

Moderator: Hello and welcome to Public Health Live, the third Thursday breakfast broadcast. I'm Rachel Breidster, and I will be your moderator for today. Before we get started, I would like to ask that you please fill out your online evaluations at the close of today's program. Continuing education credits are available after you complete our short post-test and your feedback is helpful in the development of future programs. We encourage you to let us know what topics are of interest to you and how we can best meet your needs. As for today's program we will be taking your questions throughout the hour by phone or e-mail. You can call us at any time on our toll free number, which is 1-800-452-0662 or you can e-mail us at phlive.ny@gmail.com. Today's topic is: *Ethics in Public Health, A Closer Look at Current Issues*. Our speaker is Dr. Bruce White, the Director of the Alden March Bioethics Institute at the Albany Medical Center. Thank you for being with us today, we're so excited to have you here.

Dr. White: Rachel, thank you for having me.

Moderator: Sure. So, as we've talked earlier, ethics is a really large and complex issue. So in order to start honing in on the topic, can you talk about what are the objectives that you hope to accomplish today during our hour together?

Dr. White: Well, just a few things before we start. I really appreciate David Hoffman from the State Department of Health getting us together. It's that networking that's really critical to what we do in ethics and in ethics education at the Alden March Bioethics Institute, so thank you again for that.

Moderator: Sure.

Dr. White: Let's start with some definitions, and I think that we have some slides that maybe illustrate these later on, but ethics is really about making decisions where we can all live better lives. We want life to flourish to the degree, to the extent, that it possibly can. We think that making better decisions rather than worse decisions will make that possible, will make that happen. So a little bit about definitions and then we want to focus on some current issues, really, from the newspaper. In fact, I think if we had taken today's newspaper, or really yesterday's newspaper that talks about HPV vaccine, that would have been a perfect topic for today as well. So what we'll talk about are things that are in the news, that really illustrate how good, ethical decision making impacts people's lives for the better rather than for the worse.

Moderator: When you look at it in the big context and think about things in the news, this is a big topic. So why don't we start with the word ethics, which in and of itself is kind of a loaded word. Would you give us a break down of what we mean when we talk about ethics?

Dr. White: Well, if we start with the root word from the Greek, "ethos," it means character. When Aristotle and the Greek philosophers first started writing about good character, they were really thinking about virtues, what makes a good person a good person. Thinking that if good people were making decisions, that they would be better decisions rather than worse decisions. Morality is a similar word. It comes from the Latin, "moralis," and it means custom. What we would like for people to do is to *customarily* make better decisions rather than worse decisions. But it's really about the quality of life, you know that we have, and about the decisions that we make in everyday life.

Moderator: Okay. Now, you have a quote that you shared with me from William Roberts' book. I found it a very interesting quote. I'm wondering if you could speak about that and the impact it has had on ethics and what you'll talk about today.

Dr. White: I think if we can bring that slide up, it would be really good at this point, because it talks about everyday life. “To live is to act; to act is to choose; to choose is to evaluate.” We talk about values in ethics, and every single decision that we make we really evaluate the principles or the goals of our life in making those decisions, so this brings it down to earth. Every single decision that we make has an ethical component.

Moderator: Sure.

Dr. White: But, “To live is to act; to act is to choose; to choose is to evaluate.”

Moderator: Sure. So this broadcast is about public health ethics, but all of us, every day, are involved in these different ethical decisions. Now, one of the things that we are going to talk about and look at is some of the differences in terms of, from a public health standpoint or from a clinical standpoint, what are the different priorities, who are the stakeholders, and who is invested? So can you talk to us about that? I know we have a helpful image that will illustrate it, but if you could talk about that, that would be great.

Dr. White: Well, the ethics or the applied ethics fields that we wanted to kind of compare and contrast today were professional ethics, research ethics, clinical ethics and public health ethics. It really is bringing this sphere either closer or making it much wider. Starting with professional ethics, that’s a really good place to start, because when people think of ethics they think of how professionals should act. Every profession has a code of ethics. We’ll talk about the American Public Health Association’s Code of Ethics and look at guidelines later, but in public health ethics the stakeholders, you know, are the public itself. Professional ethics is really designed for the professionals, to help them make better decisions. Research ethics deals with human research subjects. I have selected four topics today; all of them are dealing with drugs, which is a topic that’s very dear to my heart. But it also shows how we regulate drugs and how we investigate drugs. I think when you and I talked earlier, there was a recent New York Times report about an experiment regarding a new drug that was being used in fragile, ex-children, in autistic children. The mom who was being interviewed, you know, for the story by Andrew Pollack was very concerned because it looked as if the study was going to be closed and her child who had been benefiting, you know, from participating in this study was no longer going to have access to that drug. That’s because the mom, unfortunately, was confused about treatment and research.

