"Principlism" and Frameworks in Public Health Ethics

Briefing Note

For up-to-date knowledge relating to healthy public policy

How can we perceive and address ethical challenges in public health practice and policy? One way is by using ethical concepts to inform our thinking. One does not have to be a specialist in ethics to do so. This document is part of a series of papers intended to introduce practitioners to some values, principles, theories and approaches that are important in public health ethics.

Introduction

In this paper we will focus on principle-based approaches in public health ethics, comparing some of their features with those of principlism, the well-known and widely-used "four principles" approach in medical ethics.

We will first look at some of the main features of principlism and then with those features in mind we will turn to public health frameworks that rely on principles to see what they have in common as well as how they might differ.

Understanding and recognizing some of principlism's main features can help practitioners to:

- Better situate their own ethical deliberations in public health by seeing both the differences and the similarities between various ethical approaches;

- Identify and make explicit principlist orientations guiding themselves or others in health care or in public health settings, whether in research or practice;

- Having identified those orientations, communicate more effectively; and

- Understand some of the historical context and philosophical orientations that underlie public health ethics.

Public health ethics only began to gain prominence as a distinct field within bioethics around the year 2000 and its proponents have had the task of defining it as distinct from medical ethics due to the distinct nature of public health (e.g., Childress et al., 2002, p. 170; Dawson, 2011, p. 1; Upshur, 2002, p. 101). Indeed, many papers in public health ethics begin by articulating the differences between medical ethics and public health ethics, arguing that the differences between clinical practice and public health practice may require different ethical approaches. The overwhelming emphasis has been upon the differences, partially in reaction to a poor fit between individualistic and autonomy-heavy clinical approaches and the collective and population-level orientation of public health practice (Kass, 2004, p. 235). However, they also have much in common; there is much that public health can and does draw from work that has been done, and from ground that has been broken, in medical ethics.

Since its first appearance in 1979, the "four principles" approach of Tom Beauchamp and James Childress has transformed the way in which medical ethics are understood and practised. This approach is known by various epithets, including the "Georgetown mantra," the "four principles" approach, and "principlism," as we shall call it here;[1] all of these refer to their *Principles of Biomedical Ethics* (Beauchamp & Childress, 1994), now in its seventh edition. The dominance of this approach in medical ethics has had effects beyond the clinical setting: principlism has cast a long shadow over bioethics more generally, including public health ethics.[2]

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[1] The norm appears to be to apply the term "principlism" to Beauchamp and Childress's work, and the term "principle-based approach" more widely and generically to other work in practical ethics that applies principles. Principle-based approaches include both the "four principles" approach used in other settings as well as approaches that employ different principles and methods altogether.

[2] Note for clarity: we are aligned with Dawson (2010a) in seeing medical ethics and public health ethics as contained within the larger field of bioethics. We will consistently refer to each of these three using these terms. For a visual representation, see slide #5 in this web presentation: http://www.ncchpp.ca/ftp/2015-ethique-pw1/en/index.htm

Part one – What is principlism?

Principlism is a normative ethical framework that was designed for practical decision making in health care. Its basic approach is an attempt to bypass intractable disagreements at the level of normative ethical theory and the resulting lack of agreement about how to proceed. Instead, the authors focus on what people generally do agree upon, in the form of general, mid-level principles. They observe that "often little is lost in practical moral decision making by dispensing with general moral theories. The rules and principles shared across these theories typically serve practical judgment more adequately (as starting points) than the theories" (Beauchamp & Childress, 1994, p. 17). They say that this is because "theories are rivals over matters of justification, rationality and method but they often converge on mid-level principles" (Beauchamp & Childress, 1994, p. 102). Due to this general convergence on principles, they call principlism a common-morality approach.

