

Concluding Plenary Session: Finding the Balance—Tools for Promoting and Protecting the Public's Health

Lina Al-Karkhi

*Manager, Public Health Law and Ethics Program, Public Health Agency of
Canada*

Lina Al-Karkhi, Manager of the Public Health Law and Ethics Program of PHAC, thanked attendees, speakers, and moderators for participating in this very stimulating, challenging, and informative conference. The test of a conference is whether it yields a new understanding of the issues that can be translated into participants' work in their own domains, and this conference was very successful in that regard.

Paula Todd

*Host, Person 2 Person with Paula Todd
Author, A Quiet Courage: Inspiring Stories from All of Us*

"This morning I said to myself, 'Wow! My roof didn't fall in! I didn't get poisoned by my toothpaste! My car didn't blow up!'" said Paula Todd. She is the host of TVO's *Person 2 Person with Paula Todd*, a graduate of Osgoode Hall, and author of the bestselling book *A Quiet Courage: Inspiring Stories from All of Us*.

Ms. Todd said that this conference had heightened her appreciation for the behind-the-scenes work that keeps the public safe. When it is done right, this work goes largely unnoticed, because it strikes a delicate balance between intervention to protect the public well-being and recognition of individual rights. At times the work requires legal tools such as regulations, standards, and commissions of inquiry, while at other times the job can be done with non-legal tools such as education and leadership.

Ms. Todd introduced four panellists, who would address four questions about maintaining the balance in protecting the public's health:

1. Why do we need public health law?
2. When does it go too far?
3. When does it fall short?
4. What are the alternatives?

Dr. David Mowat

*Acting Deputy Chief Public Health Officer, Public Health Practice and Regional
Operations Branch, PHAC*

Dr. David Mowat, Acting Deputy Chief Public Health Officer, Public Health Practice and Regional Operations Branch, PHAC, began with a response to the first question. The law, he said, has always been part of public health. In fact, legal means were the first levers that public health had, dating back to the 14th century.

A key concept in public health law is that it be minimally intrusive. Some laws affect or constrain behaviour, while others constrain choice through the regulation of products and the environment. For example, people can't choose to buy an unsafe crib, because they are not allowed on the market.

Dr. Sheela Basrur

Chief Medical Officer of Health, Assistant Deputy Minister of Public Health, Ontario

Dr. Sheela Basrur, Chief Medical Officer of Health and Assistant Deputy Minister of Public Health, Ontario, pointed out that the answer is the same as that to the question, "Why do we need public health?" We need it to promote the health of people as a collective in a way that is not possible with individuals.

Public health is necessary for dealing with patterns in human health that are visible only in the aggregate and amenable only to collective control. The smoking ban, for example, goes beyond individual behaviour change to protect restaurant workers from an occupational hazard. Jane Speakman, Legal Counsel, City of Toronto, added that provincial public health law is needed to fill the gaps left by a patchwork of jurisdictional responses.

Dr. Ross Upshur

*Canada Research Chair in Primary Care Research
Director, University of Toronto Joint Centre for Bioethics*

Dr. Ross Upshur, Canada Research Chair in Primary Care Research and Director, University of Toronto Joint Centre for Bioethics, said that without public health law, life would be "nasty, brutish, and short."

The British public health acts of 1848 took utilitarian moral theory and put it into practice to address social needs during a period of rapid industrialization and high mortality—challenges similar to those we face today with globalization. However, to have public health law requires an active and legitimate sense of the public and of the common good. It needs to be anchored in the principle of harm. When individual or collective interests start to harm others, a legitimate tool for restricting them is required.

Jane Speakman

Solicitor, Municipal Law Section, City of Toronto

Jane Speakman referred to the comment Dr. Butler–Jones made during the opening keynote: everyone agrees that public health law is a good thing, but the art is knowing when to legislate.

Ms. Todd asked Dr. Mowat to provide a few examples of public health law that has gone too far. First, the law goes too far when legislation is based on insufficient evidence or when authorities fail to revisit legislative decisions once evidence becomes available. Second, given that public health law is supposed to be the expression of society's wish to protect its members, laws enacted without public support are in trouble. To a certain extent, public health laws must be self-enforcing.

For example, smoking in banks is not tolerated by the public. The importance of social support is clearest when "silly" laws are introduced and the resulting media mockery affects the public's image of public health. Third, laws sometimes fail to take into account a competing, more serious risk that they introduce. For instance, Toronto's recent rash of playground closures in response to new safety standards contributed to children's risk of health problems associated with low physical activity. Fourth, liability standards suggest that it is worse to do something that goes wrong than to do nothing to protect the public.

As an illustration, Dr. Basrur joked that she was known for a time as "the sushi lady" in Toronto because of a bylaw requiring that fish served uncooked be frozen before use. The law was introduced without sufficient consultation with the Japanese restaurant industry, and the public health department could not demonstrate the burden of disease to legitimate its necessity. It was quickly withdrawn.

In other cases, though, "too far" is in the eye of the beholder, Dr. Basrur added. "If people agree with you, it's, 'You're a great leader.' If they disagree, it's, 'You're being political.'" Discussions on proposed laws, such as those on smoking and on pesticides, can become very polarized. Though it should not be partisan, public health is always intensely political.

Dr. Upshur asked how public health officials can enter a politicized arena and maintain their objectivity. "How do you ensure in your own practice that you're not becoming partisan?" he asked. Speakman replied that it is her responsibility, as legal counsel, to step back, consider all the questions that could be raised about proposed legislation and find the balance. This process helps to craft laws that stand up to challenges, even if they do not go as far as public health authorities might wish. Consultation within as well as outside of public health is an important part of the process, as is knowing when to legislate.