Moderator: Right.

Dr. White: The research project was designed specifically to determine whether or not it was a safe product. It really wasn’t designed for treatment. Well, we hope that it eventually becomes something that would be available for treatment, but in this particular instance it was really more for safety. People are confused. The third category that we selected was clinical ethics. Clinical ethics is what we do every day. In fact, we have had three consults this week at the hospital specifically on trying to help families. Oftentimes, when patients lack decision making capacity, we need to help them make better decisions rather than worse decisions, but it is focused on the physician/patient relationship. A very intimate, and like every field of ethics that we’re talking about, it’s trust. But this is more than intimate trust that we’re going to find with public health ethics. Then the last one is public health ethics, and the stakeholders here are the community. Again, in every single instance that we’ll discuss today it’s, in a nutshell, how much liberty do we take away or limit to the individual in order to maximize benefit for the community so we are a community where life can flourish? Does that make sense?

Moderator: It makes perfect sense. While it makes sense, that's such a complex issue because how do we ever get straight answers to those questions and I think, you know, as you're going to explain throughout the day we'll have to look at a case-by-case scenario. Now, having looked at that chart and seen a little bit of the clinical ethics, the research ethics, can you talk about public health ethics and how we would define what we mean when we say public health ethics?

Dr. White: I think we have a quote from Powers and Faden, "Public health ethics involves a systematic process to clarify, prioritize and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders, and science and other information." Let me take a moment and talk about those principles because that's really important to everything that we're going to be discussing today. So the four principles of medical ethics or health care ethics are beneficence, nonmaleficence, autonomy, and justice. Beneficence, from the Latin word "bene," means we want to do good, we want to maximize good to the extent that we can.

Moderator: Sure.

Dr. White: But with drugs and other decisions in the public health arena, oftentimes we can't do good while at the same time not risk harm. So nonmaleficence, how to do good and avoid harm, is what ethics is much about. Autonomy comes from two Greek words, "auto" and "nomos," self and law, respectively. Each of us should be a self-law to ourselves, to any degree possible. We want everyone to live their life in freedom, in liberty, make their own choices and maximize, you know, their potential and allow their life to flourish. But also at the same time, we want to be—in fact if you look at the Declaration of Independence, "All men are created equal..." the implication there is "all men," so my liberty is really no greater than your liberty. So we've got to find some kind of way of living in a community and justice is about fairness, equality, appropriate allocation of resources based on what's available. So again, autonomy and justice, they're juxtaposed, just as beneficence and nonmaleficence, and that's what public health is all about. How much liberty do we take or deprive the individual in order to maximize benefit to the community?

Moderator: This certainly seems like a complex question to ask. Now, I understand that public health ethics can be defined in terms of a field of study and a field of practice. Can you talk about that a little bit?

Dr. White: Well, we often think of art and science. Even teachers, you know, think about art and science. When we think about science, we're thinking about theory—how we learn how to do things. But in doing what we have learned, we often find that it needs to be nuanced, and that's the art. So in philosophy there's the theory that we need to deal with, which are the principles beneficence, nonmaleficence, autonomy, and justice. Then there's the application, which is how do you apply it at the bedside? I love principles, they're really helpful, but in each case that we'll be talking about today, we really aren't going to know from the principals themselves what actions or decisions to make and that's ethics.

Moderator: Okay. Now, are there different viewpoints regarding the role of ethics in public health? I mean, certainly, it seems like there could be room for different interpretations or different perspectives on how do we weigh these juxtaposed ideas such as beneficence and nonmaleficence?

Dr. White: If you look back at the Powers and Faden definition it talks about prioritization. It's like you've come to a fork in the road and you have to take one path versus the other. You're trying to

decide which option is the best. You look at all of what you know about this path versus the other path in order to elect one course over the other. HPV vaccine is a really good example. HPV, in fact—might be good to share a little bit about the story. We've made HPV vaccine available to young women. There haven't been that many young women that have actually received the vaccine, depending upon the area in which you live. I think the report that I read was about 30 to 35% which is not inconsistent with voluntary immunization rates in the fluid and we'll talk about that later. However, the number of HPV infections that have been identified in these women have dropped by 58%. So the vaccine hasn't been available that long and it's been entirely voluntary, but the rate of infection has really dropped dramatically and that is so beneficial to everyone. It's a consequence of herd immunity, in the fact that if we keep the transmission rate between individuals down, it will collectively help the community. Regardless, it's been—think of how to go through life with less of a fear for cervical cancer than you would otherwise, what a wonderful benefit, and for generation after generation. If we can interrupt the spread of the disease, we can decrease the rate of cancer, and children's children will benefit from that.

