From Theory to Practice: Working Towards Common Principles and Frameworks for Population and Public Health Ethics

Pre-conference Workshop
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Presented by:
CIHR-Institute of Population and Public Health
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Workshop Background and Objectives

Population and public health ethics can be distinguished from traditional bioethics by its primary focus on: (1) populations rather than individuals; (2) a wide range of interventions that often occur outside of the health care setting and health sector; and (3) prevention of illness and disease. Population health ethics also brings equity to the forefront, addresses deeply embedded (upstream) social determinants of health, and considers health issues as part of interconnected global systems.

Ethical frameworks for population and public health are intended to inform action and decisions regarding policies, programs and resource allocation, for instance. While some work has been undertaken to develop and refine specific frameworks and underlying principles for population and public health ethics, there remain gaps in our understanding, conceptualization, and application of these frameworks.

The workshop on population and public health ethics frameworks was jointly sponsored by the Canadian Institute of Health Research-Institute of Population and Public Health (CIHR-IPPH), National Collaborating Centre for Healthy Public Policy (NCCHPP), the CIHR Ethics Office, the Public Health Agency of Canada (PHAC), and Public Health Ontario (PHO). It provided an opportunity for diverse participants, interested in population and public health ethics, to consider and critique potential guiding principles and frameworks for the field. The workshop was intended to facilitate discussion about the merits of different approaches to population health ethics and to consider implications of ethics frameworks in the Canadian context and beyond. Focusing on a limited number of existing frameworks, participants were also asked to consider broader questions such as:

- Is it desirable or possible to have a single framework for population and public health ethics?
- If so, under what conditions?
- What overarching ethical principles should inform population and public health decision-making and intervention?
- Who are the key stakeholders to engage in advancing this work?

The specific objectives of the workshop were to:

- Build capacity amongst workshop participants for population and public health ethics by considering the application of ethics principles to a hypothetical case study

of relevance to population and public health research, policy, and practice;

- Stimulate discussion amongst workshop participants about ethics frameworks for population and public health

Welcoming Remarks

Dr. Nancy Edwards, Scientific Director, Canadian Institutes of Health Research–Institute of Population and Public Health

Dr. Nancy Edwards welcomed participants and said the workshop had two objectives. The first was to build capacity for population and public health ethics research, policy, and practice by considering the application of ethics principles to case studies. The second was to stimulate discussion about ethics frameworks among interested stakeholders.

Dr. Edwards asked participants whether they are involved in research, policy, or practice. Approximately one-third of the participants raised their hands for each role. She then asked participants whether they consider themselves ethics experts. About one-third said they did.

Opening Plenary Panel Presentations

1. Public Health Ethics Frameworks: An Introduction

Dr. Nicholas King, Assistant Professor, Department of the Social Studies of Medicine; Associate Member, Department of Epidemiology and Biostatistics, McGill University

Dr. Nicholas King said frameworks supplement other more general models of ethics, or "models for ensuring that people make decisions that are good."

The first model described by Dr. King is the Saint Model, also known as Virtue Ethics. This model posits that a virtuous person, having a good character, will make good decisions. Dr. King said this model was inadequate, due to three major problems. First, "virtue" is difficult to define, and there is no clear consensus on who has the right to define virtuous characteristics. For example, ideals of virtue for men and women (as defined primarily by men) have traditionally been quite different. Second, it is difficult to ensure that individual deciders «are

virtuous – can virtuous characteristics be taught, or are they innate? Finally, good people can make bad decisions.

Dr. King then proposed the Moses Model, also known as deontology, which is based on following rules. Under this model, "as long as decision makers follow rules that are good, the decisions will be good, even if they are made by bad persons," he explained. The problem with this model is that it does not specify who makes the rules and who they apply to. The model does not take into account the importance of outcomes or context—adherence to good rules may still result in bad outcomes, particularly in circumstances that the rule-makers did not envision.

The John Stuart Mill Model, or consequentialism, was Dr. King's third proposal. He called this the "ends that justify the means" model, whereby decision makers should seek to maximize good outcomes and minimize bad ones. The model also had problems: "Who decides what counts as a good outcome? Should we have a single moral authority or a consensus?" Dr. King asked. Moreover, many would argue that some actions are categorically wrong no matter how good the outcome might be. Finally, outcomes cannot always be accurately predicted in advance.

