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Principles for Public Health Ethics – A Transcultural Approach

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1. Introduction

The last century has brought about a renaissance of medical ethics, transformed to bioethics due to a wider range of ethical challenges in medicine transcending the traditional physician-patient relationship. Ethical discussions of issues related to health – from the status of the embryo to access to the health care system up to questions of physician-assisted suicide – have since mainly been framed under the heading of "bioethics". But hardly any ethical discussions concerning the public's health have been led. In continental Europe, for example, little effort is being made to establish an explicit ethics framework for public health – although systematic ethical approaches for public health are needed as the immanent conflicts between the social good and individual rights are and become more and more obvious e.g. in the context of a threatening influenza pandemic caused by a new human influenza virus subtype.

This paper underlines the need for a public health ethics framework. I will argue that such a framework has to be normatively set apart from bioethics. Yet, to work with a concise set of mid-level principles and to utilize the well established methods of applied ethics – such as balancing and specification – will also prove well in public health ethics. This is what we can learn from the experiences in bioethics.

2. From Influenza to HTA – Ethical challenges in public health

Infectious diseases count among the major global health threats. Although vast ethical challenges are associated with these diseases, bioethics has neglected to deal with ethical aspects of infectious diseases and population health. Selgelid observes a "10/90 divide" which means that only 10% of all bioethics work deals with what constitutes 90% of all health burden – namely infectious diseases.[1]

Nowadays we are facing a possible influenza pandemic caused by a new human influenza virus subtype. Thus there is need for ethical debates on infectious disease control to inform policy making processes in this field. The bioterrorist threats, especially after September 11th 2001, and the SARS outbreak in Toronto in 2003 have stimulated a systematic discussion of a need for public health ethics and infectious disease control. Ethical aspects like finding the balance between protecting the public and restricting individual liberties are issues in these discussions. Especially the lessons from Toronto show that it is necessary to deal with ethical aspects of pandemic influenza preparedness as early as possible. Ethically sound and morally acceptable approaches for influenza preparedness plans should be founded in these discussions. In order to develop and to maintain public trust and cooperation, transparent and ethically justified regulations have to be discussed prior to a dilemma situation as part of preparedness planning.[2]

Other ethical challenges appear in public health. Among them are questions of how to conduct good epidemiological research (e.g. with vulnerable populations), which health inequalities are justified and which are morally devastating, whether to implement compulsory health programs (such as measles vaccination or screenings for some diseases), whether manipulative health education might be permissible, whether smoking should be banned from public places, how to balance the conflict between an anticipated health benefit of a public health campaign that might stigmatize some subpopulations (e.g. campaigns against high infant mortality among migrants) etc.[3] Also Health Technology Assessment (HTA), a procedure applied in public health to anticipate the impact of innovative tools and approaches in health, considers ethical aspects and implications. But a lack of systematic ethical approaches for HTA can be observed.

How can we approach these challenges? Normative theories in ethics and applied ethics are supposed to tell us how to act – or at least to give us criteria with which we can judge the moral implications of a motive or act. To arrive at norms in the context of these health challenges, we might first turn to the Hippocratic ethic to see if this traditional medical code with its norms can be a valid normative source for public health as well.

3. Do medical ethics and bioethics know the answers?

In medicine the Hippocratic Oath was an influential document that told the doctor to do good to his patient and to avoid harm. But the oath left the decision of what was good or harm to the judgement of the doctor – not the patient. Thus it is no surprise, says Veatch, that with progress in medicine and biotechnology that gave more leeway with regard to treatments (or with refraining from those) the Hippocratic ethic had to be overthrown: "The Hippocratic ethic will be relegated to the ash

[1] Selgelid MJ (2006) *Ethics and Infectious Disease*. Selgelid MJ, Battin MP, Smith CB (Ed.) *Ethics and Infectious Disease*. Malden: Blackwell Publishing: 3-19.
[2] Childress J (2005) Just Care: Rationing in a Public Health Crisis. *Update* 20: 1-7.
[3] See for a number of case studies Coughlin StS, Soskolne CL, Goodman KW (Ed.) (1997) *Case Studies in Public Health Ethics.* Washington: American Public Health Association.