Moderator: Thank you for sharing that example. Now, one of the things that we talked about earlier and you referenced was that every profession has a code of ethics that guides the actions that they take in that field and public health is no exception. The American Public Health Association, as I understand it, has a code of ethics and I wonder if you'd share a little bit about that and the various principles that they have laid out.

Dr. White: I think if you pull up the slides now, the audience can see those. We can just list them. Again, every profession has a code of ethics. It's not an exhaustive list; it's really more of a set of aspirations. Some are more legalistic than others. But again, public health is the individual versus the community. I hate to—it almost is like a conflict, but in ethics what we're really talking about is a dilemma that forces us to choose between values. In this code of ethics from the American Public Health Association, it's a guide to help those people that are in the field, those public health care professionals, and to make better decisions rather than worse decisions. I think if we look at the guidelines now, we can list them and go through them very, very quickly.

Moderator: Sure.

Dr. White: But the goal of public health is to address the causes of disease just like with the cervical cancer and HPV. But also address, you know, what the requirements are for good health rather than bad health. We're dealing with that with obesity.

Moderator: Sure.

Dr. White: In fact, only today there's a report in the New England Journal of Medicine about what we're talking about: the influence of the state versus others when it comes to good health. Wearing seat belts, you know, wearing helmets, all of those are really good examples of taking individuals' liberty in order to maximize the benefit to the community. And that's number two: achieve community health while respecting individual rights. I think we have a few more of these.

Moderator: Yeah.

Dr. White: Policies, programs, and priorities are developed and evaluated with input from community members. The stakeholders are the people who live in this particular area, in this state, in this nation, and they have a say in deciding what our public health priorities should be. Public health care

professionals should advocate and work for empowering disenfranchised, vulnerable populations so they have greater access, you know, to health care.

Moderator: Sure.

Dr. White: Public health professionals should seek information to implement policies and programs. We want to use evidence-based principles and we'll talk about that in the various illustrations of the cases we have today. As public health professionals we want to provide communities with information and obtain consent for their implementation. Act in a timely manner with resources and the mandate as given by the public, usually that's a matter of funding from the state legislature, and we want to incorporate a variety of approaches. It respects the fact that one way doesn't always work and we need to be trying multiple ways.

Moderator: Right.

Dr. White: Implement programs and policies in a manner that enhances the environment. We want to be green communities to the extent that we possibly can and we want to protect confidential information. I think every single code of professional ethics would have that included as an element. And the last two, ensure professional competence of employees—if the public, the stakeholders, expect a degree of confidence and we want those, ensure that through programs that we have in place. And lastly, we want to be collaborative, we want to build trust and effective relationships with others in the community because it really takes a village.

Moderator: So some of this, I mean, there's 12—obviously they're well-articulated, well thought out, but it almost seems like common sense. I mean what we're talking about is trying to maximize the public good. You know, do the least harm and do that while getting input from the people that are going to be affected and do it in a way that's professional and maintaining respect and confidentiality.

Dr. White: Fortunately, or unfortunately, almost every code of ethics reads in exactly the same way. The lawyers through their models, professional responsibility, are a little bit more legalistic. And they deal with individual specific cases, but again, you can see these are very broad. How do you apply them? So we have the art, okay, that's got to be coupled with the science in order to make better decisions rather than worse decisions. I think that we'll see that in each of the cases that we discuss today.

Moderator: Absolutely. Now, those guidelines that you just reviewed are for public health. Are there vast differences, I know you touched on this earlier when we looked at that chart, between ethics as they relate to public health versus clinical health? I mean, what would you say are the main differences between the two?

Dr. White: If we were to go back to that chart, I think that there's unique circumstances that need to be carefully articulated for each one of those. The physician/patient relationship in clinical ethics is so different even though it's only slightly different in some degrees from the researcher and the subject, that you really need to have different—you need to place emphasis on different principles. I hate to remind people of the Tuskegee experiment. This is the one that was publicized early in the 1970s, but it's almost like the public health officials who were collecting information about the natural course of Syphilis forgot about the need to care for individual patients. So it was almost like they placed, you know, the—they prioritized obtaining research data over making important decisions, careful treatment

decisions for the patients. And sometimes it means we shouldn't be doing this research, we should be treating the patient, rather than participating in research. The most important thing to do is stop the research and treat the patients. Again, that's different. One would think that everybody is trying to help the patient, but you can see that in that particular instance, the public health physicians were thinking, well, I'm going to collect this data that's going to be more important to the community rather than this one individual. And that's where ancient philosophy— well, not really ancient philosophy, but Immanuel Kant, a German philosopher, said we should never use people as a means to an end. They're always important as an end to themselves, and what those researchers at the Tuskegee experiment were doing was using people as a means to an end and we shouldn't do that.

