Michael Kirby is a celebrated Australian judge. He was a Justice of the High Court of Australia. On 30 October 1997, I was invited to deliver the second Kirby Lecture by the Australian Institute of Health Law and Ethics at The Australian National University. In my speech, I elected to highlight the antisocial behaviour of tobacco companies, which were pursuing markets for products they knew were harming health.

Your invitation is very welcome. By conducting this session, you honour the singular and special Michael Kirby, and in your choice of speaker you make another choice that is very much appreciated by that person.

Michael Kirby is an old friend. He was president of the Sydney University Union one year when I was a director and our paths have crossed often since then, usually to my benefit and edification.

He is one of the finest of all Australians living today. He holds two bachelor degrees and a Master’s degree, has two senior communal honours, is a Justice of the High Court, has been chancellor of a university, holds honorary degrees and has played a prominent and important role in issues related to the rights of people within this society and its legal system as well as in other societies around the world. He is an outstanding person. It has been a privilege to know him as a friend and the naming of this lecture by the Australian Institute of Health Law and Ethics is a proper tribute to him.

The theme of your conference this year is ‘Public Health and Private Risk’. No doubt many of your contributors will want to approach this in their own way, just as this contribution will do. Consider just for one moment, and as an example of the awkward interface between public and private health, the question of smoking and health. The tobacco companies have shown that they are bad corporate citizens. They have behaved outrageously over a long time.
They denied the obvious in asserting over many years that smoking caused no diseases and that nicotine was not addictive—when for a long time they knew differently. The first papers linking smoking and fatal illness appeared in about 1948—almost 50 years ago—and for the decades after 1948 the companies put their commercial position ahead of intellectual honesty and ahead of their responsibility to the societies in which they live and operate and from which they drew their profits.

Now, knowing what they know, they are knowingly and deliberately promoting death and disease in compliant emerging nations, again pursuing commercial advantage and ignoring the health consequences of what they do.

What has become clear is that tobacco companies will do, in relation to smoking, whatever is permitted under the law, irrespective of the consequences that their actions may have for the society. In quality what they do is equivalent to those who allowed, knowingly, blood contaminated with the HIV to be transfused into people when that action could have been avoided. Those who allowed infected blood to be transfused were spreading sickness and disease—so are the tobacco companies. So it is war. We have to respond by making the laws do what we want, for it is only the law and regulations made under the law that will force the companies to change their disgraceful behaviour.

That they argue a right to injure people in the name of ‘freedom of choice’ is bizarre—but it illustrates the extent to which value questions determine how people regard these various issues. It is especially poignant in view of the efforts of tobacco companies to minimise or neutralise the information going to the members of the public to allow people then to make their own decisions.

On the other hand, I recognise the right of people to make their own decision about whether or not to smoke, asking only that they have an adequate basis of information on which to base any decision. Later, I will present arguments about individual rights versus communal rights that might be relevant here.

But let me digress for a moment. A late colleague was a surgeon and refused to carry out certain surgical procedures on smokers. He demanded that they became ex-smokers before he would act. His actions seemed wrong—he was an agent trained to give a specific service and appointed by society with monopoly rights to render that service; he was not a moral watch-dog appointed to look after the morals or actions of his patients.

In approaching public health generally we have a dilemma presented by underlying questions of philosophy. Most clinicians are trained to respond to one patient at a time—to the person who is seeking their assistance rather than to the society of which that person is a part. In ethical terms we call most clinicians deontologists—they respond in terms of the ethics of duty of care
and ignore the needs or rights of the wider society. It is not that they do not care about the society in which they live—it is rather that they see themselves as champions for the patient rather than for the society.

Public health practitioners are different. They tend to consider the society first and the individual second. In a philosophical sense they are more akin to utilitarians who look to the good of the whole society before the needs of any individual within that society. Of course, their utilitarian tendencies disappear when they or a member of their family falls ill.

