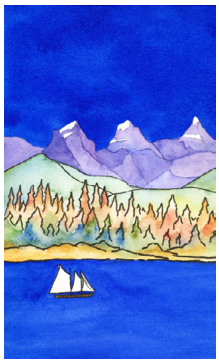

CHAPTER 4

Exploring Public Health Ethics: Social Justice, Solidarity, and the Common Good[1]

Marjorie MacDonald

"A public health ethics must begin with recognition of the values at the core of public health, not a modification of values used to guide other kinds of health care interactions." **(Baylis et al., 2008, p. 199)**

PUBLIC HEALTH (PH) ETHICS is a relatively new but growing field of applied ethics (Bayer et al., 2007; Baylis et al., 2008; Dawson & Verweij, 2007; Lee, 2017). PH professionals have long grappled with ethical issues in their practice. It is only in the last 25 years that PH ethics frameworks—grounded explicitly in PH principles and values to address ethical issues in practice—have become available. Historically, public health nurses have not received guidance about their unique ethical concerns when relying on perspectives from health care ethics or nursing ethics. Instead, a rights-based

approach (Zahner, 2000), or the health care ethics principles of autonomy, beneficence, non-maleficence, and justice—specifically distributive justice (Beauchamp & Childress, 1979)—were used as the appropriate framework to support ethical PH nursing practice (Vollman et al., 2003). These approaches tend to be more relevant to clinical nursing practice than to PH nursing.

As PH ethics developed, theorists and practitioners across disciplines began to recognize that health care ethics did not provide an adequate theoretical foundation for PH ethics (Jennings, 2003). In the 1970s and 1980s, some authors proposed the need for a system of ethics specifically oriented to PH (Beauchamp, 1976; Lappe, 1986). Still, we have only claimed and named PH ethics as a distinct area of scholarship since the late 1990s (Kass, 2004). In fact, according to Kass, authors rarely used the term "public health ethics" prior to the year 2000. To illustrate the growth in the field, I conducted a Google Scholar search for the term "public health ethics," covering the 30-year period between 1980 and the end of 2009. This search produced 2,360 references, for an average of 30 publications per year. A similar search in Google Scholar—for the next 12 years—a period spanning from the beginning of 2010 to the end of November 2021—returned a list of 9,560 references on the same search term, "public health ethics," for an average of 869 per year. Although Google Scholar is not likely to have captured all publications on the topic, it does give a good sense of the significant growth of scholarly literature in the field.

Recent developments in nursing ethics, as influenced by feminist and relational ethics, have broadened the ethical focus in the field to encompass at least some of the ethical concerns of PH nurses. Yet, there are almost no PH nursing-specific ethics frameworks available. Considering that PH nurses focus primarily on communities and populations—as does PH in general—it is likely that ethical issues in PH nursing will be best addressed by emerging developments on relational frameworks, although these frameworks may need to be modified for use in PH nursing. I will discuss this further in the section on PH nursing ethics.

In this chapter, I build on my analysis of PH ethics in the 2013 (second) edition of *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice* (Storch et al.) and add new developments in

PH ethics since 2010.[H] I review the development of PH ethics through two historical streams, define the term PH and its core functions, the meaning of the term "public" in relation to PH, and describe the history and evolution of the field of PH ethics. I discuss how PH ethics differs from health care ethics, and how it has been implemented in nursing. A range of current PH ethics issues are presented, including a discussion of PH research ethics, environmental and global health ethics, and the ethics of pandemics. I conclude with a summary of key developments in PH ethics, and a listing of PH issues for the future. Finally, I pose some questions for reflection for readers.

What Is Public Health?

As Verweij and Dawson summarize in brief: "Public health is a contested concept" (2007, p. 13). It is a term with multiple shades of meaning that is often misunderstood. Some understand PH to mean health care provided within the publicly funded health system. This misinterpretation occurs, in part, because PH operates under the radar; people are generally unaware of its existence until a PH crisis strikes. Other aspects of the Canadian health care system, however, such as acute hospital care, are highly visible in the lives and awareness of Canadians.

The focus and scope of PH action is one aspect of PH that is increasingly contested. Some argue that PH should be narrowly conceived, dealing only with PH issues that relate directly and specifically to health matters, such as communicable diseases, clean drinking water, food safety, and the like (Bernstein & Randall, 2020). These issues, and how governments handle them, are generally uncontested and usually implemented without controversy. PH issues that have political dimensions, however, are often controversial. For example, proponents of a narrow scope for PH argue that addressing issues related to the environment, personal behaviour, and many of the determinants of health (e.g., education, income, employment) is beyond the scope of PH (Bernstein & Randall, 2020; Rothstein, 2002).

Potvin (2014) reported on articles from the Quebec press that proposed placing limits on PH and its scope. These writers argued

that (a) PH should stick to infectious diseases and not address social and economic policy issues; (b) PH should not be allowed to use its moral authority in areas not directly related to health; and (c) PH should not stray into areas of social action. Rothstein (2002) argued that just because social problems exist, that does not make them PH issues. He further argued that an all-inclusive notion of PH is ineffective and counterproductive, and suggested that the government overreaches when it engages in non-health-related actions, because such actions are not within the purview of PH.

On the other hand, many others, including most PH leaders and practitioners, support a broader model of PH that focuses on health inequities, social epidemiology, and the nature of causation in PH (Bernstein & Randall, 2020; Goldberg, 2008; Lurie & Fremont, 2009). Rather than focusing strictly on communicable diseases, they maintain that PH should be addressing the social, economic, and ecological determinants of health from a social justice perspective. Goldberg (2009), for example, suggested that if PH does not address the underlying causes of ill health and disease, PH practitioners are not doing their jobs and will not improve population health. Moreover, a broad scope is consistent with most widely accepted definitions of PH. Indeed, core competencies of PH (e.g., Public Health Agency of Canada, 2008) and codes of ethics in PH (e.g., American Public Health Association [APHA], 2019) explicitly define a broad scope for PH practice. Additionally, the history of PH in Canada demonstrates an increasing expansion of the scope of PH over the past century (Tam, 2021). Those who argue for a narrow scope of PH seem not to understand either the nature of PH or its development, aims, benefits, and history.

Definition of Public Health

Public health holds many meanings for many people. Here, I include one representative definition that will be useful for framing this chapter: Public health is "what we, as a society, do collectively to assure the conditions in which people can be healthy" (Institute of Medicine [IOM], 1988, p.1). Common elements across all definitions of PH include collective effort, societal responsibility, and attention to social and environmental health determinants. The moral aims of

PH are to promote health equity and to promote the health of the population as a social good that allows people to pursue other valued goals (Powers & Faden, 2006). As evidence accumulates about growing global health inequities, a concern with inequitable health status among disadvantaged and marginalized populations has emerged in PH (World Health Organization [WHO], 2008).

Since PH practitioners aim to improve the health of whole communities and the population at large, their strategies do not focus solely on individuals. With the guidance of PH professionals, local governing bodies (such as state/provincial governments, municipalities, or regional health authorities) provide societally oriented interventions. Providing safe water, ensuring a safe and accessible food supply, public sanitation, taking action to control or prevent communicable diseases, preventing chronic diseases, and promoting health equity are just some of the PH interventions that require collective rather than individual action. The collective nature of these activities often requires legislative authority and may infringe on the rights of individuals, thus raising distinctive ethical challenges. A range of public organizations such as non-profits, schools, professional groups, and others may also develop and deliver community-oriented interventions (Childress & Gaare Bernheim, 2015; Institute of Medicine, 2002).

Core Functions of Public Health

PH in most countries has a set of core functions. Not every country defines the core functions of PH in the same way. In the US, for example, there are three core PH functions: assessment, policy development, and assurance. In addition, the Centers for Disease Control and Prevention (CDC) (2020) in the United States has also identified ten essential services of public health, developed originally in 1994 and updated in 2020, to bring PH in line with current and future PH practice.

In Canada, we define the core functions of PH on a federal level as health promotion, health surveillance, disease and injury prevention, population health assessment, and emergency preparedness and response (Canadian Institutes of Health Research, 2021). Provinces have developed their own frameworks to

further define core PH functions in their region. For example, in British Columbia (BC), the Ministry of Health developed a framework for PH in 2005. This framework included a broad overview of PH (reflecting an expansive model), the core functions and programs of PH, and strategies in PH. It provided an equity and population lens that shapes the understanding of PH and its functions, as well as the capacity of systems to support PH activity (e.g., health information systems, human resources, research, legislation, and others; BC Ministry of Health, 2005). Twelve years later, the provincial government updated the core functions framework as the *Guiding Framework for PH* (BC Ministry of Health, 2017).