Moderator: Absolutely. It's interesting because the things that we're going to be talking about, the issues we're looking at today, one of the things you and I talked about is that when we're making the ethical decisions, the way we view them today might not be how they're viewed a year from now, ten years from now. So we can look back at that and it—you know, like you said, it's hard to bring it up to remind people and hopefully in the issues we'll discuss today, we're making decisions that come a year from now, come ten years from now, we can feel comfortable with the decisions we have made. So let's start talking about the representative public health issues that you'll be discussing with us today.

Dr. White: Well, again, all of them deal with drugs. I'm a pharmacist, I have a deep interest, you know, in trying to help people deal with drugs and drug therapy differently, you know, based on these ethical principles that we'll be discussing. But the first one that we're going to be discussing is mandatory immunizations. Should we make people get shots in order to benefit the public? The second one that we'll be talking about is availability of emergency contraceptives. The third one is the availability of medical marijuana. And then the last one is physician-assisted suicide. Now, I want you to help me here because I want to be—I want to be cautious. I want to present balanced arguments and my goal is that if I have a personal opinion, no one really knows what it is.

Moderator: Sure.

Dr. White: You know, after we finish the conversation, I may be passionate in arguing one position versus another but I want to be equally passionate, because people's values are embedded in the arguments that we're going to be discussing and be making today. I don't want to appear disrespectful of those arguments in any way. But I'm going to—and we're going to illustrate with each of these cases, oftentimes, a law is going to settle the issue. And it's not that the ethics questions has been resolved by legal answer, it's just that in our society when we're trying to balance individual liberty with community safeguards and community rights and benefits, it's the law that really kind of settles this is a way that we can live with it. So the ethical question is what *should* we do? The legal question is more like what *can* we do? What do we *have* to do? And oftentimes those are the same, but you'll see in these cases that we'll be discussing today that they still are different.

Moderator: Sure. So let's start by talking—the first one that you mentioned is mandating flu vaccines. Give us a history on vaccines, the flu vaccine and how it has been used, just to frame the discussion we're going to have.

Dr. White: Well, other people may answer this question differently than me. But if someone were to ask me how has public health really helped—benefited the public, especially here in America, the two things that I would say is that it's brought us safe and clean water and the second it's made vaccinations available to everyone. Having grown up in a small town in Tennessee where there were polio cases, in

fact, our public health doctor in my hometown, Elizabethton, Tennessee, was himself a victim of polio so he was paralyzed because he had polio. So having polio vaccine available, look, we've almost eradicated that disease and it's been so, so marvelous. The flu is a little bit different. It's communicable. Each year in America we have about 25-, 30-, 35,000 people who die every year from the flu. The people who are the victims are most often very, very young or very, very old. They usually die from complications of developing pneumonia. But having lived through the H1N1 scare in 2009 and then having read John Barry's book, *The Great Influenza*, H1N1 scares the living daylights out of me. If you read the book, it killed more people than the plague in the middle ages, a great percentage. It reached even to Alaskan villages and devastated populations there. One of the interesting things when you read the book is that the author theorized with experts that it developed in Haskell County, Kansas, where there was a mixture of swine, hogs, and chickens, because of the farming community, and it was just the right mix for the mutation, you know, of the virus. So H1N1 is going to kill people. So can we reduce the number of fatalities, you know, by asking people to get their flu vaccine? More importantly, can we ask healthcare workers, you know, to be immunized so they can reduce the transmission of the disease. To be honest, from an altruistic point of view, be more readily available, you know, to take care of other people who are sick and decrease the transmission to their families because you've got nurses, you know, pharmacists, physicians, that are going to be working in the hospital that are going to be coming into contact with people who have H1N1 and if they work, they're going to be going home. So can we use immunizations? And we know from data from Japan that the more people who take the flu vaccine, just like the more people who take the HPV vaccine earlier, that it reduces the transmission of the disease. But healthcare workers for various reasons haven't—they have been reluctant to get the vaccine. Again, having to make someone do something that they really don't want to do, some people who feel like that if I take the flu vaccine, I'm going to catch the flu. That hasn't been proven in the literature, but it's still a myth that's been so difficult to dispel. So in Pennsylvania, the hospital of the University of Pennsylvania, a couple of years ago required employees of the hospital to get flu vaccines and they made it a condition of employment. So the University Hospital, it's a private institution. In fact, hospitals do this all the time when it comes to evaluating the availability of antibodies in the body to fight certain infections. People—when I move from hospital to hospital, people recheck me to see whether or not I have been exposed to chickenpox or been exposed to German measles. And if—if my antibody titers aren't high enough, they're going to ask me to get another MMR. So we have a history of making employees do things like that to reduce the transmission of disease. But with the flu vaccine, it's been more of a struggle. In fact, I think one of the slides reminded the audience that in 2009, the current Commissioner of Health here in New York issued an emergency regulation that would require hospital employees to get the flu vaccine. That was challenged. The suit was—or the lawsuit was eventually withdrawn. I'm so grateful that we almost broke the bank—reached a breaking point, you know, but somehow or other it was diverted. But making people take the flu vaccine I think would have really helped.