heap of history – a benevolently paternalistic morality that may have worked for a culture in which patients were patient – when they were (as the word *patient* implies) passive, long-suffering, ignorant, and believed to be incapable of making choices."[4] As a consequence, bioethics entered the scene – most famously comprised in the four-principles-approach by Tom Beauchamp and Jim Childress.[5] They added the benchmark "respect for autonomy" to the Hippocratic principles "do good" (beneficence) and "avoid harm" (non-maleficence) that provides the core of their personal ethics principles for the patient-physician encounter. Yet, with technological progress and necessary decisions in situations of scarcity that appeared (e.g. doctors had more patients that needed dialysis than they could bring to this renal substitution therapy), the perspective had to be widened. Bioethics had to find answers to social challenges of biomedical progress and scarcity. Thus Beauchamp and Childress added the core principle of social ethics, i.e. justice, and gave some criteria for the good and right distribution of scarce resources.

Does the bioethics paradigm with its basic focus on personal ethics provide a sufficient framework for public health ethics? Probably not – as bioethics focused on individual good and autonomy and hardly ever thought about population health.[6] As such it is no wonder that bioethics has seldom dealt with infectious diseases and possible population health implications. At least in continental Europe and especially the German speaking realm, there are seldom public health scientists engaged in ethical discourse. Some papers mapping the terrain of public health issues actually only impose bioethics principles and methods on public health, calling this public health ethics.[7] But the focus on normative concepts of public health ethics is different from bioethics as the moral enterprise of public health is different from that of biomedicine. They both belong to different scientific and practical paradigms and scientific communities with different goals. These paradigms are neither incompatible nor incommensurable. Yet they are complementary and have different moral foundations and tasks; and they need different normative orientation.

Accordingly, there is a conceptual flaw to use bioethics for a primary ethical orientation of a population perspective in public health ethics and it is consequently inappropriate to focus on bioethics principles. Public health ethics has to emancipate from bioethics – theoretically – to sharpen its focus, taking into account the goals, approaches and competences of public health, and – practically – to enter discourses and communities of public health sciences and public health policy makers. Yet, an account to public health ethics based on principles seems a fruitful practical approach, as the practicability of the bioethics principles to the practitioners of biomedicine has proven well in the last 30 years and thus serves as an analogous example of good practice in applied ethics.

4. A concise set of ethical principles for public health practice

4.1 Why a concise set of principles?

The Public Health Leadership Society (PHLS) has provided a set of twelve rules under the heading "Principles of the Ethical Practice of Public Health "[8]. They appear as rules, rather than principles as they themselves have called them because they express principles like respect for autonomy, social utility and so on but already in a specified form. "Specified" means that these principles are already branched out by considering each other. Take for example the second rule: "Public health should achieve community health in a way that respects the rights of individuals in the community." To achieve community health means to achieve "good" for the group which is close to the principle of social utility. The phrase "respect the rights of individuals" mirrors what can be expressed in short with "respect for autonomy" (or one could argue "justice" as they talk of "individuals" in the plural).

The twelve rules of the PHLS do have a good value; they provide a very detailed and lengthy instrument. But these twelve rules are no principles as we would understand principles in applied ethics. The set of their rules is detailed and not so much generalized and comprehensive as the four principles are in the context of bioethics. Yet, that it is this concise set of four bioethical principles that became so famous and proved well in the context of bioethics is more than a pragmatic reason to use prima facie mid-level principles to build an ethical corridor or framework for public health as well. I believe that it is still true what the Belmont Report (for which Tom Beauchamp was staff writer) demanded for a practical approach: Rules of codes of professional conduct are often "inadequate to cover complex situations; at times they come into conflict, and they are frequently difficult to interpret or apply. Broader ethical principles will provide a basis on which specific rules may be formulated, criticized and interpreted."[9] Against this quote, the "Principles of the Ethical Practice of Public Health" of the Public Health Leadership Society appear like a code that consists of rules.

