Medicine of the Person.
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If you wish to walk fast, walk alone, but if you want to walk far, walk in company. African proverb.

Public Health Medicine: How many responsibilities? How great a responsibility.

At the team meeting last September to prepare for this session of the Medicine of the Person, we intended another lecturer, an experienced person, previously responsible for public health in Switzerland, to speak on this occasion. That has not proved possible. Believe me, I have regretted this. As I prepared my paper for today, I had the feeling that he would have been a far better helmsman than I could ever be. As thread passing into a needle, after other doctors had declined the invitation to speak, I agreed to talk about my work, about my responsibilities and about my responsibility as a public health doctor.

I asked myself what interest an account of the responsibility of a public health physician could have for you. You are, on the whole, practitioners, people who care for individuals, actual people, whereas I am concerned with the health of large groups. I work at the heart of an organisation but I do not fully share its sense of direction. There are times when I feel caught in a trap. But who can feel in full charge of every aspect of professional practice, even in one's own consulting room? These thoughts have led me to muse on my responsibility, its limits; in brief, how I share responsibility. You will recognize, that if my power is modest, my responsibilities cover a huge area. My responsibility, both professional and personal, is often in play, almost always shared, and sometimes, on my part alone, badly exercised.

To define my task, to try to give it depth and enrichment, I wanted to read Paul Ricoeur, who quotes Habermas, Jonas and Levinas. I found myself a little bit lost in the ins and outs of ethics and responsibility. I have also read Raymond Masse, an anthropologist from Quebec, who has written widely on ethics and public health. I made some notes and then blamed myself for wasting time, for wandering around inside the pot, for prevaricating and, in short, for not *accepting my responsibility*! But I was involved, I must write something for you, even if not much, even if poor. The magnolia has been in flower for a long time and the translator was waiting. One Sunday, when I was alone in our large house in Dijon, I began to despair and felt the temptation to withdraw. Then Étienne sent me an e-mail from Moulins where he was working: *"Take courage for your presentation. I would say that a public health administrator can exercise responsibility only with difficulty when the politicians, responsible to make choices for public health, lack the courage to undertake this responsibility."* He added by telephone: "The message about public health is very important. Everybody is concerned about the organisation of public health, that is not going anywhere. What one has to say about the administration is, therefore, very important." And again, "I ask this question of you, concerned, as you are, with hepatitis C in Burgundy: I have a patient, with hepatitis C, who injects himself with érythropoÏétine. In Moulins (that is in the Auvergne, not in Burgundy), there is no provision to gather in and to eliminate syringes. In other areas of the department provision does exist. Why is it so badly organized? If the patient did not inject himself, but received injections in a surgery, run by nurses, there would be a charge! There is insufficient money!"

Thank you, Étienne. And so I find myself face to face with my responsibilities: for the patients and their requirements. What is public health doing for the real problems that they encounter?

What does public health mean for us?

I borrow from Philip Lecorps, psychologist and teacher in the field of the ethics of public health, the following general reflection: "Let us not be afraid, since life is something from

which we shall not come out alive". As Doctor Knock has said: "Every man who is well is unaware of his illness" Health is not a daughter only of medicine but the fruit of a collection of political commitments. The share of the state in the care of the health of the population is only 10%-15%. Much more important is the share given to war or peace, agricultural or industrial choices, poverty, housing, conditions for work. Ideally, the politics of health ought to rest on reflection and on a concern of the State, and the people responsible for political decisions, in order to guarantee conditions that are favourable to the lives of human beings.

In practice, in France at least, this general involvement of health in the concerns of the world of politics – and of society in general - does not exist outside the recurring problems of the financing of care. Responsibility for the health of the population - decisions about public health – also resides, in a general fashion, in the minister charged with health.

Public health has many facets and finds its origin in the state alone.

"By dint of observation public health brings into being and develops its measuring instruments; by dint of intervention it comes to control harmful elements; by dint of proposal it supports a culture, attitudes, patterns of behaviour as it aspires to longer life free from incapacity."