Moderator: So let's talk about it from an ethical standpoint. I mean, I think all of these are ethical issues when we're talking about do we force someone to get a vaccine if we think it's going to protect the community as a whole, if we think it will protect their patients or make them more available to their patients? How do we answer that question? I mean, what are some of the things that go into consideration?

Dr. White: Well, it's a settled principle of law that we can do it and the United States Supreme Court ruled in a Massachusetts case around 1911. So we know that we can do it, and for state public health officials it really is to what degree we want to make people do something that they really would benefit from doing themselves, but we want them to do it for the right reason. We don't want them to do it

because we're making them do it. It's a delicate—it's a delicate balance. You know, a really good example in nonpublic health care is the right of eminent domain. You know, as populations expand we need a better transportation system. Here in New York there's a really good example. You have Saratoga County just north of the Mohawk River. Do we need another bridge? You know, if it really—if the growth really takes off, we're going to probably need not only one, but maybe two more bridges. Or we'll have to expand. If we want to build a bridge we're probably going to have to take someone's land. Land that's been in someone's family for generations, and we don't really want to do that.

Moderator: Sure.

Dr. White: But then again, we have—we're entitled as a community, you know, to take public—to take someone's private property for public use if it's in the community's best interest. I think that's exactly what we're talking about with the flu vaccine. You know, we're taking someone's liberty, you know, and we'd rather not do that. But we're doing it for the benefit of everyone.

Moderator: So sometimes the question then becomes who's the one who makes the decision about what's best for the community? And that's really where a lot of these things start to get complicated. One of the things that you had talked about was people's right to privacy and how does that factor in?

Dr. White: Well, the reason the right to privacy is so important in America is because it's a fundamental right. In other words, we can't take bits of privacy away from individuals without a very dramatic compelling state reason to do so.

Moderator: Sure.

Dr. White: And in fact, that's really what we're talking about today. The flu vaccine is taking the individual's rights, and these next couple of cases we'll be discussing if the state is stopping us from doing something that we would really like to do. We think it's in our best interest, whereas the state or those stakeholders, the representatives that make the laws think that it's probably better that individuals not have that liberty. So it really does work both ways.

Moderator: Yeah.

Dr. White: And again, one of the goals of public health is to involve all the stakeholders in the decision, and it's a public debate which is why it oftentimes takes so long to resolve some of these dilemmas because we do it incrementally.

Moderator: And trying to take into consideration all of the different voices that are at the table regarding the decisions.

Dr. White: Yes.

Moderator: So the next issue that you'll talk about is the emergency contraception, the over the counter availability. Let's start off talking about what we do know about emergency contraception?

Dr. White: Well, Dr. Yuzpe, a Canadian physician in the early 1970s first suggested the notion that women should have emergency contraceptives available if they have unprotected sex. Many times, even when people take birth control pills conscientiously, that pregnancy can result from that.

Moderator: Sure.

Dr. White: If someone misses one or two pills, that really does interfere with the medicine to work effectively. So Dr. Yuzpe created the Yuzpe method in the early 1970s and suggested that women have an extra pack of birth control pills available so if they have unprotected sex, and by unprotected, I'm talking about sex that might cause pregnancy—if they have unprotected sex, they could take all of the pills in that package, 28 if you have a package of 28—you could take all of the pills at one time in a concentrated dose and really decrease the likelihood that you're going to have an unwanted pregnancy. In fact, public health departments around the country in student centers, student health centers in universities, have known about this, and we've got hundreds of thousands of women who in the 30 to 35 years prior to developing Plan "B" or Plan B-like products used that Yuzpe method to prevent unwanted pregnancies. So emergency contraceptives that we have today are usually one or two pills but they're the equivalent of an entire pack of birth control pills. That's not exactly, but it's a good approximation.

Moderator: So rather than having to take the entire package to prevent pregnancy which is what has been known historically, now there's the availability where you just have to take one or two pills to achieve essentially the same outcome?