JUSTIFICATION

Simple agreement, however, is not enough. Principlism does not just look at people's actions or beliefs and then declare that the commonly-held values are morally justified. Beauchamp and Childress discuss three models for justifying moral principles: deductive, inductive and coherence-based. **Deductive justification** (top-down) means that an overarching moral theory generates one or more principles that will determine moral decision making.[3] Another approach is **inductive** (bottom-up): this means that principles are generalizations derived from case- or situation-based judgments. The third approach is in-between, relying on strengths drawn from each: it uses the notion of justification by **coherence** among commonly held moral intuitions (i.e., something that is intuitively reasonable, that fits within a person's system of beliefs). This model tests for and produces coherence using a method called **"reflective equilibrium."** Starting with commonly held moral principles, reflective equilibrium subjects them to a back-and-forth process of distillation, refinement, and

clarification by testing principles against one another and by refining them with observation and case-based moral judgments.[4] Neither the principles nor the case-based judgments are primary or absolute. Rather, each is subject to change or to replacement, and each is used to hone and test the others. Reflective equilibrium could reveal that what one considered to be a central belief ought to be rejected, based on its not fitting with the rest. In this sense, there is no "foundation," strictly speaking; one could say there is a core. In reflective equilibrium, principles are subject to constant evolution and critical analysis (Beauchamp & Childress, 1994; Marckmann, Schmidt, Sofaer, & Strech, 2015). Principlism depends upon this means of justification, coherence through reflective equilibrium, which is supposed to reflect both common acceptance and rigorous testing and refinement. According to Beauchamp, what justifies moral norms "is that they achieve the objectives of morality, not the fact that they are universally shared across cultures" (Beauchamp, 2007, p. 7).

PRINCIPLES

What are principles, then?[5] Beauchamp and Childress claim that principles are like rules in that they are "normative generalizations that guide actions," but when considered more closely, principles are less specific in content and less restrictive in scope than rules (Beauchamp & Childress, 1994, p. 38). "Principles are general guides that leave considerable room for judgment in specific cases and that provide substantive guidance for the development of more detailed rules and policies" (Beauchamp & Childress, 1994, p. 38).

Through the process of reflective equilibrium, the authors developed four principles: respect for autonomy (individuals' freedom and choice), nonmaleficence (not harming others), beneficence (doing good for others), and justice (broadly understood to include distribution of material and social goods, rights, and terms of cooperation) (Beauchamp, 2007; Beauchamp & Childress, 1994).

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[3] This orientation is often associated with the expression "foundational" when referring to principles. For a discussion of some implications of the metaphor of foundationalism, see Sherwin (1999).

[4] To learn more about reflective equilibrium, see Daniels (1979) for a clear exposition.

[5] For further reading on principles, we recommend Beauchamp (1996, pp. 80-85), in which he clarifies an important difference by distinguishing between principles occupying a foundational role in a theory (they would be unexceptionable, foundational and theory-summarizing) as compared to principles within a coherentist conception (they would be exceptionable/prima facie, and nonfoundational).

APPLYING THE PRINCIPLES: BALANCING AND SPECIFICATION

The four principles are universal but not absolute. The authors argue that through reflective equilibrium they have generated ethical principles that apply to everyone, so they are said to be universal. However, instead of being absolute, they are *prima facie*. *Prima facie* (meaning literally "at first view") implies that, other things being equal, any one principle may be morally binding, but that other moral considerations could intervene to take precedence in cases of conflict when thinking about what to do in particular situations (Beauchamp & Childress, 1994, p. 32; Frankena, 1973, p. 27). This means that balancing principles is important. Depending on the circumstances, principlism can accommodate beneficence taking priority over autonomy, or autonomy taking precedence over justice, etc., according to how they are weighted in particular cases. That is to say, prima facie principles allow for one overriding another, depending on the circumstances.

Finally, the four principles are not formulated so as to be directly applicable to one or another situation. As we saw above, they are rather "the most general and basic norms," or "the most general values of the common morality" (Beauchamp, 2007, p. 7). They require further specification. Specification is an exercise in considering particular contexts and figuring out how the principles may be applied. It amounts to developing a principle's meaning and scope in various contexts, types of situation or specific situations. By specifying how principles are to be applied, rules and norms are developed for practical application. Through reflective equilibrium, these are always subject to change and refinement based on judgments from particular cases.

