A Grounded Theory Study of the Approaches and Mechanisms Used in Public Health Practice for Everyday Ethical Dilemma Negotiation and Resolution

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

Public health professionals experience dilemmas in their everyday work and many of these dilemmas are challenges where they must find the most ethical way to manage the situation. How these dilemmas are approached, negotiated, and resolved is an area that has been given little attention in the literature and in the Canadian public health system. This paper describes the everyday ethical dilemmas experienced by public health professionals working in two publicly funded health units along with the mechanisms they used to negotiate and resolve these challenges. Using grounded theory this thesis also outlines the approaches used by these public health professionals to manage the everyday ethical dilemmas they experienced in practice. The findings may provide guidance for other public health professionals who are faced with making challenging decisions concerning everyday ethical dilemmas experienced in practice.

Keywords: public health, everyday ethics, grounded theory

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Dedication

I would like to dedicate my thesis paper to my husband, Peter, my children, Colin and Abby, and my mother, Sharon, as a way to show my appreciation for the support they gave to me while I pursued a post-graduate degree. Their patience and understanding led to the success I achieved while undertaking this educational and professional endeavour.

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1.0 Introduction

The discipline of public health ethics is unique as it blends frameworks from bioethics, social justice, human rights, philosophy, and law. It is also a discipline that is relatively new making it an area that warrants further study (Bernheim, 2003; MacQueen & Buehler, 2004). Although frameworks have been developed to aid public health professionals with the identification of ethical issues they may experience (Kass, 2001), to my knowledge, there has been little attention given to the approaches public health professionals in publicly funded health units undertake when they negotiate and attempt to resolve these challenges. Furthermore, little is known about the mechanisms and principles used by these public health professionals when attempting to manage everyday ethical dilemmas. This review of the literature will describe the evolution of public health ethics, the various ethical principles that have been applied within a public health setting, and recent research conducted on the ethical issues experienced in public health practice.

2.0 Literature Review

2.1 Public Health

Public health is a practice that is primarily concerned with the health of a group, community, or an entire population whereas most medical interventions focus on one individual's health (Buchanan, 2008; Holland, 2007; Nuffield Council on Bioethics, 2007; Wilson, 2009). As Jonathan Mann (1997) states, "public health comes to you, while you go to the doctor" (p. 7). Although the main objectives are "to measure, explain, maintain, and improve the health status of target populations" (Holland, 2007, p. vii), public health practice was founded on the belief that it is society's responsibility to protect and promote the health of everyone and not just to

protect the health of a few (Buchanan, 2008; Callahan & Jennings, 2002). Thus, social justice is said to be one of the key foundational principles in public health (Krieger & Birn, 1998; Rodriguez-Garcia & Akhter, 2000). Public health practice is also concerned with initiatives that are collective which means that public health involves the coordinated and collaborative actions of a number of people or organizations (Wilson, 2009). As stated by Wilson (2009), "the goal of public health should be not simply to promote health per se, but also to provide the conditions under which people can freely choose to be healthy" (p. 189).

Conventional public health practices are fairly broad but most involve initiatives such as healthy eating seminars, services including immunization clinics or sexual health clinics, prenatal health education for pregnant women, child health information for new parents, and food safety and inspection of restaurants or other eating establishments (Ontario Ministry of Health and Long-Term Care, 2008). However, public health practice is more than just clinics and seminars. Public health has expanded to be a multi-dimensional profession focusing on a wide array of health determinants. Public health includes "not just physical health, but also mental, family, and environmental health" (Holland, 2007; Marcellus, 2005, p. 416). The term public health has also frequently been used in two distinct ways (Wilson, 2009). One way is to explain the health of a population, so that we might say, for example, a high incidence of smoking in a population is bad for the health of the public. A second way is to explain the activities undertaken to ensure that the health of the population is protected and promoted such that health promotion is part of the public health department's mandate. Either explanation is routinely used by public health professionals, medical practitioners, health researchers, and the general public.

Although most people believe public health is about preventing disease and disability, and promoting health, public health professionals in various organizations and government agencies must also systematically collect information for surveillance purposes to establish disease control and prevention interventions, and to develop and evaluate community programs (Holland, 2007; MacQueen & Buehler, 2004). The basis of public health, therefore, is identified by epidemiological data obtained through research and surveillance. Even though the ultimate goal of public health is to prevent morbidity and mortality, success is usually measured by "statistical lives and rates of incidence of disease" (Holland, 2007, p. vii). Understandably, the objectives and methods of public health practice-based activities can sometimes overlap with those provided by medical practitioners to reduce morbidity and mortality; however, public health practice is usually seen as being a distinct entity (MacQueen & Buehler, 2004).

2.2 Public Health Ethics

Ethics is a branch of philosophy concerned with the distinction between right and wrong, moral choices, duties, obligations, human conduct, and the behaviour of individuals in society (Last, 1990; Treasury Board of Canada Secretariat, 2005). Ethics also examines the justification for moral judgments and what is just or unjust (Treasury Board of Canada Secretariat, 2005). A paper by Andre and Velasquez (1987), published in the journal, *Issues in Ethics*, describe ethics as "well-founded standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues" (p. 1). Andre and Velasquez (1987) also define ethics as standards that impose obligations to keep people from breaking the law or hurting another individual. These standards include elements such as honesty, compassion, and loyalty. Moreover, Andre and Velasquez (1987) describe ethical

standards as rights, such as the right to life, the right to freedom from injury, and the right to privacy.

In the 1940s, the ideals of ethics in health care, medicine, and medical practice, such as the Hippocratic Oath, were eclipsed against a backdrop of scandal and abuse. Ethics came to the forefront in people's minds during this period in time because of the violations of human dignity by those under the influence of the German Nazi command (Bayer and Fairchild, 2004). These atrocities in our history characterized a desperate need for ethical standards to be established. Certain medical practices and the authority of physicians were being questioned and a new mindset was evolving that focused on the concept of individual autonomy. The belief that no individual should be required to participate in medical endeavours – no matter how important for the public good – without his or her informed consent began to predominate. Thus, the field of medical ethics and bioethics emerged making an enormous impact on the future practice of health care, medicine, and medical research (Bayer & Fairchild, 2004). Although the dominant theme in medical practice was the good of the individual and his or her autonomy, little attention was given over the years to the ethics of public health in the literature, and the ethics of everyday operations in public health practice (Callahan & Jennings, 2002; Roberts & Reich, 2002). In the book, *Public Health Ethics*, by Stephen Holland (2007), he outlined that the year 2000 was the point in time when efforts to articulate the ethics of public health practice were beginning.

Canadian researchers from the University of Calgary, Kathleen Oberle and Sandra Tenove, published a paper in the journal, *Nursing Ethics*, in 2000, describing a study they conducted focusing on the moral and ethical issues experienced in public health nursing. Oberle and Tenove outlined that moral and ethical issues are a source of stress for public health nurses and most of

the research on ethics in nursing has been focused in the hospital setting and only anecdotal evidence has been identified in public health nursing. Oberle and Tenove (2000, p. 428) based their study's findings on the work of Jameton (1984) who describe three types of moral and ethical problems experienced by nurses:

1. Moral uncertainty – "when one is unsure what moral principles apply or what is the moral problem being experienced",
2. Moral dilemmas – "when two or more moral principles apply, but they support mutually inconsistent courses of action", and
3. Moral distress – "when an individual has a belief about what should be done, but is prevented from doing so by institutional or other constraints".

Oberle and Tenove (2000) surmised that each of these moral problems was also experienced by public health nurses, but moral distress or uncertainty occurred most often. They outlined from their own research that ethical decision-making in public health nursing appeared to be "in contrast to most extant ethical frameworks, which seem to represent the ethical decision-making process as essentially linear;" however, "ethical issues in public health nursing are so rooted in context, and so interwoven and complex, that they are seldom amenable to this type of analysis" (p. 435). Moreover, Oberle and Tenove stated that it was important to help public health nurses understand the distress they experienced as an ethical issue or ethical dilemma and that their concerns were not unique to their profession.

In 2001, the evolution to define public health ethics appeared to have established its roots when Nancy Kass published a paper in the *American Journal of Public Health* where she wrote "codes

of medical and research ethics generally give high priority to individual autonomy, a priority that cannot be assumed to be appropriate for public health practice" (p. 1776). Callahan and Jennings, in their 2002 paper in the *American Journal of Public Health*, supported Kass by writing that "in early bioethics, the good of the individual, and particularly his or her autonomy, was the dominant theme, not population health" (p. 169). Callahan and Jennings also asserted that increased interest and attention in population health was emerging, ethical dilemmas faced by public health professionals were attracting attention, and courses on public and population health were beginning to be taught. They also identified that ethical issues in public health practice could be assembled into four general categories: 1) health promotion and disease prevention, 2) risk reduction, 3) epidemiological and other forms of public health research, and 4) structural and socio-economic disparities in health status (Callahan & Jennings, 2002).

Stephen Holland (2007) wrote that public health professionals encountered distinct ethical challenges and not just moral problems which are usually seen in medical ethics and bioethics. He suggested this because public health practices promise health benefits to a specific population or community; albeit sometimes at a burden or cost to individuals. Holland (2007) also wrote that public health professionals experience challenges that create a dilemma between the rights and needs of individuals and the rights and needs of a population or community. Moreover, Holland (2007) described public health ethics as being "an offshoot of medical ethics, but distinctive from bioethics because of the nature of public health itself" (p. vii). Many in the health field have come to realize that public health initiatives are broad and the focus is not typically on one particular individual but rather to address the needs of a specific group, an entire community, or the population at large (Callahan & Jennings, 2002; Upshur, 2002).

Progress toward establishing a definition of public ethics continued with Gostin, who in 2001 (p. 124), outlined that public health ethics should be viewed from three perspectives:

1. "Ethics *of* public health (professional ethics)" such that the ethics of public health should be concerned with the professionalism of public health professionals to "act for the common welfare" and instil a sense of "public duty and trust". An ethical code for public health professionals would help clarify the "distinctive ethical dilemmas faced by public health professionals".
2. "Ethics *in* public health (applied ethics)" such that public health refers to the enterprise of public health and public health should always be an ethical endeavour and provide programs and interventions that are in the best interest of not only individuals but also the broader community in which the individuals live. However, certain public health practices may require sacrificing one or more individual's interests to achieve an overall outcome.
3. "Ethics *for* public health (advocacy ethics)" such that professionals who work in the field of public health must be dedicated to convincing the public and government that healthy populations and reduced inequalities are goals that must be sought after. Although some public health policies and practices can, and do, infringe on human rights, it is critical that individuals are treated with dignity and respect to ensure their health and well-being while at the same time promoting their rights.

A professional code of public health created by the Public Health Leadership Society (2002) and adopted by the American Public Health Association appeared to follow the sentiments described above. These sentiments were further expressed in an editorial published in the Journal of the

American Public Health Association by Thomas, Sage, Dillenberg, and Guillory (2002) which described the necessity for a professional code. This code identified twelve principles of ethical practice to ensure that initiatives developed improve the health of the public and are conducted morally. Specifically, the code states there is "an obligation to care for the well being of others" and although there may be a "need to exercise power [by public health professionals] to ensure health, at the same time [there is a need to] avoid the potential abuses of power" (Public Health Leadership Society, 2002, p. 5). The code also states that these values are "at the crux of public health ethics" (Public Health Leadership Society, 2002, p. 5). In ongoing support of these efforts, the American Public Health Association continued a special primary interest group (which began initially in the 1980s and is ongoing to this day), called the Ethics Special Primary Interest Group, as a way for public health professionals to facilitate discussions and network with their professional group, population health researchers, and other scholars (American Public Health Association, 2010; Callahan and Jennings, 2002).

In 2002, Childress et al. attempted to provide a definition of public health ethics by stating that public health ethics was a "loose set of general moral considerations such as values, principles, and rules that are relevant to public health" (p. 171). According to Childress et al., there should be an ongoing effort to justify these considerations and provide guidance in decision making as to what constitutes ethical policies and ethical practices. As outlined by Holland (2007), public health ethics is needed to justify public health interventions that were aimed at protecting and promoting a population's health and Horner (2000, p. 52) stated that "every proposed new public health intervention should be carefully evaluated for its ethical dimension". Childress et al. (2002) also recognized that public health activities were complex and conflicts may (or will certainly) occur when considering which ethical principles apply to a given program or

intervention. Even though public health ethics does not commit to any one standard or known ethical principle or value, Childress et al. (2002) suggested that several ethical concepts must be applied in everyday public health practice. These were:

- "producing benefits";
- "avoiding, preventing, and removing harms; producing the maximum balance of benefits over harms and other costs (i.e., utility)";
- "distributing benefits and burdens fairly (i.e., distributive justice) and ensuring public participation, including participation of affected parties (i.e., procedural justice)";
- "respecting autonomous choices and actions, including liberty of action; protecting privacy and confidentiality";
- "keeping promises and commitments; disclosing information as well as speaking honestly and truthfully (i.e., transparency)"; and
- "building and maintaining trust" (p. 171-172).