Given the criticisms of these models, Dr. King observed that many ethicists have proposed using frameworks as an alternative. He defined frameworks as "an elucidation of a set of values to consider when making a decision, and a methodology to determine how these values might impact a specific decision." Frameworks ask questions about the place of values in decision making, said Dr. King, listing three broad categories of values.

The first category is civil liberties, or individual rights. This includes the right to travel, the right to refuse treatment in a nascent pandemic, and the right to privacy.

The second category of values relates to justice. Justice implies proportionality, namely ensuring there is a good reason to implement public health interventions that are burdensome. Justice also means fairness and equity. If fairness is impossible, reciprocity is to be considered, said Dr. King: "If we cannot act fairly, can we compensate people for the disproportionate burden they have borne?"

The third category of values revolves around public involvement in procedures, said Dr. King. This includes transparent decision-making, public participation in these decisions, public trust of decision makers, and justification of all decisions to the public.

Dr. King said that "while frameworks do not specify unconditional attributes, rules or goals, they do specify questions." This has led many to consider them as abstract and impractical, providing little guidance for making specific decisions.

"That is not the point of frameworks," said Dr. King: "They ask questions; they don't provide answers." Many people also feel that frameworks do not help with prioritizing values that come into conflict, said Dr. King. While he agreed this is true, he said that "frameworks are there to elicit values, not to give steadfast rules on which ones can predominate."

Frameworks are often criticized as window dressing, or a means of legitimizing decisions without going into the necessary self-reflection and critical thinking. "This is not a fair criticism," Dr. King said. "If you use them as window dressing, then they will be, but if you take the time to use them properly then they can influence decisions."

While frameworks ask questions about ethics, they do not state the proper place for ethics. This is important when determining public health interventions, programs, or research.

Dr. King said one of the main difficulties with frameworks is that "many assume a kind of certainty that we rarely see in practice." He pointed to inconsistent information on the magnitude of the H1N1 threat and the perils of obesity as examples.

He concluded that "frameworks are vital for specifying the values underlying public health decision-making, but they won't make decisions for you."

2. An Ethical Framework for Public Health Projects

Dr. Don Willison, Senior Scientist, Public Health Ontario

Dr. Don Willison talked about efforts at Public Health Ontario (PHO) to develop an ethics support service for the province. He said this service would address research and other evaluative activities involving humans.

The service would also meet many existing requirements, most notably the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS-2). When these new standards were released in 2010, they "reoriented the guidelines according to three core principles: respect for persons, concern for welfare, and justice." Dr. Willison said PHO expanded on these TCPS-2 principles by interpreting them through a public health lens.

Respect for autonomy is an important TCPS-2 principle, but it is not always the priority for public health. "We are not isolated beings," Dr. Willison said, referring to the literature on relational autonomy. An individualistic orientation predominates in TCPS-2, except when it comes to Aboriginal communities. Dr. Willison said respect for communities should be acknowledged more broadly, both with regard to autonomy and concern for welfare.

He examined the principle of justice in public health, noting that this includes a positive obligation to promote equity. Reciprocity, also, figures important: "We need to be sure we give something back to those who take on risk or restrictions for the benefit of others."

Dr. Willison then presented nine guiding questions to ask of any proposed protocol:

1. What are the objectives of the project? How are they linked to potential public health benefits?
2. Is the proposed method appropriate to meet the objectives?
3. Who are the expected beneficiaries?
4. What are the potential burdens and risks? How have risks been mitigated or minimized?
5. Are risks justified in light of potential benefits?
6. Is selection of participants/data sources fair and appropriate?
7. Is individual consent warranted? Is it feasible? Is it sufficient?
8. Is community engagement warranted? Is it feasible? If so, what level of engagement?
9. What are the social justice implications of the project?

"Many of these questions will look pretty standard. The public health perspective comes out in the accompanying text that examines these questions more deeply," said Dr. Willison. For instance, the question about burdens and risks of a school-based surveillance of body-mass index raises questions about stigmatization of those identified as overweight, potential adverse consequences of sharing results with parents, and how the roll-out of the program may affect the relationship between the community and public health providers.