A vast ambition!

I am obliged to present to you the account, not felicitously, of regional public health, as it is in France because this is the level at which I work. I work for the regional directorate for health and social concerns in Burgundy (DRASS), This is the regional service of the Ministry of Health. Burgundy is made up of four departments. In each of them there is a departmental directorate known as the DDASS. Be assured, the picture is complex. It is not for nothing that, in Chinese, "France" is called "Fa Guo" or "land of the law", that is to say that laws and regulations follow one another without end. The new one never cancels the existing one. I will try to simplify the situation for you.

The regional public health includes three areas: health promotion, health planning (health institutions and health care services) and health security.

It is here that the medical inspectors of public health (the title given to public health doctors employed by the Ministry of Health, of whom I am one) have to exercise their responsibilities and practise their skills by method and by relationship, in other words, to act ethically.

My Responsibilities, my place in the Institution.

I have been responsible for many years for piloting the regional policy in the struggle against Aids and chronic hepatitis (B and C) The aim is to provide preventive action through care and support for afflicted people. For several months I have been responsible for the register of addictology for the whole of Burgundy. Addictology is the medical specialty concerned with patients who are dependent on drugs whether it be legal ones, like tobacco or alcohol, or forbidden ones like heroin.

The skills necessary for public health are multiple: epidemiology, anthropology, sociology, and economics. The skills are multi-professional. I am most skilful in the field of epidemiology but I am also aware of limitations and mistrustful of the tyranny of numbers.

The Planning and Organisation of Care.

In the area of addictology, my particular responsibility, this year, has been in the strengthening of services, alike in hospitals and in other care centres. I am not alone: I work under the authority of a director, previously a doctor, and with inspectors responsible for legal and financial matters. They have no formal training in public health but they are professional administrators open and competent in their domain. They expect me to define the needs (where and how many?) and the necessary means (what and how many?). We share together the preparation of notes and reports. My task involves taking note of the consummation of drugs, awareness of the activity, practices and difficulties of the care teams and the demand for complementary methods. All would indeed be simple if the

figures spoke for themselves, if the hospital teams would collaborate with the doctors and pharmacists in the towns and with the other care centres. In certain areas there is a working network where different professionals share responsibilities, but this is far from the case everywhere in Burgundy. For me a responsible task would be to facilitate such a network. But this year it is not a question of achieving something in depth because of some new regulations (Fa Guo!). We need to act quickly to enable hospitals to have the means of financing, by June, new posts as our national plan on addictions anticipated. Indeed I have insufficient time to spread myself over the four corners of the region in order to meet the hospital teams working on addictology, to appreciate the reasons for their requests and to become aware of their bonds with other health professionals. I would have done it, you can be sure, in company with my colleagues in the departmental directorates for health and social affaires (DDASS). Unable to achieve the ideal, I intend to adopt common criteria to enable my departmental colleagues to talk with these teams and to make a critical appraisal of the means requested. On a later occasion, we will make the regional synthesis together. I discard my responsibilities in depth on to others who know the local situation in principle. I am aware of the weight of these tasks. It is in situations like these that I feel myself a little bit caught in a trap. This is when I fear that the distribution of means to hospitals is, at the end of the reckoning, arbitrary.

It is not that a lack of time, compelling a financial distribution without depth, darkens the decision of the health authority. I also have difficulty in appreciating the consequences of the decision that I propose. Two years ago this is what I did in the same area, but at departmental level, when the government undertook a large campaign to prevent the use of cannabis. We ought to have put consultations in place aimed at young consumers of cannabis, but for that we have very little money. Hospital B has sent in a project to open a process of consultation. The administrative inspector, and I myself, held the opinion that the addictology team of this hospital was not working adequately with the doctors and local care centres and that, in spite of our repeated demands; the doctor in charge of addictology had not shown an interest for several years in illicit drugs. I, therefore, considered that the hospital's proposal was not viable and that, if we approved it, something else would have been affected. The finance was, therefore, given to another hospital that already had an important consultation in addictology to enable it to adapt it to the needs of young people. The balance sheet for this year showed that the existing consultation had been well adapted to the needs of young people but had not benefited from additional means given to it! And at hospital B, there were not always consultation facilities for young people, neither at the hospital nor at the care centre! What would have happened had the finance been given to Hospital B? Without the means to reply to this question, experience shows me that the action of the health administration does not automatically have the right effect and that it cannot achieve anything without the involvement of medical teams and hospital directors.