Defining the "Public" in Public Health

There are several ways that "the public" is understood in PH. Because we cannot give a solid, all-encompassing definition for the term, we will instead explore the various ways in which the notion of the public is contextualized in discussions around PH.[3]

We can understand the term "the public" as a collection of people, as a space for action, or as a set of values (Mold et al., 2019). People often use the term "public" synonymously with "population," a term that has long been "bound up with the history and practices of PH" (Mold et al., p. 10). As Krieger (2012) proposed, a population is more than a statistical entity; rather, we must understand the term "population" with respect to its internal relationships and its connections to other populations. Thus, a population is inherently relational. As we shall see, these ideas about the meaning of "public" and the relational nature of populations undergird some perspectives in both PH and feminist ethics.

The public and PH are not fixed and concrete entities. Rather, they are social constructions that "change and vary by time and place" (Mold et al., 2019, p. 7). Because of its broad focus, PH tends to encompass a range of publics; the meaning of the term "public" itself is slippery. As claimed by Verweij and Dawson (2007), the public is both a target of action and a process of collective action. "As Newman and Clarke argue, part of what makes the public is a set of legal and democratic values that mark out a domain distinct from private interests" (Mold et al., 2019, p. 9, paraphrasing Newman &

Clarke, 2009, p. 4). All of these notions of the term "the public" have implications for ethical issues in PH.

In a recent review of the distinctive challenges of PH ethics, Faden et al. (2019) defined the object of focus in PH as a community, the public, or a population, with each term carrying subtle differences in meaning. Community is the "most morally laden" of the three terms (p. 5). It refers to a cohesive group that shares values, language, culture, and history. Community's etymological similarities with "common" reflect community's appeal to the common good. Unlike community and common, the public is also "a discrete unit that corresponds with state boundaries" (p. 4) and thus connotes an official political structure. The term "population" tends to minimize the implication of shared characteristics and has a less "inward looking orientation" (p. 5) than the term "community."

What Is Public Health Ethics?

In a broad sense, the purpose of using PH ethics is to guide practical, ethical decisions about problems that affect population or community health. Scientific evidence informs ethical analysis, and PH leaders make decisions in accordance with accepted values and standards (Ortmann et al., 2016, p. 3). PH ethics builds on its parent disciplines of PH and health care ethics. It is "a systematic process to clarify, prioritize, and justify possible courses of PH action based on ethical principles, values and beliefs of stakeholders, and scientific and other information" (Centers for Disease Control, 2017, "Public Health Ethics", para. 1). Often, practitioners use an ethics framework to operationalize and guide the process of ethical analysis.

Gostin (2001) proposed three analytic perspectives on PH ethics: the ethics *of* PH, ethics *in* PH, and ethics *for* PH. Callaghan and Jennings (2002) added a fourth type they name "critical public health ethics" (Nixon et al., 2005; Nixon, 2006).

An important take-away message from the early years is that there is broad agreement that the principles of health care ethics (autonomy, beneficence, non-maleficence, and justice) are not always a good fit for the ethical issues that arise in PH (Kass, 2001; Keeling & Bellefleur, 2016; Nuffield Council on Bioethics, 2007; Turaldo, 2009). This is because the principles have an

individualistic orientation centred on client rights; priorities which sometimes work to the exclusion of the common good.

The most common ethical theories applied in the early days of PH ethics derived from various strands of liberalism that many authors argued do not provide an adequate moral foundation for PH (Callaghan, 2003; Ortmann et al., 2016). Several authors have since attempted to lay out a set of principles more relevant to the moral aims of PH (Baylis et al., 2008; Upshur, 2002), but even these were limited. Recently, authors have specified a broader range of principles appropriate for PH (e.g., Filiatrault et al., 2017). In a systematic review, Abbasi et al. (2018) concluded that there has been a shift in PH ethics frameworks from liberal and individualistic values towards an emphasis on the collective values and principles of community.

Although there is a strong orientation to social justice and equity in PH and its ethics (Powers & Faden, 2006), many writers still see PH primarily from a distributive justice perspective (the fair allocation of resources) (e.g., Childress & Bernheim, 2015; Persad, 2019). Ethics for PH, however, reflects a populist ethic which Gostin (2001) argued is intended to serve the interests of populations, but in particular, the needs and interests of the marginalized and disadvantaged. A populist approach thus reflects an appeal to the common people. Such an ethic needs to account for more than distributive concerns (Moroni, 2020).

The strong connection between social justice and critical PH ethics is also worth noting. To date, there have been few publications on critical PH ethics. Even the journal *Critical Public Health* lists only seven articles under the search term "critical public health ethics." Although there has been some discussion in online blogs about the relationship between critical PH ethics and the critical sociology of public health (Lupton, 2012), that discussion has not been developed further and is now somewhat dated. I suggest that more work to develop the field of critical PH ethics might expand the theoretical base of PH ethics in a fruitful direction.

Among other factors, "institutional arrangements and prevailing structures of cultural attitudes and social power" (Callaghan & Jennings, 2002, p. 172) influence the development of PH problems and related ethical issues. Callaghan and Jennings call for policies

and interventions to be "genuinely public or civic endeavors" and suggest the need for "meaningful participation, open deliberation, and civic problem solving and capacity building" (p. 172) in the creation of both the interventions and the management of ethical issues that come with them. This commitment to participation is a long-standing tradition in PH and health promotion (Francés & La Parra-Casado, 2019; MacDonald & Mullet, 2009). It is also consistent with a range of philosophical perspectives, including feminist perspectives, communitarian perspectives, and perspectives encouraging deliberative democracy (that is, a democracy in which deliberation is seen as a crucial aspect of decision making). Reflecting these ideals, public participation is included as a value or principle in some newer PH ethics frameworks (e.g., Abbasi et al., 2017; Marckmann et al., 2015).[4]

How Does Public Health Ethics Differ From Health Care Ethics?

The difference between health care ethics and PH ethics lies in the distinction between PH and health care. In health care ethics, the main focus is on the needs, interests, and concerns of individual patients as they interact with and receive care from practitioners and the health care system for their illnesses. In PH ethics, however, practitioners focus on the health of the population as it is affected by social and political structures as well as environmental conditions.

A more extensive discussion of the difference between health care ethics and PH ethics can be found in MacDonald (2014), where I discussed three main features of PH that create specific moral concerns. First, the initiative in PH versus health care comes from the professional, not the patient. Second, since PH interventions target populations or communities specifically, the benefits for the individual may be negligible (i.e., the classic "prevention paradox"; Raza et al., 2018).[5] Third, PH interventions are potentially pervasive (e.g., water fluoridation), such that it is difficult for individuals to either refuse or consent to participation. These distinct foci in PH versus health care create very different demands for ethical analyses, and each raises its own unique ethical challenges regarding choice, individual good, and the common good.

Another difference between health care ethics and PH ethics is that some health care ethicists have not typically demonstrated a concern with the social determinants of health (Baylis et al., 2008; Pauly, 2008), although this has begun to change (Puyol, 2012; Spruce, 2019). For example, Levin and Fleishman (2002) observed that PH ethics has much to contribute to bioethics "by broadening the primary focus of bioethics from individual autonomy and clinical care to include the contextual issues in health care decision making, the value conflicts inherent in population-based programs, and the social and structural determinants of population health" (p. 166). Twenty years ago, Callaghan and Jennings (2002) emphasized that the time had come to integrate the ethical problems of PH into bioethics.

Some authors, especially during the COVID-19 pandemic, called on health care ethicists to draw on the insights and developments of PH ethics (Saenz, 2021). Dunham et al. (2020) suggested that because COVID-19 has introduced such significant challenges for clinicians and health care systems everywhere, practitioners who care for individual patients also need to consider and orient themselves to the common good. That is, clinicians need to understand the collective public as their patient and learn about collective ethics. Dunham et al. argued that those who understand collective ethics will be better able to understand system-based decisions. This will be necessary to minimize moral distress for health care practitioners, because a shift to prioritizing the collective over the individual is likely to put many practitioners into a zone of discomfort where they believe that they are "practicing at the edge of [their] competency" (Dunham et al., 2020, p. 474). Organizational supports will therefore be necessary to facilitate this change.

DeBruin and Leidar (2020) added that in PH crises like the COVID-19 pandemic, which involve resource shortages, health care systems can become overwhelmed. In these cases, norms guiding care may have to shift from individual well-being and autonomy to focus on common benefit. That being said, efforts to strike a balance will be important because practitioners will still have to care for their individual patients.