Conflicts will occur, and one concern may need to be promoted over another on a particular occasion. However, there are no simple rules for how to balance principles when they conflict with one another in a specific circumstance. No one principle has any predetermined value over any others. Principles must always be complemented and implemented by the exercise of judgment.

3. Public Health Ethics in the Field: What do Practitioners Want from Ethics Frameworks?

Christopher McDougall, Research Officer, National Collaborating Centre for Healthy Public Policy

Christopher McDougall said the six National Collaborating Centres for Public Health (NCCPH) are knowledge brokers connecting researchers, practitioners, and decision makers. The National Collaborating Centre for Healthy Public Policy (NCCHPP) is one of these six centres. The public health ethics stream of this organization aims "to support the integration of public health ethics tools into practice and policy across the country."

McDougall mentioned examples of NCCHPP initiatives related to network building, knowledge translation, and the development of tools for integrating ethics analysis into policy processes. He then presented an overview of recent NCCHPP ethics workshops for public health practitioners, including one that explored the difficulty of deriving practical guidance for decision-making during the 2009 H1N1 outbreak response from the "ethical commitments and principles endorsed in existing ethical frameworks" contained in pandemic preparedness and response plans.

McDougall discussed preliminary conclusions from these workshops, which were generally focussed on in the integration of ethical analysis into routine and emergency decision-making. He said that most participants showed an interest in "an overall sketch of what moral theory is and how relevant [to public health] it is." He said participants prefer workshops that provide case studies and allow them to deliberate about specific ethical dilemmas through small group work. Participants also want these workshops to be supported by online resources, allowing them to explore key philosophical concepts in greater depth. McDougall mentioned strong support across all the workshop participants surveyed for access to some sort of public health ethics consultation service. Finally, he referred to questionnaire results showing that participants want ethics resources and tools to help them face 4 specific issues: (1) decision-making under conditions of empirical uncertainty; (2) managing political interference in public health decision-making; (3) respecting cultural diversity; and (4) dealing with chronic material scarcity.

"A good framework is something that is not moral theory but that is not divorced from it either," said McDougall. Such a framework should be primarily heuristic and pragmatic, in that it provides both a language and a space for practitioners to use in their deliberations over what to do as well as their decisions-making over how to do it.

4. Reflections on Ethics Analysis on Cases of Population Health Interventions

Dr. Sarah Viehbeck, Senior Evaluation Associate, Canadian Institutes of Health Research–Institute of Population and Public Health

Dr. Sarah Viehbeck offered reflections on recent work by the Canadian Institutes of Health Research–Institute of Population and Public Health (CIHR–IPPH). Dr. Viehbeck discussed the CIHR-IPPH Debate and Dialogue Series in Population and Public Health Ethics (hosted from October 2010–May 2011). In that series, speakers were invited to analyze the ethics related to case studies of population health interventions. The five most consistently mentioned concepts and principles related to population and public health ethics to come out of recent Debate and Dialogue series were social justice and equity; relational concerns and reciprocity; common good; precautionary and harm principles; and citizen engagement.

The importance of context in public health interventions had come up in discussions, she said. The need for supporting interventions was also important: "When you ban smoking in cars in the presence of children, how do you support people in quitting in response to that intervention?" she asked, adding that one intervention may create the need for another.

Issues related to the range and nature of available evidence (or lack thereof) to inform ethical decision-making related to population health interventions was another challenge that emerged in the analysis of cases in the Debate and Dialogue series. Finally, Dr. Viehbeck said interventions can have multi-level and multi-sectoral dimensions that influence the relevance of ethical principles. How might these features of population health interventions influence the ethical considerations associated with those interventions?

The partners involved in the CPHA workshop are also working on an ethics casebook, with a call for cases to be released in July 2011 (http://www.cihr.ca/e/44006.html). She mentioned some of the cases that had been examined during the 2010–2011 virtual Debate and Dialogue Series as illustrative examples of the breadth of cases that could be submitted to the *Casebook on Population and Public Health Ethics*.

5. Discussion

A participant began the discussion session by stating that ethics must be underpinned by a common set of values. "Do you feel we have a common set of values?" she asked panelists.