Furthermore, as noted by Childress et al. (2002), all public health practices must be grounded in each of these general ethical and moral concepts. Moreover, the provision of public health initiatives must be seen as a benefit that society and governments need to pursue to protect the health of the public from any known or anticipated harms. Childress et al. posed two questions that require further attention:

- "How can we make these general moral and ethical considerations more specific and concrete to guide actions and decision-making in public health?"; and
- "How can conflicts be resolved?" (p. 172)

Finally, Childress et al. (2002) stated that ethical conflicts will continue to occur requiring public health professionals to regularly discuss and debate how best to protect and promote the public's health. Childress et al. also outlined that these debates should take into account certain constraints such as limits to liberty and privacy and use of paternalism as these must be negotiated and resolved to be able to achieve the desired public health outcome. As noted by MacQueen and Buehler (2004), public health interventions and practices with no redeeming value are unnecessary, and perhaps even viewed as unethical, because scare resources would be wasted.

2.3 Ethical Principles in Public Health

Public health initiatives and interventions tend to deliver programs that follow utilitarian, paternalistic, and communitarian value systems; however, the ethical principles that predominate in bioethics have primarily focused on civil liberties and individual autonomy (Callahan & Jennings, 2002). What this means is that public health practice embraces a set of values that can sometimes be viewed as being in conflict with the individualistic, autonomous-centred decision-making that usually predominates clinical practice and medicine (Bayer & Fairchild, 2004). As outlined, one of the driving questions in public health ethics is how do we make general ethical principles and concepts to more specifically and concretely guide the actions and decision-making of public health professionals when they are designing and delivering public health initiatives? Moreover, how do public health professionals resolve discord when applying the principles to a certain initiative or action, especially when the principles in some ways can be opposing?

As noted, in 2001, Dr. Nancy Kass pioneered the creation of a six step ethics framework for public health. She identified the main ethical issues that public health professionals may experience and need to consider in everyday practice. Kass posed these as questions that public health professionals need to ask themselves along with an explanation as to how these ethical questions should be debated and/or justified:

1. What are the public health goals of the proposed program?

The first step is to ensure public health programs, interventions, or research is designed to ultimately achieve a reduction in morbidity or mortality. Other benefits; however, can include increased employment or coalition-building with the goal to create stronger, healthier communities. Moreover, benefits should focus on who will benefit from the initiative. This can include such actions as blood pressure screening, seat belt laws, and speed limits to further an individuals' ability to protect their own health. Interventions can also target one group with the focus to protect the health of others such as regulations requiring partner notification of infectious diseases.

2. How effective is the program in achieving its stated goals?

The next step is to require that the stated goals of an intervention, program, or research initiative are realistic and not based on assumptions. Although it is conceivable that some goals may not be immediately achievable, public health professionals need to carefully examine if they are basing the program goals on data or other evidence that supports the proposed goals or if they are basing the goals on assumptions and anecdotal evidence. Although in some cases, the quality or volume of evidence may be viewed as inadequate to

make decisions regarding implementation of a program or intervention, it is important for public health professionals to determine which evidence is *good* enough to justify implementation of the program or intervention. Consequently, it must be made clear that the greater the burden or limits on autonomy or civil liberty for a targeted population, the stronger the evidence that is needed before consideration is given to implementing the program.

3. What are the known or potential burdens of the program?

The third step is to require that evidence be available, as assessed in point two above, which suggests the program will achieve the stated goal(s). Then, it must be established that the burdens or harms are minimized. This includes: a) risk to privacy and confidentiality as it relates to the collection of information (e.g., surveillance data) which may reveal patterns about groups or neighbourhoods that can be stigmatizing or the collection of individually identifiable information (e.g., disease reporting and contact tracing), b) risks to liberty and self determination such that public health has the authority to implement actions to contain or limit transmission of a disease by mandating vaccinations, or wide-spread spraying or animal culls to prevent the spread of viruses, and c) risks to justice if interventions are targeted to only certain groups and not others resulting in social stigma if it is assumed these groups are those who carry a certain disease or are the only people at risk.

4. Can burdens be minimized? Are there alternative approaches?

The fourth step is for public health professionals to identify the burdens associated with any public health action or initiative and to ensure these burdens are minimized whenever

possible. If, as noted in step three above, a risk is identified, public health professionals are ethically responsible to find ways to modify the action or initiative to minimize the burden while not decreasing the effectiveness of the program outcomes. Public health professionals are ethically required to implement programs that limit risks or harms such as liberty, privacy, and justice. For example, if a voluntary screening program will result in nearly the same number of individuals taking part as a mandatory program then it would be ethically inappropriate to make such a program a requirement.

5. Is the program implemented fairly?

This step refers to distributive justice, meaning that the benefits and burdens of public health actions and initiatives must be distributed fairly among the entire group or population who will experience the burdens and benefits. Clean water, for example, must be available to everyone in a community and not limited to a few and cardiac risk reduction programs should not be targeted to only white men when women and other ethnic groups are also at risk of cardiovascular disease. This does not mean that all programs must be distributed equally among all groups or communities, but the allocation of programs must be fair and not proposed arbitrarily or on the basis of assumptions; distribution must be based on evidence with a focus to reduce societal inequalities.

6. How can the benefits and burdens of a program be fairly balanced?

The final step in assessing the ethics of a public health initiative is to make a decision whether the expected benefits justify the burdens that may be experienced. Although public health professionals may not have the authority or ability to implement all programs they

> believe would be beneficial, they do have a responsibility to advocate for programs that will improve the public's health. They also have a responsibility to remove from consideration programs or actions that are unethical because the evidence is inadequate, discriminatory, or does not justify limiting individual liberty. This process involves procedural justice requiring public health professionals to engage communities in consultation and discussion to determine which initiatives or actions should be implemented while recognizing that certain limits or other burdens may be required. A balance must be sought such that the greater the burden imposed on communities or individuals the greater the expected benefit must be. Moreover, coercive programs should only be implemented when absolutely necessary (and only with adequate evidence) and should never be considered when a less restrictive program can achieve a similar goal.

Further attempts to provide guidance to public health professionals for the justification of the delivery or implementation of a certain public health program or intervention has been provided by Dr. Ross Upshur. In 2002, Upshur published a paper in the *Canadian Journal of Public Health* that identified a set of principles for public health professionals to consider when designing and delivering initiatives in everyday practice. The four principles identified by Upshur, as he described in his paper, are not to be taken as absolute and authoritative but rather as guidance when justifying that certain public health actions are necessary.

The principles identified by Upshur include the harm principle, the principle of least restrictive or coercive means, the reciprocity principle and the transparency principle. Upshur (2002) began with the harm principle explaining that this principle provides a foundation for public health

ethics. He identified the harm principle as a standard that can be used by public health to justify an initiative or action that may restrict the liberty of an individual or group to protect the health of many. The harm principle, he stated, needs to be applied when attempting to prevent injury to others and another's own good is not sufficiently warranted if detriment to the broader public can be prevented.

The second principle outlined by Upshur is the principle of least restrictive or coercive means. According to Upshur, this principle recognizes that a variety of means exist to achieve public health outcomes. However, public health authority should be reserved for exceptional cases. Upshur outlined that coercive measures should be used only when justified and where less restrictive means have failed to achieve the desired outcome. The first step should be education, consultation, facilitation, and discussion before punitive measures, sanctions, bans, or quarantines are implemented.

The reciprocity principle is the third of the four principles described by Upshur (2002). This principle outlines that society must be prepared to facilitate efforts to provide ethical initiatives that are designed to protect the public's health and consequently public health professionals are obligated to assist individuals and communities be involved in initiatives that protect their health. This means that, for some, complying with public health requests may impose a burden such as a sacrifice of income or time. The reciprocity principle stipulates that compensation should be given to those who experience these burdens and sacrifices.

The fourth principle described by Upshur is the transparency principle. This principle states that all stakeholders are to be involved in the decision-making processes and each have equal input, and that decisions and accountability are clearly stated. Upshur also stipulated the decision-making process should be free from political interference and influence by special interest or advocacy groups. Upshur concluded that it must be understood these four principles do not provide public health professionals with a list of specific actions they need to undertake to ensure they are delivering ethical practices but rather these principles are guidelines that can aid with providing explanations and justifications for why certain public health initiatives or actions are needed.

Bayer and Fairchild (2004) have also provided their expert opinion regarding the ethical principles that should (or can) be applied to justify the delivery of public health initiatives. They described the precautionary principle as another value system to aid with ethical dilemmas in public health practice. Because one of the mandates of public health is the prevention of risk, and when that is not possible, the management of risk, they outlined the precautionary principle stipulates there is an obligation to protect populations against reasonably foreseeable threats, even under conditions of uncertainty and seeks to avert disasters and guide decision-making. In some instances, this is done within the context of incomplete knowledge or evidence. However, Bayer and Fairchild (2004) pointed out that many believe even small precautionary or preventive measures from public health interventions can produce significant collective benefits. Therefore, in the face of grave threats, public health officials may mandate interventions even when it is unclear or unknown if such threats may result in significant or widespread harm. However, others recommend against the use of the precautionary principle as a decision-making aid

(Peterson, 2007). Scholars, like Peterson (2007), maintain the "precautionary principle is either too imprecise or tends to be too absolutistic, in that it prohibits activities that, intuitively, ought to be permitted" (p. 6). However, Balog (2009) stated that "from a public health perspective, treating and reducing harm should be preferred over adhering to a belief about interventions that do not exist or are not effective" (p. 618).

Another approach that may be considered as a way to handle the ethical challenges in public health is to focus on human rights (Holland, 2007). Scholars like Mann (1995) and Gostin (2000) described a rights based approach as being practical since the intent is to protect and promote population health in the most effective way to improve the public's health and this can be done by enforcing human, or universal, rights to health and health care. Moreover, they suggested that a rights based approach would focus public health as being moral since human rights would, for most people, be seen as (obviously) ethical. However, these scholars recognized that a rights based approach is not perfect. A rights based approach can create conflict during decision making since human rights do not always coincide with social justice. With that being said, a rights-based approach, as noted by Mann (1995) and Gostin (2000) has some positive aspects. The positivity is that rights can be instituted into law and supported by regulations or sanctions since rights can be seen as ambiguous for some people. The only way to make things clear is to state the requirements and the subsequent punishments. The term ethics has little formal impact for the public, and for many people, ethics is seen as guidelines. Thereby, redefining public health ethics in terms of rights may be, as noted by the authors above, the most effective way to address the ethical challenges that public health professionals will face because the dilemma is

now the rights of the individual versus the rights of the community to protect health and well-being.

Compulsion and coercion, which are viewed as contrary to medical-based values, can be sometimes central to the delivery of public health initiatives (Bayer & Fairchild, 2004). Legal systems, as well as international human rights sentiments seem to agree that allowing governments to infringe on personal liberty in cases of public emergencies or disasters to prevent further risk to a group or population is worthy and can be an ethical course of action (Bayer & Fairchild, 2004). Therefore, it is the collective harm that warrants a need for an intervention even when the threat posed to certain individuals may not be significant. Bayer and Fairchild (2004) maintained that those who are employed in the public health sector recognize that a focus on the public's health requires a population-based analysis and willingness to recognize that the ethics of providing collective health interventions may require certain limitations upon an individual's autonomy. These limitations may also include certain restrictions on individual privacy, as is needed for public health surveillance activities, and certain restrictions on liberty, as may be needed in cases of isolation and quarantine, than would be justified by an autonomy-focused values system (Bayer & Fairchild, 2004).