Epidemiologists, who are one brand of public health practitioner, are dazzled by the figures they gather and are liable sometimes to abridge individual rights in the pursuit of data. An example is the testing of pregnant woman for infection with the HIV. This is an important and a valid pursuit of public health. The information is necessary and important for obstetricians as well as epidemiologists. But, unless there is specific informed consent, and unless there is pre-test counselling, the general conditions for performance of HIV testing of individuals are compromised. So far, the public health practitioners have not done well in this area and few women, if any, have received pre-test counselling before HIV tests were carried out on them.

And many public health interventions do limit individual choice. The prohibition on driving under the influence of alcohol limits the right of people to drink to excess and drive motorcars. The reasoning is that the freedom that is gained by drinking and driving is more than offset by the costs to society as a whole and by the collateral injury to innocent third parties who might chance to get in the way. Not only that, but the doctrine espoused by John Stuart Mill says that damage to innocent third parties is sufficient reason (he actually says the sole valid reason) for society to limit the freedom of action of any individual person.

We do not allow people to drive without a seatbelt for the same reasons. We restrict permissible speeds for the same reasons. In each case we restrict individual freedom and in each case the benefits to society outweigh the costs to individual freedom and in each case the consequences of greater individual freedom include increased costs to all citizens through higher hospital costs or to ‘bumping’ of some people out of accident and emergency departments to make way for the victims of avoidable road crashes.

Not that public health is insignificant. Most of the advances in general communal health up to 1950 were brought about by advances in the public health system. Those improvements were due to things like improved housing, improved nutrition, waste removal, provision of clean water, adequate birth control and so on. In almost every case, some restriction of individual rights was
involved, but in every case the gains to the society as a whole far outweighed these costs to individuals. The rights limited were often rights to exploit or be exploited or the limitation in individual rights associated with the payment of rates and taxes.

Since 1950, advances in longevity have been due partly to improved public health, and partly to improved methods of treating people with disease. Interestingly, the correlations of health are most obvious with income and with the shallowness of income gradients—by which I mean that the more economically egalitarian a society, the better seems to be its overall health.

So with tobacco we have moved now to restrict the right to advertise, to sell and to use tobacco products. The companies and their allies argue that these restrictions curtail their rights. But, we could ask, their rights to do what. To injure? To kill? To maim? To cause addiction? To mislead? To obfuscate? In developing economies of course, tobacco companies appeal to the cupidity of governing elites, offering jobs and taxation revenue in return for avoidable death, sickness and addiction—and the elites accept the money.

We can go from the example of tobacco to the issue of fluoridation of water. My children grew up with just one cavity among them whereas I, who grew up before Sydney water supplies were treated, had what is called ‘the great Australian mouth’ full of amalgam from dental caries. The considered opinion of public health practitioners is that fluoride in water is the difference and we now add fluoride to the drinking water of many conurbations.

But the decision to fluoridate a water supply affects the water that is drunk by all the citizens using that water. Unless someone can get an alternative supply, or unless they remove all additives, there is no way of avoiding the fluoride. And some citizens, whether or not you think they are muddle-headed, are opposed to fluoridation and to fluoride. They stand up for their freedom to damage themselves if they so wish. As legal guardians, they assert their rights to injure their children—and, much as I disagree with them, think they must be heard. Using Mill’s doctrine, they injure only themselves, and we have little right to interfere.

We have to determine when we will introduce things across the whole society against the wishes of a minority. It seems proper that it only be done when the benefits are great, when the case is well proven, when failure to act affects innocent third parties and when we can justify the loss of individual freedom. Being Jewish, I would have this view. Coming from a minority that has had its share of oppression and maltreatment it is easy to understand that minorities do have rights to be heard and respected—our challenge is to balance those rights properly against the rights of the whole society.
Not all public health practitioners really accept that there is often a loss of autonomy or personal liberty in the decisions they favour. They have their own ideological blinkers of which we need to be aware. Their decisions might make good public health sense but frequently involve losses to other people. Our challenge is to balance one right against another, and to make wise and fair choices in the process. It follows that, rather than answers which are absolute, we are often involved in making subjective assessments as one usually does with value questions.

As a digression, it might be mentioned that in Cabinet, a large number of decisions involved no controversy and were made quickly, and a small number involved the balancing of competing values, one with the other, and took a very long time to determine.

