Integrating Public Health Ethics into Public Health Policymaking: Being in the Room Where It Happens

Currents in Contemporary Bioethics

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Abstract: This commentary takes up a challenge posed by Franklin Miller in a 2022 essay in *Bioethics Forum*. Dr. Miller queried whether bioethicists could be useful in public health policy contexts and while he refrained from issuing an ultimate opinion, did identify several challenges to such utility. The current piece responds to the challenges Dr. Miller identifies and argues that with appropriate training, public health ethicists can be of service in virtually any context in which public health policies are deliberated and decided.

I. Introduction

Public health policies seek to provide health benefits to populations and individuals, yet often require restrictions on individual liberties. The height of the COVID-19 pandemic centered these tensions and presented a number of ethical challenges. In addressing some of these issues, Franklin G. Miller posed a provocative question in a 2022 *Hastings Bioethics Forum* commentary: "Should ethicists be at the table in public health policy deliberations?"[1] Miller argues that the answer is not self-evident and that having ethicists represented in public health policy contexts is neither necessary nor sufficient for just, evidence-based policy. Moreover, he notes, there are many advantages to positioning ethicists external to policy deliberations, including (a) acting as external critics; (b) publishing external policy-related scholarship; (c) educating and training public health scientists and officials; and (d) serving as ad hoc ethics consultants for policymakers. Miller is careful to avoid taking an express position on the question he poses, suggesting instead that the question is "worthy of debate."

This commentary takes up the challenge Miller poses and argues that public health ethicists are essential team members in supporting public health policymaking. In Section II, the commentary locates public health ethics as a distinct subfield within the broader field of bioethics. Understanding this distinction is critical to understanding and highlighting the relative lack of institutionalization of public health ethics. In Section III, the commentary argues that appropriately trained public health ethicists can provide significant guidance during policy deliberations. Finally, in Section IV, the article articulates pathways and recommendations for building capacity of trained public health ethicists with the skills needed to be useful in public health policy deliberations.

II. Public Health Ethics as a Distinct Field

In public health a continual tension exists between initiatives that generate population benefits and individual liberty interests. Additionally, questions regarding equity, just distributions, and best approaches to integrating evidence are persistent in public health decision-making. Public health practitioners can access and adopt existing frameworks (e.g., Kass, Marckmann)[2] to conduct a preliminary approach to identify and

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analyze ethical issues. However, as the complexity of ethical dilemmas increases, these frameworks are not sufficient substitutions for experts trained in ethics and policy.

Biomedical ethics or bioethics has persisted in the United States as a guiding force in clinical and research ethics at least as far back as the 1970s.[3] In the US, it is rare for hospitals and health care organizations to exist without the representation of ethicists or some capacity for resolving ethical problems. The Joint Commission's mandates have further bolstered and solidified ethicists' role in hospitals. Specifically, The Centers for Medicare and Medicaid Services ("CMS") have officially vested The Joint Commission with "deeming authority" such that organizations that satisfy Joint Commission accreditation requirements are *deemed* to satisfy the various requirements to participate in Medicare or Medicaid.[4] Given health care organizations' reliance on Medicare and Medicaid funding, Joint Commission accreditation requirements are prerequisites for hospital operations and viability. The Joint Commission began requiring "hospitals to have both ethics education and a mechanism to address ethical issues in patient care" in 1992.[5] Since then, the Joint Commission has steadily added ethics requirements including but not limited to the need for guiding ethical principles (LD.04.02.03), informed consent (RI.01.03.01), and shared decision-making (RI.01.02.01). Joint Commission requirements are typically satisfied either through ethics committees (made up of professionally diverse members and usually one community member) and/or ethics consultation services. Committees and consultation services provide a mechanism to resolve ethical dilemmas that emerge in patient care.

Unlike the centralized accreditation that establishes ethics as a requirement for clinical care and research, public health authority is shared between federal and state governments and arguably is funded primarily through state budgets. This allows for significant variation both in public health policy decision-making and in any developed protocols for integration of ethics through a committee or consultation model.