Dr. White: That's correct. And initially it was available by prescription, and the United States was one of only one or two nations around the country that didn't make emergency contraceptives available to all women. So it was really—the issue was not the availability of the product, it was whether or not it should be prescription versus nonprescription. Now, you mentioned earlier about historical context, and this is a really great case to illustrate that, because the right to privacy that we have in the United States articulated really the way it has been was a consequence of a 1965 case called *Griswold versus Connecticut*. And in Connecticut, I mean, law professors would argue with me on the way I'm describing this case, but it was really about whether or not doctors in Connecticut could tell married couples how to avoid getting pregnant and even have the conversation with them about unwanted pregnancies and the tools that are available. I told you I was a pharmacist. My very first job I was a soda jerk in a small town drugstore. Condoms were not available, readily available. If you wanted to buy condoms they were behind the prescription counter and you had to go—you had to ask someone for them. I mean, can you imagine, you know, teenagers today thinking of the world in that context? But all of this has really evolved because of our right to privacy.

Moderator: Sure.

Dr. White: So with prescription, with prescription medicines, the medicines—the emergency contraceptives are less available than they would be if they were available OTC.

Moderator: Right.

Dr. White: So the argument is whether or not they should be available, to whom should they be available, how widely should they be available, and how much information do people need before they buy them? We know from the Yuzpe method that the products are completely safe and effective and we know from their availability from countries around the world that harm hasn't really resulted. But values in America, the family, you know, the family unit needs to be protected. One of the ways we protect the family unit is that we reduce the riskiness of promiscuity between people who are not

married. Does making condoms and emergency contraceptives available to those people reduce the likelihood we are going to really protect the family? Now, the same argument of course was made with the availability of HPV vaccine. We were thinking if we had HPV vaccine, people would suddenly have more unprotected sex than they would otherwise.

Moderator: So the question really is—it's almost different as you said earlier than the original. When we were looking at the flu vaccine, it was, do we force someone to take something to protect the community, and with this we're looking at, okay, we have this drug available from other countries and from history we can see that it's safe and effective, but do we restrict access to it because of a belief that we're going to somehow negatively impact society's health?

Dr. White: That's it. That's it. I mean, for a teacher that's exactly what you want to hear from someone that you're having a conversation with. I mean, you've made the point.

Moderator: So what have the courts said on this issue?

Dr. White: Well, it's evolving.

Moderator: Sure.

Dr. White: And I'm thinking that probably emergency contraceptive is going to be available to everybody pretty soon. And that's the way it's directed. After—I think from the slides we have got today, some people can read the newspaper articles themselves. A lot has happened since then. I mean the Obama Administration has been breaking—I mean, it's been changing its position based on what the court said. But if you look at—I mean the very last thing is the FDA was approving something for persons 15 years and older. Well, you know, I mean, we mentioned earlier on one of the slides that I was the Public Health Officer in Tennessee for a while, that was in Moore County, Tennessee. At the time, we had one 12-year-old who was pregnant almost every month. We had one of the worst teenage pregnancy rates of any county in Tennessee, and Tennessee has 95 counties. It's just unfortunate, you know, that children are having children. I see that as just as much a threat to the security of the family and the family unit as I do many of these other issues.

Moderator: So again, another really complex issue that we have to weigh in to—what's going to benefit the community and there might be various opinions based on the stakeholders, but ultimately there's going to be some legislation that sort of settles—

Dr. White: —And again, we in America, the way that we get along with one another is that we believe in the rule of law, and we respect the law. We'd like for people to make decisions based on what they think is best.

Moderator: But sometimes we have to look out for others.

Dr. White: Absolutely, and we codify it.

Moderator: So let's talk—we have another issue to discuss and that's the use of medical marijuana. So let's talk about that. I know it's currently been in the forefront of the news, so just start off giving us some history or background on that—on that issue.

Dr. White: Well, marijuana has been available as a drug for centuries. It started in—there's a book that I intended to recommend to people that's from the 1970s when the drug abuse war, you know, was being raged so widely in America, even more than it is today, and it was written by Consumer Reports. It's got a really great history of medical marijuana and I think my—we have my textbook reference, so much of that history is referenced there as well. Queen Victoria took marijuana, you know, as a drug when she was delivering her children, you know, it was a drug that was available to her. It was a tincture. It was really taking the marijuana leaf, macerating it, pouring alcohol through it and then collecting the tincture, you know, that resulted. But it was a formulary product. In fact, it was available for physicians under the Marijuana Tax Act here in the United States in the early 1930s. You had to have a special license, but you could prescribe it. So it was available. I don't want—to be honest, marijuana as a drug is safer than alcohol, because someone could drink alcohol to toxic levels and die as a consequence of the alcohol. You know, according to Consumer Reports Journal, no one has died from marijuana intoxication. So again, some people would get really upset with me for saying things like that, but it's that value. I'm giving you scientific information.

Moderator: Sure.