Dr. King noted the differences in values between public health ethics and bioethics. He said the doctor-patient interaction is focused on the autonomy of the individual patient and the good behaviour of the clinician. In contrast, public health ethics starts from action at a population level: "At a larger level, things may benefit some individuals and harm others," he said. Because of this, he said autonomy is not a priority in public health. "When dealing with populations, you will be dealing with situations where values come into conflict," he said. "The important question is to identify what to do in these situations."

Dr. Willison added that "we live in an increasingly cosmopolitan society with no common set of values." He said this could create considerable dissension across groups about moving forward.

Another participant asked Dr. Willison about his organization's health ethics support service, noting he was concerned that clinical ethics was different from public health ethics, and that there might be "a dramatic disconnect between the theorizing and the people doing the work on the ground."

Dr. Willison said he recognized this. It was the reason PHO had focused on empowerment: "We want to empower people; we don't want to provide a centralized source of knowledge." He said they intend to work with facilitators to spark knowledge exchange and generate ways of moving forward.

Dr. King agreed that theorizing is disconnected from what occurs on the ground. However, he said it's good that public health frameworks are not a set of intricate rules to follow, since it is impossible to formulate a single set of rules that could deal with all situations.

McDougall said participants in his workshops had asked for a support service, but he had "deep hesitations about this in practice." He said they had started a small ethical accompaniment project that focused less on administrative solutions—it was not a top-down model.

A participant wondered what Dr. Snow would have done if he had been obliged to go into public consultation before removing the Broad Street pump handle: "That handle would probably still be there!" He said he finds this kind of 'paralysis by analysis' upsetting, and fears frameworks that are unable to provide solutions.

Breakout Groups: Sodium Reduction Case Study

The group divided into six sub-groups to discuss the dietary sodium reduction case study using one of three frameworks for population and public health (see Appendix 1). After an hour of discussion, the groups reported back to the facilitator and also provided written notes. Their observations are summarized below.

1. Analysis of the "Intervention Ladder," from Nuffield Council on Bioethics

Table 1
Notes: Kristiann Allen, CIHR-Ethics Office

The ladder is too one-dimensional, and may be more appropriate for questions of regulating individual choices than for dealing with the interface between government and industry. Significantly, the essential discussion about values is missing, and must precede any use of the ladder.

This said, the ladder has the benefit of being clear; it is written in the language of elected officials and health practitioners, and therefore would be useful when dealing with these groups. Still, it would be easy for politicians to use this model restrictively without a full understanding of the case evidence. This is especially true of the sodium reduction case, which has limited published evidence.

Finally, instead of a linear ladder, the table proposed a more complex and nuanced analytical grid, which would have "community ↔ prosperity" along the *x* axis and "liberty/individual choice ↔ equity" as the *y* axis.

Table 2
Notes: Don Willison, Public Health Ontario

This case presents several ethical issues. The issue of choice relates more to food producers, since consumers retain the choice to use a salt shaker. The case raises equity issues since mandatory sodium reduction could increase food production costs, affecting producers and consumers alike. If the intervention is limited to changing labelling, the issue of equity still comes up, as those with low literacy rates are disproportionately affected.

Unfortunately, the ladder is not useful on its own. It provides little guidance in stimulating discussions. It looks only at one dimension, namely the public acceptability of actions.

A discussion on values and principles is more useful than this limited framework. A complete framework should also include discussions on the existing evidence. This is especially important in the sodium reduction case, where it is lacking.

2. Analysis of "justificatory conditions for public health interventions," from Childress, et al.

Table 3
Notes: François Benoit, National Collaborating Centre for Healthy Public Policy

Ethical issues in this case are mostly from the food producer's point of view. Most interventions would require the industry to change their product, involving research and development costs. Other countries may not face the same restrictions, resulting in fewer sales for Canadian products in a global market. The case also raises proportionality issues, namely greater health benefits for the population vs. the rights of industry.

Sodium reduction changes little from the consumer's point of view, since they always have the option to add salt. However, healthier options may increase manufacturing costs, having a negative impact on health equity for low-income and remote populations.

The framework and case study could be improved. The discussion group found the moral considerations in the first part of the framework interesting, but the second part obtuse and technical. Using terms that are more broadly understood would improve this. The case study was too complex for a 45-minute session. A participant said that the fault for failure might lay more with them, since they were non-linear and ineffective in their approach.