The power of federal deeming authority explains why, despite being a nominally private organization, health law scholars generally regard The Joint Commission as a quasi-governmental entity.[6] That is, the investiture of deeming authority combined with the absolute necessity of participation in federal health care reimbursement programs imbues Joint Commission accreditation with something akin to force of law. The legal and political power of Joint Commission accreditation has played a significant role in institutionalizing health care ethics practice and capacity within hospitals and other health care organizations subject to the Joint Commission's deeming authority.

Much like requirements for clinical care, legal and regulatory requirements have established ethics review as a mandatory element of human subjects' research. For example, the Common Rule mandates the establishment of institutional review boards (IRBs) charged with reviewing federally funded research (unless exempt).[7] Health research is largely depended on federal funds, particularly from the National Institutes of Health, which is the largest funder of health research in Global North countries.[8] This reliance on federal funds establishes requirements issued by the federal government as necessary to pursue human subjects research which are therefore ubiquitous at all research institutions. These requirements include IRB review and associated ethical requirements (e.g., consent) to engage in research.

Public health ethics differs in its orientation from clinical and research ethics. Clinical ethics prioritizes individual patient values alongside health care professional expertise to guide decision-making at the patient level. Research ethics emphasizes the importance of advancing generalizable knowledge to make progress with high emphasis on autonomous decision-making of research participants and on guaranteeing human subjects protections. This is in stark contrast to the prioritization of population level decision-making in public health. Public health practice also differs from clinical care and research in the lack of an established accreditation organization with powers that mirror those of the Joint Commission or the reliance on federal funding to advance research. Unlike the centralized accreditation that establishes ethics as a requirement for clinical care and research, public health authority is shared between federal and state governments and arguably is funded primarily through state budgets. This allows for significant variation both in public health policy decision-making and in any developed protocols for integration of ethics through a committee or consultation model.

III. Public Health Ethicists' Role in Policy Deliberation

Public health policy "includes the advancement and implementation of public health law, regulations, or voluntary practices that influence systems development, organizational change, and individual behavior to promote improvements in health."[9] Public health policy decisions prioritize population-level health benefits and as a result may infringe on individual interests or rights in order to advance health needs of the com-

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munity. For example, school vaccination requirements aim to reduce incidences of common pediatric illnesses (e.g., chickenpox), but may infringe on individual beliefs regarding vaccinations. The tension between public and private/individual interests has been the subject of seminal Supreme Court decisions (e.g., *Jacobson*).[10] Yet, even where courts or other lawmakers have established legal rights or standards, there is still tension in the "grey zone." Law can set boundaries for state or federal governments' actions, both limiting their capacity to infringe on individual rights and empowering their decision-making. However, within those boundaries policy makers can still face tensions about whether specific decisions are ethically supportable. Ethicists are trained to weigh competing values and interests of relevant stakeholders and apply norms and standards for the purpose of resolving value tensions, including those raised in public health policy decision-making. This training positions ethicists to collect relevant facts, data, or evidence and consider (or help others consider) potential decisions or actions in the context of competing values among stakeholders.

There are limited examples of leading public health institutions that integrate ethicists into decision-making and policy-setting processes. For one, the CDC Office of Science does specify how ethics can be integrated into day-to-day decision-making.[11] However, there are two critical gaps in assessing such integration. First, it is unclear whether or how ethics work is integrated at the state and local level where significant public health policy decision-making power resides. And second, it is unclear whether integration of ethics is operationalized through the inclusion of trained ethicists in decision-making and policy-setting processes. Such inclusion may not be feasible or necessary in all circumstances, but significant gaps in training for policymakers may limit their capacity to identify, analyze, and resolve ethical dilemmas as the issues emerge. As noted above, there is little evidence that would suggest widespread institutionalization of public health ethics at all levels of public health policy. A lack of consistent representation of trained public health ethicists or appropriate ethical analyses in public health policy decision-making could further exacerbate variations and inequalities in public health outcomes among different geographic areas.