The authors stress the importance of recognizing that using their work depends upon specification and balancing, and that this is the only way to achieve a practical outcome using their method. They also stress that judgments "cannot be rigidly dictated by some formulaic method" (Beauchamp & Childress, 1994, p. 36). That is, principlism is not an algorithm; it is conceived as a guide, a tool, a means of navigation in problematic and sometimes intractably difficult situations. They see "disunity, conflict and moral ambiguity as pervasive aspects of the moral life" (Beauchamp & Childress, 1994, p. 107).

Principlism can be thought of as a normative ethical framework. While the distinction between theories and frameworks is not clear-cut, principlism can be viewed as a framework that has been worked out with extensive theoretical analysis. Among other reasons, the feature that defines it as a framework for our purposes here is the primacy of its applied role as a practical aid to deliberation. While there is extensive theoretical discussion in *Principles of Biomedical Ethics*, the practical tool that emerges is a framework that is supported by that discussion, and theoretical elements need not necessarily be invoked in its application.

Summary: Key features of principlism

Principlism is a **normative ethical framework designed for decision making** in health care. It is a **common-morality approach** relying on four mid-level **principles**: respect for autonomy, nonmaleficence, beneficence, and justice. The normative force of the principles arises from a **coherence-based model of justification** that differs from top-down (moral theory) and bottom-up (case- or situation-based) models of justification but that employs both types of reasoning through **reflective equilibrium**. That is, principles are subjected to theoretical analysis to clarify them and render them coherent, and they are also informed by judgments arising from particular situations. Each principle is to be considered **prima-facie binding** and none is to be considered primary. Principles are **contextualized and applied through specification** and they are **balanced against one another** depending upon the situation.

SOME OF PRINCIPLISM'S STRENGTHS

It is immediately and broadly applicable

Principlism has simplicity, scope, flexibility and applicability on its side. Given the general, prima facie nature of the principles, principlism is applicable, with specification and balancing, in a wide variety of contexts involving clinician-patient interactions.

It is accessible to practitioners and not just experts

Starting with mid-level principles allows clinicians to "get straight to work" on ethical deliberation without becoming enmeshed in theoretical debates and

without the need to specialize in theories and their justificatory mechanisms, their nuances, etc.

It preserves a link to ethical standards and to commonly held values

Reflective equilibrium is a very powerful means of balancing theory and practice, while keeping an eye on commonly held ethical standards.

SOME OF THE MAIN CRITICISMS OF PRINCIPLISM

It is too individualistic – there is more to life than autonomy

Despite the alleged equality of the four principles, overwhelming emphasis has been placed on autonomy over the years (Callahan, 2003; Gillon, 2003). Indeed, in reflecting on his and Childress' original goals in producing *Principles of Biomedical Ethics*, Beauchamp says that their proposal was to shift health care's preoccupation from beneficence towards autonomy (Beauchamp, 2007, p. 3). To their credit, we must also note that the authors meant to draw social justice more into the mix also. Yet, individualism, overemphasis on autonomy, and the pre-eminence of individual liberty over community or collective goods are well documented in the literature in medical ethics, and are a central point of departure for many proponents of public health ethics.

It oversimplifies

According to Callahan, a reductionistic tendency is a serious failing of principlism. Due to its reduction of ethical issues to manageable, action-oriented specification of a limited number of principles, principlism performs a "blocking function." It is a kind of "ethical reductionism" that allows us to "cut through the ambiguities and uncertainties that mark most serious ethical problems," and that "unwittingly invites us to stop our moral analysis at that point" (Callahan, 2003, p. 289) at the expense of developing a richer sense of the moral life and all that it entails, including "caring feelings as well as dutiful desires" (Tong, 2002, p. 419).