Table 4
Notes: Ryan Melnychuk, Public Health Agency of Canada

The core issue in the case is whether to promote mandatory or voluntary sodium restriction in processed food. The food industry wants self regulation and voluntary labelling whereas the government prefers a mandatory approach.

The case raises several ethical issues. Removing salt increases choice for consumers: it is possible to add sodium to a meal but more difficult to remove salt from prepared food. There are also equity issues. A participant felt that mandatory guidelines would increase equity whereas limiting interventions to food labelling would be inequitable to low income groups,

who are less likely to pay attention to labels. Removing sodium may require the development of new, more expensive preservatives, a cost ultimately passed on to consumers.

The framework helped to analyze the case. It made the table look at different aspects and how these aspects affect the intervention. It helped to generate a rich discussion taking in many different viewpoints.

The framework has some weaknesses. It does not encourage questions on ethics or values. It does not raise the issue of equity. The question of feasibility is missing, and is important in this case since most food in Canada is imported. The issue of public acceptance is also missing: there may be a public outcry about dictating salt levels that could be mitigated by instituting a gradual sodium decrease over time.

3. "An Ethics Framework for Public Health" from Kass, NE

Table 5 Notes: Nancy Ondrusek, Public Health Ontario

A sodium reduction intervention would be a burden on the food industry and consumers. The industry would have to change their product, leading to increased costs. Decreased salt could reduce shelf life, creating problems for stores needing to replace products more often. This could also increase costs for consumers, who would have to throw out food more often. Since Canadians like saltier foods, low-sodium products could result in a loss of sales for the food industry.

The table reflected on how to minimize these burdens. The option of adding salt to food reduces the burden on consumers. Subsidies for low-income populations could be introduced if mandatory reduction increased costs. Perceived burdens could be reduced with education initiatives explaining why sodium reduction is important and how to cook with less salt.

Some felt that mandatory sodium reduction would increase equity. Since children eat lots of high-sodium processed food, mandatory sodium reduction would benefit them as a vulnerable group with reduced capacity for self-determination. Mandatory restrictions are fairer than voluntary restrictions; in the case of voluntary restrictions, if low-sodium foods were more expensive, it would be easier for the wealthy to choose healthier options.

The framework had some strengths but mostly didn't work well to analyze the case. It led to a more systematic consideration of the issues. It was abstract enough to open up the discussion on different perspectives. However, it was not normative or directive enough. The question about effectiveness does not help decide how to use the evidence. The question on fairness does not specify fairness for whom, and this case needs to be considered from the perspective of

industry and the population. The framework does not clarify the values that decision-makers bring to the table, which could influence how they approach an issue, for example when attempting to operationalize agreed-upon principles.

The framework could be improved in several ways. First, a question looking at relevant contextual considerations would be helpful, such as precedents for similar regulations. Second, a question on what the proposed interventions mean for vulnerable populations should be added. Finally, the framework should ask if the evidence is sufficient, providing explicit guidelines on how to look at the existing evidence.

Table 6, Notes: Julie Senecal, CIHR-Institute of Population and Public Health

Any intervention should result in broad actions targeting consumers and producers. This means guidelines for the food industry and education initiatives aimed at the population. The principle of the least intrusive intervention should be followed.

Sodium reduction affects many sectors. First, the food industry as a whole must change. Second, public health authorities, NGOs, government, and researchers all have a role to play. Finally, the Canadian public is affected, with low-income groups affected disproportionately.

This case does not restrict individual liberty, as people can always add salt. Less salt in foods could cause them to spoil faster, creating other problems. A pilot project should be tried to anticipate such problems.

The framework has strengths and weaknesses. It allows for a systematic approach towards decision making and helps identify relevant stakeholders. However, it deals more with the evidence base than with ethics and does not consider policy.

The framework could be improved in many ways. It should encourage comparisons of different approaches to a problem. It should also consider the unintended consequences, including differential effects, of an intervention. Sub-bullet points would be helpful, prompting people to consider other issues. In the end, it might be easier to examine ethical values and principles and apply them to the issue than to use the framework.

4. Comments on Breakout Group Discussions

Facilitator: Dr. Ryan Melnychuk, Public Health Agency of Canada

A participant said that the analysis may have been too hard on the frameworks: "Public health decisions get made in a matter of weeks or months. You can't go through a problem like this in

an hour." **Dr. Ryan Melnychuk** agreed, adding that frameworks provided people with some ability to think over those problems.