IV. Pathway Towards Effective Integration of Ethicists

There is little doubt that accreditation within the health professions, including public health, norms practice and policy to a significant extent. Caution is warranted in drawing any glib comparisons that would rely on accreditation authorities to motivate or establish integration of ethicists into public health policy contexts because relevant public health accreditation bodies do not generally enjoy deeming authority. Nevertheless, it is critical to understand that accreditation generates powerful signaling effects that may establish social and institutional norms. For example, one 2012 study of law enforcement officers found that accreditation requirements are strongly associated with officers' perceptions of their agency's priorities.[12] The Public Health Accreditation Board ("PHAB") is the most influential accreditation body within public health. PHAB sets accreditation standards for health departments and identifies itself as "the sole national accrediting body for public health in the U.S." PHAB formed in 2007 as the result of a national conversation led by a variety of organizations including CDC, the Robert Wood Johnson Foundation, the American Public Health Association, and the National Academy of Medicine. While PHAB standards are voluntary and PHAB is not invested with deeming authority, its standards maintain signaling and norm setting affects as the sole public health accreditation body. Ingram, Mays and Kussainov reported in 2018 that, compared with unaccredited local public health systems, accredited systems "enjoy improvements in service delivery … increased focus on the delivery of public health services … and seem to do this with a greater array of partners."[13] Similarly, Dada et al. conducted a cluster analysis of local health departments' performance in meeting PHAB accreditation standards, arguing for the significance of the design because:

> [s]tudies demonstrate the potential that PHAB accreditation has to transform PH practice and improve PH agency capabilities to deliver essential PH services. For example, benefits regarding performance management, quality improvement, accountability, and transparency have been associated with accreditation, as well as areas of practice such as resource planning, community engagement, and the ability to identify and address gaps in workforce development.[14]

PHAB accreditation standards do mention ethics. Standard 10.3 references the need for ethical integrity in a health department's organizational culture (Table 1). More specifically, Measure 10.3.1 A requires health departments document "[a] process describing how ethical issues are deliberated and resolved" (Table 1). The criteria for such a process are detailed, requiring information regarding the composition of teams, decision protocols, steps for re-evaluation after integrating new information, and communications planning. The Measure requires health departments to document that the process described was implemented in resolving or preventing the "occurrence of an ethical issue." If no such occurrence can be documented, the health department must submit documentation of an exercise completed that uses the described deliberative process (Table 1).

Specific measures requiring ethics capacity have been in place in the PHAB accreditation standards since at least Version 1.5 (2014). Building on the PHAB standards, the National Association of County and City Health Officials ("NACCHO") has released material intended to help health departments build ethics capacity,

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Table 1
Relevant Ethics Measures in PHAB Accreditation Standards

	Required Documentation 1 (Process)	Required Documentation 2 (Prevention)	Dated Within
Requirements for Satisfaction of PHAB Accreditation Measure 10.31.A	Which individuals have ethical decision-making responsibility	Resolution or prevention of ethical dilemma using specified process OR	5 years
	How decisionmakers gather information and who provides input	Exercise using specified process	
	How the decision may be re-evaluated pending new information		
	How the decision is communicated back to relevant parties of interest		

observing that "[g]iven the array of stakeholders and issues dealt with by local health departments (LHDs), health officials and their staff must be ready to handle ethical dilemmas that arise in day-to-day practice."[15] NACCHO also conducted an assessment of local public health ethics capacity and found a wide variety of barriers to identifying and resolving public health ethics issues.[16]

Importantly, of LHDs that responded, 46% reported barriers in identifying public health ethics issues, 51% reported barriers in training staff adequately, and 64% reported barriers in accessing relevant resources. 37% of LHDs that responded reported as a barrier difficulty in facilitating the deliberation process. These are all barriers that can be scaled or at least diminished by having trained public health ethicists represented in policy deliberation.

