the old. Alternatively, should she accept the deontological view that every person has absolute moral value and an equal claim on the health service? This might lead her to favour providing for each person in proportion to his or her present need insofar as this can be met by health care. Or should she take account of people's merits in recommending how resources should be shared between them? Renal unit consultants have sometimes been accused of taking social merits and demerits into account when selecting patients for dialysis; and social standing certainly influences the health care people get, since it affects their use of the private sector. However, few public health doctors would be happy to see National Health Service resources allocated on merit. The debate is more about whether these resources should be allocated so as to maximise human welfare or to meet present need.

Medical ethical codes

How far are these principles embodied in the rules found in medical ethical codes? Take the modern restatement of the Hippocratic Oath known as the Declaration of Geneva (Table 1), which some of us signed when we graduated. Among its nine promises, the first should be particularly welcome to public health doctors, since its reference to 'the service of humanity' highlights our responsibility to the community as a whole; the second, sixth, and seventh are concerned with maintaining the standing of the profession and appropriate relationships within it; and the third is general. Each of the other four promises hints at some aspect of one of the four main ethical principles already discussed. 'The health of my patient will be my first consideration' is about beneficence; 'I will respect the secrets . . . confided in me' is about one aspect of autonomy; 'I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient' is about fairness (although age, gender, and sexual orientation need to be added); and 'I will maintain the utmost respect for human life . . . and . . . will not use my medical knowledge contrary to the laws of humanity' is about non-maleficence.
Examples of ethical conflict

The Declaration of Geneva and other medical ethical codes were, of course, written primarily with clinical practice in mind; and although in general they provide a good guide for the clinician, the application of some of them can cause conflict between clinicians and public health doctors. As noted above, in National Health Service practice conflict can arise between the clinician who says that 'the health of my patient is my first consideration' and the public health doctor who says that the available resources can more productively be used to benefit someone else's patient or to prevent people becoming patients at all. Another area of conflict lies in the field of health in the Third World, where there are situations in which some public health doctors are saying that certain people should not be treated even though resources to treat them exist, because in the long run treating them will reduce rather than increase human welfare. Conflict also arises in the area of epidemiological research and surveillance.

Epidemiological research and surveillance

The ethical debate about epidemiological research and surveillance involves the fifth promise in the Declaration of Geneva: 'I will respect the secrets confided in me'. This rule concerns autonomy for patients, which is held to include their right to decide for themselves whether information about them, to which their doctor has access, should be shared with anyone else. Certain exceptions to the rule that such information should not be given to third parties without the patient's consent have, of course, long been accepted: doctors are required to notify infectious diseases, and ethical committees sometimes permit the disclosure of data in medical records to research workers, on the ground that the possible benefits these activities may bring to the prospective patients who make up society are more important than the individual's right to privacy. Despite what the Declaration of Geneva says, opposition to the disclosure of data in these circumstances has tended to come not so much from clinicians as from a small minority of lay people who see themselves as the guardians of patients' rights.

One context in which the appropriateness of obtaining and analysing data on patients without their consent for the sake of the public good was recently debated was the proposal that the prevalence of HIV infection in this country should be kept under surveillance by testing anonymised blood samples which had originally been collected for clinical purposes in places like antenatal clinics and accident and emergency departments. Doll [4] put the utilitarian view. 'How it can be unethical', he said, 'is incomprehensible, as it can do no possible harm to anyone and can do much good'. In response, Gillon [5] referred to the World Medical Association's Declaration of Helsinki on research on humans, which says that this should only be carried out on people who have given informed consent, and that 'concern for the interests of the subject must always prevail over the interests of science and society'. He also argued that people on whom any test was carried out had the right to know the result if they wanted. Others reacted to this argument by pointing out that people's privacy was not violated if their blood samples were anonymised before testing, and that those who wanted to know their HIV status could always have a special test for this purpose. The outcome of the debate was the Government's decision to initiate a programme of HIV testing of anonymised blood from samples which had been given for other purposes, and that these tests would be done without getting people's specific consent, although the wishes of any who spontaneously objected to their blood being tested would be respected. The public good thus seems to have been put first.