"We need an education session on the frameworks first, then a tool to help access some of these frameworks," said a participant. He added that the framework had been unable to get his table under the surface to debate the ethical issues.

A participant asked whether public health ethics needed to be considered differently with regard to research, practice, or policy. Another participant answered that he was not sure practice and policy were separate: "A lot of times in our practice, on the ground, we are trying to determine policy." Dr. Melnychuk said it was an interesting challenge to integrate the visions of practitioners into policymaking.

A participant said the case study was too complicated for a short session. It was important to choose a simpler topic because people did not necessarily have the context. For instance, he mentioned that many people were not aware the food industry argued for more salt in cereals to ensure longer preservation because of distribution challenges due to Canada's size.

5. Overview of Table Notes

Across the tables, participants agreed that while the frameworks had some strengths—such as the ability to articulate issues in clear language, and to approach decision-making systematically—each approach was hampered by its inability to address the issue from multiple perspectives. Participants critiqued the inability of the frameworks to take a multi-sectoral approach, in which the needs of consumers, food producers, public health authorities, NGOs, government, and researchers are all considered.

In addition, while some felt that the frameworks could serve to stimulate discussion of ethical and equity considerations, most agreed that the frameworks themselves failed to address this critical component in an effective manner. Concerns were expressed that the frameworks should focus more sharply on existing evidence, to help determine whether it is sufficient, and where additional evidence may be required. All agreed that more time would be needed to effectively address the case studies.

Closing Plenary

Justice and a Public Health Ethics Framework

Dr. Norman Daniels, Professor of Ethics and Population Health at Harvard School of Public Health.

Dr. Norman Daniels said he had attended a conference where many participants had said there was little evidence of the need for sodium reduction. Dr. Daniels agreed about this lack of evidence, noting that evidence is necessary to make interventions.

Dr. Daniels said he thought the questions addressed in the workshop exercise were too complex to cover in the time allotted, and that the "frameworks were being blamed for the lack of time." Moreover, he thought the context of the case was difficult to focus on, which might have prompted additional misplaced criticism of the frameworks.

Despite the negative reactions from the tables, Dr. Daniels said he continues to think that frameworks are useful in getting people to think about underlying values. He said frameworks vary in the way they raise issues: "Kass asks general questions, Childress cites objectives or principles, and Nuffield has lots of discussion on the role of the state."

The disagreements raised in the breakout sessions had been good. "People do not in general like disagreement—people want answers," said Dr. Daniels, but a framework should not be treated as "an algorithm for getting answers." He said disagreements are an important part of addressing all potential ethical issues.

Dr. Daniels said the Nuffield Council on Bioethics report goes beyond the intervention ladder referred to in the workshop. The report proposes a complete stewardship model of the state that had impressed him at the time of its publication.

He said this stewardship model converged with his own interest in justice and health policy: "We have begun to understand that the health of a population is a broad measure of its social justice." Dr. Daniels said health has to be justified as a moral value, because it is connected to a broadening range of individual opportunities. People who only concern themselves with health and not the distribution of jobs or housing are not seeing the whole picture, he said, adding that "social justice is good for our health."

The Nuffield report highlights two goals in any health policy, namely to improve the health of populations and to distribute services fairly, said Dr. Daniels. He said these goals are in tension when one is compromised in favour of the other. He brought up the issue of universal coverage

to illustrate this tension. Although most countries agree on the need for a universal health care system, Dr. Daniels said that "my own country has been an outlaw in this matter." He pointed to the enormous power of private interests standing against the notion of the right to health.

Dr. Daniels said the Nuffield report emphasizes the state's role in securing basic healthy conditions, access to medical services, promoting and protecting the health of children and the vulnerable, and reducing unfair health inequalities. This complex state role is not captured by the intervention ladder alone. The ladder only deals with the importance of choice, and that is all it is trying to do, he said.

The extensive literature on the value of choice shows that "choice is important, but one shouldn't take choice to be intrinsically important," said Dr. Daniels. Giving too much importance to choice in public policy will lead to problems, he said, adding that the state has to limit choice, specifying the conditions under which it is important.