As outlined by Childress et al. (2002), voluntary co-operation is preferred for many public health professionals even though mandatory measures are methods they can legally implement. Voluntariness is seen not only to be a way that reduces the necessity of invoking coercive power, as co-operation is being sought, but it also enhances the public's health without also burdening the individual (Childress et al., 2002). While a public health perspective may not necessarily

always allow for the acceptance of every individual's views, as reported by Bayer and Fairchild (2004), it should not be seen in any way as being insensitive to the importance of also protecting and promoting autonomous decision-making and individual rights. In the context of public health initiatives, the question that is often debated is whether "paternalism and the subordination of the individual for the good of all" should be integral in an ethical framework for public health that would aid with decision-making or whether an autonomy-focused, anti-paternalistic value system should predominate (Bayer & Fairchild, 2004, p. 488).

The role of paternalism in public health is a challenge, as noted by Bayer and Fairchild (2004). Public health has sometimes been seen as embracing measures that go beyond what some may view as a desire for justified paternalism – which is less common in medicine. But, as described by the authors, to justify paternalism it can be argued that the protection of workers against hazardous workplaces (even though they themselves may choose to accept the risk) can be justified because of the coercive economic and social context within which the workers are employed. As stated by Eriksson, Nilstun and Edwards (2007), the risk is "influenced by a wide range of factors and aspects of the setting in which risk is communicated and dealt with in [people's] everyday lives" (p. 32). Other examples of managing risk included protecting motorcyclists from the hazards of non-helmeted riding not solely because of the possible health care costs imposed on society if a rider is injured but because some are too young to appreciate the hazards (Bayer & Fairchild, 2004). In many cases, as illustrated by Bayer and Fairchild (2004), it is the failure to implement a public health initiative that requires ethical justification such as cases of epidemic threat where interventions can be seen as burdening individuals and imposing limits on their freedoms.

The utilitarian, communitarian, and paternalistic principles along with the precautionary principle and human rights, in some cases, can provide guidance for the creation of public health interventions. Therefore, as noted by Bayer and Fairchild (2004), are we not morally bound to prevent unavoidable suffering and death and are we not morally and ethically obligated to ensure the well-being of the public who may otherwise be inclined to do things or expose themselves to risks or diseases that could otherwise be prevented? These questions are those that divide bioethics and public health ethics. Thus, the predicament for public health professionals is to identify instances when certain ethical principles such as paternalism are justified and to set limits when concepts such as liberty and privacy should be forfeited, but at the same time, finding ways to identify principles that can preserve autonomy and free choice, whenever possible (Bayer and Fairchild, 2004; Childress et al., 2002).

Scholars, such as Callahan and Jennings (2002) have suggested that, surprisingly, little attention has been given to public health ethics when the core values and practices of public health often involve a focus less on the individual and more on the common good. They declared that for many in the public health profession, the concept of bioethics is not broad enough when considering the issues that can arise when one seeks to protect the public's health. Moreover, they recognize that individualism is a central value in bioethics and the role of moral values in decision-making was a contribution of bioethics; however, in public health the issues go beyond these few core moral values and, as noted, include ethical principles such as paternalism, liberty, and privacy (Bayer and Fairchild, 2004; Callahan and Jennings, 2002).

2.3.1 Paternalism in Public Health Practice

Restrictions on those who represent a risk to others is viewed as falling clearly within the broadly accepted exercise of power by government to protect the public's health (Bayer & Fairchild, 2004). However, the ethical issues that emerge when this authority or power is instituted can be viewed as controversial when the risk to others is uncertain (Childress et al., 2002). As noted by Bayer and Fairchild (2004), the question that arises for many individuals who do not wish to encourage government intervention is – what moral weight should be given to the possibility and potential severity of harm when there is little or no evidence to support the need for this exercise of power? This raises an issue that is fundamentally different from those behaviours that represent primarily a threat to individuals themselves. It appears that here is where the view of paternalism emerges and where the tension between public health perspectives and autonomy-focused bioethics lies (Bayer & Fairchild, 2004).

An example of paternalism to protect the public's health is the limits that have been placed on the use of tobacco. Tobacco use is the single most important cause of morbidity and mortality in Canada and is one of the ways in which the contention towards paternalism has both shaped and limited public health policy (Health Canada, 2007). Bayer and Fairchild (2004) outline three broad sets of policies have been adopted to confront the challenge posed by tobacco: 1) restrictions on advertising, 2) imposition of taxes, and 3) limits on public smoking. In each case, public health officials can argue that these measures were needed to protect the health of third parties, innocent victims, and children. Broad public willingness to agree with paternalistic justifications for anti-smoking policy has become more and more evident. For example, Bayer and Fairchild (2004) report that the "most dramatic reflection of the willingness to embrace

paternalism was to be found in measures seeking to 'denormalise' smoking" (p. 487). They surmise that, typically, health promotion campaigns are not thought of as paternalistic, but in many instances they go beyond just the provision of information and will often attempt to transform the desires and preferences of the group in which the initiative is directed.

2.3.2 Liberty in Public Health Practice

As patterns of morbidity and mortality transform in the twentieth century, the role of certain public health measures, such as quarantine and isolation, have become used less and less as risk management public health initiatives. Chronic conditions are replacing infectious diseases as preeminent threats to the public's health (Bayer & Fairchild, 2004). Historically, isolation and quarantine were two mechanisms used in the public health field that, in certain cases, were critical to the protection of the public's health. Isolation and quarantine to control infectious diseases involved few authoritarian procedural protections and no restrictions, as outlined by Bayer and Fairchild (2004), and the rights of individuals were viewed as subservient to the judgements of those with public health authority.

Bayer and Fairchild (2004) further described the controversial health intervention measures of isolation and quarantine such that these practices were known to limit a person's day-to-day activities and bring to light the ongoing tension between individual liberty and protecting the public's health. In this comprehensive 2004 paper, they wrote that for many, the confinement of individuals with a disease and those exposed to an infectious disease raises questions about the level of risk that justifies a person's loss of liberty. Isolation and quarantine were initiatives that for many people were two of the most restrictive type of interventions where authority can be

exercised in the name of public health. Bayer and Fairchild (2004) noted that although there have been lingering public health threats such as tuberculosis, most infectious illnesses requiring quarantine were relatively uncommon in the twenty first century. However, in 2002, the threat of Severe Acute Respiratory Syndrome (SARS) resulted in many governments re-instituting one of the oldest public health tools to combat the outbreak of SARS – isolation and quarantine.

The spread of SARS took medical practice back to an era when there were no definitive diagnostic tests and no known vaccine or treatment (Bayer & Fairchild, 2004). SARS received widespread media attention when in 2003, the Washington Post, published an article describing how fears caused public health authorities in one Ontario town to close a high school and to institute an order to home quarantine 1,500 students (Brown, 2003). Closing of the school was viewed as being necessary because one student who attended the school was diagnosed with SARS. The provincial public health officials warned the student and teachers that anyone who violated the home quarantine would be hospitalized under the authority of public health (Brown, 2003; Gostin, Bayer & Fairchild, 2003).

Subsequently, Bayer and Fairchild (2004) wrote that in the fall of 2003, public health authorities anticipated a resurgence of SARS; however some believed that the isolation procedures used during the 2002 outbreak were too stringent. They described how the USA office of the Centers for Disease Control (CDC) reported that individuals quarantined after contact with an asymptomatic SARS patient had no detectable risk of infection. Moreover, there were no identified cases in which an individual transmitted the disease to his or her contacts while under quarantine. Based on this new evidence, less restrictive surveillance and quarantine

recommendations were implemented (Bayer & Fairchild, 2004; Cetron & Landwirth, 2005). These included:

- passive monitoring on the part of the individual with no activity restrictions;
- active monitoring by healthcare workers either by phone or in person;
- working quarantines where persons who are at occupational risk of infection, such as health care workers, may be restricted to their homes or designated facilities during off duty hours;
- focused measures (such as building closure or event cancellations) to increase the social distance among members of a group where transmission was believed to have occurred; and
- community-wide or regional measures (such as school closings and transportation system shut downs) to increase social distance in areas where extensive SARS transmission can occur.

Restrictions on liberty can nonetheless also involve restrictions on freedom – effective freedom and formal freedom. Effective freedom is "having the power or capacity to act in a certain way" and formal freedom is "the mere absence of interference" (Holland, 2007, p. 47). Effective freedom can put people "in a position to do things they would not otherwise be able to do" (Holland, 2007, p. 47). Thus, the provision of public health initiatives can be justified if the goal is to promote freedom – the positive view of effective freedom. Although intrusive or coercive, public health interventions, as described in the SARS example, may appear to undermine a person's freedom, these interventions in some instances can be seen as completely justifiable.

These practices can be justified since the intervention also promotes freedom positively, as effective freedom, in that it gives people the capacity to act in a certain way to protect their health and the health of those around them.

2.3.3 Privacy in Public Health Practice

The tension that exists between the privacy rights of an individual and the need for access to and disclosure of personal health-related information for public health initiatives is one of the most debated ethical dilemmas that face public health professionals, epidemiologists, researchers, and practitioners as noted by Bayer and Fairchild (2004). Epidemiology has long been known as a foundational science in public health practice and surveillance is one critical element that aids public health professionals and researchers to find ways to protect the public's health (Bayer & Fairchild, 2004). Bayer and Fairchild (2004) also described how some epidemiologists and public health researchers reported that regulations and guidelines designed to protect the autonomy and privacy of individuals are sometimes inconsistent and can often conflict with the objectives of public health initiatives. They maintained that to implement these guidelines and regulations according to the bioethical value system would require significant modification to many well-established methods and public health processes resulting in a negative impact to the delivery of essential public health interventions.

Another commonly held public health appointed mandate is to monitor and intervene when the public is facing a health threat (Bayer & Fairchild, 2004). These surveillance activities can often result in healthcare practitioners, and especially physicians, being required to report confirmed (or suspected) cases to provincial or national disease registries. Tensions can arise among health

practitioners and privacy advocates regarding what some may feel is an assault on their privacy. However, as Bayer and Fairchild (2004) described, these issues can usually be resolved by ensuring that the rights of the individual are given priority. Recently, in the USA, the Department of Health and Human Services has identified epidemiological research as being exempt from informed consent requirements provided: a) the risk to participants is minimal, b) the research does not record data in a way where individuals can be identified; and c) the research could in no other way be conducted (Coughlin, 2006). This exemption signifies that the benefits of epidemiological research and records-based research, in some cases, are important enough to override the impracticality and burdensome process of seeking consent through an individual-focused values system. Nevertheless, many acknowledge that individuals should be told, as a matter of course, that their information might be used in future epidemiological studies or surveillance activities (Bayer & Fairchild, 2004).

An example of the conflict between privacy and public health arose in the context of the AIDS epidemic in the 1980s (Bayer & Fairchild, 2004). Public health efforts to prevent the spread of the disease was, in the minds of some people, overshadowed by concerns expressed by advocates for homosexual men regarding threats to privacy and civil liberties. These concerns were noted as arising due to the proposed reporting requirements that infected partners must be informed of their exposure to HIV as a mechanism to reduce the spread of the disease. Debates arose as to why there was a need to treat AIDS differently from other diseases. Historically, mandatory case reporting by name was necessary as was the investigation of all potential contact persons for infection of the disease, including isolation of infected individuals (Bayer & Fairchild, 2004). However, advocates stated that the reduction of AIDS needed to focus on education and

behaviour change, the protection of rights and privacy of people infected with HIV, and a rejection of coercive measures.

Bayer and Fairchild (2004) asserted that the approach to reducing the spread of AIDS needed to be voluntarism. They stated that for public health policies to be effective in controlling the spread of HIV these policies must not violate the rights and privacy of individuals. The United Nations Office of the High Commissioner for Human Rights and Joint United Nations Programme on AIDS also concluded that coercive public health measures were counterproductive since they tended to "drive away people most in need of services and failed to achieve their public health goal of prevention through behavioural change, care, and health support" (Office of the United Nations, 2006, p. 78). Surveillance reporting was in the minds of some individuals, counterproductive in that it would drive people away from testing and counselling which were essential control measures in the public health campaign against AIDS. This belief seemed to predominate regardless of the fact that public health departments had an exemplary record in protecting the privacy of individuals in any name-based disease reporting. Bayer and Fairchild (2004) surmised that "public health interests do not conflict with human rights and it has been recognized that when human rights are protected, fewer people become infected" (p. 479).

2.4 Ethical Issues Studied in Public Health Practice

The literature review conducted in preparation for my thesis research pinpointed three qualitative studies that outlined the ethical issues experienced by public health professionals in a population or community context. Opportunely, these studies also highlighted some of the strategies used to

resolve these challenges. Although none of this research was conducted in Canada, highlighting the fact that little research has been conducted on these issues in the Canadian context, these studies do provide background and examples of the means being used by public health professionals. Each of these studies is described herein.