Curiously, this same reductionistic tendency is said to account for the enormous success and influence of principlism. Evans (2000) sees the principles as a system of "commensuration," a term associated with the calculability and predictability of accounting, that "takes the complexity of actually lived moral life and translates this information into four scales by

discarding information that resists translation" (Evans, 2000, p. 32). Thus, its success arose from its simplicity, the potential for standardization it offers, and the way it satisfied the need to show transparency within a bureaucratic system such as the US's political and health care contexts.

"This bed is too hard" – principlism is rigid and absolutist

Sharing much in common with the criticism that principlism oversimplifies, this objection relates to the tendency to rigidly apply principles without due attention to nuances and individual judgments. According to Toulmin, a "morality based entirely on general rules and principles is tyrannical and disproportioned, and ... only those who make equitable allowances for subtle individual differences have a proper feeling for the deeper demands of ethics" (Toulmin, 1981, p. 38). This author is a proponent of casuistry, a bottom-up case-based approach that builds from similarities between judgments in specific cases and that attends to the particular. He argues that principlism's proponents err too far on the side of using principles like axioms from which, in a "quest for certainty," they make deductions (Toulmin, 1981, p. 37). One might say that this does not reflect the way in which principlism was intended to be used (Massé, 2003), but that the criticism does apply in full force to those who would use it in this mechanistic way.

"This bed is too soft" – there is no guidance and nothing to hold it together

Although it is now used to present the approach in a neutral way, the term "principlism" was originally coined pejoratively by Clouser and Gert (1990) in their first of several critiques of the four principles approach. Approaching the work from a strongly theory-based perspective, the authors claim that principlism lacks a sufficient theoretical foundation. For them, since principlism lacks a "moral theory that ties the 'principles' together, there is no unified guide to action which generates clear, coherent, comprehensive and specific rules for action nor any justification of those rules" (Clouser & Gert, 1990, p. 227). Others point out that these authors have different expectations of moral "theory" and that they cannot but arrive at incompatible conclusions about what works or about what is acceptable (e.g., Davis, 1995), whether in terms of foundations, methodologies, justification, etc. Proponents of a principlist approach do not expect or wait for general

agreement upon something that could satisfy these theoretical aspirations. Instead of debating those issues, they focus (and depend) on the mid-level principles where a certain degree of agreement is said to exist already.

Part two – How does principlism relate to principle-based approaches in public health?

In public health, the tools used for applying ethics in practice generally take the form of ethical frameworks. Since about 2001, numerous frameworks have been developed to guide ethical decision making in diverse areas of practice, with early influential examples including Kass (2001), Upshur (2002) and Childress et al. (2002), and with more recent examples including Willison et al. (2012), ten Have, van der Heide, Mackenbach, & de Beaufort (2012), and Marckmann et al. (2015). To date, the field of public health ethics has produced a diversity of frameworks for various purposes, which is a dramatically different landscape from the more monolithic terrain of medical ethics in which principlism dominates.

Frameworks in public health are less all-inclusive than theories and are more modest in their ambitions. Frameworks generally serve as guides, highlighting issues and values that would be relevant in a particular situation, and they encourage deliberation. In contrast to theories, frameworks are tools that are more intended for daily practice.

It is important to note that public health ethics frameworks do not map neatly onto principlism. Some have more and some less in common with principlism. The frameworks that have been developed to date vary considerably.[6] They vary in terms of their underlying philosophical orientations, from a more traditional liberal-based orientation to a more expansive, communitarian or collectivist-based orientation (MacDonald, 2015). They vary in terms of their overall scope, in that some are intended to be applied generally to any situation one might encounter in public health (e.g., Kass, 2001; Marckmann et al., 2015), while others are intended

for specific situations like dealing with pandemics (e.g., Thompson, Faith, Gibson, & Upshur, 2006), addressing obesity (e.g., ten Have et al., 2012), or justifying public health interventions that infringe upon autonomy (e.g., Upshur, 2002). Some make their underlying philosophical justification explicit, some make reference to other traditions to hint at their justification, and some simply get on with things and make no such reference at all. Some frameworks are structured around a series of questions, while others are based on a list of principles. Many frameworks provide structured guidance so that anyone using them will have a clear, ordered set of considerations or questions to address so that ethical issues will be highlighted, while others lack such a structured approach and leave users more on their own with a list or a set of considerations to think about and to use.