A concise set of broad ethical mid-level principles that are formulated and theorized by ethicists (maybe embedded in interdisciplinary working groups) seem to be useful tools for practitioners to use. A concise set of prima facie principles and a manual of ethical methods how to use them is like a baton passed on from ethical theorists to practitioners.

4.2 Benchmarks to consider – An "ethical toolbox" for public health researchers and practitioners

Thus, in this paper, a concise set of broad central norms – analogue to the four bioethics principles – shall be offered as a public health ethics framework for discussion. The principles that are – in my opinion – adequate to serve as generalized norms as a public health ethics framework are social utility, respect for human dignity, social justice, efficiency and proportionality (see table 1). With five principles this is still a concise set. Passed on as an "ethical toolbox" from the toolmakers (the ethicists) to the public health practitioners and scientists, they are benchmarks for good and right public health research and practice. They are norms public health practitioners and researchers should follow by bringing them in a balance and/ or specifying them to more concrete moral rules and judgments to apply in particular contexts.

Social Utility: "Social utility" is for public health what "Beneficence" is for (bio-)medical practice. Both enterprises – public health and (bio-)medicine – try to generate the good, in this case health. Whereas "beneficence" is traditionally the principle of personal ethics to describe a moral duty of the physician, "social utility" is a principle of social ethics. The net-

[4] Veatch, R. (2000): Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients, *J. Medicine and Philosophy* 25, 701-721. p. 702.

[5] Beauchamp TL, Childress JF (2001) *Principles of biomedical ethics*, 5. edition. Oxford University Press, New York.

[6] Callahan, Daniel; Jennings, Bruce (2002): Ethics and Public Health: Forging a Strong Relationship. *AJPH* 92: 169-176.

[7] Schröder P (2007) Public-Health-Ethik in Abgrenzung zur Medizinethik. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* 50: 103-111.

[8] Public Health Leadership Society (2002) *Principles of the Ethical Practice of Public Health*. Version 2.2.[www.phls.org].

[9] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) *The Belmont Report. Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC.

benefit of "social utility" is to be sought in the whole of the population or group that is at stake. Some people in public health, such as Mackenbach[10], believe that "social utility" is at the heart of public health and many public health practitioners are virtuous persons that came into public health to bring about as much health as possible. Others, such as Miettinen[11], even insist that there cannot be any other moral norm than social utility to guide the practice of public health, which is a position I challenge.

	Moral Aim: Maximizing good consequences (consequentalistic / teleological)	Moral Aim: Respecting rights (deontological)
Individual Level		• **Respect for Human Dignity**
	• **Proportionality**	
Social Level	• **Social Utility** • **Efficiency**	• **Social Justice**

Table 1: Principles for public health ethics assigned to ethical categories.
Source: Self-study drawing on a scheme developed by Robert Veatch[12]

Respect for Human Dignity: If we only focused on "social utility" as a moral norm to abide by in public health practice and research, this might have devastating consequences. It would then be allowed to instrumentalize or sacrifice individuals (or whole groups) if only this provided a greater net-benefit. Although in extreme cases it might be ethically permissible to restrict individual liberty – e.g. when a contagious person with a deadly disease who resists to voluntarily going into isolation is forced into isolation or is not allowed to use an airplane – "respect for human dignity" reminds us of our duty not to sacrifice or instrumentalize individuals and to respect their free wills. Although "human dignity" is difficult to define[13], it has become a transcultural value and should prima facie be considered to be a "side constraint"[14] to "social utility".