2.4.1 Baum et al. (2009) Study

A recent study published by Baum et al. (2009), sought to identify the ethical issues faced by public health professionals in Michigan USA. Participants included public health officers, medical directors, environmental health directors, and health educators. The Baum et al. (2009) study also sought to identify the values that underlie ethical reflection and problem solving in public health practice, the processes that public health professionals used to resolve such issues, and their views of the potential use of ethical frameworks that may aid with decision-making. The authors purposefully sampled thirteen health departments (out of a total of 45) to ensure diversity in geography, jurisdiction (city, country or multi-county district), community demographics and governance structure (board of health or county commissioners) (Baum et al., 2009). Audio-recorded semi-structured interviews were conducted with ground-level and managerial staff. Thirty-seven interviews were conducted with local health department staff plus six high-level state health department employees along with two elected board of health members from local jurisdictions. Public health professionals were interviewed about the following: how do you perceive your daily work; what is the nature of the issues you face; how do you resolve these issues; and what are the principles and values that are considered when faced with challenging ethical issues?

The authors of this study stated that a definition was not provided as to what the researchers meant by an ethical issue thereby allowing participants to discuss the issues that they perceive to be ethical challenges in their work (Baum et al., 2009). The authors report this was done so as to not lead the participants in one way or another. Participants were asked to explain why they identified a particular issue raised as an ethical issue and many shared the view that ethical issues were those that were difficult to resolve and that required judgements about what the right actions were and how to balance competing concepts of what is right or wrong. Some recognized that, at times, laws or regulations were insufficient to guide resolution; in other cases, resolution was a complex process because of multiple factors that must be considered. Many identified ethical issues when public health policies or practices ran counter to their professional principles or deeply held values. A broad set of values were brought forth from the interviews such as an emphasis on fairness, efficiency of practice, and stewardship of public funds. Other values included helping the most vulnerable, respect for individual autonomy, being consistent, helping the most people, and using evidence-based programming; however, no clear pattern of priority was identified among these values regardless of the occupation held by the interviewee.

The researchers concluded there were five broad categories of ethical dilemmas that public health professionals face in everyday practice (Baum et al., 2009). These were:

1. Determining appropriate use of public health authority.

   This category was described by public health professionals as an understanding and knowledge that they have substantial authority that can limit an individual's freedom and privacy or affect the economic viability of businesses in a community. For example, public

health professionals knew they can close a contaminated beach that is an important source of tourism revenue due to a public health hazard or contamination and they can place restrictions on a person's autonomy when a partner must be notified or when mandating treatment for an infectious disease.

2. Making decisions related to resource allocation.

Public health professionals reported that they struggled with the need to allocate limited public health resources including program funds. This required making difficult choices among competing programs and population groups such as how many influenza vaccines to provide or when to cut staffing levels in clinics.

3. Negotiating political interference in public health practice.

Public health professionals also reported the need to negotiate tensions that emerged from public oversight of certain practices. This proved to be ethically challenging for many because these tensions can created pressure to "bend the rules" or to sacrifice best practices. For example, there were instances of political pressure placed upon public health officials to allow non-compliance with certain environmental health regulations or political pressure to perform duties inconsistent with scientific evidence or to maintain programs that addressed the need of the day rather than the greatest health need in the community.

4. Ensuring standards of quality of care.

Public health staff outlined they have a strong commitment to ensure and maintain quality care across different populations and to meet their professional obligations to do what is

perceived as "right" even when faced with resource limitations or program constraints. But, they faced an ethical dilemma when they were compelled to provide lower quality care to certain populations because of program rules or limited resources.

5. Questioning the role and scope of public health.

Many public health professionals shared macro-level or big picture concerns about what the public health system should do and what functions or services it should provide. A disconnect was reported by these individuals between the types of services being provided in their community and their view of public health's mission, role, or scope. A subsequent issue they identified was maintaining professionalism as a public employee. Many public health professionals reported that at one time or another, they experienced a difficult relationship with a subordinate or a supervisor. Moreover, they reported that their interactions with the public can create ethical tensions and can impede their ability to work effectively or cooperatively with the broader community (e.g., serving on boards of outside organizations interested in input from or influence over public health officials).

The study by Baum et al. (2009) also sought to identify methods of resolution for ethical challenges being experienced by the public health professionals who were interviewed. Most reported that they relied on consultation with colleagues, supervisors, and public health professionals in other local or state departments to aid with the resolution of issues. Some relied on their own personal experiences and moral grounding as the basis for their decision-making. In some cases, their own religious beliefs and values were used as guides, but others referred to the principles conveyed during their upbringing as to what seemed the right thing to do. Other

informal methods of resolution mentioned (although infrequently) were formal frameworks for decision-making such as a code of ethics or other disseminated decision-making tools/guides. One health department reported developing a formal decision tool to use when making resource allocation decisions however the tool was very new and had only been used one time prior to the interview being conducted with the research team.

Baum et al. (2009) concluded the public health professionals interviewed for their study seemed to be divided on what they believed to be a few core values associated with public health. The participants seemed to only agree on one thing – there are a wide variety of values that aid them in their work. However, overall, there was a focus on a commitment to the concept of fairness and utilitarian reasoning – doing good for the most people. These individuals seemed to convey that their professional experience working through ethical challenges over time built a repository of knowledge and insights on which to base future decisions. But interviewees reported decisions were made based on their own assurances that the benefits and burdens of outcomes were equitably distributed in the population.

Although some study participants reported using guides to aid them with their ethical decision-making and resolution of issues, these appeared to be informal mechanisms used by just a few individuals and none had been formal or published broadly. However, many interviewees indicated they would consider using such mechanisms if they were made available. The research team reported tools of this nature may encourage a thorough and rigorous analysis of an issue for many public health professionals thereby aiding them with their decision-making process. Moreover, they believed that a tool kit may also help identify certain assumptions or beliefs not

addressed previously. However, the authors clearly stated that empirical testing for effectiveness and acceptability of such a mechanism or tool kit would need to be conducted with those who would benefit – which are practicing public health professionals.

2.4.2 Rogers (2004) Study

A few years before the Baum et al. study, Rogers (2004) published a study which sought to identify the ethical issues encountered by staff in the development and implementation of public health activities at two sites in Scotland. Interviews were conducted with staff from the public health directorate in a National Health Service Trust and a public health demonstration project in child health using what they reported to be a stratified sampling strategy to access a wide range of roles and occupations. Three main categories of ethical issues were identified, which were fairly consistent with the US study outlined previously. These included: paternalism, responsibilities, and ethical decision making.

The Scottish public health professionals identified paternalism as an issue in situations where there was no mechanism for obtaining informed consent from communities for new interventions, nor for people to opt out of community-wide interventions (Rogers, 2004). Interviewees from this study identified that community consultations, for example, can be paternalistic as the power and control that communities can actually exert over defining their needs or choosing interventions was limited by professionally imposed parameters, such as requirements for evidence-based decision-making. Further, individuals and communities or populations who were most likely to have interventions imposed on them were least likely to participate in consultations.

In addition, the authors of this study found that interviewees suggested paternalism became prevalent when there was a desire to withhold information from the public that may cause fear and anxiety. Some interviewees argued that people wanted more rather than less information; therefore, public health professionals debated the difficulty they experienced in deciding how open to be with the public about errors or accidents, and how to be honest without causing wide-spread public anxiety. One strategy reported by interviewees was to release intentionally "opaque" information, through careful wording. However, participants in this study recognized that the public demands a high level of honesty, and that suspicion of cover-ups could be harmful to the trust that is built with the public. Additional challenges identified by the interviewees was the desire for public health to get a fair hearing in the media when perceptions of error occur, the complexity of providing up-to-date and accurate health information, and the generally poor understanding of public health practice among politicians, the public, and the media.

This study by Rogers (2004) also found that many public health professionals have no direct relationship with the public. In Scotland, public health work often entails dealing with unidentified individuals which some public health professionals reported made it difficult to feel responsible to the public. However, some maintained that the lack of relationship made it easier when it came to resource allocation decisions. Other responsibilities that were identified as challenging were setting boundaries such as being assigned a specific responsibility to deliver a package of care and adherence to protocols but realizing the package of care or protocols did not meet with the immediate needs of particular families. Moreover, additional ethical issues arose regarding their limits of responsibility such that how much does (or should) public health staff *champion* for a certain population group when this may conflict with their own personal style or

views. Some thought that personal values should not influence professional ethics whereas others believed their personal values shape the boundaries within which they could meet their work responsibilities.

Public health professionals who took part in the study also described various barriers to fulfilling their responsibilities (Rogers, 2004). This included things such as meeting targets, working with partners, and political influences. Interviewees identified that meeting targets for accountability purposes raised numerous ethical issues such as inequitable service delivery and compromised patient autonomy. Meeting targets were viewed as sometimes going beyond the power or capability of staff and, for some, was seen as directing resources away from other important health priorities. Public health professionals in this study viewed targets as misleading and sometimes reducing complex issues to what seemed to be simple, measurable solutions. Other issues included working with partners who may not have shared goals and commitment, which can lead to misunderstandings and possible exploitation. Interviewees indicated that although partnerships can be constructive, combining professional groups also had its challenges. There were opinions expressed by the interviewees that some groups can have differing values and an alternative work ethic resulting in competition between groups with diverse standards and professionalism.

Additional challenges identified by the public health professionals in this study were associated with the close relationship between public health and politics (Rogers, 2004). Interviewees outlined that responding to inquiries from politician's diverted time and resources from other responsibilities they viewed as being more urgent or important. In some cases, political

influences were reported as being used to satisfy unhappy constituents and this was viewed by public health professionals as being unfair to others who waited patiently for assistance or care. Political influence was also reported as making it difficult for public health officials to withdraw a program even in times of fiscal constraint. However, it was identified that political influence was sometimes useful when aid was needed to draw attention to a specific issue or public health concern.

Scottish public health professionals also identified ethical decision-making as focussing on a desire for evidence based decision-making and shared responsibility (Rogers, 2004). They reported that implementation of public health practices should be directed by decisions that are more likely to be agreed by all parties and to be successfully implemented. Shared responsibility, they surmised, should be seen as being appropriate by all members of the group. However, it was recognized that these ideals can be compromised as lack of time was often reported as a factor limiting a public consultation process and the search for evidence. This was identified as leading to a lack of details that can compromise a public health initiative. Related to this, public health professionals identified "pragmatism" as an issue. To them, pragmatism referred to multiple pressures and incompatible aims which can lead public health staff to "finding the path of least resistance" and asking "what will be good enough, or achievable?" (p. 448).

Moreover, the public health professionals in the Rogers (2004) study identified various complexities in the process of decision-making and the fulfillment of responsibilities. They reported that some decisions require various levels of political approval which led to tensions among politicians and health care professionals. The view was that politicians are usually seen as

not wanting to be associated with unpopular decisions – "leaving a decisional vacuum at times" (Rogers, 2004, p. 448). Other areas of decision-making where public health professionals in this study experienced ethical dilemmas involved relations with pharmaceutical companies, confidentiality, and conflict of interest. Although public health staff saw the financial benefit of accepting funding from pharmaceutical companies to aid with the support of programs, they also saw this as raising various ethical concerns including inequity in services, circumventing prioritizing processes because of new funding for specific initiatives, pressure to accept interventions that may have poor evidence, feelings of inappropriateness for commercial funding for a national health service, potential for companies to use the funding as an avenue for lobbying efforts, and the lack of a mechanism for identifying and handling conflicts of interest. Finally, they discussed issues of confidentiality that arose and the lack of guidelines or policies along with the lack of awareness of confidentiality issues when working with partners outside of the public health system.

Various suggestions identified by the study author, Rogers (2004), for resolving ethical dilemmas experienced by paternalism, responsibility, and decision-making included:

- avoiding exploitation rather than gaining individual informed consent for community-wide interventions;
- improving community consultation processes through greater clarity and openness to avoid paternalism; and
- careful identification of competing values and obligations as these are issues in public health that are sometimes unavoidable and therefore need to be debated in the day to day workings of public health.