Regardless of the form that a framework takes, whether a series of questions or a list of principles, values[7] will either be highlighted explicitly or evoked indirectly. In the question-based type of framework, principles and values are still present but only implicitly so, and are contained within the questions themselves. Consider, for example, Kass' question-based framework, which asks, "Is the program implemented fairly?" (Kass, 2001, p. 1780). Clearly, defining "fair" will lead deliberations towards values or principles like distributive justice, social justice/equity, reciprocity, etc. In Marckmann et al.'s (2015) framework, also question-based, one can easily extract values and principles (benefits, harms, autonomy, equity and efficiency) from the five questions, framed as "normative criteria"; there is also a list of procedural principles for a fair process. In short, frameworks that are not explicitly principle-based are still relying on principles for their normative force.

For those who are already familiar with some ethics frameworks for public health, some of their similarities with principlism may be clear. Bearing in mind some of the main features of principlism that we touched upon earlier, we might see that they are, to varying degrees, also found in public health ethics frameworks. Indeed, many of these normative ethical frameworks are:

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[6] For some papers characterizing the differences among public health ethics frameworks according to different criteria, we refer the reader to Lee (2012); MacDonald (2015); and to ten Have, de Beaufort, Mackenbach, & van der Heide (2010) for further reading.

[7] For our purposes here, we consider principles to be values expressed in normative language to guide action. They are formulated like "... you should take into account that ...".

- Designed to aid decision making,

- Using a common-morality approach, in which

- Principles are:

  - either listed (or evoked by questions),

  - prima-facie binding (alternatively, in some cases they are pre-ordered in priority),

  - contextualized and applied through specification, and

  - balanced against one another depending upon the situation.

Though public health ethics frameworks vary widely in terms of how they appeal to principles (and their justificatory source), we can see that many either assume or explicitly depend upon a coherence-based model of justification through reflective equilibrium for normative justification.

One early and influential framework for public health ethics is Upshur's (2002) *Principles for the Justification of Public Health Intervention*. This framework can serve as an example of how some bridging has taken place between principlism in medical ethics and public health ethics. Upshur argued that due to differences between clinical medicine and public health practice, "simply importing conceptual models" would not suffice, and the direct application of the four principles would be problematic for public health practice (Upshur, 2002, p. 101). On this basis, he proposed four other principles (harm principle, least restrictive means, reciprocity and transparency) intended to serve as a starting point for a principle-based approach adapted to a "specific, but significant domain" in public health (Upshur, 2002, p 102). Interestingly, it would appear that the other features of principlism were largely adopted, principlism being seen as a "robust and useful" framework (Upshur, 2002, p. 101) which was already familiar to practitioners. Similarly, Massé (2003) proposes an expanded set of values (including the four principles but adding in six more: promoting well-being, defending the common good, utility, paternalistic responsibility, solidarity and precaution) for a principlism that is adapted to public health.

Dawson argues that the primary role of a framework in public health is "to aid deliberation by making relevant values explicit" and, once they are brought into focus, "those values are then used to guide or 'frame' decision making" (Dawson, 2010b, p. 196). In this discussion, Dawson is considering the general functional roles of theory and frameworks in public health ethics, without suggesting that these roles are clear-cut. He views the main role of theory as providing justification, and the main role of frameworks as aiding deliberation. In this context, he observes that while a framework should be clearly linked in some way with theory, and thus with justification, the primary role of a framework is such that it should not be too focused there. Rather, "there is nothing wrong with a framework taking certain theoretical considerations for granted and concentrating upon aiding busy decision makers through the provision of a checklist of relevant considerations, principles and issues to keep in mind" (Dawson, 2010b, p. 192). This is consistent with applying the four principles. In public health, however, because there is no consensus about which framework to use, it is of central importance to find the right framework for the particular context so that one can identify the main values or issues for consideration.