To turn now from surveillance to epidemiological and public health research: many, if not most, of our profession would probably agree with the Interprofessional Working Group on Confidentiality chaired by Sir Douglas Black, which the Board of Science of the British Medical Association initiated in 1984. This group recommended that research based on health records which would be impeded or prevented if consent had to be obtained from the subjects of these records could go ahead without their consent provided that the custodian of the records agreed and that the research protocol was approved by a properly constituted research ethics committee [6,7]. An example of research of this kind would be a project in which the possibility that a particular industrial chemical caused a type of cancer was to be explored by first using old factory payrolls to compile a list of several thousand people who had been exposed to the chemical, and then seeing how many of these people had

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Table 1. Promises embodied in the Declaration of Geneva (World Medical Association, 1948, 1968, 1983)

| Promise | Details |
|---------|---------|
| I solemnly pledge myself to consecrate my life to the service of humanity; |  |
| I will give to my teachers the respect and gratitude which is their due; |  |
| I will practise my profession with conscience and dignity; |  |
| The health of my patient will be my first consideration; |  |
| I will respect the secrets which are confided in me, even after the patient has died; |  |
| I will maintain by all means in my power, the honour and the noble traditions of the medical profession; |  |
| My colleagues will be my brothers; |  |
| I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient; |  |
| I will maintain the utmost respect for human life from its beginning, and even under threat I will not use my medical knowledge contrary to the laws of humanity. |  |
subsequently developed the relevant type of cancer according to databases such as regional cancer registers. To insist that each subject's data should only be extracted from these sources if he or she consented would make the research impossible, since some would have died and others would have changed their addresses. It seems entirely appropriate that in such a situation an ethics committee should be able to permit or deny access to the data on behalf of the subjects. I would go a little further and say that in any worthwhile records-based research project it should be sufficient to have ethics committee approval rather than the consent of each individual subject, provided that the subjects are not to be asked to provide additional data and that the results of the research will be in the form of statistics which do not allow individual subjects to be identified.

In research in which records are to be used to identify subjects who are to be approached directly for further data, there may be a stronger case for requiring that the custodian of the records should not release any data from these records to the research worker without the subjects' consent. However, I have to admit to having collaborated with clinicians in interview studies of patients ascertained from medical records, with ethics committee approval, in which the patients knew nothing until they received letters from me, sent out with their medical attendants' consent, to say that our interviewer would shortly be getting in touch with them. The interviewer did not question them without first obtaining their written consent to being interviewed, but their consent for us to be given their names was never obtained; and yet very few, if any, of them expressed any disquiet about this.

Yet, there is a trend throughout the Western world towards insisting that patients' consent be obtained before any data relating to them or any samples of their body fluids are used for epidemiological purposes. Epidemiologists find this trend worrying because getting consent from every subject is often impossible or prohibitively expensive, while excluding subjects from whom consent cannot be obtained can distort the results of epidemiological studies. Anxieties were particularly aroused by the appearance in 1990 of a proposal from the Commission of the European Communities for a 'Council directive concerning the protection of individuals in relation to the processing of personal data' with the aim of 'establishing an equivalent, high level of protection in all the member states of the Community' which would facilitate exchange of data across the national frontiers within the Single Market [8]. The proposal was approved by the European Parliament with numerous amendments in March 1992, and reissued with changes taking account of these amendments in October 1992 [9]. The intention is that it should finally be adopted later this year after further consultation.

Two elements of the amended proposal could pose particular problems for the epidemiological use of medical records. First, the processing of personal data concerning health would in general only be permitted if the data subjects had given their written consent, or if 'the processing is performed in circumstances where there is manifestly no infringement of privacy or fundamental freedoms'. 'Infringement of privacy' is not defined, which could leave unresolved the legality of epidemiological research in which medical records are analysed without approaching their subjects. However, the proposal leaves room for member states to permit health data to be processed without subject consent 'on grounds of important public interest', so the need to have regard to the public good as well as to individual privacy is not totally forgotten.

The second problem which the amended proposal poses for epidemiological research is a stipulation that personal data should be 'kept in a form which permits identification of data subjects for no longer than is necessary for the purpose in view'. This takes no account of the fact that personal data which are kept beyond the time required by their original purpose can often be used for the public good in other ways. The above example of a study of cancer incidence in a payroll population illustrates how this can happen. Fortunately, as with the requirement about written consent, there is a let-out clause in the proposal which appears to open the way for member states to protect epidemiological research if they wish. This clause allows states to 'lay down appropriate safeguards for personal data stored for historical, statistical, and scientific use'. It is important that both this clause and that allowing data processing without subject consent on grounds of important public interest should be followed if and when the directive passes into British law.

National Health Service practice

Two areas of conflict within National Health Service practice between the clinician and the public health doctor were identified above. The clinician is expected to have as his first consideration the health of his patients, rather than the health of everyone in the community. The public health doctor, on the other hand, has to try to ensure that everyone gets a fair share of the National Health Service's limited resources, which brings her into conflict with the clinician when this policy involves denying some of his requests for his particular patients. As Hoffenberg said in his Harveian Oration [10], public health doctors who commit themselves to 'the greatest good for the greatest number . . . lay open a clear conflict with the traditional clinical role which places the interests of an individual patient in the centre of the stage.'