2.4.3 Bernheim (2003) Study

Another qualitative study described in the literature was a study conducted by Bernheim (2003) in Washington and Atlanta. This study used focus groups to interview state and territorial health officials, county and city health officials, and staff from the CDC. The author of this study grouped the ethical issues identified by participants into four major categories. The categories were somewhat similar to the ethical challenges described in the Baum et al. (2009) and the Rogers (2004) study. These challenges were: public-private partnerships and collaboration in general; the allocation of scarce resources, setting priorities, and choosing among different groups and health needs; the collection and use of data and information; and politics and relationships with other government officials and legislative bodies.

The study participants described public-private partnership ethical concerns as arising from the emphasis to create partnerships and collaborative initiatives with the business sector, faith-based organizations, consumer or advocacy groups, and non-profit agencies. The dilemmas the public health professionals faced when building partnerships were either perceived or real conflicts of interest such as accepting funding from private companies or pharmaceutical business who were looking to influence public health programming in some way or to have their services publicized to certain groups or individuals. Another item of concern that officials expressed was the reality of being linked to organizations that could influence decisions or policies regarding the health of the population (Bernheim, 2003).

The allocation of resources was a second category of ethical challenges the public health professionals in this study identified. Resources were outlined as a concern because public health

professionals felt pressure by higher authorities to “mandate” programs and to dedicate time and resources that could be implemented in other, and perhaps, more effective ways. A third category of challenges concerned the collection, use, and dissemination of data. These concerns were related to the risk of collecting imprecise data and making inaccurate assessments and reporting. These concerns arose especially when there was a need by public health professionals to be pressured to secure funding for a specific program or to publish the results, or to move forward with a particular program or intervention.

The fourth and final ethical dilemma identified by the participants in this study revolved around constraints through the establishment of governmental relationships. The public health professionals reported that at times they felt a need to compromise certain values because they had to work within a politically charged system. One interviewee described an example of a needle exchange program for drug users that they knew would reduce disease, but could not be implemented because of political pressure (Bernheim, 2003).

Bernheim (2003) surmised that overall there were two types of ethical dilemmas that emerged. The first was the challenge of appropriately balancing the benefits and risks in public health practice to ensure the public received the best care and interventions possible. The second was related to professional practice and how best to manage the demands and the conflicts of interest that may arise in day-to-day delivery of services and programs. The author concluded that although the public health professionals struggled over the legal and ethical implications of their responsibilities, they played an important role in defining new partnerships and relationships, allocating resources, and the collection of information for decision-making and policy analysis.

2.5 Public Health Practice or Research

As described in the previous section, there are numerous ethical challenges experienced by public health professionals. In addition to these challenges, defining the boundary between public health practice and public health research is an added demand in the evolving field of public health and public health ethics (MacQueen & Buehler, 2004; Rogers, 2006). MacQueen and Buehler (2004) outlined that public concern appeared to be shifting from a fixation on the harms and risks of participating in research to a greater appreciation of the benefits. They stated that in some cases public health interventions are not deemed research if the main objective is to provide care for individuals. But, they did ask people to question whether it was research or practice if data was being collected on the safety and effectiveness of a typical initiative where the primary interest is to inform management. Furthermore, they questioned whether it was research or practice when data is being collected to inform the conduct of similar interventions in the future or in other locations. MacQueen and Buehler appeared to believe there is a dual role in the delivery of public health interventions such that depending on the context it can be either research or practice or both research and practice.

To further support MacQueen and Buehler (2004), Buchanan and Miller (2006) suggested that to identify the social value of an intervention or research project, an analysis must be undertaken to not only look at the risks and benefits to the individual participants but also the benefits and risks to the population as a whole. Buchanan and Miller (2006) argued that a public health research ethics perspective should be "associated with broadening the conceptualization of risks and benefits deemed ethically relevant in deliberations on health research" (p. 730) and they identified five conditions that should be met to justify public health intervention research:

1. a large population is in need,
2. the research is expected to determine if the proposed intervention will be less expensive than a known effective, yet perhaps, more costly intervention, and the proposed intervention is hypothesized to be nearly as effective,
3. constraints do not allow universal provision of a known effective standard intervention,
4. there is a high degree of likelihood that the less expensive intervention can (and will) be implemented on a wide scale, and
5. there is community endorsement of the research.

Under these circumstances, Buchanan and Miller (2006) surmised that research on less expensive, less effective interventions may be ethically warranted. Thereby, they concluded that consideration should be given to the "practicality of universal public health protections as being ethically valid and crucial to consider" (p. 731). They also reported that research on less expensive, less effective interventions can be justified if there is "feasibility to providing population-wide protections provided the risks to participants are reasonable and proportionately balanced in relation to the proposed health benefits and the value of the knowledge to be gained by conducting the research" (p. 731).

Buchanan and Miller (2006) also concluded that if Kant's ethical values are followed "people should never be treated merely as a means to an end" and many would agree that subjecting people to "treatments (or interventions) known to be inferior to existing alternatives is morally impermissible" and "it is exploitive to provide participants with anything less than the best,

because offering an inferior treatment would be sacrificing their welfare for the sake of science" (p. 731). Moreover, considering the role of public health within a community or population, is it not a fundamental right of community members to identify a meaningful role in determining the conduct of research that may affect their lives? Buchanan and Miller (2006) believed so and concluded that from a public health perspective, the following applies:

- "the research community has an overriding obligation to protect the entire population by collecting adequate data about the safety of interventions before they are made publicly available" (e.g., it is socially irresponsible to put forth a new intervention or practice if a conservative burden of proof has not been met and reasonable doubts persist about its merit);
- "it is essential to recognize that the purpose of conducting research is to produce new knowledge, knowledge that is valued because it leads to improvements in care and in the health of the population as a whole" (i.e., although participants must be protected from harm and exploitation, their psychological, social and physical needs must be seen in the context of volunteering to participate in research);
- "it is unjust to discount the needs of the population as a whole in testing health interventions and it is unacceptable to focus exclusively on the participants alone, and not give due attention to the larger social ramifications of the research" (i.e., from a public health perspective, population needs must be considered and therefore the cost effectiveness of various treatment options must be taken as a valid moral concern such that a concern for justice is ultimately about distributing social resources, and rights and responsibilities fairly especially in meeting the needs of the least well off – if large

> segments of the population are denied access to effective treatments or interventions because they cannot afford them, then justice has not been served) (p. 732).

There also appears to be an ongoing debate in the research ethics literature as to whether evaluation of public health programs and interventions delivered to the citizens in the communities being served by them constitutes human participant research (Centers for Disease Control and Prevention, 1999; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). A recent review study conducted by the Public Health Research, Education and Development Program (PHRED) found that less than half of all Ontario health departments had a documented definition of research. Moreover, not all health departments in Ontario had a process for determining if a project should undergo an ethics review before implementation – 89% of public health units had a process in place but, five public health units did not. Although a review process was in place for most departments, nearly one-third indicated that their processes did not conform to the Tri-Council Policy Statement for the ethical conduct of research with human participants (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). This is surprising in that the TCPS is a document commonly used by a wide array of institutions and organizations in Canada to assess and analyze research for conformity to the principles of respect for persons, concern for welfare, and justice.

It is conceivable that, in some cases, the imposition of an informed consent process would be unexpected by clients of public health programs who are seeking, for example, prevention

services (MacQueen & Buehler, 2004). Furthermore, MacQueen and Buehler (2004) outlined that informed consent for involvement in a program evaluation that some may not view as being research may be an unnecessarily complex process and may raise concerns about the actual level of risk involved. These scholars suggested that a complex consent process may also introduce a misperception among some individuals that the program, and not just the evaluation component, constitutes research. They argued that the unintended consequences of requiring a consent process may result in potential clients declining services that could be of benefit to them and the validity of the evaluation undermined because of low or biased participation rates.

From a public health perspective, MacQueen and Buehler (2004) summarized that research ethics should be guided not only by giving consideration to the risks and benefits to individual research participants but also to society. They outlined that a public health framework on research ethics needs to be based on a values system where the risk to participants is not unreasonable relative to the potential benefits, and participants may choose whether to seek these benefits in exchange for their contribution to research and socially valuable knowledge. MacQueen and Buehler (2004) reported that regardless of whether public health interventions or practices are deemed to represent research or practice, it is essential they be conducted ethically. They believed this emphasizes the need for a public health ethics review mechanism that is responsive to crises and sensitive to the levels of risk, especially when projects involve potentially vulnerable populations.

3.0 Study Rationale

The practice of public health embraces a set of values and principles that are often, if not always, in conflict with the autonomy-centred principles focusing on an individualistic and anti-paternalistic perspective. Public health professionals and public health researchers would argue that the orientation, problems, and concerns of public health are different enough from those of medicine and medical research that the tools and concepts in bioethics and medical ethics are insufficient to address the issues commonly experienced in everyday public health practice (Baum et al., 2009). This argument, by Baum and others (2009) identified that the emphasis on individual autonomy in bioethics does not adequately address the population orientation of public health. Thereby, limitations on the rights of individuals in the face of public health threats were supported by tradition and it is the "collective hazard that provides the warrant for intervention even when the threat posed by any individual may not attain the standard of significance" (Bayer and Fairchild, 2004, p. 489). As Jonathan Mann (1997) wrote, "from public health, protection against broad health threats like epidemic disease, unsafe water, or chemical pollution is expected" (p. 7).

Even with the creation of a code of public health, a framework of public health ethics developed by Kass (2001), along with Upshur's principles and other theoretical commentaries and reviews, I found there to be a lack of research conducted on the *everyday ethical dilemmas* faced by public health professionals working in public health units in Canada. For the purposes of this research an *everyday ethical dilemma* refers to a difficult or challenging issue commonly experienced in daily public health practice. These dilemmas may create a professional or personal conflict for the public health professional or could simply be a tension, discomfort, or

competing obligation about a particular situation or decision to be made. These dilemmas may cause a public health professional to take a certain perspective or perform a specific action to manage the struggle they were experiencing. Therefore, I felt there was a need for research that described how public health professionals working in public health units approach, negotiate, and resolve such everyday issues. In my view the following questions seemed to prevail:

- What are the everyday ethical issues that public health professionals working in public health units experience?
- How are these everyday ethical dilemmas approached, negotiated, and resolved in practice?
- What ethical frameworks are used by public health professionals, if any, and which are most helpful in addressing these everyday issues to achieve resolution?
- How are known ethical principles and values incorporated into decision making and programs by public health professionals?

4.0 Proposed Study

4.1 Research Purpose and Questions

As noted, I decided to conduct this study because of the lack of general scholarly knowledge concerning the everyday ethical dilemmas that take place in the Canadian public health system. Specifically, I sought to investigate how the public health system manages these dilemmas. I attempted to address the research questions outlined below using grounded theory by identifying

the approaches and mechanisms that Canadian public health professionals used to negotiate and resolve the everyday ethical dilemmas they experienced when developing and delivering programs and interventions. My specific research questions were as follows:

1. What everyday ethical dilemmas do public health professionals report they face in everyday practice?
2. How are these dilemmas negotiated and resolved by public health professionals?
3. What are the experiences of public health professionals as they negotiate and resolve everyday ethical dilemmas?
4. What ethical principles, values, or foundations do public health professionals use to aid them in negotiating and resolving the dilemmas they experience?
5. What decision-making processes and approaches do public health professionals undertake to resolve the everyday ethical dilemmas that they face in practice?

5.0 Methodology

A qualitative approach was necessary to explore the everyday ethical dilemmas of public health practice to be able to obtain the depth of information needed to investigate the perceptions and views of ethical issues being experienced in everyday practice. Further, a qualitative approach allowed for exploration about how public health professionals negotiated and resolved these dilemmas. A qualitative research approach also enabled an analysis of the stories that participants shared to describe their experiences.

Following constructivist grounded theory methodology outlined by Charmaz (2006), study participants were encouraged to share the various ways they think about the specific phenomena of public health ethics. They were encouraged to speak about their experiences while dealing with an ethical situation and how they went about approaching, negotiating, and resolving that situation. The flexibility of a qualitative approach, as described by Charmaz (2006), provided the ability to follow leads that emerged from the discussion and gave a focus and direction that a quantitative approach would not be able to provide.

5.1 Settings and Participants

I originally intended to focus my thesis research on the dilemmas experienced in one Ontario public health unit by conducting eight to ten in-person interviews before reaching saturation. Furthermore, I intended to focus my research strictly on the dilemmas experienced in the area of health promotion and disease prevention However, recruiting a sufficient number of study participants in this one health unit proved to be difficult. Fortunately, an opportunity arose to collaborate on a larger study being conducted by my faculty supervisor, Dr. Elaine Wiersma, and her research team at Lakehead University. The topic of this research project was directly relevant to my thesis research. The purpose of Dr. Wiersma's study was to create a public health ethical framework. The public health unit interested in developing this framework approached the research team to conduct the project.

