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Akiva Turner, PhD, JD, MPH

ABSTRACT

Whereas public health practitioners and leaders regularly make decisions that require some degree of ethical consciousness, sometimes these decisions are guided or even heavily influenced by political ramifications rather than healthcare and public health ones. Some relatively recent decisions in Florida and at the national level involving public health authorities may have been made where politics won out over sound public health practice. Only a few studies exist regarding what public health employees consider to be ethical issues in practice and there are few formal bodies that guide ethical practice in public health. In this commentary I argue that attempts to bridge the gap between academic public health ethics and practice will have to address the political nature of public health entities. Ethicists may need a better understanding of the political interference experienced by practitioners as well as weigh in with ethical analyses, invited or not, during the public health political process.
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In 2009, public health departments were occupied with the H1N1 epidemic and the dispensing of H1N1 vaccinations. At that time, I was the Director of Communicable Diseases for the Broward County (Florida) Health Department. Each county was responsible for distributing vaccines to community providers. Initially, only small quantities were in hand and county health departments were faced with an ethical problem of determining allocations. We had far more demand than we had supply. At the county health department level we could see electronic requests by provider and we knew our vaccine inventory all too well. Often, late at night, and working around the clock, health department leaders would stare at a single computer screen and discuss our inventory that was going out faster than it was coming in. We had to disseminate what little vaccine we had, but the questions arose - to whom and how much? We had Centers for Disease Control (CDC) guidance that listed four priority groups (CDC, 2009). However, we did not have enough vaccine even to meet the demands of providers that might serve one priority group. There were certain external political pressures facing us in making these decisions and the computer was blinking waiting for us to choose who would receive and who would not. We had to push the submit button that night. We did so without bending to outside political considerations though it was not at all easy.

It was also in 2009 that I returned to the Florida Department of Health (FDOH) after having worked for two years in New York. Before leaving Florida to go to New York, I served as the CEO of A. G. Holley State Hospital, Florida's tuberculosis (TB) hospital. During my tenure at A. G. Holley, there were many political pressures to close the hospital but the FDOH kept it open. The hospital had an amazing cure rate and played an important role in the control of TB as well as in teaching and research. In 2012, during one of the state's largest TB outbreaks in years, the FDOH closed the facility and contracted with two other entities to provide inpatient TB care. There was no objective input concerning the ethics of closing the facility before the decision was made, and no objective input on how to make the transition an ethical one. It just had to be done and it had to be done quickly. At an incident command meeting to close the hospital, at which I was present, it was made blatantly clear that any employee who suggested the hospital should remain open would no longer be employed by the FDOH. I have not seen any data or a comparison of cost, quality of care, and patient outcomes between when the hospital was open versus the State's new model of TB care. That would be essential to look back upon to review the ethics of the decision at least in hindsight. My point here, though, is that this closure, pushed by political pressures, impacted the way TB

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care is handled in Florida. Yet, to my knowledge, there was no public health ethical analysis about such a closure and no ethicists stepped forward to voice an opinion. Nevertheless, some of the nation's leading TB experts did question the closure making arguments that were ripe for an ethical analysis (Furlow, 2012).

Public health practitioners and leaders regularly are confronted by ethical decisions, albeit many less newsworthy than the closure of a TB hospital during a TB outbreak or launching a major emergency vaccination enterprise during a vaccine shortage. I should note that most decisions public health authorities make are probably ethical.

There have been a few studies surveying public health employees about what they consider to be ethical issues in practice. For example, a study of public health practitioners in Michigan found five categories of ethical issues important to practitioners: (1) determining the appropriate use of public health authority; (2) making decisions related to resource allocation; (3) negotiating political interference in public health practice; (4) ensuring standards of care; and (5) questioning the role or scope of public health (Baum, Gollust, Goold, & Jacobson, 2009). However, the major theme that arose is that "political issues engendered ethical tensions and challenges in daily practice" (Gollust, Baum, & Jacobson, 2008, p.340). In another set of focus groups, Bernheim (2003) found that "participants described ethical issues that arise because they felt constrained by governmental relationships and politics" (p. 107). Indeed, the third factor in the first study above, "negotiating political interference," influences the other four. This factor may be why some ethicists have suggested that the very scope of public health is fundamentally political (Gostin & Bloche, 2003).

The academic endeavor of public health ethics is relatively new compared to the field of medical ethics and the connection between the academic enterprise and actual practice is in its very infancy (Thomas, 2008). Various approaches have been proposed to assist public health actors to incorporate ethics into practice. Some have suggested formal ethics education (Bernheim, 2003; Thomas, 2008). Others have suggested developing useful tools and frameworks that practitioners can use in day-to-day practice (Baum et al., 2009). Still others have suggested that an organization serve as a clearinghouse with a database of ethical cases and issues and how they were resolved (Pestronk & Jacobson, 2008). Though excellent ideas, the suggestions do not adequately address the political interference that permeates ethical decision making in governmental public health practice.

I am aware of at least two attempts to create a structure to incorporate public health ethics formally into public health agencies, particularly in the area of planning. In 2005, the CDC developed a process that involved an outside ethics subcommittee to the Advisory Committee to the Director (ACD), as well as an internal ethics committee and a public health ethics position to provide coordination (Barrett, Bernier, & Sowell, 2008). The CDC established educational activities, an internal consultation procedure, and developed ethical guidance documents. Unfortunately, according to the CDC website, at its "April 25, 2013 meeting, the ACD unanimously voted to terminate the ethics subcommittee and instead convene a workgroup on an ad hoc basis." The ACD minutes state that "because some ethics-related functions are inherent in the Office of CDC's Associate Director for Science, CDC staff recommend "sunsetting" this subcommittee and convening it as a workgroup on an as-needed basis" (CDC, 2013).

The FDOH, Office of Public Health Research, also supported and launched a temporary workgroup of mostly outside ethicists, primarily charged to review a pandemic influenza plan. The workgroup, of which I was an internal member, produced a 2010 report for the FDOH. At that time there was also an employee in the FDOH with the title State Public Health Ethicist. This person oversaw an Ethics and Human Research Protection Program. He was also a member of the workgroup. Though FDOH still has an Institutional Review Board (IRB), the position delegated a broader ethics mission beyond research was specifically eliminated by the legislature.

These examples beg the question of why there are few such bodies advising public health authorities and why in some cases they have not been sustainable. Funding issues is an easy answer but I think it goes much deeper than that and is interwoven with the major ethical issues facing public health practitioners (i.e. political interference). Such bodies are likely to be funded and ultimately controlled by the very governmental entity that seeks the advice. Internal ethics groups are likely to feel the same pressure as practitioners, and most outside ethicists would be unlikely to bend their opinions to political will. Therefore, a politicized governmental entity may not be willing to fund and provide ongoing support to a body that may render an ethical opinion that would run counter to its political desires.

Attempts to bridge the gap between academic public health ethics and practice will have to deal with this political nature of public health entities. Consequently, a formal structure to a state or local public health department may not have great influence

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on public health practice. Instead, ethicists may have to focus their craft more closely to the source of the political influence, not just to the practitioner who makes decisions beneath the weight of that influence. This focus would need to go beyond examining public health governmental action (Holland, 2010). It would mean that ethicists gain a better understanding of the political interference experienced by practitioners as well as weigh in with ethical analyses, invited or not, during the public health political process. By doing so, the distance between the growing intellectual discipline of public health ethics can reach the practice it seeks to affect. It sounds like dirty work for philosophers, academics, and ethicists but politics is part of the very nature of governmental public health.

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