Dr. White: Now, that's not to say that it's not dangerous when you smoke marijuana because some reports are that it causes cancer just like cigarette smoking would cause cancer. But marijuana is a very safe and effective drug for some purposes. Glaucoma, for people who have high intraocular pressure, marijuana reduces the intraocular pressure. If someone could take marijuana, you know, and reduce the need for other medicines when they have glaucoma and reduce the likelihood of blindness, why would we not want them to have that drug available?

Moderator: So what are the issues? What comes up when—you know you can present scientific evidence that says this can reduce this chronic condition or this pain for this person and we can see that there has been a historical use of marijuana, why has it become an ethical issue? What's the core?

Dr. White: Federal regulators in the 1920s and 1930s issued report after report after report that indicated that if you start smoking marijuana, that you probably are going to start using harder drugs as a consequence of that. California, which is really kind of curious— California in 1913 or so, was the first state to criminalize marijuana and they were also the first state to authorize medical marijuana. So does marijuana lead to harder drug use? You'll find some reports that say yes, and some reports that say no. You have the state of Colorado who only recently decided to regulate marijuana the same way they regulate alcohol. Again, lawyers would argue with the way that I'm making that claim. But yet, that's—that appears the way that it's going to be in the future. So in California, in the 1990s, a group of people were able to get a bill, a proposal, a proposition on the ballot that would allow the citizens of Arizona to decide whether or not to make marijuana available for medical purposes, and it was called the Compassionate Use Act. Only last month or—wasn't it, that Vermont passed the very similar statute? I'm sorry, I think Vermont had done it earlier. I don't want to confuse it with the physician-assisted suicide statute; I'm getting those mixed up now. But other states have done so too. I think there's twenty, plus the District of Columbia that have decided to make marijuana available to patients if they meet certain medical criteria which in effect means the physician is supposed to write it. But again, does marijuana lead to harder drugs? The United States Supreme Court decided this in a case—the Raich Case, Gonzalez versus Raich. Very, very good case. It is about state's rights versus federal rights. I would recommend that for people who are non-lawyers to really read that. It's an excellent opinion—where if they read The New York Times—because what swayed the justices and Justice Stevens wrote the majority opinion—what swayed the justices is the ability to control it. I think that just as soon as

marijuana can be made available in a standardized dose—marijuana is lithophilic, it's very, very hard to extract the drug itself from the plant—I think once science figures out exactly how to deliver a certain milligram dose and then determine that that's the dose that would be effective for glaucoma or anything else, I predict that marijuana is going to be available, you know, by prescription.

Moderator: Sure, and it seems like very similar—the ethical issues that we would consider are very similar to what we were looking at with the emergency contraception in terms of should we allow people to have access and there's the debate on one side about is this beneficial to the target population versus could it potentially harm the community?

Dr. White: How much harm to the community are we really—are we willing to risk?

Moderator: Okay, so let's in the interest of—we have a few questions from the audience—I want to make sure we have time to get to them so let's talk about the physician-assisted suicide, because that's the last topic before we take questions. What's the issue with physician-assisted suicide?

Dr. White: Well I think—and this is the one I remembered earlier, this is May 20th, Governor Shumlin in Vermont signed the Death With Dignity Act and if you look at the statute it's very similar to Oregon's Death With Dignity Act. So there are four states in the union now: Oregon, Washington State, Montana by court decision, and then Vermont. Vermont is the first time that the legislature, you know, passed the statute that was really signed by the governor. In both Oregon and in Washington, it was by public referendum, like the Compassionate Use Act. That's one of the nice things about the western states, primarily the western states, for issues that are very, very difficult for the legislature, they can propose to the public, you know, by proposition, and those statutes were enacted by public referendum. In Montana, it was a judicial decision. It was based on First Amendment rights, individual liberty. You know, can—should the government interfere with someone's decision, you know, to take their own life if they have a terminal illness and they're suffering and they have determined that there's some things worse than dying. Or, in fact, living is worse than dying. So in Vermont, they have the physician-assisted suicide statute now, Death With Dignity. It's a debate that's been going on in America and around the world. I think in the few slides—this is really a great conversational topic for a seminar, because if you look at murder, mercy-killing, which is euthanasia, suicide, and physician-mediated death, just looking at the definitions and understanding the differences between them. But because of the technology in America today, I love this quote, I think it came from McGuire, "Death has lost its medical and moral simplicity. It is no longer a moment, but a process. A process that can be lengthened or shortened." The classic cases that make us think about this are the ones that went to the courts like Karen Ann Quinlan who was surviving on a ventilator, Nancy Beth Cruzan who was living because of artificial feeding, and then the Terri Schiavo case which was the argument between the spouse and the parents that took—that was in the courts, you know, for a dozen years. And she lived in a persistent vegetative state for 15 years after she collapsed at home. The other articles are from the medical literature. It's the—I'm sorry, a Journal of American Medical Association article. Janet Adkins was Dr. Kevorkian's first case and she had just been diagnosed with Alzheimer's disease. I think the case after that was the one from New York, Diane—involving Dr. Timothy Quill of Rochester. Then you have the Oregon Ballot Measure that was enacted in 1994. It was in the courts for three years after that. One of the nice things that's come from Oregon is that every single year they have been publishing data about how the law has worked and how many patients have availed themselves of the opportunity to get a lethal prescription, you know, from a physician, how many patients have died as a consequence of taking the medicine versus the disease process itself. It's briefly, patients who are terminally ill who have decision making capacity, who go to their doctor and tell the doctor that I would really like to have a lethal dose of the