Social Justice: "Social Justice" is another side constraint to social utility. It not only matters to better the net-benefit. It also matters how the benefits and burdens are distributed.[15] At the heart of public health research there are questions of health inequalities. Yet, it is not *a priori* clear what inequalities are justified and which are morally unacceptable. In other words: "Under conditions in which various socially situated groups interact with one another under conditions of inequality, what inequalities matter the most?"[16] An account of justice that grounds on sound criteria can help to identify what has to be done that all persons can live decent lives.

Social justice is the norm that tries to keep public health from discrimination, stigmatization and exclusion, it promotes fair treatment for those who have less chances for health and less chances to lead a full and flourishing life[17] – no matter if the overall net-benefit significantly rises or not while supporting this population.

Efficiency: When distributing goods – to either raise the net-benefit and bringing health to all or when supporting the most disadvantaged – "efficiency" becomes an essential principle that needs to be included in the concise set of mid-level principles for public health ethics. Although it seems to only support social utility or social justice by guiding these to spend resources responsibly, it has to be a principle at the forefront of public health practice. (It would be "effectiveness" that was more identical with "social utility" and "efficacy" that was closer to "beneficence" – hence, "efficiency" is complementary to "social utility").

Literally all public health systems worldwide lack resources. Thus to use the scarce resources efficiently is a moral duty because in this way more good to more people – including disadvantaged persons – can be achieved. The principle "efficiency" would thus demand in public health, e.g., to use evidence-based public health measures and to implement cost-benefit-analysis. It should be included in the concise set of ethical principles to always and prominently reassure public health practitioners and researchers that it is also a moral duty to be efficient.

Proportionality: The fifth ethical principle demands that when weighing and balancing individual freedoms against the social good this shall be done under the principle of proportionality. In the words of Childress et al. proportionality "is essential to show that the probable public health benefits outweigh the infringed general moral considerations […]. For instance, the policy may breach autonomy or privacy and have undesirable consequences. All of the positive features and benefits must be balanced against the negative features and effects."[18] But proportionality is also a principle that comes to the forefront of public health ethics principles by casuistic reasoning: Experiences of the SARS outbreak, which has revived public health ethics enterprises, draw the attention to this principle. If these experiences were not made in the case of the SARS outbreak in Toronto, it would probably not be a priori clear to focus on proportionality. Singer et al. report: *"In the initial stages of the outbreak, authorities named the woman who carried SARS to Canada from China, and her son, with the family's consent, because they believed it would provide additional public health benefit. Although public health officials took great pains to avoid linking ethnicity and illness, the linking of SARS with someone who had travelled from China, combined with the public's limited understanding of transmission, resulted in many people unnecessarily avoiding Chinese businesses. Proportionality requires that private information be released only if there are no less intrusive*

[10] Mackenbach J (2005) Kos, Dresden, Utopia … A Journey through idealism past and present in public health. *European Journal of Epidemiology* 20: 817-826.
[11] Miettinen OS (2005) Idealism and ethics of public-health practitioners. *European Journal of Epidemiology* 20, 805-807
[12] Veatch R (2000) *Theory of Action (Principles Summarizing Obligations and Rights.)* Washington: (Handout).
[13] Geier M, Schröder P (2002) The Concept of Human Dignity in Biomedical Law. In: Sándor J, den Exter, AP (Ed.): *Frontiers of the European Health Care Law: A Multidisciplinary Approach.* Erasmus University Press, Rotterdam, 146-182.
[14] Nozick R (1974) *Anarchy, State, and Utopia*. Basic Books, New York.
[15] Powers M, Faden R (2006) *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford University Press, Oxford.
[16] ibid p. ix.
[17] Gostin LO, Powers M (2006) What does social justice require fort he public's health? Public health ethics and policy imperatives. *Health Affairs* 25: 1053-1059. Schröder P (2004) *Gendiagnostische Gerechtigkeit.* Lit, Münster.
[18] Childress JF, Faden RR, Gaare RD et al. (2002) Public Health Ethics: Mapping the Terrain. *Journal of Law, Medicine & Ethics* 30: 170-178. p. 173.

means to protect the public health. For example, naming an individual or releasing a photograph could be justified if that person violates a quarantine order."[19]

Hence, to consider proportionality as an explicit public health ethics principle seems very central to equip public health practitioners also in cases of pandemics and emergencies which belong to the field of public health.[20]

4.3 Benchmarks not to consider – also for conciseness' sake

Some readers might miss norms in this ethical toolbox. So let me first repeat that conciseness is a duty for a public health ethics framework. As such I focused on only five mid-level prima facie principles that seem to me by far the most comprehensive and essential benchmarks for good and right public health practice and research.