In the second main criticism of principlism above, its reductionism was viewed as a very serious shortcoming, in that it invites users to wash away the nuances of ethical deliberation. Clearly we must bear this in mind if we are to view frameworks as checklists for aiding busy decision makers who do not have the time for ethical nuances. This reveals a practical tension that will afflict any framework, whether principlism or any of those developed for public health. Practitioners must find a balance between a tool that is so sophisticated and complete that it is unusable and one that is simple to use but fails to highlight issues with the subtlety or depth that it should. Frameworks help, but they do not do the work, and they are only as effective as their users. The more that those users can adopt a critical perspective, and the more they are attuned to and practised in the use of ethical concepts, the better will be the analyses and the decisions that result. This is easier said than done, but there is no replacement for critical awareness, the practice of questioning the givens as one navigates work and life. We should not pretend that a framework will capture this, though some may help; and at the same time we ought not to reject the practical value of frameworks for bringing important issues to the foreground. Indeed, there is room for frameworks and for their application with a critical perspective by users who do not stop thinking but are instead stimulated to think critically about the issue at hand,

even going beyond what the framework overtly suggests.

WHAT CAN FRAMEWORKS OFFER?

As with principlism, frameworks in public health ethics, whether they are closely related to principlism or not, can help practitioners to perceive ethical issues, deliberate about them, come to decisions about what to do, and justify those decisions. A well-chosen framework can help practitioners to do this work by:

- Drawing in relevant principles and values that suit the context to help reveal issues,

- "Framing," by providing a structure for deliberation,

- Providing a common language for discussion,

- Providing an entry point at a level that is accessible for non-experts in ethics,

- Offering the flexibility to be open to critical questioning of taken-for-granted norms,

- Identifying in some way the rationale for the selection of these principles or questions for this particular area of practice or issue, and

- Offering practical guidance and some kind of order or structure to help users apply the principles to the issue and balance them in cases of conflict.

BUT THEY HAVE THEIR LIMITS

- Frameworks are not algorithms. While they can help highlight issues and guide deliberation, they will not replace the work involved in navigating complex situations.

- While it may be seen as a virtue, the simplifying function of a framework should not lead us to ignore the ethical complexity and depth in situations. A critical perspective (as revealed by the questioning of givens and by asking, "Why are things like this?" vis-à-vis who has the power, who makes the rules, and what issues arise with respect to social justice) is hard to capture and is often not elicited by frameworks. Adopting and applying a critical perspective can serve as an essential complement to their use. Without it a framework can be a crude tool indeed.

References

Beauchamp, T. L. (1996). The role of principles in practical ethics. In L. W. Sumner & J. Boyle (Eds.), *Philosophical perspectives on bioethics.* Toronto: University of Toronto Press.

Beauchamp, T. L. (2007). The "four principles" approach to health care ethics. In R. E. Ashcroft, A. Dawson, H. Draper & J. R. McMillan (Eds.), *Principles of health care ethics, second edition. Chichester,* John Wiley & Sons, Ltd.

Beauchamp, T. L. & Childress, J. F. (1994). *Principles of biomedical ethics*, *fourth edition.* Oxford: Oxford University Press.

Callahan, D. (2003). Principlism and communitarianism. *Journal of Medical Ethics, 29*, 287-291.

Childress, J. F., Faden, R. R., Gaare, R. D., Gostin, L. O., Kahn, J., Bonnie, R. J., ... & Nieberg, P. (2002). Public health ethics: Mapping the terrain. *Journal of Law, Medicine & Ethics, 30*, 170-178.

Clouser, K. D. & Gert, B. (1990). A critique of principlism. *The Journal of Medicine and Philosophy, 15*, 219-236.

Daniels, N. (1979). Wide reflective equilibrium and theory acceptance in ethics. *The Journal of Philosophy, 76*(5), 256-282.

Davis, R. B. (1995). The principlism debate: A critical overview. *The Journal of Medicine and Philosophy, 20*, 85-105.