In the early years, there was a deep divide between the commitments of theorists in health care ethics and commitments of those

working in PH ethics (Bayer & Fairchild, 2004). "The core values and practices of PH, which often entail the subordination of the individual for the common good, seem to stand as a rebuke to the ideological impulses of bioethics" (p. 474). Thus, Bayer and Fairchild concluded that standards for guiding PH ethics cannot be derived from the assumptions of bioethics, in which individualism is dominant and the principle of autonomy has pride of place. As discussed above, and as we shall see later in the chapter, this perspective is beginning to shift.

Implementing Public Health Ethics in PH Nursing

Despite growth in the fields of health care ethics and nursing ethics over the past decades, there has been little development in ethics specific to PH nursing. Few nurse researchers have conducted empirical studies on ethics in PH nursing. This is illustrated in a recent systematic review of reviews on bioethics topics (Mertz et al., 2020). The authors found that of the 76 reviews included in the study, most were from the fields of nursing and medicine. Fifty percent dealt with clinical ethics, 36% with research ethics, but only 14% with PH ethics.

Aroskar (1979, 1989), Fry (1983, 1985), and later, Oberle and Tenove (2000), identified that the moral concerns of PHNs might not be the same as those of most other nurses. These nursing studies predated recognition by most bioethicists that ethical issues in PH differed from those in health care more generally. The authors of the nursing studies suggested that the professional codes of ethics in nursing might require PHNs to violate those codes while engaging in population-focused nursing practice.

Despite these early observations by PH nursing authors, in a review of the ethics content of community health nursing textbooks, Zahner (2000) found that many had no ethics content at all, and only 30% had separate chapters on ethics. When ethics was included, the dominant ethical theory was a duty-based, deontological perspective. Surprisingly, given its prominence in PH more broadly, Zahner found a utilitarian perspective in only 14% of the sample, while human rights and distributive justice theories

(versus social justice) were the theoretical basis in 23% and 25% of the texts, respectively. None of the authors of these texts mentioned a communitarian ethical perspective, nor did they discuss the distinction between PH and health care ethics. This is consistent with Kass's (2004) observation that very little appeared in the literature on PH ethics prior to the year 2000.

In summary, few nursing articles relevant to PH ethics appeared in earlier stages of PH ethics history. Despite the fact that the PH ethics literature in nursing was scant early in the history of PH ethics, the nursing authors cited above were actually ahead of the field in identifying ethical issues in PH practice, and particularly in observing the frequent tension between individual autonomy and the collective good.

The following definition of a PH nurse provides important clues about the ethical challenges for PHNs. "A PHN/community health nurse combines knowledge from public health science, primary health care (including the determinants of health), nursing sciences and the social sciences. The PHN focusses on promoting, protecting and preserving the health of populations" (CPHA, 2010, p. 8). Although the focus is on population health, PHNs do some of their population-focused work with individuals. PHNs also recognize that individuals and communities are inextricably linked (Diekemper et al., 1999); thus, PHNs must take a relational perspective. This dual nature of the PHN role, with a concurrent focus on the care of individuals and the health of the population, creates unique ethical challenges for PHNs (Oberle & Tenove, 2000) that are not generally experienced by nurses working in other areas of practice nor by other types of PH professionals.

Given the lack of PH nursing ethics frameworks, professional codes of ethics for nurses are important guides for practice because they reflect a professional consensus on matters of ethics. As noted earlier, the authors of one systematic review found that the majority of ethical frameworks used in nursing were the codes of ethics for professional nursing organizations (Mallari & Tariman, 2017). In the past, however, several authors pointed out that nursing codes of ethics did not reflect the nature of PHN practice, nor did they provide guidance for the unique ethical issues in PH nursing (Folmar et al. 1997; Fry 1983, 1985). The 2008 and 2017 versions of

the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* both address some of the concerns of PHNs. The language used in these documents opens the possibility that ethical decisions might be different when the community or population is the primary concern. This is particularly evident in the values listed in the 2017 CNA *Code of Ethics* under the headings of "Promoting Health and Well-being" and "Justice." For example, in the third ethical responsibility under "Promoting Health and Well-Being," the 2017 CNA *Code of Ethics* specifies that when a community health intervention interferes with individual rights, nurses advocate for and use the "least restrictive means." This is one of the earliest PH principles identified in the first PH ethics frameworks (Kass, 2001; Upshur, 2002), and it addresses the individual versus collective tension in PH ethics. Thus, its inclusion in the 2017 version of the CNA *Code of Ethics* is an important improvement.

In addition to the value statements and their accompanying ethical responsibilities, the 2017 CNA *Code of Ethics* includes a set of ethical endeavours. These endeavors are broad aspects of social justice that relate to the need for social and system change to promote health equity. The CNA did not consider these endeavors to be part of nursing's core ethical responsibilities, although they are still part of ethical practice. I would argue, however, that several of these ethical endeavours actually do reflect the core ethical responsibilities of PH nursing, even if they are not core responsibilities for the rest of nursing.

Several statements under the heading "Ethical Endeavours" in the 2017 CNA *Code of Ethics* are explicitly reflected in national community health nursing documents defining the roles, responsibilities, and competencies of PHNs (Community Health Nurses of Canada, 2019; Canadian Public Health Association, 2010b). These include

> utilizing the principles of primary health care for the benefit of the public and persons receiving care … recognizing the significance of social determinants of health and advocating for policies and programs to address them … maintaining an awareness of major health concerns, such as poverty, inadequate shelter, food

> insecurity and violence, while working for social justice, individually and with others, and advocating for laws, policies and procedures that bring about equity. (p. 18)

Thus, the 2017 version of the CNA *Code of Ethics* represents a further step forward in reflecting the ethical responsibilities of PHNs. In the US, there is a code of ethics for PH (American Public Health Association, 2019) that PHNs are expected to follow in addition to their own nursing code of ethics. A similar PH code in Canada could support PHNs in fulfilling their ethical responsibilities for population and community health. The following Ethics in Practice case illustrates the unique ethical responsibilities of PHNs.

ETHICS IN PRACTICE 4-1

E-Cigarette Legislation

The federal government has asked your health unit to comment on a new regulatory framework for electronic cigarettes in Canada, specifically the recommendation that "[E]lectronic cigarettes (e-cigarettes) that resemble conventional cigarettes (e.g., similar size, false filters, lighted tip, etc.) should be prohibited in Canada." Given your **PH** nursing background in smoking prevention, and your involvement in the Canadian Student Tobacco, Alcohol, and Drugs Survey, your Medical Officer of Health has asked you to prepare the health unit's response.

The intent of the legislation is to avoid "renormalizing" conventional cigarette use and prevent e-cigarettes from becoming a "gateway" for cigarette smoking, especially among youth. However, the proposal may also diminish the adoption and use of e-cigarettes by current smokers trying to quit. (Adapted from a case developed by the National Collaborating Centre for Healthy Public Policy ([2016]).

REFLECTIVE QUESTIONS

1. *What are the ethical issues in this case?*
2. *What **PH** ethics principles and/or values are relevant to this situation?*
3. *How would you go about making this decision?*
4. *What decision would your health unit make and why?*

The development of PH nursing ethics in Canada has lagged behind both PH ethics and nursing ethics. A feminist relational perspective on nursing ethics, however, has informed some areas of PH nursing practice such as tuberculosis (TB) care and treatment (Bender, 2009), working with high-priority families (Browne et al., 2010), child protection clients (Marcellus, 2004), and perinatal substance users (Marcellus, 2005), all of whom might be considered vulnerable, oppressed, disadvantaged, or marginalized in some way.

Drawing on notions of relational practice (Hartrick Doane & Varcoe, 2007), relational autonomy (Sherwin, 2004), and relational ethics in nursing (Bergum, 1994), the analysis of PH nursing practice with the population groups as described by the authors above reveals considerable congruence with other perspectives on PH ethics. Examples include a relational account of PH ethics (Baylis et al., 2008; Kenny & Sherwin, 2008; Kenny et al., 2010), critical PH ethics (Callaghan & Jennings, 2002; Nixon, 2006), feminist ethics in PH (Rogers, 2006), and a communitarian ethical perspective (Etzioni, 2003; Jennings, 2007; Selznick, 1998). These perspectives are also reflected in emerging PH ethics frameworks. The following Ethics in Practice case illustrates that "doing good" might not be as simple as it seems, because ethical challenges arise.

ETHICS IN PRACTICE 4-2

Ethical challenges with HIV Treatment as Prevention (TasP)

Recent scientific evidence has generated enthusiasm about a new approach to treating human immunodeficiency virus (HIV). Early access to HIV testing and immediate treatment for those who test positive—an approach referred to holistically as "treatment as prevention" (TasP)—is a powerful way to help end the HIV pandemic. Epidemiological and clinical researchers have demonstrated that the early treatment of HIV infection can have positive health outcomes not only for those treated, but also for preventing HIV transmission to non-infected people. Additionally, TasP can reduce TB morbidity and mortality.