Ms. Todd asked whether there are rules for preventing partisanship. Dr. Basrur replied that the most important ones are self-awareness, an understanding of one's role in the broader system, and a motivation to do the right thing in that system. "If you're true to yourself, then you know when you're not objective, and you remove yourself," she said. Public health is more politicized at the provincial level, because the role of bureaucracy is to support the government of the day. The role of a public health official is to provide advice; the decisions rest with someone else.

Ms. Todd suggested that another conference be devoted to the question of whether all public health agencies should be at arm's-length from government. "But then you lose your influence," Dr. Basrur pointed out.

Dr. Mowat said policy is a two-stage process. Public health agencies are very good at the first stage, which is gathering evidence and facts. But they are not good at the second stage, which is considering the potential results of action, placing value upon them and weighing competing interests. Public health is unable to take responsibility for all the economic, legal, labour, and other contextual factors of a decision; that is the job of politicians. The public health official's job is to give the best possible advice. "There is a lot of pressure to tell people what they want to hear," he concluded. "But if all you're telling them is what they want to hear, then you don't need to be there."

The discussion moved to the question of times when the law does not go far enough. Dr. Upshur suggested that, given changes in the drug resistance of diseases such as tuberculosis, the current framework for confinement may be too purposive. "We need government to be brave, to see the people who are bearing the brunt of the illness and how they can be protected," he said.

Ms. Todd asked about confinement during SARS: how many court orders were required, and how many people voluntarily complied? Speakman replied that 27 court orders were issued by the Medical Officer of Health under a special statute—very few considering that more than 13,000 people had to be isolated. The orders were issued only in the most extreme circumstances, and it was very difficult for people to comply, but everyone was amazingly cooperative.

Ms. Todd raised the importance of credibility, which is difficult to build and easy to lose. In Toronto, the decision to place signs in restaurant windows was a test of the public health department's credibility. Initially, restaurateurs were against it, but in the end it helped build the public's faith in restaurants and in the department. Dr. Basrur said the impetus for the program was an article and editorial cartoon in the *Toronto Star*. "You've got a huge momentum to do more at a time like that than during times of peace," she noted. It is not a purely regulatory system: a red card means closure, and a green card allows a restaurant to stay open, but the yellow card drives compliance.

"Sometimes public health is so successful that we forget we need it," Ms. Todd suggested. Dr. Mowat agreed. "You never see a headline reading, 'Child Does Not Die of Meningitis,'" he said. Public health has to act unobtrusively, while maintaining public support. If immunization is done well, the diseases become invisible, and some people will ask why so much money is being spent on preventing them.

Questions and Discussion

A participant recounted the example of one community where there were five deaths at an intersection before traffic lights were placed there and another in which there were six deaths, and there was still no light. "How much evidence do you need?" he asked.

“The standard of proof is as much a philosophical question as a scientific one,” Dr. Upshur said. The current shift towards evidence-based medicine sometimes implies that one standard of scientific evidence is the only valid one. Often there is little evidence to support a public health initiative, and public deliberation is required.

Dr. Mowat pointed out that there is a bias in medicine toward randomized clinical trials, but these are not an effective model of investigation in public health. This presents a challenge to determine new standards for evidence in public health and finding new ways to synthesize evidence. Dr. Basrur added that it goes beyond the question of evidence. Just as knowledge of risks is not enough to shift individual behaviour, in this case knowledge was not enough to shift the opinions or ability of the government to change the problem.

A participant suggested that the principle of least intrusion takes on a different meaning if taxation is considered to be an intrusion into property rights. How does this affect the balance, if the same outcome can be achieved much more cheaply with regulation than with education?

Dr. Upshur replied that this question is very important and should be the topic of a follow-up conference. Economic criteria and political expediency often trump other considerations, and the use of least restrictive measures is sometimes abused by public health, because it is easier to jump to more coercive measures. Dr. Mowat added that the principle of cost-effectiveness should be applied when comparing the tiny investment in public health with the vast investment in health care, in spite of the demonstrated utility of a population health approach.

Dr. Basrur noted that public health tends to shy away from taxation, because it is seen as social engineering. However, Canada’s taxation system already incorporates social engineering to support industries such as film and mining.

A participant asked the panel to comment on the role of advocacy in public health law development.

“It is the role, opportunity, and duty of public health officials to speak for those who have no voice or whose voices are too far from power to be heard,” Dr. Basrur replied. “Who better to advocate than the leadership?”

Ms. Speakman suggested that sometimes there has been too much reliance on the law, and more creative solutions are needed. She pointed to the example of confinement for tuberculosis. Often people with this disease have bigger issues to deal with, such as housing and mental health problems, and discharge planning may be as important as confinement in reducing the risk of transmission.

Dr. Upshur suggested that it is important to have an image of what the world would look like with an ideal set of public health laws and practices, because that ideal provides the

momentum for advocacy: a goal to move toward. Advocacy becomes dangerous, Dr. Mowat added, if it causes public health officials to become selective in their use of evidence. Assuming the dual role of scientist and advocate requires caution.

Dr. Mowat closed the conference. He thanked attendees, on behalf of the organizing committee, for their enthusiasm and participation. He gave recognition to those who had worked behind the scenes to bring the conference together. Finally, Dr. Mowat thanked the conference sponsors and colleagues at ALPHA and CPHA.