I believe we have to live with this conflict. The only alternatives are that clinicians should stop seeking the best for their patients, or that public health doctors should stop participating in the allocation of health resources which are not enough to meet all the health needs of every member of the population. For clini-
cians to stop seeking the best for their patients would be to deny the principles of beneficence and non-maleficence so far as these patients are concerned. For public health doctors to stop participating in resource allocation would be to leave the more far-reaching decisions on the rationing of health care almost exclusively to people without the knowledge, skills, and attitudes that a good medical education inculcates. The decisions are those for which purchasers are responsible, which determine how resources are distributed between different programmes, and between methods of treatment (especially those needing investment in new facilities) within these programmes. One way in which the public health doctor should be able to contribute to these rationing decisions is to ensure that they satisfy medical ethical principles such as beneficence and fairness.

The second kind of conflict within National Health Service practice is the conflict in which public health doctors are involved about the fairest way to share resources between different fields of health care. Should the emphasis be on providing for each person in proportion to his or her present need and so leveling up those whose needs are greatest, or on achieving maximal improvement in the overall health of the community as measured by the QALY, or some similar index?

In measuring QALYs, each actual year of life is scored between 0 and 1. A healthy year scores 1 and an ‘annus horribilis’, when life is not worth living, scores 0. It is questionable whether any existing scoring systems reflects quality of life accurately; but if one did, it would seem reasonable to use the average number of QALYs which a particular treatment added to each recipient’s life to measure the benefits of the treatment. In that case, the health service would be maximizing human wellbeing if its resources were used to add as many QALYs as possible to the life of the population. Such a policy would appear to serve the simple utilitarian goal of ‘the greatest good of the greatest number’. The idea of tackling the problems of rationing along these or similar lines has received considerable support, especially from economists [11,12] but also from some public health doctors and other senior health-care workers. The approach is not so very different from that adopted by the renal unit consultant who is presented with more candidates for dialysis or transplantation than he can satisfy, and who gives priority to the younger ones because they can be expected to gain more years of life from treatment than the older. It can be argued that to discriminate in favour of the young against the old, as both this consultant and the user of QALYs do, offends against the principle of fairness or justice; but one can also argue that this discrimination is a move towards redressing the unfairness of some people having much shorter lives than others!

Nevertheless, many public health doctors see it as fairer to seek to provide for people according to their needs than to maximise overall health in the way that the use of QALYs and similar indices is intended to do. They criticise QALYs partly because of the methodological difficulties in quantifying quality of life, but more because they dislike valuing people’s lives in proportion to their fitness and life expectancy. This, they think, discriminates against groups such as the elderly and the handicapped who are already widely felt to receive less-adequate health care than the rest of us. Alwyn Smith has been to the fore among these critics, and has pointed out that the debate is essentially about whether the Health Service should be used primarily to increase the mean level of health in the community, or to reduce the variance of health by targeting resources particularly at the disadvantaged, and so giving to each in proportion to his or her present need [13,14]. The first alternative may be the more beneficial, since its goal is the greatest good of the greatest number. The second alternative seems to score more highly on fairness or justice. Smith suggests that political debate is needed to enable a choice to be made between these alternatives [15].

Health in the Third World

Some public health doctors maintain that there are people in the Third World who should not be treated although treatment is available. Maurice King [16] has argued that the demographic transition now taking place in many Third World countries differs crucially from that experienced by the West in recent centuries. He describes the transition in the West as having involved three stages: the first when there was an equilibrium between high birth and death rates; the second when a falling death rate was combined with a birth rate that was still high so that the population increased; and the third when economic and social gains led to a fall in birth rate so that equilibrium was restored. Much of the Third World is, he argues, stuck in the second stage, because much of the fall in death rate there has been brought about by ‘vertical programmes’—of mass immunisation, and oral rehydration for diarrhoea, for example—which have not brought with them economic and social gains like the factors which brought the birth rate down in the West. He describes this second stage with no way through to the third as a ‘demographic trap’, in which the death rate will ultimately rise again as pressure on resources increases and the environment deteriorates. This ‘vertical’ public health is thus, he suggests, leading through ecological deterioration ‘to starvation and to the destruction of the very population it is intended to benefit’, and unless measures such as family planning and ecological support can be introduced on an adequate scale, ‘such... measures as oral rehydration should not be introduced on a public health scale, since they increase the man-years of human misery, ultimately from starvation’.

In terms of medical ethical principles, King seems to
be implying that although these vertical programmes are beneficent in the consequences to which they lead later. ‘However’, he adds, ‘the individual doctor must rehydrate his patient.’ Once again the clinician with his absolute respect for individual human life seems to be contrasted with the more utilitarian public health doctor. However, King’s assessment of what the public health doctor can achieve in this situation may be too negative. Success in delivering health and family planning services synergistically to Third World communities has, for example, recently been reported by Taylor [17].