You are a PHN and your Medical Health Officer and Chief Nursing Officer have asked you to work with a team to develop the TasP program. You recognize that to achieve the aims of TasP, several important ethical challenges must be addressed, including

developing relationships and trust with the HIV community. (This case was adapted from a research article [Sugarman, 2014]).

REFLECTIVE QUESTIONS

1. *What are additional ethical challenges in this case?*
2. *What ethical principles, values, and perspectives are relevant to this case?*
3. *How would you go about identifying and addressing these ethical challenges?*

In conclusion, nursing ethics and PH ethics have common ground through their application of feminist relational ethics.[6] Further advancements in the field will require drawing on the work above to develop ethical frameworks or guidelines for PHNs in dealing with other major ethical challenges in PH, such as the issues discussed below related to pandemic ethics.

What Is the History of Public Health Ethics?

The history and accomplishments of PH can be divided into three streams. The first stream reflects a history of coercive and authoritarian actions to control raging epidemics in the Middle Ages. Such measures persisted into the past two centuries, with severe restrictions not always imposed equitably across the population (Fairchild et al., 2020; Nixon et al., 2005). This history has haunted PH into the 20th century in relation to the epidemics and pandemics of Spanish flu, polio, Ebola and others. This history continues to haunt PH to this day in relation to other infectious disease pandemics such as Severe Acute Respiratory Syndrome (SARS-COV), swine flu (H1N1), avian influenza (including H5N1 and H7N9), and COVID-19 (SARS-CoV-2).

According to Kass (2004), Stage I of the modern era of PH ethics began in the 1970s and 1980s with the ethics of health promotion and the PH response to Aquired Immune Deficiency Syndrome (AIDS) (MacDonald, 2014). This response was known as AIDS exceptionalism (Smith & Whiteside, 2010), defined as "departures

from standard PH practice and prevention priorities in favour of alternative approaches to prevention that emphasize individual rights at the expense of public health protection" (Fisher et al., 2009, p. 45). This created its own set of ethical problems (MacDonald, 2014). Recently, Benton and Sangaramoorthy (2021) have revisited the question of whether AIDS exceptionalism has exacerbated the problems associated with exceptionalism in other areas of public health. They argue that it has, because this exceptionalism has further fragmented health delivery systems and reproduced unintended inequalities. They suggest that to end the AIDS pandemic, we must also end AIDS exceptionalism and return to tried and true principles of PH action.

The second historical stream reflects a more positive history of social justice and political action to improve population health (Nixon et al., 2005). In this stream, nurses were engaged in many progressive social movements (Beauchamp, 1976; Buhler-Wilkerson, 1993). During this period, PH achieved major advances such as improved water quality and sanitation, sewage treatment, maternal and child health services, improved housing and working conditions (Lalonde, 1974; Rutty & Sullivan, 2010), and the control of several communicable diseases.

The result of these and other PH measures was a dramatic improvement in population health, with increased life expectancy and reduced morbidity in both Canada and the US. In fact, PH interventions, rather than medical treatment and health care, contributed substantially to these improvements (Rutty & Sullivan, 2010; Tam, 2021). In Canada, there was a 30-year gain in life expectancy over the course of the 20th century, 25 years of which was due to PH interventions (Canadian Public Health Association [CPHA], 2010a; Tam, 2021). In the US, life expectancy increased 3.3 years between 1990 and 2015; 44% of the improvement was due to PH measures (Buxbaum et al., 2020).

In Stage II (from the beginning of the 21st century until about 2010), frameworks specific to PH ethics began to be developed. At this time, ethicists proposed new philosophical and political foundations that went beyond the classical utilitarian and contractarian theories (e.g., civic republicanism and communitarianism). It was in Stage II that PH ethics came into the limelight in Canada in the wake of a SARS

outbreak in 2003, which spurred efforts to renew the PH system and its infrastructure to be better prepared for the next PH crisis. SARS demonstrated that Canada was ill-prepared to deal with the ethical issues raised by serious epidemics (Singer et al., 2003). Some suggest that this history has repeated itself in the COVID-19 pandemic, which began in 2019 (Yu et al., 2020; Serebrin, 2021).

Canada has lagged behind the United States and the United Kingdom (UK) in the development of a focus on PH ethics, although Canadian ethicists have recognized the need for a "robust, coherent and meaningful ethic for public health" (Kenny et al., 2006, p. 402). Canadian feminist ethicists, through their theoretical work, have made important contributions to the broader development of PH ethics (Baylis et al., 2008; Kenny et al., 2010), particularly from a relational perspective. In fact, these authors have been widely cited since 2008. Several of the newer PH ethics frameworks contain relational principles proposed by these authors, such as relational autonomy and relational solidarity.

The most recent contribution to PH ethics in Canada was the development of several ethics frameworks by the national and provincial governments to guide decision making in pandemics. I discuss these in the final section of this chapter. The National Collaborating Centre for Healthy Public Policy, one of six PH collaborating centres in Canada, has established an extensive set of resources on PH ethics in general, and on ethics guidance for COVID-19 in particular. Other countries have also developed guidelines for action in a pandemic, as well as ethical decision-making frameworks.[7]

Kass (2004) described Stage III as the future of PH ethics, which she believed would revolve around three potential areas of concern: (a) public health research ethics; (b) environmental justice; and (c) global justice. She correctly predicted that ethics related to each of these areas would be the focus of debate and development in the future. Stage III encompasses the period from 2010 to the present day. In addition to the three areas of future concern identified by Kass, a number of other, perhaps smaller developments in PH ethics have emerged in this stage. Some important developments in this Stage III period include

1. *The availability of several new PH ethics frameworks for ethical analysis that are increasingly specific to PH aims*. Many of them include a broader range of principles (or normative criteria) more relevant to PH than the earliest PH ethics frameworks, which drew primarily on the four principles of health care ethics. Developers of these newer frameworks tend to draw from a wider theoretical and philosophical base; some of these frameworks are explicitly communitarian or include some communitarian principles (e.g., solidarity, relational autonomy, community participation). This was not the case with earlier frameworks (Baylis et al., 2008). Some Stage III frameworks also include methodological steps for ethical analyses that provide explicit guidance for ethical decision making. Such guidelines were absent from the earlier iterations.
2. *An expanded set of criteria to judge the adequacy of PH ethics frameworks*. The only authors found to provide such criteria in the early days of PH ethics were Kenny et al. (2006), who suggested five criteria that an appropriate PH ethics framework should meet.[8] First, the framework should address the tension between PH and individual interests. Second, it should take into account the public interest and the common good. Third, it should clarify the relationship between PH and health care. Fourth, it should attend to the social determinants of health. Fifth, it should recognize the importance of reducing health inequities and attending to the most vulnerable. Additionally, Marckmann et al. (2015) proposed that a good PH ethics framework should have, at a minimum, two features: a clearly defined ethical foundation to ground it; and a systematic, methodological approach for applying ethical criteria.
3. *Movement away from the centrality of the classic tension or struggle in PH ethics over the importance of individual rights and autonomy versus the common good*. Many authors still refer to this classic tension, which is embedded in most of the earlier PH ethics frameworks. Prior to the COVID-19 pandemic, PH ethics had, in general, started to shift away from "its traditional concern with the tension between

individual autonomy and community health" (Lee, 2017, p. 5) toward recognition of the complexity of interconnections and our place among social and ecological systems. This balanced perspective is important in pandemic ethics because society's response to a pandemic requires partnerships between PH and health care and reconciliation of the individual and the common good. Despite this shift, this tension has been a central ethical issue in the COVID-19 pandemic and the public's response to restrictive PH measures (Woods, 2022).

4. *A proposed merger between PH ethics, bioethics, and environmental ethics*. In 2017, Lee proposed that insights from PH ethics, bioethics, and environmental ethics need to be brought together to help people address the complex and interconnected ethical issues in PH, health care, and the environment. PH ethics focuses on health at various levels, specifically individual health, community health, and environmental health. As a field, therefore, PH ethics provides a framework for integrating analysis across these levels of concern. As noted in point 3 above, ethicists in PH have been dissatisfied with what they see as the false dichotomy of individual rights versus community health, and are now considering and acting upon values that are based on an understanding of our interconnectedness with each other, animals, and the environment (Lee, 2017, p. 10). The One Health[9] movement (El Zowalty & Järhult, 2020) is a reflection of this interconnectedness, as is global health and justice, and more recently, planetary health[10] (Whitmee, 2015).
5. *Movement away from a sole focus on distributive justice in PH ethics to include social justice as the moral foundation of PH ethics*. As noted previously in the section above on "What is Public Health Ethics?" many authors in the field refer only to distributive justice as a principle in PH ethics (e.g., Childress & Garre Bernheim, 2015), despite arguments that social justice should be the focus in PH ethics (Powers & Faden, 2006). Close to 50 years ago, Beauchamp (1976) coined the term "public health as social

justice," as noted in Wallack (2019), implying that PH practice, interventions, and actions, grounded in principles of social justice, aim to improve health and health equity. Thus, social justice is both a process and an outcome—as well as a central value and strategy—in PH (Wallack).