As mentioned before, *"beneficence"* is a principle of personal ethics with a rich history in medical ethics; so it rather belongs in the toolbox for medical or biomedical ethics. *"Non-maleficence"* demands not to harm individuals in the medical context. Yet, if taken to the public health ethics framework (as a norm that forbids to harm groups or individuals for the public good) it does not add anything new that would not be covered by the other principles – especially as non-maleficence forbids harming single patients in treatments, to harm them on their demand or to take too much risk in therapies. These cases – although prevailing in medical practice and research – are not as the forefront of public health that is, compared to a physician-patient relationship in which the physician might prescribe pharmaceuticals or do surgical interventions, non-interventionalist. Yet, in cases where persons have to be immunized or mandatorily screened there might be a conflict for the physician and his or her medical ethics and the public good. Whereas the physician should be bound to (bio-)medical ethics, the public health practitioners have to follow public health ethical norms. Concrete moral conflicts might have to be solved for those situations – e.g. by narrowing down the leeway for physicians.

Sometimes *"precaution"* is discussed as a principle for policy ethics and as such might be a candidate for the ethics of public health and / or public health. But precaution "is all about taking early anticipatory preventive action" [21] and as such reflects a value that is already at the core of public health. Weed and McKeown consider it also to be a specification of the more general principle beneficence[22] (or, as I would say, "social utility" or "social beneficence" rather than "beneficence").

Some might expect *"solidarity"* as a central benchmark for public health ethics. I omitted this for two reasons. First, solidarity is often an expression of mutuality or reciprocity. And as such only indirectly a moral norm – rather it is prudential. But if one has in mind that solidarity tells us what we owe to each other, I would rather say that "solidarity" adds nothing new to the debate that "social justice" would not cover. In other words: from an ethical point of view, duties of solidarity must be justified as duties of "social justice".

Values and norms such as "truth telling" and "avoiding killing" also belong to personal rather than social ethics and are to a great extent covered by the principles of "social justice" or "respect for human dignity". The same applies to "public trust". "Public trust" is an essential value in public health and especially in times of a public health crisis. In this case it would further the state to act more effectively and as such further "social utility" if people trust and thus act compliantly. Furthermore, "respect for human dignity" demands to tell people the truth[23] and "social justice" means to act on persons' behalf. As such, following these principles would mean to further transparency which leads to public trust[24] – and to "social utility" as a consequence.

5. Methodology – What we should learn from Beauchamp and Childress

To repeat, conciseness is a virtue of an approach of applied ethics – such as bioethics or public health ethics. A set of generalized norms – namely principles – that represent central moral benchmarks to follow in the conduct of biomedicine or public health respectively is most helpful to non-ethicist practitioners and researchers. This we can learn from The Belmont report and the Beauchamp and Childress approach – and the worldwide applications of their approaches.[25]

We can further learn that it is fruitful to conceptualize principles for applied ethics as universal prima facie principles that can be balanced and specified.[26] What does this mean more concretely?

The principles are universal because they reflect moral convictions all people share worldwide. This is the thesis of a "common morality" that grounds Beauchamp's and Childress' approach.[27] Defenders of a transcultural "common morality" believe, in the words of Veatch, "that there are common 'pre-theoretical' insights – moral laws, rules, feelings, intuitions, or perceptions of maxims – that are shared by peoples throughout the world. Evidence for this claim is gleaned from commonly shared judgments that certain behaviors such as killing, harming, and lying, are morally wrong. Others cite universally agreed upon rights that are 'self-evident' or otherwise known to all (giving rise to a world-wide acceptance of a Universal

[19] Singer, Peter A., Benatar, Solomon R; Bernstein, Mark et al. (2003) Ethics and SARS: lessons from Toronto. *British Medical Journal* 327: 1342-1344. p. 1342f.