The Promotion of Health.

The French law of 2004 about public health lays down the role of the state in the conduct of health politics.

The organisation for the promotion of health and the prevention of diseases, with which I am concerned, (Aids, hepatitis, addictive behaviour) and also many others, changed from the beginning of 2007. This law ("Fa Guo") has created a new regional organisation without, however, giving it appropriate personnel. My director takes care of its direction (and I myself, from early February, have rejoined it for more than half of my time). The group consists of 4 people among whom a medical colleague is in charge of the coordination of the whole. As the bulk of my work occurs inside the public health grouping, and as my office is next to my colleague's and opposite those of the public health nurse and of the inspector, I take part in the day-to-day work of this small regional team. Nothing is officially laid down about my place, my responsibilities, my duty or my power of suggestion or of decision. I take it rather

as an opportunity, for the time being, to pursue my specialist responsibilities and to take part, when available, in the work of the team. Here I have the position of an active observer, even though my arrival, wanted by the director, has not been prepared beyond the specialised case files for which I am certainly responsible. I am, in short, an apprentice in a new structure, the functions of which, as also the new Internet sites, are “under construction”.

One of these functions, and an important task of the group, is financial provision. Some “people” ask us for subsidies to carry out public health activities. We assess their requests and agree to them, in total or in part, or refuse the financial provision that they wished for. The meeting of the committee concerned with programmes takes place in February. It has before it about 300 requests for subsidies from the whole region. I was not present for the whole meeting as I had another obligation. Some members of this committee have left it, frustrated, critical, considering themselves badly informed. This happened while the representatives of the local departmental teams also left it, bruised, feeling themselves misjudged and misunderstood when they should have been organizing themselves very quickly as their work had to be accomplished according to a very short schedule.

The Place of My Responsibility.

A little later, I heard precisely very severe assessments about the presentation of the files of some local teams, and hardly flattering comparisons with those of another local team. These facts made me think of the judgements of professors over the marks for an examination. It was exactly as though they were attributing good or bad marks. I felt that this was far from an approach to public health that respected people, far from *“the aim of the good, with and on behalf of others, within just institutions”,* according to the definition of ethics by Paul Ricoeur. I also said to myself that I was playing a part in this “unjust” institution and that, perhaps I ought to, and could, take a part of the responsibility. I did not feel myself responsible for the way in which the meeting had unfolded, nor for the preparation for which, in depth, I had hardly been associated. We are all devoted to the goal of working towards prevention and education for health. Why, then, has such a reaction occurred? I have neither the desire nor the courage to go more deeply into this situation. I have, nevertheless, thought that some of them were not very proud of their own work. One does know that such a feeling changes into criticism of another person if one does not recognize it.

Our responsibility is also involved in this. Few of these financial measures were really understood by the people who read the files. They are judged only from their descriptions in the files, which is only from what is written. The organization means that a person, acting on limited criteria about the financial package, can judge an action severely and decline it by grasping one of its negative characteristics. One could then join the person who is prompting the action if it resonates with a recognized need. People from a rural zone might find it hardly attractive. I am in principle opposed to a negative interpretation that has no outcome. I have not insisted on my opinion. It was not I who held responsibility for the particular health problem to which the project was a response. My challenge would not fall within my competence. I am not completely sure that I have not abandoned the defence of this file through abdication of responsibility.

But as I have embarked in the same boat, confident about the common goal, and putting a wager on good will, I was able to propose that, if the local teams were of the same opinion, they should come together again to compare their methods, to express their expectations. I have done this out of respect for the people and the work of the local teams. I also thought of our responsibility towards people who are involved in prevention and who expect of us a serious examination of their projects and replies as fully serious. It seems to me that we have a collective responsibility to improve our competence.