As mentioned above in the section "What is Public Health Ethics" (para. 5), many have argued that there needs to be more than distributive concerns in applying the principle of justice in PH (Moroni, 2020; Rogers, 2006; Young, 1990). For example, in a study in Alberta regarding immunization policy during the H1N1 pandemic in 2009, the authors demonstrated the predominance of distributive justice principles and the resultant problems associated with this view of justice. They argued that distributive justice caused difficulties for vulnerable groups and suggested that policymakers use a social justice approach as an alternative to distributive justice in pandemic immunization policy (Torrie et al., 2021).

6. *A significant focus on PH ethics in a pandemic* (or "pandethics" as coined by Selgelid [2009]). Several epidemics and pandemics have afflicted the world since the turn of the 21st century (e.g. SARS, H1NI, avian influenza, Ebola). Many authors have suggested that specific countries, and the world at large, were not adequately prepared for COVID-19 (Fairchild et al., 2020; Yu et al., 2020), despite warnings from WHO and PH experts. Thus, some countries—including Canada, the US, and the UK—have developed ethics frameworks and pandemic plans for guiding their responses to COVID-19. Around the world, governments have struck national and international committees and commissions to advise them on the local, national, and global responses to COVID-19. In addition, researchers globally have been conducting considerable research on all aspects of COVID-19. Ethical issues related to the pandemic are front and centre in the news, in conversations, and on social media.

In the following two sections, I discuss recent developments in Kass's three areas of concern for the future of PH ethics (PH research ethics, environmental justice, and global justice). In many ways, these three areas intertwine. Global justice encompasses the issue of global health equity as well as the ethics of global health and justice. Environmental justice interconnects with environmental health and environmental health ethics, as well as global justice, global health, and global ethics. PH research ethics applies to research on global and environmental health in the context of public health, and all of these have implications for justice.

Public Health Research Ethics

Kass (2004) discussed PH research ethics only briefly, but she believed that a central question would be whether ethical requirements for PH research should differ systematically from ethics requirements for other types of research involving human subjects. Several authors have since taken up this question (e.g., Bromley et al., 2015; Taylor, 2019). Although Kass acknowledged that much PH research would resemble other research in the intent to develop generalizable knowledge, she argued that conceptually, PH research is different in that it often involves the whole community or the population to be its "patient." This unique characteristic has different demands for ethical analysis. Kass's question has still not been resolved, nor have existing ethics guidelines for research fully addressed it (e.g., TCPS 2, 2018; the *Belmont Report*, 1979). The authors mentioned above have studied ethical issues in PH research with communities or populations as a whole, especially given the evolution of community-based participatory research (CBPR) (Banks et al., 2017; Wallerstein et al., 2017) in which the community as a whole is a primary stakeholder.

In Canada, the federal government established a Panel on Research Ethics (PRE) in 2001 (Panel on Research Ethics, 2022). This panel, in turn, struck an expert committee in 2014 (the Population and Public Health Research Advisory Committee [PPHRAC]) to advise on issues specific to the ethics of population and PH research (MacDonald, 2015b). The rationale emerged from a view within the PH community that the *Tri-Council Policy Statement on the Ethical*

Conduct of Research Involving Humans (TCPS 2) did not specifically address all relevant ethics issues related to research in population and public health (PPH). I had the privilege of sitting on that expert committee. The aims of the PPHRAC were "to identify key ethics issues in these fields of research, help craft ethics guidance in response to these issues, and advise on how such guidance could best be integrated into the TCPS 2" (MacDonald, 2015b, p. 7).

Despite my involvement in developing that guidance, I no longer believe that the committee fully addressed all the relevant ethical issues for PPH research. The main findings of the PPHRAC were that the TCPS 2 guidance, as it stands, is applicable to PPH research, but that examples and clarifications were necessary regarding some ethics-related aspects. These changes have been added to the 2018 version of the TCPS 2. One such area clarifies that, for PPH research, prior informed consent is not required in situations in which obtaining consent will preclude answering the research question. For example, an exception to the requirement for informed consent would be a situation in which a cluster-randomized trial is used to compare two different community-wide "stop smoking" campaigns in two separate communities. If informed consent was required in this situation, community members would be alerted to the presence of the campaigns, and this knowledge could affect the group response, creating validity problems. Thus, the research question could not be answered under these circumstances (TCPS 2, Article 3.7A, 2018).

Another addition was a clarification of the difference between observational research, as defined in the TCPS, and epidemiological observational research. Observational research, in general, refers to studies in which the behaviour and talk of participants are observed in natural settings (Jangiani et al., 2019), and can be qualitative in nature. Qualitative observational studies are different from the category of observational studies (non-experimental research designs) used in epidemiology (Mays & Pope, 1995). In epidemiological observational research,

> an investigator observes what is occurring in a study population without intervening. Sometimes these are called natural experiments. Observational studies may be

> descriptive or analytic. Examples of analytic studies include case-control, cohort, cross-sectional, and ecologic studies, as well as hybrid designs and the data are often quantitative. (Kelsey, 2008, p. 609)

Taylor et al. (2016) have pointed out that there are ethical issues in PH research that are not considered in traditional human research guidelines. For example, the revised TCPS 2 does not fully address the nature of community engagement in research, and how researchers should work in and with the community. In such a situation, the subject is often not an autonomous individual, but an entire community or population group. Taylor and colleagues (2016) argued that current regulatory frameworks do not provide sufficient moral guidance for researchers conducting primary prevention research in community settings, where the entire community is a stakeholder and outcomes are at the community level. They suggested that communities, not just individuals, have interests and rights that researchers must take into account.

The corresponding researcher duties in this type of investigation include duties to respect the community, to do no harm to the community, and to benefit the community. These duties, however, do not readily translate to similarly worded duties owed to individual research participants. In the 2018 TCPS 2, the focus seems to be primarily on individuals as research subjects or participants, and does not include harms or benefits at the community level.

The exception to this is Chapter 9 of the TCPS 2, "Research Involving the First Nations, Inuit, and Métis Peoples of Canada," in which the rights and welfare of Indigenous communities as a whole are acknowledged. The chapter's main principles include the need for researchers to engage with the community; to balance individual and collective interests; to respect codes of research practice that go beyond the scope of ethical protections to individual participants; and to acknowledge the important role of Indigenous communities in promoting collective rights, interests, and responsibilities that also serve the welfare of individuals.

This chapter in the TCPS 2 is directed specifically at investigators doing research in Indigenous communities. Thus, it may not be read or considered by PPH researchers doing research in non-Indigenous

communities. I argue that in a PPH research context, the TCPS 2 needs to provide guidance for research with communities as a whole that may comprise populations other than Indigenous Peoples.

Another issue that has implications for ethics in PH research is the emergence of, and increase in, community-based participatory research (CBPR). This type of investigation focuses on research subjects with lived experience of the phenomena under study, or people who have responsibility for such populations (for example, members of community agencies). Rather than being "subjects," they are understood to be active participants who are involved at every stage of the research process. In most nursing research, and in much qualitative research, investigators generally do not use the word "subjects," but instead refer to "participants." This shift in role from subject to participant raises several ethical challenges. Bromley et al. (2014) identified and categorized several challenges that reflect some very difficult-to-manage issues that are not generally included in ethical guidance from research ethics review boards. For example, the shift from subject to participant "calls into question current understandings of consent and autonomy" (p. 907). Consent may be required from the community as a whole, as represented by community leaders who have authority to speak for the community in consenting to research. In CBPR, participants are both individual and collective actors, and yet ethics review boards often "sidestep this difference between individual and collective identities and do not resolve the question of who can decide for whom in research" (p. 907).

Buchanan and Miller (2006) examined the implications of the moral imperative in PH to protect population health, and raised questions about the appropriate norms to guide research ethics in this context. The authors argued that taking a PH perspective on research ethics means "broadening the conceptualisation of risks and benefits deemed ethically relevant in deliberations on health research" (p. 730). Researchers must identify benefits and risks not just for individual research participants, but also for the population or community as a whole. Examples of community risks may include the stigmatization of communities on the basis of the research findings, or community economic losses. These issues are not, in my view, adequately addressed in the TCPS 2 guidelines or in

the relevant guidelines of other countries (e.g., the US *Belmont Report* [1979]).