Focus groups were planned for Dr. Wiersma's study with all frontline staff to explore the ethical issues in public health practice. Consequently, my study was extended to include focus group data and a second public health unit. In totality, I conducted three in-person interviews and three

focus groups with public health staff before reaching saturation. One possible limitation of using both interview and focus group data was that responses from a single interviewee may have been systematically different from the responses received from a focus group participant. In many instances, focus group participant's ideas or thoughts can be triggered by the responses provided by another participant. In a one-on-one interview, some key thoughts or ideas may not have been conveyed as there was no other participant triggering those thought from which to build upon. Unfortunately, due to difficulties in recruiting and time limitations no other methodological alternatives were possible.

The staff at one of the public health units served mainly urban clients and had over 300 employees whereas the other public health unit served both urban and rural residents and had approximately 200 employees. The interviews and focus groups were conducted with a total of 18 staff; three participants were male and 15 were female. Staff worked within a variety departments and specialized in areas such as: a) child, youth, and family health which included breast feeding, dental health, and hearing and speech language services, b) healthy living which included health promotion and protection activities such as preventing tobacco use, healthy eating, and healthy communities, c) clinic services such as genetic counselling, and d) administration services such as finance and reception.

A combination of selective and convenience sampling was used for recruiting participants. All public health professionals involved in the study had been working at their health department for at least one year. The final sample consisted of nine staff who had worked in public health for an extended period of time (e.g., more than 10 years). Six worked in public health for less than 10

years and three for less than five years. The final sample consisted of a range of ages which included younger staff (under 30) and more experienced staff (over 40). Most staff worked full-time. To ensure participant anonymity, I chose not to detail the number of interviews or focus groups conducted at each health unit. I also intentionally omitted providing specific details about the educational background of participants and the positions they held at the health unit. To do so may have risked identifying participants to readers.

5.2 Ethics Review and Clearance

Before I began my thesis research, ethics review and clearance was sought through the Office of Research Ethics at Lakehead University. Upon receiving notification of ethics clearance, the first public health unit was contacted. A letter was written and mailed to the main point of contact within the public health unit (Appendix A). This letter was followed by email and telephone communication to discuss the study and address questions. My main point of contact then forwarded names of interested individuals. I sent an information-consent letter by email to each interested individual and scheduled interviews. A signed consent letter was obtained from each participant in person prior to beginning the interview (Appendix B). At the close of the interview, participants were provided with verbal appreciation and within two weeks a letter of appreciation was mailed to the participants (Appendix C).

Recruitment and informed consent for the second public health unit required a different procedure for Dr. Wiersma's ethical framework study. Thus, I submitted a modification request to the Office of Research Ethics at Lakehead University for review. Upon receiving clearance of the modification request, an email was sent by the public health unit leadership team to all staff

inviting their involvement in the ethical framework project which included my thesis research. An administrative assistant at the public health unit scheduled the interviews and focus groups. The participants for the larger study were recruited in a way that was deemed appropriate for the public health unit.

The interviews and focus groups were audio-recorded, with each participant's permission (Appendix D). The recordings were transcribed by two professional transcription specialists. The transcription specialists were required to sign a confidentiality statement as part of their contractual agreement. The word-for-word transcription aided with the theme coding that was conducted. The interviews were scheduled for one hour whereas the focus groups were scheduled for two hours.

5.3 Data Collection

An interview and focus group guide were developed but these were used for instructive purposes and not as a formal script or a prescriptive list of questions (Appendix E). The guides were organized based on various themes; however, during the process of conducting the interviews and focus groups a sequential list of questions was rarely followed. The interviews and focus groups were semi-structured and conversational and the ordering of questions was guided by the study participants to allow them to tell their experiences in a way they felt most appropriate. Data collection attempted to discuss the following areas:

- Identify the everyday ethical dilemmas public health professionals experience;
- Describe the dilemmas experienced;

- Understand how the dilemmas being experienced were approached, negotiated, and resolved;
- Describe the ethical principles being used to justify practices, programs, actions, and interventions;
- Describe how the negotiation and resolution of the dilemmas were coordinated within the public health professional's own role in the public health unit and within the broader organizational structure;
- Identify the use of organizational policies and procedures to aid in the negotiation and resolution of the dilemmas being experienced; and
- Address the impact of the dilemmas being faced on future public health practices.

Interviews were conducted by me and focus groups were conducted jointly with Dr. Elaine Wiersma.

5.4 Data Analysis

My analysis of the data collected from this study was conducted according to grounded theory methodology. As outlined by Charmaz (2006), grounded theory methodology uses various levels of coding. Therefore, I began by naming the concepts being studied and organizing the concepts into segments by closely examining each interview transcript line by line (i.e., everyday ethical dilemmas, process for negotiation or resolution of dilemmas, and ethical principles or values used). Next, I used open or initial coding to capture what I saw the data portraying and identified several theoretical categories for each segment. Words, sentences and/or phrases within each

segment were reviewed to identify the various themes. Themes were collapsed or expanded, and sub-themes were identified and organized in relation to the various segments.

Based on further review and reflection of the initial themes and sub-themes that I had identified, Dr. Wiersma assisted by redirecting my data analysis and recommending I demonstrate how the various segments and themes relate using a dichotomous chart format. Thus, axial or focused coding was the next step in the analysis process that I undertook. This is the coding process when the data are rebuilt in new ways (Charmaz, 2006). The focus while axial coding was to specify the concept under study and its context. Axial coding ensured the segments identified related to themes and helped to detail the themes and the overall concepts. In a succinct way, the chart outlined which of the various processes for dilemma negotiation and/or resolution were used by the public health professionals for a specific ethical dilemma they experienced. Subsequently, this helped to code the themes and sub-themes in a more logical and meaningful way to the idea it represented. Further, the chart helped with comparing the themes to each other to further analyze the data. The chart was used to group similar themes and in some instances to remove extraneous themes or sub-themes.

Finally, I commenced with selective or theoretical coding to determine how the segments related to each other and to theorize how the relationships between categories were developed.
I used the process of concept mapping to visually represent the relationships between the main ethical dilemmas being experienced by the public health professionals and the values and approaches used in everyday public health practices for dilemma negotiation and resolution.

Theoretical coding helped to tell a coherent analytic story and it is through this process of constant comparisons of the data that the grounded theory was formed (Charmaz, 2006).

6.0 Findings

I initiated the interviews and focus groups with a general question about ethics to help set the context for my overall discussion with the public health professionals and the everyday dilemmas they experienced in practice. I began by asking the public health professionals to describe what *ethics* meant to them. Similar to the protocol used by Baum et al. (2009), I did not provide a definition of what I meant by ethics as I did not want to seem as if I was leading the public health professionals to respond in a particular way. However, I anticipated their responses to this question would not only help me understand the professional ideals held by the public health professionals, but also the personal ideals they held. Generally, the public health professionals who took part in this study reported that ethics was a decision-making guide for how people should think and act. However, they also described certain factors and elements that were important or desirable to them as public health professionals. I identified these as values. These values related to the following three themes, in no particular order:

- personal values,
- process values, and
- empathetic values.

The public health professionals described *personal values* as beliefs, morals, principles, and personal and professional behaviour. They identified *process values* as undertaking certain

necessary activities or actions which were conveyed by the public health professionals as being accountable and evidence-based, following mandates, being transparent, ensuring welfare (e.g., privacy, confidentiality, informed consent) and being effective and efficient. Moreover, the public health professionals identified various *empathetic values* such as being fair, giving respect, justice, being objective, making a difference, and not causing harm.

Our discussions on the meaning of ethics then segued to the exchange of stories and experiences highlighting the ethical dilemmas the public health professionals experienced in everyday practice. Succeeding this, the discussions progressed to the sharing of experiences about the ways the public health professionals negotiated and resolved these dilemmas. The everyday ethical dilemmas, and actions for negotiating and resolving dilemmas, focused on a diverse range of practice-based elements and seemed to challenge each public health professional's own morals and values, professionalism, and the way they provided services. The public health professionals outlined certain challenges as being ethical issues knowingly whereas others were unaware the concern they identified might also be considered an ethical dilemma. Similar to the protocol outlined above, I did not provide a definition of what I meant by an everyday ethical dilemma as I did not want to impose a definition on the participants. I wanted participants to discuss the issues that they perceived to be ethical challenges in their work.

Some of the examples shared were from public health professionals who worked as facilitators of community-based initiatives whereas other examples came from public health professionals who worked as service providers for specific client groups. Each public health professional appeared to enjoy discussing the dilemmas and struggles they experienced. The discussions that arose may

have provided stress relief as well as learning and an educational opportunity. Several of the dilemmas identified did not appear to be new or novel as many of the public health professionals seemed to grapple with the same underlying issues.

The public health professionals revealed several themes associated with the everyday ethical dilemmas they experienced in practice. These four main themes were: *making choices and finding alternatives when resources are finite*, *health inequities*, *balancing and accommodating relationships*, and *achieving impact and effectiveness*. Subsequently, I found that several themes emerged for the way public health professionals negotiated and resolved these dilemmas in everyday practice. The various actions or strategies the public health professionals used to negotiate and to reconcile everyday practice dilemmas were what I identified as *mechanisms*. The three themes that emerged were: *managing mechanisms*, *collaborating mechanisms*, and *innovating mechanisms*.

As noted, the mechanisms the public health professionals used to negotiate and resolve the everyday ethical dilemmas they experienced were actions or strategies. This involved the implementation of various processes that may already be in place within the public health unit to ensure program effectiveness and address inequities in health services, techniques used by the public health professionals to manage concerns or relationships with clients or communities, and/or practices or activities that were used to ensure resources were adequately managed and mandates were met. The public health professionals employed these mechanisms to help them achieve a successful and ethical conclusion to the dilemma they had experienced or to be able to reach a satisfactory or accommodating conciliation. Finally, I found the avenue for how public

health professionals negotiated and/or resolved an everyday ethical dilemma to be related to two key approaches; *practicing in an ethical way* or *ethics in a practicing way*. Each of the themes of dilemmas, mechanisms, and approaches are described in detail in the following sections.

6.1 Everyday Ethical Dilemmas in Public Health Practice

The everyday ethical dilemmas described by the public health professionals who took part in my study related to the following four themes, in no particular order:

1. Making choices and finding alternatives when resources are finite
2. Health inequities
3. Balancing and accommodating relationships
4. Achieving impact and effectiveness

6.1.1 Making Choices and Finding Alternatives when Resources are Finite

Working in an environment where resources are finite resources created an ethical dilemma for many public health professionals. They stated they were often competing for resources, managing wait-lists and individual demands, and always looking to find ways to ensure needed resources were available for their clients, community groups, programs, and services. Because resources were finite, choices had to be made about which programs and services to provide and, in some instances, alternatives had to be found. When speaking about resources the public health professionals explained they were not just referring to financial support for programs and services but also time and human resources (i.e., having adequate time and available people). The text that follows describes one participant's experience trying to meet their professional

obligation to the broader population without losing sight of the individual needs of certain members of their community:

> *"We each have pretty clearly laid out responsibilities in terms of our client contacts. So we have a caseload and we have certain programs that we run so in one way that's priority. And then within that, perhaps certain clients need just more support, more individualized service, so I might spend more time with certain clients over others. That's kind of personally. And then as a member of the team, we're constantly having to make decisions about who gets our service because resources are finite, there are wait lists, and so it is something that we really truly battle with."*

The public health professional who shared her experience working in an environment of finite resources seemed to feel professionally obligated to follow the plans and priorities their health unit had established. But, they also felt personally obligated to use their time to tailor certain services to meet the individual needs of clients, and chose to act on this obligation. This individual, and others who described similar situations, were at times conflicted between program priorities and individual client needs as well as balancing the needs of different clients within their programs. The public health professional seemed to feel that it was a justified action to tailor certain services to specific members of the community as the means would justify the end (i.e., a healthier population and community). Two other participants shared their unique experiences in managing finite resources in their everyday work by saying:

> *"I think another internal barrier is funding as well, and it affects a lot of things. When you look into your program, and we have part-time staff, and the amount of*

work that we do is a very high load but yet there isn't funding for us. We only have a part time program support person."