Conclusion

Although the relationship between clinical and public health ethics poses problems in the Third World, it appears that in the context of epidemiological research and National Health Services practice in the United Kingdom the two ethical approaches are at heart complementary and must be harnessed together even if they sometimes seem to conflict. Although the clinical approach is more deontological and the public health approach more consequentialist, both are about applying the principles of beneficence, non-maleficence, autonomy, and justice to people. Although clinicians have special responsibility for the particular people who are their current patients, they, as well as public health doctors, should also have a concern for the health of their potential patients—all the other people in the districts they service.

Epidemiological research ultimately aims to benefit these potential patients, and their right to have such research carried out in their interest must be taken as seriously as the right to privacy of past and present patients. The proposal for a European directive on data protection encourages professions in each state to draw up codes of conduct regarding the application of the directive in their own sectors [9]. This needs to be done for medical records in the United Kingdom, perhaps as a collaborative venture between the Royal College of Physicians and other national bodies, in a way that equably balances the interests of potential and existing patients. As a prototype for a code of conduct regarding medical records, I commend the model code of practice which the Commission of the European Communities itself published, several years before the draft Directive, in a working party report on the confidentiality of medical records edited by George Knox [18]. This code was based on the assumption that there is ‘a positive ethical duty to use medical records for the benefit of the whole population’ [19].

National Health Service practice also exists to benefit all people, especially during their spells as patients. Within the National Health Service the clinician must act as advocate for his own patients, and the public health doctor must uphold fairness in the sharing of resources between all the patients in her region or district. In the conflicts to which this will inevitably lead, she must recognise that he is only doing his duty, and he must accept that at the end of the day the available resources must be rationed fairly. As the budgetary controls of the ‘new’ National Health Service, with its internal market, raise the pressure on the clinician to practise rationing within his own practice, he is in any case being increasingly forced to internalise the conflict between wanting the best for each individual patient and needing to share limited resources fairly between many patients. He is learning to apply public health ethics as well as clinical ethics, as I believe he should. If clinicians do this, then, as Godber put it [20], they need not feel ‘that their duty to do everything possible for the patients presently in their care debars them from making decisions or advising on the other kinds of choice that must be made for the community’. Clinicians and public health doctors need to collaborate in these fields, as well as on research-related matters such as the epidemiological use of medical records. If we do, we shall be following in the footsteps of Gavin Milroy, the founder of this lecture. He wrote, in his suggestions to lecturers, that his ‘only desire’ was ‘to promote the advancement of medical science along with the interests of philanthropic benevolence and of social welfare’ [21]. The common principles of clinical and public health ethics point us to the same goals.

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The Journal seeks articles of merit, whether they be reports of original research or critical reviews. The Editor is assisted in his choice of articles by expert referees.

The following notes are for the guidance of potential contributors.

**The title** of the article should be as succinct as possible and the text should be interspersed with subheadings, as appropriate.

A **summary** of not more than 200 words should be included and will be printed at the start of each article.

The **text** should be typewritten in double spacing on one side of A4 paper and pages should be numbered consecutively. Please write as concisely as possible. Amendments should be made in the text and not in the margins. A separate **title page** is requested; this should carry the title, the name of the author(s), medical degrees and principal appointment(s), and, in addition, a full postal address for correspondence should be given. Two copies of each article should be supplied.

**SI units** should be used in the text and the author is responsible for their correct usage.

**References**

References should conform to the Vancouver style. They should give names of all authors, followed by initials, unless there are more than four authors in which case the first four only should be given, followed by *et al.* (however if there are five authors only, all names can be quoted). The title of the article should be followed by the title of the journal (*Abbreviated to style of Index Medicus*), the year of the publication, volume number, and first and last pages. References to books should give the names of authors, (and/or editors), title, place of publication and publisher, followed by the year of publication.

Please note that accuracy of references will be the responsibility of the author.

Each **figure** (illustration) must be submitted on a separate sheet and given a number which accords with the order in which it appears in the text. **Tables** also should be presented in this way. **Captions** to Figures should be as brief as possible and listed separately. Each Figure should be identified with the name of the author as well as a number. The page format is 17.5 cm × 22.5 cm deep (single column width 8.4 cm). Figures will be reduced, where necessary, to fit this format.

**Line figures** should be presented on plain white paper or drawing paper. **SI units** should be used throughout. **Photographs** (including x-rays and micrographs) should be printed on high-quality glossy paper and any lettering should be presented on an overlay.

Please note that **generic names** should be used for all drugs; **brand names** may follow in parenthesis if necessary.

**Fillers** on medical and related topics (historical, anecdotal or critical) are welcomed. They should not exceed 700 words, and are published at the discretion of the editor.