The first professional responsibility for each of us is to make ourselves competent. In this area, as in many others, one gains competence through the exchange of ideas by confronting experiences.

I have to say that, as a result, my director asked me if I could act as animator for this meeting. This is a story that is not yet finished. The second episode first destabilized and then comforted me. For at this meeting, I saw arriving, several minutes late my colleague who had neither been proposed nor announced! I confess that that at first irritated me. I said to myself that he ought to have asked if he could come instead of imposing himself. His participation proved fruitful. We have had a particularly valuable exchange with the local teams and I came to the conclusion that he had done the right thing in joining us. This piece of history is indeed still being written. My responsibility and that of the local and the regional teams is not simply internal. It reaches out to the population of Burgundy, aiming at the improvement of health. Be that as it may, I must take on another subject.

My Place and My Responsibility with My External Interlocutors.

I do not possess a hierarchical position in relationship to the professionals involved in prevention and care in the region of Burgundy. The position stands in contrast to that of a public health doctor in Spain. I have a certain power linked to my position as "technical advisor" to the regional directorate for health and social concerns (DRASS). I am required to express an opinion on financial demands. I have to organise the coordination and facilitate the way in which the different institutions relate one to the other.

I have become aware, during the last few weeks, of the responsibility that I could have in my relationship with the doctors involved in anonymous and free consultations for the HIV infection. A few months ago, in fact, the National Council on Aids, a kind of specialised committee on ethics, published a report on screening in France and on desirable proposals to improve it. At the beginning of May, the president of the Council for Aids, invited by the person in charge of infectious diseases in Dijon, came to present this report at a meeting of everyone concerned in these consultations. Such meetings are very rare. The doctor responsible for screening consultation in Dijon called me. He asked me to stimulate his colleagues to hold a good discussion meeting and to make known to the president of the National Council for Aids, their observations, comments and their evidence. Two of these doctors spend half their time in the hospital and half in private consultation. I am also afraid that they may not come. I appreciate that it is not easy to lose income. The doctor from Dijon, to whom I speak about this, is more aware of their responsibility than I am. She said to me that if one is a doctor responsible for a consultation about screening, one must take part in order to improve the quality of one's practice. She said that their responsibility is not limited to either individual or to daily consultation, She said that it is up to us to speak to them. That is true. In fact, I really had no difficulty in convincing these two doctors. They are ready, with sufficient warning, to report their consultations and are happy to come.

Regulation, Responsibility and Freedom.

From February 1st 2007, it is forbidden to smoke in a public place in France. It isn't as new as all that but the new task is the desire to enforce this new decree. Over a few days, hospitals are informed by lots of circulars, as also are establishments for handicapped people, schools and educational establishments, on the levels of interdiction. Interdiction may be total or involve the possibility of smoking rooms. Warning is also provided about the sanctions expected, a fine for the recalcitrant smoker, a heavier fine for the manager who proves weak and who, by his attitude, allows, or encourages, addiction to smoking. Two years ago, at the heart of the programme to prevent addictive behaviour, all the action and the support undertaken in schools resulted in encouraging respect for the law. The pupils accept this situation infinitely better than the adults who surround them. The adults are angry at the example given to them. Our ministry wishes to show itself as effective as the Interior Ministry. Let me explain. Road accidents have greatly decreased in France since

people have respected speed limits. Speed limits have been respected since the Minister of the Interior installed radar equipment at the side of roads and inflicted fines, or even the withdrawal of licences, in respect of non-compliance. Indeed, the Minister of Health announces that doctors, acting as inspectors of public health, are to go into hospitals to set in motion legal proceedings against people smoking in defiance of the law! Our directors, acting in an authoritarian manner, obediently sent doctors to be trained in repression! Ten years of study to impose a fine. Dependence on tobacco is indeed recognized as an illness . . . I told my director that, acting as an official, it was not possible to obey in the case of a matter that went against conscience. I also added that these particular controls were not in the interest of health but solely to give the impression that the Administration was acting with effect. What is required of us is something that can dare to be called results. How often have you imposed controls? How often have you enforced fines?