"And I think in the end, to have people come and work collaboratively takes more time and it takes more money. And so then that was always a bit of a barrier is that in order to work that way, you need more time. And people are always stretched for time, and so often you'd have people withdrawing in their participation because they just didn't have the time to give it."

These two public health professionals identified situations where they wanted to do more to improve the health of their community yet were unable to pursue these endeavours because there were no additional resources available (i.e., time and money). These appeared to be examples of moral dilemmas because the public health professionals felt that they knew what should be done, but were unable to do so by constraints that were beyond their control.

The public health professionals who took part in this study also felt conflicted by their attempts to determine what programs to provide and what organizations to work with to make the best use of public health resources and those of their community partners. One participant shared their experience by saying:

"I've worked more recently within cross-cultural contexts with First Nation communities and it's given me a full sense of just how time-consuming and challenging it can be to work cross-culturally and that I need to take that seriously; and that there are really different ways that are often culturally-based and that I can't assume, even though I'm trained to a large degree to assume that

that's the way it should be. Because if you happen to be middle-class white woman whose been trained in a western academic institution, it tends to be linear. It tends to be moving towards an outcome as quickly as possible. Well, I'm only at the early days of comprehending that there are other ways of doing things and that it's actually quite time-consuming when you really start, when you want to meet people, where they're at, and it doesn't matter if somebody has a substance abuse issue or, and I don't know, or whatever. You've got to be ready to spend the time."

Working with groups, organizations, and entire communities is time consuming and the public health professional who shared this experience knew that to provide an effective service the community development process could not be rushed. Moreover, they knew that to establish the buy-in of community groups, it was critical to ensure services were evidence-based and would proceed effectively. However, when a public health professional was unfamiliar with the community they can feel constrained and a dilemma arises as to how choices about using their time should be made or whether alternative ways of working should be found.

Another challenge identified by the public health professionals was sustaining programs when external funding ends, or when the delivery of programs and services are reprioritized, meaning public health is no longer able to support the program with staff time. This resulted in the public health professionals striving to find ways to sustain services knowing there may be a day when they can no longer facilitate the program or partnership within the community. One participant

shared their view by saying: *"it's a difficult time in the non-profit sector and they have scare resources"*. Two other participants expressed the following:

> *"I honestly think that if the money went away, the [program] would've gone away as well. And it's not that these people are not passionate about the issue. But the reason for coming together was because somebody had money. And so I guess it, like the struggle we had made sense when you look at it from that perspective, right? And if there was no money, there probably would be no [program]."*

> *"So we're really mandated to reach out to community partners and I'm afraid in this present environment – maybe it's going to get better. But, this is what I'm seeing at the moment is that the role has been inequities in terms of the resources of public health, vice vi, community partners. But, I think those are only going to increase because public health, I'm assuming, will remain funded at a certain level. And, I'm seeing a significant diminishment of that in my own community. I don't think it's just here in this community. And, so we're almost less equal, so it just magnifies everything that I've already said. I mean, not less equal in terms of enthusiasm, competence, or initiative. But, less equal in terms of resources."*

The public health professionals who shared their experiences described the uncertainty they sometimes felt when working with communities to deliver programs and services. They also identified a situation where they felt there was inequity. These challenges created a dilemma for the public health professional as they were mandated to implement certain programs but felt conflicted in providing a service for members of their community knowing the service will end if

funding is not found to sustain it within the community itself (e.g., by a community group or NGO). The public health professionals seemed to question whether it was ethical to provide a service that may not be able to be sustained long-term.

Moreover, the public health professionals in this study felt they needed to ensure the public was aware that public health cannot fix all issues nor address all determinants that may affect health. The public health professionals reported that through their community development initiatives they often needed to make it clear that public health does not have endless resources. However, they also felt that it was a critical as part of their work to build capacity within communities and establish partnerships to ensure communities can independently work towards addressing the various determinants of health long-term. A participant conveyed this by sharing her experience:

> *"There are many, many community groups that are now competing for resources. So a dilemma for us is that when community partners look at us they observe that we've got better resources than they are and it's a dilemma in terms of, you know, if we really are functioning as sort of an equal partner when we're sitting around the table. Because there's either an expectation that we'll do everything because we've got the resources; or that the counter to that is the notion that we have to be careful when we partner with communities that we're not loading on our hopes and programmatic expectations to our community partners".*

This participant elaborated further by conveying the following:

> *"We discovered we had a fabulous program on our hands; but then we ran out of money because the funding ran out and we weren't in a position to continue to*

fund it. So, I mean for me that's a dilemma. I mean, we did get a lot of rich learnings from that and we were pretty innovative in trying to implement the learnings that we received from that funding to implement it into our programming in other ways. But that being said, I think there are limits to that innovation that there is an ethical dilemma sometimes about going out and getting short funding – I mean, short-term funding – when you know it's going to end; because who's going to sustain it? Because, I mean, the whole philosophy of public health is community capacity building and working with your community partners to identify issues and helping them get the resources they need to deal with that issue."

The public health professionals who shared their thoughts felt strongly that they had an obligation to ensure their community was not left in flux when public health funding was no longer available. To them, this was a dilemma as it was a perplexing and difficult situation. The public health professionals who took part in this study strove to meet their professional obligations and ensure that those who would benefit from certain programs and services receive those services regardless of who was managing the service.

Furthermore, the public health professionals found that there were instances when they had to focus on the principle of liberty and self-determination over other professional obligations. Making a choice regarding two priorities was an everyday dilemma for them. One example was a situation where a public health professional felt she had an obligation to teach a parent to advocate for her child which required more of her time than she could afford. But she knew that

if she built and maintained trust with the parent by spending the required time with her to teach her the skills she needed, in the long run the benefits for this family would be timeless and likely spill over to other aspects of their lives. She was creating a condition where the family could freely choose to be healthy. This participant expressed this dilemma by sharing their experience regarding their time as a finite resource:

> *"You're always kind of thinking, is this a parent who I can assist to become that advocate for their child which will take more of my time, taking time away from others. So those decisions about where I put my time and my efforts are very ongoing and constant."*

Finally, the public health professionals outlined experiencing time constraint dilemmas. These challenges were experienced when public health professionals needed to balance their administrative obligations with their client service responsibilities. They struggled with deciding on the level of detail needed to complete various reports. The more time spent working on reports took time away from being able to focus on service delivery and direct client interactions. Moreover, a high demand for services meant the public health professionals were seeing increased numbers of clients, but less and less of their time was spent with each individual client. Therefore, things like professional development or skill improvement were regularly postponed. The public health professionals reported that although it may seem as if they were improving services by meeting immediate demands and increased caseloads, they felt they may also be hindering client service by not spending adequate time with clients nor improving or developing their own knowledge and skill set.

Making a choice to spend additional time finalizing an administrative report, making a choice to spend additional time with a client to address a specific need, or deciding to not pursue professional development are everyday ethical dilemmas the public health professionals experienced. Although some people may view these to be practical challenges and concerns, these demands on the public health professional's time created internal conflict for the public health professionals. It seemed there were instances when it was difficult for the public health professionals to reprioritize and/or decide how to spend their time and there were instances when they questioned their choice as right or not. One participant shared an example that relayed her experience:

> *"Individual skills in time management where you're balancing direct client contact, which is the most important thing and I think we all believe that, but having to do the more paperwork kinds of things like reports which are also important, but how detailed? I struggle personally with getting into huge detail in my reports so that it's very clear and parents are supported with that report along with everybody else, but they're incredibly time-consuming and they cut into my direct client time. So it's that balance that is just ongoing and constant, and how do I change that?"*

This participant went on to share the following:

> *"Trying to see as many children as I can, it's that quality piece that suffers, and my own professional development, the time that I spend just learning and improving my skills and rechecking what I'm doing, all that time. It's much easier and pressures are such that that gets shoved away. And, that's not right either."*

Another participant shared his thoughts by saying:

> *"Just check the numbers off. There, I've seen more but I had to spend less time with them, and I haven't been able to develop my skills or to refresh my skills to do a good job. But, to do the job well – you think you are, but you're not checking it to see the results because your time is finite, it's a resource, and it's like I cut my wait list down but instead of seeing them for an hour once a week, I see them for a half hour every two weeks."*

One participant summarized the challenges of making choices and finding alternatives when resources are finite by saying: *"we have to choose where are we going to put [our] resources."*

6.1.2 Health Inequities

A second theme of everyday ethical dilemmas experienced in public health practice related to health inequities. The public health professionals generally described health inequities as differences in the health status of families in their community who were struggling financially and those who were not. They reported that those who struggled financially and with their health do not do so intentionally, but do so because of their external environment which makes certain concerns and problems they experienced outside their control. Within this theme of health inequities, two sub-themes emerged. These were: harmonizing short-term needs with long-term needs, and victim blaming, alienation and isolation.

6.1.2.1 Harmonizing short-term needs with long-term needs

Several discussions with the public health professionals about health inequities focused on what the public health professionals believed was a misperception about how health inequities should be addressed within their communities. This dilemma, as they described it, related to what they viewed as a misunderstanding by many that if public health implements programs and services focused on the short-term health needs of clients the community's long-term health needs will also be addressed. Based on their theoretical education and experiential knowledge, the public health professionals inherently understood that less educated and lower socio-economic status people tend to live in neighbourhoods that create additional health inequities. One participant expressed this concern by saying:

> *"Some of the issues keep coming forward all the time and a lot of the poorer populations tend to be located closer to bigger industries, closer to the high traffic areas. So, I was just reading something the other day actually that even brought up the whole thing of ethics, is it ethical for that to happen? Why is it that all these rich people aren't located near these industries that are polluting and that sort of thing?"*

The public health professionals also knew from their work that people living in poorer communities tend to prioritize their health needs differently than those who live in higher socio-economic communities. Meeting basic needs, such as food and shelter, becomes a priority over treating a child's speech impairment or quitting smoking. Thus, the public health professionals strongly believed reducing poverty will help families and communities improve their health as

poverty is one issue that prevents many people from making healthy decisions. One participant shared their view by saying:

> *"We're visiting families who can't make it on the money that they're getting from Ontario Works or the working poor families who can't make ends meet on $10 an hour at a part-time job with no health benefits. So we're trying to promote health when we know the social determinants of health – poverty – is the number one issue that affects health, so it just feels like so much of it is in vain."*

The experiences shared by these public health professionals outlined the imbalances they saw in their communities as to how people were viewed and treated. This seemed to create a dilemma for them between their own moral responsibilities and that of their professional obligations. They knew that providing programs and services to address an individual's immediate health needs gave no assurances that the person's long-term needs would be met. The public health professionals who shared their experiences as part of this study struggled with how they should pursue correcting a societal misperception that stigmatized certain segments of their community.

The public health professionals also felt the general public viewed public health professionals as "nagging" rather than helping. They were always telling people what to do or not to do, but not necessarily helping people obtain what some viewed as the necessities of life. One participant described her thoughts:

> *"We just tell people what they can and can't do constantly. You know, don't drink too much, don't smoke, put on your sunscreen, get more exercise, do this, do this, and do this. But, people that are living under the poverty line are people who*

don't have enough to eat or that are addicted to substances or don't have a consistent roof over their head. People need to have their basic needs met before we can start nagging them about all the other stuff."

This participant commented further by saying: *"In terms of all of the partnership mobilization, all of that stuff, and I think that we do that very well. But, we don't necessarily always help people's basic needs to be met."* Another participant described their experience:

"Well, I'm certainly very much interested in issues of health and equity and how the public health sector contributes to narrowing the gap in health inequities, rather than expanding it. And in relation to this, I'm very interested in how we can make sure that we are not contributing to health inequities by perpetually designing universal interventions that always go to a more educated and better off, you know, people or case. Because it's easier to do and that we tackle some of the harder issues to deal with so that we can shift the population curve. That's one particular issue of my interest. The other one is just understanding how a variety of strategies compare in public health and maybe stepping up policy development of public health, working in the domain of policy development as opposed to awareness-raising and teaching, education and so on."