The Joint Commission model and outcomes provide evidence that accreditation connected to practice is most important in driving ethics institutionalization and capacity. Accreditation is also powerful in informing education and training standards. Considerations related to the educational footprint of bioethics within degree-granting programs at schools and programs of public health are beyond the scope of this commentary. Even so, adding provisions related to public health ethics in the Council on Education for Public Health's (CEPH)[17] accreditation could also have effects in institutionalization. Yet, while necessary, the presence of ethics requirements in public health education is not sufficient to establish a workforce that possesses adequate capacity to handle ethical problems in every day practice and policy. Ethics requirements within the curriculum would, however, establish ethics as significant in those contexts. This may improve upon the limitations in current ethics training of public health practitioners while also equipping and motivating practitioners to seek out the expertise of public health ethicists in policy contexts.

V. Training in Public Health Ethics

Public health ethics as a field has not sufficiently offered opportunities to train and build expertise within the subfield. This is in stark contrast with its counterparts. Clinical and research ethics education has advanced to include master's degree and certificate programs, a growing number of fellowships, and post-doctoral training programs. Furthermore, clinical ethics has established trainings to obtain professional licensure and certifications — which is increasingly becoming a norm within the field.[18] Fellowships have addressed an important need in clinical and research bioethics to allow for disciplinary diversity within the broader field. Unlike other biomedical fellowships which select candidates from a discipline-specific doctrinal degree, bioethics training programs recruit from a wide variety of fields in the humanities, social sciences, and STEM. Such bioethics fellowship programs build upon trainees' discipline-specific educations by developing skills needed for rigorous ethical analysis that attends to both process and substance. These programs often include integrated training approaches to assure that fellows learn how to discern critical medical or scientific information, institutional policies, legal mechanisms, and patient/participant values to inform an analysis for each individual case. There is little doubt that these training programs have been essential to establishing a qualified bioethics workforce.

Training programs that parallel those in health care and research ethics have yet to become standard in public health ethics. This is a limiting factor in establishing a public health ethics workforce that can provide guidance for public health decision-making. In addition, there are almost no freestanding graduate programs that offer degrees in public health ethics. And while there are some bioethics training programs that feature expertise in public and population health ethics, these are geographically dispersed and are contingent on a particular collection of faculty expertise. Such programs are terrific but may not be sustainable in the long-term given faculty movement and do not represent a sustained institutional

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commitment from the degree-granting institution to invest significant and program-level resources in training public health ethicists. Optimally structured public health training programs, including fellowships, would balance training in research skills and practical public health practices and policymaking. Such training would provide ethicists who could not only "be at the table" for public health policymaking, but could also possess capacity to support to public health practitioners. For example, under a train-the-trainer approach, public health ethicists could train practicing public health professionals in the skills needed to facilitate ethical deliberation in policy contexts.

Dr. Miller raises the question of whether training in public health ethics legitimately equips trainees with the skills needed to be of service in policy deliberation contexts. We agree that formal training in applied ethics or public health does not automatically prepare learners to operate skillfully in policy contexts. Therefore, we argue that public health ethics training, whether in a degree-seeking, micro-credentialing, or train-the-trainer environment, ought to include attention to the core components of policy work. These components include but are not limited to work on (policy) mapping, formation, analysis, translation, communications, and dissemination & implementation.

VI. Conclusion

Training sufficient to enable the public health ethics trainee to operate in policy contexts brings us back to Dr. Miller's commentary. There, he notes that even if having public health ethicists in the room where policy happens is desirable, there remain important questions related to the requisite training and education needed for ethicists to maximize the extent of their contribution. We argue that the gap of training opportunities to support a well-trained workforce is not a reason to keep public health ethicists "away from the table." Instead, we argue that the potential skills that trained ethicists could provide during public health policy processes necessitates a pathway for creating the workforce. The COVID-19 pandemic and other major public health events have illuminated the importance of integrating ethics in policymaking. Making this an opportune time to consider how accreditation, education, and training programs could provide for a pathway that would equip public health policy processes with well trained public health ethicists that could help way the critical and challenging ethical issues that are likely to emerge.

Note

The authors have no conflicts of interest to disclose.

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