Our responsibility, it seems to me, lies here. As we are short of time, we should not accept harmful tasks and split up our practice as little as possible. But without doubt, some colleagues, in the small departments, who are new at the job and isolated, are less able to resist orders. The situation is, at worst dangerous, and at best useless.

How do we guarantee health, care or the security of care provision?

I find myself at the interface between administrators and doctors. This position lies between regional public health doctors and the ministry in Paris that is still slightly more distant from the population, from real people, than we are who function at the regional level.

How can one comply with regulations and financial provision capable of disastrous consequences? What position must we take up if these consequences arise?

A colleague, a public health doctor in one of the departments of the region, presented me with a problem. He stated that care centres for drug addiction in our region have different practices. These differences concern the number of treatments as a substitution for opiates that they provide. He asks me whether this is “normal” or “acceptable”.

The director, and the team at one of these specialist centres, consider that they have to limit the number of patients accepted because they are unable to take care of more than 15 patients a day in the correct conditions. As these people have to be cared for, in general, in the centre for several months before they are able to take their medication in the dispensary of a pharmacy, the centre is saturated. There is, therefore, a waiting time of three months before one can be admitted. But the prescribed treatment must be undertaken, for the first time, by a doctor from a specialised centre, or by a doctor in a hospital. Next, the people treated must take the syrup on the spot everyday. This makes possible a time for meeting and a word with the nurse who gives the methadone. This all takes time, and in the centre, for the fifteen patients, there is a “full time” nurse. But what is to become of the people who have asked to benefit from this treatment and who are placed on a waiting list? They generally have a local doctor who prescribes a different medication, buprenorphine which is less effective. So then they do feel bad. They often inject themselves and this produces a sensation of a shot as it did when they were taking drugs. Other people procure methadone for themselves on the streets. A young man, who was told by the centre that he must wait three months, was also a young father. He had to ask his companion to come to the doctor with him so that she could hear from the mouth of the practitioner, that if he did not receive care, this was not through negligence. She had not believed him. She thought that he was lying, threatened to leave him and to deprive him of his daughter. No longer able to hold his position, this man held a degree relevant to his work. The young man was a graduate of professional standing! In the end, he had to wait. But he was anxious to bring his testimony to us so that people, like me, should understand that when the provision at the centre is insufficient, there could be serious consequences.

At the opposite end of the spectrum, another centre, that has more and more demands, accepts more and more people and prescribes with all its might. The doctors and the nurses “act more and more quickly” in order to provide medication and deliverance. My colleague wonders, and asks me, not only whether the quality of care is sufficient but, far more, if

safety is assured with double the number of patients for an identical professional provision. Methadone is not a harmless medicine. An overdose can cause death. But no patient in that department is out on the street.

I do not know which is best. There are no norms. As they do not exist, it is very likely that they would have been established, had they existed, not as an optimum, but either as a minimum or, as is more and more the case, as an average.

Each team at the two centres has reckoned *to undertake its responsibilities in a manner diametrically opposed*. I have neither the arguments nor the power to compel the one to act like the other. Conferences on the subject clarify the principles of substitution treatments, but not the methods that are really necessary.

There are clear limits to my responsibility, to our responsibility as public health doctors, limits imposed by financial restriction. Care for people addicted to drugs is not judged a priority. My responsibility here is to be fully aware of these situations and these needs. I am responsible to make them known to my administration in a manner that is both convinced and convincing. I have also drawn the attention of my colleague, the medical inspector of public health, to this problem. He is a member of the national commission on addictions.

The Enduring Responsibility.