How should researchers account for community in their consideration of PH ethics? Taylor (2019) suggests that the conventional application of research ethics to PH research is unlikely to account for the risks and benefits at the community level, producing avoidable harm to the whole community (for example, negative attitudes and beliefs about the community). Many PH researchers in the United States find the Belmont principles relevant to their work, but insufficient in that the principles fail to include the community as a key stakeholder in the research (Taylor, p. 9). Taylor suggests that the principle of community should be a critical and necessary addition to the Belmont principles. In turn, I would argue that we should also add it to Canada's TCPS 2. The following Ethics in Practice case is an example of how communities are dramatically affected by the ethical decisions that are made by public health care researchers.

ETHICS IN PRACTICE 4-3

Communities Experiencing High Rates of HIV, Substance Use, and Overdose Deaths

There are two cities in a Canadian province, each with a large community in the inner city core, that have sizeable populations experiencing high rates of HIV infection, substance use, and overdose deaths. Many of these people are also homeless. Two independently established organizations of peers, with lived experience of these issues, provide counselling and support to the populations in each city. Each of these groups works in collaboration with a community centre in their city to support the population experiencing homelessness through provision of meals, health care, transitional housing, and addiction services. A team of harm reduction researchers working in a university research centre wants to conduct a cluster-randomized trial in the two cities to compare the effects of two evidence-informed, community-wide interventions to reduce the incidence of HIV infection, substance use, and overdose deaths in these communities.

REFLECTIVE QUESTIONS

1. *What research approach is appropriate for such a study?*

2. *What are the ethical issues in this Ethics in Practice situation?*
3. *What PH ethics principles and values are important to consider in this study?*
4. *What consent procedures should this team use and why?*
5. *What steps should the research team take to plan and conduct the study, as well as disseminate the study findings?*

Environmental and Global Health, Justice, and Ethics

In this section, I combine discussion of specific topics raised by Kass (2004)—about environmental and global health, justice and ethics—because they are intertwined and difficult to separate. These topics are also rife with disagreement and controversy, and the challenges of addressing them are so extensive that it will take massive efforts on the part of nation states at a global level. Even though Kass (2004) identified them as future issues in PH ethics, the future is now, and the questions these topics pose are far from being resolved. Unfortunately, progress in addressing environmental and global ethics and justice has been limited.

Environmental health is one of the main branches of PH that focuses on the relationships between people and their environments. In environmental health, the aim is to promote human health and well-being and ensure safe and healthy communities. Practitioners work to advance policies and programs to reduce chemical and other environmental exposures in air, water, soil, and food to protect people and provide communities with healthier environments.

Environmental ethics is the study of ethical questions raised by human relationships with the non-human environment, including nature and animals (Palmer et al., 2014). Environmental ethicists identify reasons why non-human nature, species, and ecosystems have inherent value. As such, their worth cannot be reduced to economic value or other instrumental value that serve only the needs of the human species. As Palmer suggested, "Many environmental issues are as much ethical issues as they are economic or legal issues" (p. 421). Within environmental ethics, there are contrasting views about the main problems in the field,

and questions about how they should be addressed. Many PH and environmental ethicists (e.g., Kopnina et al., 2018) believe that anthropocentric attitudes, that is, "the belief that value is human-centred and that other beings are means to human ends" (p. 109) are a cause of our environmental problems, and that "anthropocentrism is at the root of our ecological crises" (p. 109).

Environmental justice, defined simply as "equitable exposure to environmental good and harm," (Stewart, 2020, p. 111), began as a social movement in the 1970s in response to environmental pollution and toxic waste dumping in racialized communities and poor neighbourhoods. Key principles of environmental justice include, but are not limited to: (a) ecological unity and an understanding that all species are interdependent; (b) the right to ethical, balanced, and responsible land use; (c) the right to political, economic, cultural, and environmental self-determination; (d) cessation of hazardous waste production; (e) accountability on the part of current and past producers of such wastes for detoxification and containment; (f) the right of workers to a safe and healthy environment; and (g) the right of victims of environmental injustices to reparations for damages (Ramirez-Andreotta, 2019).

Given the existing problems of increasing urbanization, globalization, and environmental degradation, the meaning of environmental justice has expanded to include generational and global environmental justice (Bolte et al., 2011). This expansion connects environmental justice to global health and ethics. Of all the global justice issues, however, one of the most significant and visible is that of global poverty, which our current global order has caused and perpetuated (Brock, 2021). It has also created considerable health inequities across the world.

Even more important in the context of planetary health is the issue of climate change and climate justice. Many believe climate change to be the most significant global, health, justice, and ethical issue facing the world. In 2015, *The Lancet* journal published an extensive report, "Safeguarding Human Health in the Anthropocene Epoch: Report of the Rockefeller Foundation – Lancet Commission on Planetary Health" (Whitmee et al., 2015), which described the state of the planet's health at the time and what would be required to address the problems. The authors laid out, in

stark relief, the future ethical issues we are facing as a species. While Benetar et al. (2003), and many others in the scientific community, argued for urgent action almost 20 years ago, little progress has been made.

The current global context includes rapid advances in science and technology, growing health inequities, increasing levels of extreme poverty, inequities in patterns of health care expenditures across the globe, and population growth, with its attendant increase in overconsumption and environmental degradation. In light of this, Benatar et al. (2003) argued convincingly for the importance of global health ethics when considering environmental justice. They made very clear the ethical challenges for which solutions are essential to prevent massive displacement, rebellion, and violence from those disenfranchised groups that are systematically excluded from the benefits that others have achieved, and those who may experience the negative consequences of environmental degradation (MacDonald, 2015b).

Some Useful Frameworks for Analyzing Public Health Ethical Issues

Early PH ethics frameworks were developed to help practitioners and PH leaders analyze PH issues and guide ethical decision making in specific situations. As mentioned previously, some of the early frameworks used for PH ethics drew on the four basic principles of bioethics (autonomy, beneficence, non-maleficence, and justice) (Beauchamp & Childress, 1979), with some modification to make them fit for the PH issue at hand. The frameworks developed after 2010, and particularly after 2015, were more likely to reflect the moral aims of PH, with principles that were relevant and specific to the practice of PH.

In MacDonald (2015b), I conducted a detailed comparison and evaluation of eight early PH ethics frameworks. I explained various categorizations of PH ethics frameworks and compared them on the PH issue addressed, the principles and process, and the theoretical foundation. I also critiqued these frameworks. I did a second comparison of the frameworks using the five criteria for judging framework adequacy by Kenny et al. (2006). Although these are

older frameworks, they may still be relevant to use for resolving some PH ethics issues today. However, a new evaluation and critique of recent PH ethics frameworks containing principles more reflective of PH values would likely be more helpful in resolving current ethical dilemmas.

What Are the Ethics of Pandemics?

Responding to pandemics is a PH issue on local, provincial, national, and international agendas. Although I mentioned earlier in this chapter that there had been a shift in PH ethics away from the classic tension between the individual and the common good toward balancing the two concerns, the COVID-19 pandemic has revived this paradigm struggle in PH. Because we can expect more pandemics in the future, this tension will continue to be raised. The WHO (2007) has predicted that we can expect to experience at least three pandemics per century, at intervals of 10 to 50 years; however, it is uncertain whether that timeline is speeding up, given the fact that three pandemics have recently occurred within a 20-year span (SARS in 2003, H1N1 in 2009, and COVID-19 in 2019). Although not all serious epidemics become pandemics (e.g., H7N9 [avian influenza], Middle East Respiratory Syndrome [MERS], H5N1 [another avian influenza]), these outbreaks were still serious enough to generate considerable worry given the high mortality rates associated with them (H7N9 39.3%; MERS 34.4%; H5N1 52%) (*Atlas Magazine*, 2020).

The SARS and H1N1 pandemics gave only a taste of the impact of a pandemic on countries and citizens of the world. In those past pandemics, North Americans and Europeans experienced very few of the PH containment measures that have occurred with COVID-19, such as social distancing, mask wearing, quarantine, travel restrictions, business closures, and restrictions on public and private gatherings. More recently, we have experienced challenges with the rollout of a vaccination strategy accompanied by the requirement for vaccine passports as proof of immunization.