The Nuffield report generated debate in the UK, said Dr. Daniels. It was accused of justifying paternalistic interventions and undermining individual liberty. He said these were the same flawed arguments used by opponents of motorcycle helmet laws.

Dr. Daniels said the ladder ignores a range of public health ethics issues. These include stigma, equity impact, legitimacy and disagreement, respecting privacy and confidentiality, building and maintaining trust, and keeping promises and commitments.

He said the sodium case was a restriction on industry, not a restriction on choice. "There is no restriction on individual choice as long as you still have access to a salt shaker," said Dr. Daniels.

Discussion

A participant asked Dr. Daniels why his Harvard program was currently unfunded. Dr. Daniels replied that this had to do with the recession. He said a former president of Harvard had put all the university's operating funds in the hands of hedge fund managers, creating a US$650 million loss. He reassured the participant that the lack of funding had no connection with his work.

A participant asked for examples of public health campaigns that had succeeded in moving social perception in the United States. Dr. Daniels said he wished he had better examples, but mentioned a New Zealand case whereby public demands for unproven therapies had been followed by a successful campaign of public education. A participant added that stigma and unethical behaviour had been generalized in the early years of HIV/AIDS. Dr. Daniels said that

the seatbelt case in the United States was a good example, as it had not met with the same pushback as helmet laws.

"How do you take something that is emotional and work with it?" asked a participant. He used the example of the ban on cosmetic pesticides, against which he said there was no scientific evidence but plenty of emotion. Dr. Daniels used the campaign against vaccination as a similar example of anti-scientific public outrage. He said a "deliberative process is necessary to supplement any kind of public policy framework." He said people needed to buy in, as had happened with seatbelt laws.

Concluding Remarks

Dr. Nancy Edwards, Scientific Director, Canadian Institutes of Health Research–Institute of Population and Public Health

Dr. Edwards raised two points to show how the discussion on public health ethics has progressed. First, she said the link between social justice and public health has become more important. Secondly, she said that the place of values in science is more broadly accepted. Research ethics review boards are an important structure towards ethics in scientific research and practice.

The objective of discussions is not necessarily to reach a consensus, but to make sure everyone is clear about the different values involved in the issues being discussed, said Dr. Edwards, noting that consensus is something that is arrived at slowly.

Dr. Edwards said discussions often take place in silos and use different approaches. She asked whether there was a way to bring the fields together and sort out how to best address issues of equity and population: "The convergence of our work is something we've all learned about. If we continue to tie all that together, I think we can make some good headway in coming years."

Workshop Follow-up and Next Steps

Based on participant feedback, workshop organizers were satisfied that the event met its broad objective of creating a space for critical discussion of the place of ethics frameworks in population and public health. Participants new to ethics gained some capacity through the introduction of a number of frameworks and some limited practice on their use. This said, a common complaint was the lack of time available for a more complete discussion of the

frameworks with respect to the hypothetical case study, along with more time to analyse participants' own experiences with the various frameworks (or to test the frameworks against personal experience, as the case may be).

A second, follow--up project being launched by workshop partners will help to fill this gap. A casebook in ethics of population and public health interventions will provide an opportunity for those working in public and population health research, policy and practice to submit anonymized scenarios for ethical analysis and publication. The call for cases (http://www.cihr.ca/e/44006.html) is open until September 30, 2011 and will be followed by a rigorous peer review process. Selected cases will be accompanied by an expert ethical analysis, with case authors also having the opportunity to respond. The final casebook is expected to be launched in hard-copy and online in early 2012. It is anticipated that the document will become a key teaching and learning tool in the ethics field of population and public health.

Lessons drawn from the workshop, along with the casebook analyses will, in turn, serve partners in the development or enhancement of resource material and training opportunities in population and public health ethics.

Appendices

1. Hypothetical Case Study: Sodium Reduction

Participants were given 45 minutes to consider a hypothetical case example on sodium reduction, along with questions to guide the discussion.

Guiding Questions:

- Ethical issues: What are the ethical issues that the case presents?
- Relevant values and principles: Drawing on the background materials and your knowledge of population and public health ethics, what values and/or principles are most relevant to the case?
- Stakeholders to the decision: Who will be affected by the decision, and in what ways? How are/might those most affected be engaged in the decision-making?
- Re-orientation questions: How do the issues raised in the reorientation of the case makes you think differently about the underlying ethical issues, if at all?
- Your own experience: Can you think of an issue from your own experience that you considered differently as a result of an ethics analysis? Can you think of an ethical dilemma in your work that could have benefited from such an analysis?