I am always able to dream of a perfect system of public health. That no more exists than the perfection of medicine itself. The question is not only one of responsibility. I think that we ought also, when the matter arises, to accept guilt because of the disastrous consequences of acts either undertaken or omitted. We are acting with a degree of uncertainty and we ought to accept the consequences in the short and in the long term. Vigilance could help us to rectify the firing before it is too late. But vigilance is often deficient. I think of the effects of the scorching heat in 2003 that were neither anticipated nor corrected in spite of the existence of a clear warning. At the time, I was at departmental level and on holiday. Just before the holiday, the dissemination of the message from the Director General for Health about the care of old people, at a time of great heat, appeared banal to me. A few days later, the alert was given by the funeral services that were unable to find sufficient chapels of rest. Locally, we satisfied ourselves by counting the dead. That was worse, Étienne said to me. The minister and his services denied, for several days, the comparatively high death rate indicated by the funeral services, the firemen of Paris and by some accident and emergency physicians. Yes, irresponsibility, through failure in discernment, exists.

In another area, in drug addiction, little more than 15 years ago, heroin was taken seriously. Cocaine was a cause of fear but not hashish and we allowed young people to consume it without regulation. When we questioned the street educators in Dijon about the consummation of drugs, they assured us that there was very little heroin but that they were noticing many “smoking rooms”. Well, neither did that concern the specialists in any way, nor, as a matter of consequence, public health. Now, as in France, so in Burgundy, one adolescent in two has experimented with this product and one boy aged 17 out of six smokes it regularly (10 times a month). We are beginning to see the consequences with a number of people: trouble at school, delirious puffs and, later, cancer of the lung. We had to provide specialist consultations two years ago! One also sees in this situation how often time permits us to understand the significance of our action better, how often the sign, written or not, helps us to take responsibility for it.

Responsibility Shared.

In the struggle against Aids, the associations have been pioneers in undertaking responsibility in the face of the epidemic, well before the state. Although the associations were always there and their activists less numerous; since 1996, the health and social services have had a larger place. This year, however, a new regional organisation has been put in place, the committee for regional organisation in the struggle against infection caused by the human immunodeficiency virus, (COREVIH). This committee brings together

representatives of all the players who operate in the region, including “patients and users of the health system”. This is an important stake in the sharing of responsibility, and reasonably symbolic, it seems to me. My present responsibility is to propose the best structure that permits dialogue, exchange, better coordination and better quality of care. The proposal also includes the taking of decisions in partnership between clinicians, patients, and support services, throughout the region. The establishment of profitable relationships cannot be assumed in advance. There has been mistrust for a long time between associations and clinicians, distrust by clinicians about the associations. The kernel of my work has rested for a very long time on the establishment of relationships and negotiations with doctors, carers and unpaid people or volunteers in the associations. The intention, if possible, is to achieve a system involving the least harm in the different areas for which I am responsible, for which we are jointly responsible.

But you will be saying to me that I have not always taken up Étienne’s questions. That’s true, but here we are. Concerning the elimination of syringes, I don’t know precisely how to respond to this question. It arises in Burgundy, from the responsibility of the regional network for people with hepatitis. As for the serious question of health choices, I notice that the health problems with which I am concerned in an administrative body, and that spring from governmental directives, have first been taken on board by society before the state did so. Without any doubt, the political choices are not only governmental choices. They spring from a shared responsibility. They will lead, when society is ready, to a common effort to define them

Investigation into Health as a New Dogma.

Public health carries a worrying double responsibility.

It has a tendency to present itself as a new religion, by promoting healthy lifestyles, by the protection of sexual relationships, by rules about food. It is inclined not to share the responsibility soundly but to throw onto people personal responsibility for their health, to “normalise” their behaviour in order to live in the “best of worlds”. Voltaire has indeed given us the only worthwhile recipe. “I have decided to be happy because it is good for health”.

The recipe carries, in itself, a total utopia and is as such ineffective, symbolised by the Ottawa Charter for the promotion of public health and the holistic definition of health by the World Health Organisation as “a state of complete physical well-being, mental and social”. Another philosopher, Andre Comte-Sponville, used to say that “according to this definition, if, from birth, I have been in good health for 3 days, that is a strict maximum”.

Translater : John CLARK