Despite broad public support for PH measures, a sizeable segment of the population opposed many of these containment strategies, which led to protests and demonstrations across Canada

and around the world. What seemed unique about this pandemic was that there was considerable disagreement within the population about both the effectiveness and legitimacy of the PH measures. Social media contributed to the spread of much misinformation about COVID-19, its treatment, and the PH response, which allowed for rapid promulgation of conspiracy theories. There was also considerable disagreement among scientists about these issues, and some argued that the evidence was conflicting (Angeli et al., 2021; Dahlquist & Kugelburg, 2021).

In fact, a study by European researchers defined the COVID-19 situation as a full-fledged policy "wicked problem" (Angeli et al., 2021, p. 1). This study involved an ethical analysis of the two scientific views that were put forth during the COVID-19 pandemic: the Great Barrington Declaration (Kuldorff et al., 2020) and the John Snow Memorandum (Gurdasani et al., 2021). These two scientific petitions, signed by credible scientists, translated the same scientific evidence into polar opposite advice regarding COVID-19 response policies (Angeli et al., 2021).

This discrepancy occurred because, as Angeli and colleagues (2021) argued, each group used a "different ethical compass," in which various ethical values were given different weights by each group. The Great Barrington proponents (Kuldorff et al., 2020) argued against a lockdown approach, favouring a containment approach that focused on the most vulnerable and imposed only limited restrictions on the majority. The John Snow group (Gurdasani et al., 2021) instead argued for continuing restrictive lockdown measures on everyone.

Angeli et al. (2021) recommended that a *situated policy* approach was required in this situation, involving consideration of the sociocultural and socio-economic context. Such consideration may lead to different conclusions and strategies in different contexts. They argued that a one-size-fits-all approach cannot work in all circumstances. The investigators illustrated how disagreement on policies could evolve within different scientific communities based on the values held by the various parties to the disagreement.

In my analysis of pandemic plans (MacDonald, 2013), several ethical challenges emerged in relation to pandemic planning that also have continued relevance for the COVID-19 pandemic response.

These challenges include: (a) allocating scarce resources for both prevention and treatment (e.g., vaccines, anti-virals, ventilators, personal protective equipment [PPE], and hospital beds, particularly ICU beds); (b) obligations of health care workers to provide care in the face of risk to self and family, and the reciprocal obligations of organizations to their workers; (c) implementing restrictions and social distancing measures for individuals and groups (e.g., isolation, quarantine, restrictions on travel and movement, closure of public spaces, and limits on public and private gatherings); and (d) obligations of countries to one another in pandemic responses. Because infectious agents do not honour national boundaries, as we have seen, poor containment in one country can have serious global consequences.

During the COVID-19 pandemic in Canada, one particular containment measure had serious economic consequences. This was the mandated closure of some types of businesses because of the risk of widespread disease transmission (e.g. restaurants, gyms, recreational facilities, hair and nail salons, etc.). This did not occur during either the H1N1 or SARS pandemics, perhaps because the duration of these smaller pandemics was much shorter, and economic adversities did not have time to develop. In addition to the businesses mandated to close during the COVID-19 pandemic, there were many other closures due to lack of staff and other factors that impeded the ability of businesses to carry on with regular activities. For example, by September and October of 2020, two thirds of businesses in Canada had laid off half or more of their staff. Approximately one third did not know how much longer they could operate (Leung, 2021).

Another restrictive control measure that had difficult consequences for many was the closure of schools at all levels. At the elementary level, school closures had mental health impacts on students, and economic impacts on parents who had to stay home to care for their children and could not go to work. Although "work from home" strategies helped to offset this, the impacts were debated (Edwards, 2022). The closure of churches, synagogues, mosques, and other places of worship was devastating for many of my own friends, acquaintances, and community members. It seems likely that this was true for many others in the population.

Some Public Health Ethics Frameworks for Managing COVID-19

Canada and other countries developed guidelines for managing the pandemic in the form of ethical decision-making frameworks. Given the evidence that scientists interpret data in relation to the ethical values they hold (Angeli et al., 2021), it is worth exploring the values contained in these frameworks to determine whether and how these values are a fit with the necessary considerations in PH. Do they contain values and principles that are relevant and important to the values and aims of PH?

In the four sections below, I briefly summarize the values and principles contained in four Canadian ethical decision-making frameworks for COVID-19 and/or other pandemics, exploring their relevance to PH. I have italicized these values and principles in the sections below to bring them to the attention of readers. They are also explained in more detail in Appendix 4-1, which provides a summary of the frameworks from the Governments of Canada, British Columbia (BC), Alberta, and Ontario.

Government of Canada

The Government of Canada (2021) *Public Health Ethics Framework: A Guide for Use in Response to the COVID-19 Pandemic in Canada* contains values that are relevant and specific to the moral aims of PH. The two foundational principles or values are *trust* and *justice*. In this context, justice should be understood to primarily refer to distributive justice, but aspects of social justice may be implied in the framework's focus on equity versus equality. In aiming to eliminate inequities in the burdens of pandemic restrictions on the population, the framework encompasses structural considerations and thus, the principle of *social justice*. This is suggested in the statement that attention should be paid to those most vulnerable to injustice, or those disproportionately affected by the pandemic.

The principle of *respect for persons, communities, and human rights* in the framework goes beyond the usual focus on individual autonomy because it includes the community as a whole, and thus could reflect relational versus individual autonomy with respect to

the community. Inclusion of this principle also acknowledges the need to respect the rights of Indigenous communities—again, moving beyond an individual focus. This framework also incorporates the *precautionary principle*,[11] an important concept in PH that has only been included in PH ethics frameworks since about 2015. In the principle *promoting well-being*, the community is included, unlike in most early PH ethics frameworks. The principle of *working together* could be interpreted as reflecting the notion of *solidarity*, another important principle in PH ethics that has emerged in recent frameworks. Working together also reflects a relational understanding of persons as part of the greater whole. The principle of *intersectionality*[12] (i.e., applying an intersectional lens), which encompasses and promotes social justice, has also been included.

Government of British Columbia

The BC *COVID-19 Ethical Decision-Making Framework* (BC Provincial COVID-19 Taskforce, 2020) includes similar principles to the other three frameworks. In keeping with Kenny et al.'s (2006) criteria for the adequacy of a PH ethics framework, this framework helps us distinguish between PH and clinical ethics. Respect is one of the framework's key principles, but unlike in the Government of Canada framework, only individual respect is mentioned. There are no principles that focus on doing good (often referred to as "beneficence"), although most PH ethics frameworks include it. There is reference to the *harm principle*, which reflects the paradigm tension between promoting community versus individual health and possibly impinging on individual rights. Most writers of recent PH ethics frameworks now propose finding a balance between individual and collective rights rather than prioritizing one over the other, as discussed earlier in this chapter under point 3 of the "What Is the History of Public Health Ethics?" section. The principle of *fairness* (justice) is included, and encompasses both *equality* (everyone matters equally) and *equity* (those who most need resources ought to receive them preferentially). A utilitarian view on justice is reflected in the principle that resources should be distributed to achieve the greatest good for the greatest number. *Cultural safety* is

an important substantive principle, which is not generally seen in most PH ethics frameworks, but is included in this one.

Working together is also included as a principle within procedural considerations, along with the principle of solidarity. Solidarity, however, is often viewed as a substantive principle in other frameworks. Here, solidarity is a concept inherent in the notion of "calculus of consent," in which questions such as "Why should I care? Why should I help? Why should I contribute to the public provision of others?" are asked of ourselves and others to justify why we should follow laws, rules, and policies (Jennings & Dawson, 2015, p. 31).

The BC framework is an eight-step methodological framework, in keeping with Marckmann et al.'s (2015) criteria for the adequacy of a PH ethics framework. Overall, this BC framework is quite reflective of many PH values, although it is not as reflective of PH ethical values as those found in the Government of Canada framework.

Government of Alberta

Alberta's Ethical Framework for Responding to Pandemic Influenza (Alberta Health, 2016) focuses on pandemics in general, not just COVID-19. The Government of Canada and British Columbia frameworks specify both substantive and procedural principles and values. Alberta does not discuss them separately, although the framework does include both. Some of the procedural principles are included under the value of *making good decisions*. A weak version of solidarity is inherent in the principle of respect, as is equity, although under the principle of fairness, it seems that in the framework equity and equality are conflated. A positive aspect of this framework is that there is an attempt to balance individual rights and societal need. In the principle of working together, there is a weak implication that it is related to solidarity. In the framework, the concept of inclusiveness relates to the principle of participation, which was rarely included in early public health ethics frameworks, but is appearing more frequently in newer PH ethics frameworks.