So it is easy to see why gun control is needed in the interests of communal health and the protection of vulnerable groups; it is less easy but it is still possible to see how some people conscientiously believe that gun control should not be imposed. It is most difficult to make policy with the interests of both groups in mind. But it is necessary to try, unless one turns to Mill *simpliciter* and rolls over the top of the gun owners.

Another example we might consider is the level of ambient lead. Lead does affect intelligence adversely and those taking in the lead often have no say in the level of environmental contamination with that metal in the areas they live or work. So public health legislation is needed to alter the ways that motor vehicles operate, to control vehicle emissions, to alter the costs of lead-free petrol, and to reward companies that reduce the levels of lead in petrol for those motor vehicles still requiring leaded petrol.

The final example is the case of immunisation. Put briefly, it is possible to eliminate some diseases by making the whole population resistant to them. Smallpox has been eliminated from the world. Researchers are working today to apply this goal of eradication to malaria and to HIV and we have the examples of the elimination of poliomyelitis. I remember a teenage friend dying of bulbar poliomyelitis—almost the last death from that disease. We now have no polio in this country because enough people are immune to have communal resistance high. We talk of ‘herd immunity’, which comes into play only when the susceptible minority is small. The unpalatable fact is that while we can prevent many illnesses now—smallpox, diphtheria, pertussis, poliomyelitis, measles, rubella, hepatitis B—we do not do so for many of them. One of my staff has been off most of this year with pertussis and its sequelae; a medical colleague had measles in his child; most of my staff are not immunised against hepatitis B, and so on.
Let us look at malaria vaccines for one moment. It is possible to attack the plasmodium at several points in its life cycle. But so far, researchers have had trouble developing a safe and reliable vaccine.

Some years ago a vaccine was developed, was slated for trial in the Gambia where many people had malaria. The trial was knocked back by the MRC [Medical Research Council]—the British body controlling such trials. The problem then became an ethical one: does one do the trial and thereby carry out in the Gambia a trial which was rejected in Britain—you know, not good enough for Britain but good enough for the Gambia—or, does one not carry out the trial and have many people die, perhaps unnecessarily, of malaria. Most difficulties arise where two perfectly proper principles come into conflict.

With immunisation generally we face the classic ethical dilemma. We face John Stuart Mill head-on. On the one hand we understand the benefits to be gained from widespread immunisation. We know that some of the benefits come from raising general herd immunity and that this in turn comes from high levels of community practise of immunisation. On the other hand, we know that some parents and some practitioners actually disapprove of immunisation, and that some children, for technical reasons, cannot have immunisation carried out.

The response of the Minister for Health has been to offer a bribe to parents to encourage immunisation practice and the response of some school authorities has been to link entry into kindergarten to possession of a certificate of immunisation, or a certificate of exemption, or a certificate of conscientious objection. So public health legislation is being considered with attempts to balance a public interest against private interests. If we stick with Mill, we can determine simply enough that action by party A is likely to affect party B—and that is the trigger that Mill demanded for communal action.

In summary, I resolve this matter in favour of the public health and against the individual objectors and look forward to some stronger action to force people to consider immunisation of children, in a wider as well as in an individual interest. But one word of warning—there is a small risk of serious reactions to immunisations, irrelevant for the society but devastating for the individual. And should a reaction occur in a child immunised against the will of parents, there will be hell to pay.

All these examples have shown how difficult it is sometimes to resolve issues that pit public and private interests, the interests of society against the interests of individuals. I have suggested that using Mill’s principles will resolve most of the conflicts and show us the way to move, the way that is fair as well as effective.
One feature of the life of Michael Kirby has been the eclectic nature of his interests—in the breadth of activities with which he has been associated. While his role as a Justice of the High Court may impose some new limitations on his life, I do not expect that he will change his life-long commitment to justice or to issues within society. I certainly hope not. Michael Kirby has enriched the life of his community in many ways. This conference itself holds the promise of significant community enrichment. Let us hope that Justice Kirby continues to give to all Australians the continuing benefit of his wisdom and humanity. We can only be the better for it.
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