medicine. It's not that I'm going to take it, but I would like to have it available. So if my suffering becomes unbearable that that would be a possible option for me. The doctor can't write the prescription immediately; they have to wait a period of 14 days. If the physician doesn't feel the patient has decision making capacity, there has to be verification of that. Then on the 15th day after a lapse of a waiting period, the physician can write the medicine. The pharmacist can fill the medicine and the patient would have it available. The patient, him or herself, has to take the medicine.

Moderator: Sure.

Dr. White: So it's a suicide. So it's not—if someone else did it, it would be murder.

Moderator: Right. This is sort of allowing the individual the choice—the right to make a choice over their own health.

Dr. White: Right, and those are the safeguards. It's administered by the Department of Public Health or I think they call it the Division of Health Services in the state of Oregon and they're responsible for collecting the data.

Moderator: So certainly, I mean, you have presented us with a lot to think about. A lot of very complex issues that depending on what information you have available and the context, you know, there's really a lot to consider when making these decisions. Now we have some questions, but just as a last question for you, I know additional resources if people want to learn more about what we've talked about today, what would you recommend?

Dr. White: Well, the reason I selected these cases is because there's—I have a textbook for pharmacy students and medical students called "Drugs, Ethics, and Quality of Life," so three of these, except for the H1N1 situation are discussed. Again it's presented in a seminar. There's any number of good texts. Let me recommend one other written by Gregory Pence, a philosopher at the University of Indiana, called "Classic Cases in Medical Ethics." I really think it describes very well the principles, the values, the tensions, the very end talks about technology itself and the evaluation of resources. I think in the future, probably the strongest challenge we'll have is how much money are we going to have, how are we going to spend it? How are we going to allocate those resources?

Moderator: That's a whole other—

Dr. White: It is, and it's a public health issue because it's an allocation of public monies.

Moderator: So let me ask you, we have a question from Dave from New York, and he wanted to know, "When local public health is faced with choices such as who gets the limited vaccine, what is the ethical principle that can help with those decisions?" That really ties right in to what you were just saying.

Dr. White: That's a great question.

Moderator: We only have a few minutes left before the end of the show, so if you can try to summarize such a big question into—

Dr. White: This is why it's so important for public health officials to think about these issues and to plan for them.

Moderator: Sure.

Dr. White: Because there is going to come a time when we're going to have to allocate scarce resources. There's—if you look back at those principles that we have discussed earlier, there's any number of ways that we can resolve this. And there's always going to be somebody that's unhappy with the way that we do it.

Moderator: Sure.

Dr. White: So we need to have—we need to have a process that's open, transparent, based on evidence that we have available, the best scientific evidence that we have. And then the public, to the degree that the public can, needs to resolve the dilemma.

Moderator: That's—again, it's such a complex issue and that seems to be such a straight forward answer that of course is going to get complicated as the individual situations occur. I think that's a great way to summarize not only the answer to the question, but sort of everything we have talked about today and emphasize the importance of planning for these things before they become a sort of imminent crisis, if you will.

Dr. White: Which is, again, one of the rationales for having an informed public and a public health department that is involved with providing, you know, better care, you know, for patients.

Moderator: Well, thank you so much for all the information that you have covered today. I think we have really covered quite a wealth and an abundance of information on some pretty deep and multifaceted subjects so thank you so much for being with us today and sharing your expertise.

Dr. White: Thank you for having me.

Moderator: And thank you for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME and CHES credits, learners must visit www.phlive.org and fill out the evaluation and post-test for today's offering. Additional information on upcoming broadcasts and relevant public health topics can be found on our Facebook page. Don't forget to "like" us on Facebook to stay up to date. Also, as a reminder, you can download the companion guides for this broadcast on our website, www.phlive.org. The companion guide will provide you with learning activities to help further your knowledge and understanding of the topics covered in today's program. This webcast will be available at our website within two weeks on demand and DVDs of any past broadcasts can be ordered from the website as well. Please join us for our next broadcast on July 18th as we look at the impacts of climate change on public health. I'm Rachel Breidster, thank you so much for joining us on Public Health Live.