Government of Ontario

The Government of Ontario's (2020) *Ethical Framework for COVID-19 Vaccine Distribution* is not specifically concerned with COVID-19's ethical considerations. Rather, it aims to guide decisions regarding the prioritization and distribution of vaccines, making it a narrower and more limited framework than the other three discussed here. Like the Alberta framework, there is more focus on equality over equity, although it appears that equality is understood as equity despite differences in meaning. There is a limited focus on solidarity—within the understanding of *working together*—in comparison to other frameworks. However, the authors do suggest that using all the principles will "advance relationships of social cohesion," (Public Trust, para. 1) which may be seen as reflecting the principle of solidarity. Including affected parties in the decision making is identified as important, and, therefore, may be seen as supporting participation.

Conclusion

Public health ethics has come a long way in the past four decades, with extensive theoretical and empirical work being conducted internationally, as well as in Canada. The National Collaborating Centre for Healthy Public Policy (NCCHPP) in Quebec, one of six National Collaborating Centres for Public Health, has been curating and developing an extensive array of materials and resources to help build the capacity for PH ethics in Canada. These include an online course and a range of diverse publications, presentations, webinars, and videos on PH ethics. I encourage anyone interested in PH ethics to browse the ethics section of the NCCHPP website (NCCHPP, n.d.).

Developments in the philosophical underpinnings of PH ethics and frameworks to guide practice and decision making have been substantial, with an expansion of the range of philosophies and theories and a large increase in the number of ethics frameworks explicitly oriented towards PH. Although many ethics frameworks remain grounded in liberalism, more communitarian frameworks

have emerged, as well as frameworks with a broader range of principles and values relevant to public health.

PH nursing ethics, although it has been expanding, continues to lag behind developments in nursing, feminist, and PH ethics. Nonetheless, the 2017 CNA *Code of Ethics* includes more content relevant to PH nursing ethics than previous versions. I suggest that concerted work to foreground PH nursing ethics in conjunction with these other developments would be useful. In particular, PH nursing ethics frameworks are needed that build on the insights found in feminist relational theory, nursing ethics, and PH ethics; such frameworks ought to be focused on the unique ethical challenges experienced by PHNs. To support this work, more research is necessary to clarify the nature of the ethical challenges public health nurses experience when working with communities and populations, as distinct from the ethical challenges of nurses working in institutional settings with individuals. Attention to PH ethics education for PHNs, as well as PH practitioners in general, is important to ensure that there is capacity in the workforce to deal with the ethical challenges in PH practice.

A great deal more work in public engagement is necessary to inform the values underlying PH ethics, particularly for managing public health emergencies. The COVID-19 pandemic has made clear that many in the population do not understand the legal, ethical, and historical basis for managing the challenges of a pandemic in ways that address the paradigm tension in PH between the individual and the common good, or in ways that promote population health, relational justice, solidarity, and equity.

In the second edition of *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice* (Storch et al., 2013), I concluded Chapter 20 with a long list of PH ethics issues for the future, many of which remain current today. The updated list includes: (a) defining societal versus individual responsibility for health; (b) understanding the relationship between health and human rights at the population level; (c) priority setting in public health; (d) cost-effectiveness analysis and its inability to take equity into consideration; (e) the relationship between health and economic development; (f) ethics in emergency humanitarian interventions; (g) environmental and global justice; (h) global aging; (i) global health equity;

(j) planetary health; (k) population and public health research ethics; and (l) public health system reform.

While ethical analyses have been limited for many of these issues to date, the list above provides a useful agenda for further development in the field of PH ethics. With respect to the items on this list, it will be important for nurse ethicists to continue to identify and define the ethical implications for public health nurses in order to advance the field of PH ethics in nursing.

QUESTIONS FOR REFLECTION

1. *How might you reconcile the individualist focus of most human rights approaches with the collectivist or population focus of public health ethics? Is it possible to reconcile a concern with individual human rights and population level or public health ethics?*

2. *How does this chapter provide you with guidance in thinking about pandemic responses for the future?*

Endnotes

1 This chapter is adapted and revised from: MacDonald, M. (2013). Ethics of public health. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 398–429). Pearson.

2 I have organized the current chapter in much the same way as in the second edition of this text (Storch et al., 2013), with similar headings that define public health, the meaning of "the public" in public health, the history of public health ethics, ethics in public health nursing, and ethical concerns in a pandemic.

3 Childress et al. (2002) have conceptualized three notions of public: the numerical public, the political public, and the communal public. I previously explored these three notions of public and discussed an evocative understanding of the public by Jennings (2007). (See MacDonald 2013 and 2014 for this discussion).

4 For a discussion and critique of the philosophical and theoretical basis for PH ethics, please refer to two earlier publications (MacDonald, 2013, 2015a), in which I explored the liberal foundations of PH ethics in utilitarianism, contractarianism, and rights-based approaches and discussed the emergence of communitarian perspectives in PH ethics. Drawing from a framework by Jennings (2003), I discussed how various strands of ethical and political theory connect and have implications for PH ethics. I reviewed a range of core ethical concepts from civic republican and communitarian traditions and discussed their implications for PH ethics. Finally, I explored different understandings of liberty in the liberal and communitarian traditions.

5 G. Rose, in his landmark *Strategy of Preventive Medicine* (1992) explained the paradox between the two main preventive approaches to a disease, the individual- and population-based.

6 Please refer to Chapter 1 in this book.

7 An article in which I analyze several recent PH ethics frameworks published since 2015 is currently under development.

8 I used their criteria to evaluate eight PH ethics frameworks, as noted in Appendix 2 in MacDonald (2015b).

9 One Health is an approach that recognizes that the health of people is closely connected to the health of animals and our shared environment (Centers for Disease Control and Prevention, 2022).

10 Planetary health is "the achievement of the highest attainable standard of health, wellbeing, and equity worldwide through judicious attention to the human systems—political, economic, and social—that shape the future of humanity and the Earth's natural systems that define the safe environmental limits within which humanity can flourish. Put simply, planetary health is the health of human civilisation and the state of the natural systems on which it depends" (Horton & Low, 2015).

11 For a detailed essay about the precautionary principle as it applies to public health, please see Beloin (2009).

12 Intersectionality, a broad theoretical perspective, provides a way to understand how multiple social identities (e.g., gender, race, disability, sexual orientation, etc.) intersect at the level of the individual or group and reflect social constructions of oppression and privilege (Bowleg, 2012). It is a framework that

accounts for the synergistic or amplifying effects of multiple forms of oppression (Betker et al., 2019).

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APPENDIX 4-1

Canadian Frameworks for Responding to the COVID-19 (or Another) Pandemic

	CANADA (PUBLIC HEALTH AGENCY OF CANADA)	BRITISH COLUMBIA	ALBERTA	ONTARIO
PURPOSE	• For policymakers & PH professionals making decisions in the context of COVID-19	• To ensure ethically defensible decision making • To serve as a transparent guide before, during and after pandemic • To ensure integration of shared values into decision making • Contribute to improved health outcomes and service delivery • Increase public awareness, confidence and preparedness	• To provide a resource for planners and policy makers to consider ethical implications of the choices they make related to responding to a pandemic	• To guide decisions about COVID-19 vaccine prioritization and distribution decisions
SUBSTANTIVE PRINCIPLES/ VALUES	• trust and justice • respect for humans, communities, and human rights • promotion of well-being • minimizing harm (effectiveness, proportionality, reciprocity, precaution) • working together	• respect • the harm principle • fairness • least coercive & restrictive means • working together • reciprocity • proportionality • flexibility	• respect • minimizing harm caused by pandemic influenza • fairness • working together • reciprocity • keeping things in proportion • flexibility • making good decisions	• minimize harms & maximize benefits • equity • fairness • transparency • legitimacy • public trust

PROCEDURAL PRINCIPLES/VALUES	• accountability • openness & transparency • inclusiveness • responsiveness • intersectionality	• openness & transparency • inclusiveness • accountability • reasonableness	• openness & transparency • accountability • reasonableness	
PROCESS	1. Identify issue, gather facts 2. Identify & analyze ethical considerations, prioritize values & principles 3. Identify and assess options in light of values and principles 4. Select best course of action & implement 5. Evaluate	1. Define the issue 2. Clarify the facts if possible 3. Identify stakeholders & perspectives 4. Identify & analyze principles & values 5. Identify alternative courses of action in light of values 6. Make a decision 7. Implement decision 8. Review & document decision	1. Follow ethical considerations worksheet in which the principles/values are considered for three different options (to be selected) 2. Fill in summary of decisions worksheet for the following: • the question being addressed • recommendations • this allows us to best ... • this solution does not ... • justification	No specific steps are specified other than a general directive to take the principles into account, follow human rights legislation, and take additional steps necessary to prevent and treat COVID-19 among vulnerable groups