Dawson, A. (2010a). The future of bioethics: Three dogmas and a cup of hemlock. *Bioethics, 24*(5), 218-225.

Dawson, A. (2010b). Theory and practice in public health ethics: A complex relationship. In S. Peckham & A. Hann (Eds.), *Public health ethics and practice* (pp. 191-210). Cambridge: Cambridge University Press.

Dawson, A. (2011). Resetting the parameters: Public health as the foundation for public health ethics. In A. Dawson (Ed.), *Public health ethics: Key concepts and issues in policy and practice* (pp. 1-19). Cambridge: Cambridge University Press.

Evans, J. H. (2000). A sociological account of the growth of principlism. *Hastings Center Report, 30* (5), 31-38.

Frankena, W. K. (1973). *Ethics, 2nd edition*. Englewood Cliffs, NJ: Prentice-Hall.

Gillon, R. (2003). Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals." *Journal of Medical Ethics, 29*, 307-312.

Kass, N. (2001). An ethics framework for public health. *American Journal of Public Health, 91*(11), 1776-1782.

Kass, N. (2004). Public health ethics: From foundations and frameworks to justice and global health. *Journal of Law, Medicine & Ethics, 32*, 232-242.

Lee, L. M. (2012). Public health ethics theory: Review and path to convergence. *Public Health Reviews*, 34(1), 1-26.

Massé, R. (2003). La flexibilité des critères dans la justification éthique des interventions : du principisme spécifié à un modèle centré sur les valeurs phares. In C. Hervé, B. M. Knoppers, P. A. Molinari, & G. Moutel (Eds.), *Éthique médicale, bioéthique et normativité*, (pp. 105-120). Paris: Les Éditions Dalloz.

MacDonald, M. (2015). *Introduction to public health ethics 3: Frameworks for public health ethics.* Montréal, Québec: National Collaborating Centre for Healthy Public Policy. Retrieved from: http://www.ncchpp.ca/docs/2015_Ethics_Intro3_Final_En.pdf

Marckmann, G., Schmidt, H., Sofaer, N., & Strech, D. (2015). Putting public health ethics into practice: A systematic framework. *Frontiers in Public Health*, February 2015, *3*(23). Retrieved from: http://journal.frontiersin.org/article/10.3389/fpubh.2015.00023/full

Sherwin, S. (1999). Foundations, frameworks, lenses: The role of theories in bioethics. *Bioethics, 13*(3-4), 198-205.

ten Have, M., de Beaufort, I. D., Mackenbach, J. P., & van der Heide, A. (2010). An overview of ethical frameworks in public health: Can they be supportive in the evaluation of programs to prevent overweight? *BMC Public Health, 10*, 638-649.

ten Have, M., van der Heide, A., Mackenbach, J., & de Beaufort, I. D. (2012). An ethical framework for the prevention of overweight and obesity: A tool for thinking through a programme's ethical aspects. *European Journal of Public Health*, *23* (2), 299-305. Retrieved from: https://academic.oup.com/eurpub/article/23/2/299/679530

Thompson, A. K., Faith, K., Gibson, J., & Upshur, R. E. G. (2006). Pandemic influenza preparedness: An ethical framework to guide decision-making. *BMC Medical Ethics*, 2006, *7*(12).

Tong, R. (2002). Teaching bioethics in the new millennium: Holding theories accountable to actual practices and real people. *Journal of Medicine and Philosophy, 27*(4), 417-432.

Toulmin, S. (1981). The tyranny of principles. *Hastings Center Report, 11*(6), 31-39. Retrieved from: http://www.scribd.com/doc/45111046/Stephen-Toulmin-The-Tyranny-of-Principle#scribd

Upshur, R. E. G. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health, 93*(2), 101-103.

Willison, D., Ondrusek, N., Dawson, A., Emerson, C., Ferris, L., Saginur, R., & Upshur, R. E. G. (2012). *A framework for the ethical conduct of public health initiatives*. Public Health Ontario.

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