[20] Thompson AK, Faith K, Gibson, Jennifer L.; Upshur, Ross EG (2006) Pandemic Influenza Preparedness: an ethical framework to guide decision making. *BMC Medical Ethics* 7: 12. Siehe auch: Singer, Peter A., Benatar, Solomon R; Bernstein, Mark et al. (2003) Ethics and SARS: lessons from Toronto. *British Medical Journal* 327: 1342-1344.

[21] Weed, Douglas (2004) Precaution, Prevention, and Public Health Ethics. *Journal of Medicine and Philosophy* 29(3): 313-332. p. 317.

[22] Weed, DL; McKeown, RE (2001): Ethics in Epidemiology and Public Health I. Technial Terms. *Journal for Epidemiology and Community Health* 55: 855-857. p. 856.

[23] Following Immanuel Kant – the great philosopher of human dignity in continental European philosophy – to respect human dignity would mean to never lie, without any exceptions. Kant was even of the opinion that one must not lie to a murderer that comes knocking at your door and wants to kill one's friend that hides in the back of the house. But this appears implausible to me and as such the principles proposed here are only "prima facie" principles.

[24] Childress, James F.; Gaare Bernheim, Ruth (2003) Beyond the liberal and communitarian impasse: a framework and vision for public health. *Florida Law Review* 55(5): 1191-1219. p. 1206.

[25] Tsai DF (1999) Ancient Chinese medical ethics and the four principles of biomedical ethics. *Journal of Medical Ethics* 25: 315-321. Zhang D, Cheng Z (2000) Medicine is a humane art: the basic principles of professional ethics in Chinese medicine. *Hastings Center Report* 30 (supplement): 8-12. Veatch R (2006) Benevolent Lies: Fallible Universalism and the Quest for an International Standard. For*mosan Journal of Medical Humanities* 7: 3-18.

[26] Beauchamp, Tom L. (1996) The Role of Principles in Practical Ethics. In: Sumner, Wayne und Joseph Boyle (Ed.): *Philosophical Perspectives on Bioethics.* Toronto: University of Toronto Press: 79-95. Beauchamp, Tom L. (1995) Principlism and Its Alleged Competitors. *Kennedy Institute of Ethics Journal* 5: 181-198. Beauchamp, Tom L. (1994) Principles and Other Emerging Paradigms in Bioethics. *Indiana Law Journal* 69: 955-971.

[27] Beauchamp, Tom (2003) A Defense of the Common Morality. Kennedy Institute of Ethics Journal 13 (3), 259-274. Beauchamp, Tom L. (2001) Internal and External Standards for Medical Morality. *Journal of Medicine and Philosophy* 26: 601-619.

Declaration of Human Rights)."[28] Beauchamp talks of "raw data for moral thinking"[29] that everybody in the world shares and might look like imperatives like "don't kill", "don't cause pain or suffering to others", "don't steal" or "treat all persons with equal moral considerations".[30] This "common morality" thesis of applied ethics finds more empirical evidence from the work of Harvard psychologist Marc Hauser[31] and was recently also discussed in this journal.[32]

We perhaps all believe that mid-level principles (i.e. generalized norms formulated in the context of certain applications – like the four bioethics principles or the five public health ethics principles) are agreeable on a quite superficial level. Yes, of course doctors should benefit the patient and public health practitioners should find just public health arrangements. These principles are "prima facie" which means that they should be valid as long as they come into conflict. But what if two norms come into conflict – this would then be the touchstone of the truth or at least the applicability of the respective ethics approach. With Beauchamp and Childress, I would suggest the established methods of *balancing* (especially in particular situations) and *specification* (especially when issuing policies and rules) to resolve moral conflicts.[33] I want to use a case study to argue for this methods:

Mr. R is infected with the airborne communicable disease D. He knows this – as his wife, a doctor who specialized on infectious diseases, has diagnosed him – and he knows that he is contagious with this disease. Yet, he is about to go on vacation for three weeks. It is a vacation to Hawaii he has been dreaming of for years and he does not care if he is a risk to others but wants to check in for his plane. His wife was first in a quandary about what to do but then in the meantime, while Mr. R was on the way to the airport, had informed the public health authorities. When checking in at the airport, Mr. R is identified and captured. Mrs. H is the responsible public health official to make decisions at the airport. She had recently taken classes in public health ethics when she was at a course for continuous education. She notices that there is now a conflict between "social utility" (because a whole plane is at immediate risk to contract D) and "respect for human dignity" that asks to exercise the liberty of individual's to decide for themselves. Yet she *balances* these principles and comes to the conclusion that the risk for the social utility is great enough to balance out the claims of own decision making of Mr. R. Thus, Mr. R. is not permitted to enter the plane and the health authorities of the district take over the case.

Mrs. H notices that future ethical challenges might arise – also when she is not in office but her deputies are. Thus she *specifies* the following norm reflecting the principles of social utility, respect for human dignity, social justice and proportionality: "Whenever a person is known to have a serious infectious disease that is highly contagious over the air so that it is likely that other passengers might get infected, he or she is – even against his or her will – not permitted to enter the plane but has to be held in isolation and handed over to the district's public health authorities. Yet, to make sure, this does not apply to infectious diseases like a simple cold (here to go against persons' will would be disproportionate as a cold is not a serious disease and people are likely to catch a cold once in a while anyway) or HIV which is a serious infection but cannot easily be transmitted. To prohibit persons that are HIV positive to enter planes would not only be totally disproportionate but also discriminatory against HIV positive persons." This rule be an example of a specification in which one spells out "where, when, why, how, by what means, to whom or by whom the action is to be done or avoided"[34]. It is like branching out the principles by considering each other as side constraints and "zooming into" concrete situations.

This case study is probably trivial because the case seems obvious – which would then also support the argument that you – the reader – and I seem to share a common morality, because if we both think it is obvious and plausible we seem to have the same underlying moral values. This case study should demonstrate how prima facie mid-level principles can be utilized to make decisions morally plausible and to find justifications for actions. The methods of specification and balancing are good tools in applying mid-level principles to practice.

6. Conclusion

The four-principles-approach of Tom Beauchamp and Jim Childress has been very influential and has proven well in bioethics in the last decades. It has helped practitioners, researchers and policy makers for almost three decades now to identify moral challenges, to show them moral beacons for orientation and to come to better argued for ethical decisions that improved the moral acceptability of their actions. I argued that the applicability of this approach for ethical challenges in the biomedical setting should stimulate a principled approach for ethical challenges of public health as well. Such an approach can utilize the method from Beauchamp and Childress. Principles for public health ethics, as presented in a concise set by the author, however, must be different in scope and content to meet the ethical challenges of public health. But then these principles can be applied with the help of balancing and specifications which are methods used and developed in bioethics contexts.

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[28] Veatch R (2004) Common morality and human finitude. In: Baumann E, Schröder P et al. (Ed.) Weltanschauliche Offenheit in der Bioethik. Duncker und Humblot, Berlin: 37-50. p. 38.

[29] Beauchamp, Tom L. (2001) Internal and External Standards for Medical Morality. *Journal of Medicine and Philosophy* 26: 601-619. S. 612.

[30] Beauchamp, Tom (2003) *A Defense of the Common Morality*. p. 260.

[31] Hauser, Marc D (2006) *Moral Minds. How Nature Designed our Universal Sense of Right and Wrong.* New York: Harper Collins.

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