Adapted from: Jennings B, Kahn J, Mastroianni A, Parker LS (eds). Ethics and public health: model curriculum. Association of Schools of Public Health; 2003. Available at: http://www.asph.org/document.cfm?page=782

Introduction

In many developed countries, dietary sodium intake is becoming a significant public health concern. Associated with many chronic conditions including hypertension and other cardiovascular outcomes and kidney disease, dietary sodium intake is a key area proposed for intervention. In Canada, average sodium intake greatly exceeds recommended levels and the Federal government is considering options for interventions at a population level.

Population Health Intervention

With more than 75% of sodium in the diets of Canadians coming from commercially prepared foods, much of the effort to reduce dietary sodium intake must focus on the food supply (Health Canada, 2011). In order to reduce sodium in processed food products and food service products, the Federal government is considering whether or not to impose mandatory restrictions on acceptable levels of sodium in these foods.

A mandatory restriction approach would be phased in over a four year period and would include published sodium reduction targets for foods, and an independent monitoring and evaluation plan to ensure progress and compliance with the mandatory targets.

The proposed intervention strategy is based upon literature reviews, approaches adopted in other jurisdictions, and has been subject to extensive consultation with the general public, health advocates, and a review of relevant literature. The possibility of conducting a pilot study has not been ruled out.

There is mounting pressure from the food industry to shift from mandatory to voluntary restrictions with self-declared targets for reductions. While self-regulation has been used by the food industry in other areas (ie, in the United States to reduce food marketing to children), it is thought to be less effective than mandatory regulation.

Re-orienting the case

- Consider your reaction to the above case description, and whether your ethical arguments would change, in the context of the following hypothetical scenarios:
- High-sodium, processed food products and food service foods would be required to carry warning labels to inform consumers of the potential harms rather than be subject to mandatory reductions in sodium content at point of production; or,
- High-sodium, processed food products and food service products would be subject to a special tax as a disincentive to purchasing as an alternative to mandatory reductions in sodium content at point of production.

Additionally, tables 1, 4, and 7 were also asked to consider that there is limited published evidence on the effectiveness of the proposed intervention at both the population and industry

levels. The extent to which this policy may have differential impacts across some sub-populations is unknown.

Tables 2, 5, and 8 were also asked to consider that public opinion polls suggest that the general public is not supportive of mandatory restrictions. There are differences in levels of support according to education and income levels. Health groups and professional associations have been overwhelmingly supportive.

Tables 3, 6, and 9 were also asked to consider that much of the Canadian processed food supply is imported and this may impose enforcement challenges.

2. Keynote Speaker Bios

Nicholas King

Dr. Nicholas King is an Assistant Professor in the Department of the Social Studies of Medicine, and at McGill University, and an Associate Member in the Department of Epidemiology and Biostatistics at McGill University. Dr. King conducts research in two areas: public health ethics and policy (including the ethics of biosecurity, public health preparedness, and responses to antimicrobial resistant pathogens); and health information, inequalities, and measurement (including the role of ethical judgments in the measurement and assessment of health inequalities, and the impact of cognitive biases on the interpretation of population health information).

Norman Daniels

Dr. Norman Daniels is Mary B. Saltonstall Professor and Professor of Ethics and Population Health at Harvard School of Public Health. Dr. Daniels has published extensively in the areas of philosophy of science, ethics, political and social philosophy and medical ethics, including over 10 books. His current research interests focus on the concepts of fairness and justice as related to health. Dr. Daniels is a member of the Institute of Medicine, a Fellow of the Hastings Center, a Founding Member of the National Academy of Social Insurance and of the International Society for Equity in Health, he has consulted with organizations, commissions, and governments in the U.S. and abroad on issues of justice and health policy, including for the United Nations, WHO, and the President's Commission for the Study of Ethical Problems in Medicine. He currently sits on the CIHR-Institute of Population and Public Health Institute Advisory Board and on the Ethics Advisory Board for the U.S. Centers for Disease Control and Prevention.