The everyday ethical dilemmas described above outlined a conflict between what they felt was finding a balance between benefits and potential harms. Although the public health professionals were not intentionally placing the public at harm, in their view they were questioning the redeeming value of providing services that may not have any long-term impact for those in their community who were in the greatest need of these services. Feeling as if they were "nagging"

people was seen as a potential harm to those they sought to assist, instead of helping them. Moreover, the public health professionals recognized that identifying an individual's needs and where to set priorities is extremely difficult as each person and community is unique. One participant shared the following:

> *"Even though you can say it's a generic program that you are providing, it's not. Every family that goes in really ends up getting something a little bit different depending on what comes about so ensuring that they feel that their needs are being met and their children's needs. And then again you get into the struggle of maybe what they feel are the needs for their child are different than what we feel the needs for the child are."*

After further discussion, the public health professionals seemed to identify a dilemma where they were ambivalent about the responsibility of public health. They questioned whether it was public health's obligation to ensure an individual's basic needs were being met or whether it was to support, facilitate, and assist other sectors and organizations to help people meet their basic needs.

6.1.2.2 Victim Blaming, Alienation, and Isolation

A second sub-theme related to the dilemma, health inequities, was the concept of victim blaming, alienation, and isolation. The public health professionals reported they struggled with the mindset of the public and the perception that individuals were responsible, and to blame, for not making the right choices with respect to their health. However, the public health

professionals knew that to make a healthy community, it was important to understand people in the context of their entire lives rather than focus on just one particular aspect. One participant expressed this by saying:

> *"[A] very important issue for me is the whole shift, paradigm shift, from so-to-speak blaming the victim or looking at the individual and the lifestyle changes versus looking at the environment and the changes in the environment. And that's, you know, something that I'm very interested [in], both when it comes to the social environment and the physical environment and how those factors affect public health in general and people's decision-making around actions that contribute to their health".*

This participant elaborated further by stating:

> *"I think we have in public health for a number of decades have been actually very focused on trying to correct what we as individuals do and really placing most of the responsibility onto the individual, which is not right. Changing our mindset and creating a paradigm shift and kind of understanding people in the context rather than outside of the context of their lives. That's one big ethical dilemma."*

The following are specific examples shared by two other participants with respect to understanding people in the broader context of their lives:

> *"[It's a] journey when you have a child who has special needs [which] is first of all recognizing and accepting that need, so sometimes you run into that kind of denial phase. So you kind of need to talk with parents about that. So in that*

phase, you can get reactions - anger, projecting blame. So that's a possibility. Sometimes it's a parent who has completely bought in and sees the need but just doesn't have the skills to be able to, and that's easier to deal with, and that's truly if you've got somebody highly motivated to learn. Sometimes life is just hard. If you think of hierarchy of needs, supporting your child's communication might be way beyond where you're at."

The public health professionals who shared these experiences appeared to identify a conflict within their own profession. Historically, the burden has been placed on individuals to change their unhealthy behaviours. The reality is that from a population health and systems perspective, broad policy and environmental changes must be made to support people in leading a healthy lifestyle. The public health professionals inherently knew that "blaming" people for unhealthy decisions will not result in effective, long-term changes in society. The conflict they felt appeared to be one of seeking a balance between liberty and paternalism by allowing people to be free and independent in their decisions about their own health yet knowing that in some instances there was a need to direct people in ways that will encourage a healthy lifestyle.

Another inequity dilemma that challenged the public health professionals was trying to find ways to help those most in need in their community. They reported they struggled with finding ways to reach out to these individuals and families along with finding ways for them to be engaged in public health services. Two participant s expressed their challenges by saying:

"From the perspective of what I'm interested in is the whole issue of health inequities. So how do we, what do these universal interventions mean, you know, and how much resources do we put into universal interventions versus the ones that are particularly dealing with groups that are at a disadvantage when it comes to a particular health issue? And how do we make sure that we have a good balance between those? I think that's a big dilemma because our resources might be going now towards interventions that reach people who may need much more efficient means - may benefit from much more efficient means such as checking on the website, you know, for some information. And yet we are putting a lot of resources into kind of creating promotional materials, organizing events and so on to reach them. They do come, which is probably the second or third way for them to actually get the same information. And at the same time we are missing out on those who haven't had any opportunity to reach us or we haven't reached them. So how do we reach out to those who really need us the most?"

"Putting food on the table, or shelter, we try to meet some of those. We generally have a policy to respond to any barriers like that. Like if its transportation; maybe it's a single parent with several children and it's just impossible to get here so we do respond to that with occasional provision of services in the home and we have a speech pathologist and a [dentist] who provides services in childcare settings so we try to use that. But again, we're making decisions who gets that type of service because it might be in high demand, so we're trying to set clear criteria but there's always gray areas. We're always responding, we're always trying. So I think we're meeting some of the challenges but they're always there."

As described above, an everyday struggle public health professionals experienced was one where they felt they must always be searching for the best ways to assist people with their health choices even if providing that assistance is not feasible. They are often challenged with balancing their views of justice and reciprocity. Moreover, the public health professionals reported they were not always able to identify those who may need help and many individuals were afraid to ask for help. Their experiences have shown that families in need may not always seek out services or ask for help and support from public health, even when they know public health can help. These families have the belief that public health or others in their community may judge them and some did not want to admit they have an issue or problem due to negative attention it might bring to their family. However, because the parents did not, or were not able to, advocate for their child, or left it too late to ask for help from public health, the public health professionals were not able to help the child. One participant shared her experience by saying:

> *"A lot of people are afraid to bring their child into the screen because they think, that means that there's something wrong with my child. And, that's a lot of times the reason they decline the referrals is they're worried, and especially [they think], oh, I don't want [the] teacher knowing, but really the teacher knowing allows them to be able to plan and give the child a better start at school. And, in the early screens, you can get those services before you start school and there's a lot of them."*

Another public health professional shared an example where they could have helped a child with a speech impairment had they been able to intervene during the child's preschool years. She shared her experience by describing the following:

"And the saddest story is the parents that hide their children, they won't take them out to screenings, they won't take them out to playgroups, they won't take them out anywhere because there are issues and then we get the phone call after they've started school, and because our program only goes until school entry, unfortunately we can't do anything for them. We can provide them with the information of how they can get what they want but we can't put in the referrals for them. And it's really sad that here is a child that if they had come out earlier, they could have gotten all the assistance they needed when they started school."

In their profession, the public health professionals are constantly trying to balance the provision of services for those in need who want assistance from public health and those who do not (i.e., those who are hard to reach or indicate they do not need public health services). It seems that an everyday struggle for public health professionals is the balance between equality and access to health services, the autonomy of individuals to decline services, and the voluntariness of public health initiatives.

Additionally, a public health professional shared an ethical dilemma associated with a program they provided that appeared to alienate children from their peers. The public health professional questioned whether it was ethical to continue providing a healthy lunch program when some children in the program felt ashamed about what they brought for lunch by hiding what they ate from the other children. This participant shared her experience with this ethical challenge:

"Students had to track if they met four of the [food] groups in their lunch. So, at lunchtime, they pull out their lunches and they count how many food groups. And,

so we had a discussion about Lunchables because lots of students bring Lunchables to school. I introduced this program [to the school], gave them the resources to run it, came back a couple of weeks later to do follow-ups, celebration sort of thing. And, I was talking to the teacher and I said 'So, how do you think it went?' And, she said that the kids who had healthy lunches already, their lunches just got healthier, and the kids that had unhealthy lunches they just became embarrassed over their lunches. So, they would rip off the Lunchable packages and dump it out into a paper towel or whatever to hide the fact that they were eating packaged food."

The public health professional felt ethically conflicted providing this program because she knew the food these children brought for lunch may have been all there was available at home or what their parents could afford to purchase. This meant for the public health professional the moral dilemma of allowing these kids, who were part of a healthy lunch program, to eat unhealthy foods so they did not go through the day being hungry. The participant continued sharing her experience by saying:

"So, it was like, I don't like this program anymore. We're making a child feel incomplete, and they have no control. These were like grade one students, so if they were feeling that way that made me realize, what are we doing? Are we excluding or segregating and making these kids feel really ashamed of their lives? Because it's out of their control, they can't control that."

This led the public health professional to question whether school interventions that focus strictly on children were ethical as children can be limited in their ability to make healthy decisions because of the financial constraints of their family or the choices made by their parents. One participant shared this view by saying: *"And you can educate students and empower them, but at the end of the day it's their parents that make the decisions and buy the food, and are going to send them their food, so yes, sometimes you just feel like 'what am I doing?'* This participant further elaborated by saying:

> *"Some schools they say, you know what, as long as my students have a bag of chips, that's better than yesterday when they had nothing. It is hard. We stand up there and we preach that this is what you should be doing, but at the end of the day, it really doesn't matter because sometimes these kids don't eat. It is a challenge to some different degree. It's hard to see that. It's easier to work with schools that are affluent and they have the resources to do that, they have supportive families, because they are interested and they want to be involved. They are interested, but should they get priority of our services over the schools that just because they're not interested because they've got other issues. Is it fair?"*

This situation outlined the ethical dilemma of balancing the benefits of public health initiatives with the burdens and harms. It is not always possible for public health professionals to know if the programs and services they provide will lead to negative consequences for their clients or communities especially for vulnerable populations such as children. Although the harm to the children in this situation was unexpected and not anticipated and the negative impact minimal,

this experience led the public health professionals, and others who shared similar experiences, to suggest that it is unethical to provide services that alienate and isolate certain program participants.

Another everyday ethical dilemma identified with respect to inequities was that even though many public health efforts are focused on those who are in most need of health services, there should be a fair and equitable balance so as to not exclude the general population. The public health professionals felt that by only focusing on those most in need, they risked alienating and isolating others in their community. For example, several public health professionals struggled with feeling that the no smoking legislation discouraged some people from being active with their children outdoors because they were not able to smoke near public areas such as parks and playgrounds. Although these public health professionals felt there was a need to focus on the precautionary principle and to prevent risk or harm especially with certain priority populations such as protecting children from second hand smoke, they also felt a need to not isolate the rest of the public from active outdoor living. They felt these individuals' needs should be taken into account as well. Two participants shared their thoughts on this challenge in their work by saying:

> *"And the thing that comes to mind is when we were doing the tobacco free parks and beaches bylaw, we had at length discussions because we basically were trying to decide do we go for an all-out ban for smoking in parks and beaches, and we thought no, that's not really fair. We have an obligation to protect people, like we want to protect kids and protect people in those areas, but is it fair to completely isolate people with a tobacco addiction from most areas?"*

"The team of people that I work with, we're kind of all very similar people. So when you have a group of people sitting around the table that have similar sort of lifestyles and backgrounds, we're sitting around saying, 'Well, we don't smoke so what do we care.' We weren't actually saying that, but that sort of initial perspective. Like the one thing that I said is that lots of people don't have their own camps or cottages to go to, and that's where they go in the summer is the public beaches and the public parks to enjoy that space and time. So, we don't want to isolate those people because they may have an addiction."

6.1.3 Balancing and Accommodating Relationships

A third theme of ethical dilemmas experienced by public health professionals in everyday practice involved the various relationships the public health professionals must accommodate and balance which consisted of: personal relationships, professional relationships, and organizational relationships.

6.1.3.1 Personal Relationships

The public health professionals discussed ethical dilemmas where they expressed internal conflict and personal struggles in their everyday work. Managing client relationships was reported as challenging as the public health professionals found they struggled with staying focused on what they felt was fair. These difficulties arose especially in situations where a client did not appear to want to advocate for their own health needs or continually insisted that public health provide them with assistance to address their needs and wants. These were times the

public health professionals found particularly upsetting and distressing. One participant shared her experience:

> *"You might get a call from a family, from a parent, with particular concern, and this particular parent just is the type to call and that parent over there just isn't the type to call. Their child may be kind of exactly the same in terms of need. So I admit that there's probably a tendency to probably respond to the parent who has called."*

This participant further elaborated by saying:

> *"But I really try to see that ahead of time, try to anticipate any parent – actually I do this – I try to anticipate any parent who is being that squeaky wheel. And when I'm looking at the list, I actually try to play that through my head no matter what and it's my own way of kind of dealing with that fairness, not being just responding to the squeaky wheel."*

Other situations the public health professionals struggled with personally included times when they learned about people who use public health services who did not appear to need them. They reported these were usually individuals who have the financial means but took advantage of public health services regardless. The ethical concern the public health professionals felt about this misuse of services was inequality in that those who have the financial means were taking resources away from others who may be in desperate need of these services. A participant described her experience with misuse of services as:

"There is no needs test for those clients. You want to make sure that it's open to everybody. Everybody has the option for it. But, basically, all our parents have to do is sign a piece of paper that says it's a financial hardship. It gives me warm and fuzzies when I'm dealing with clients who truly, I know, need the program. When I'm dealing with people who just signed and are self-employed and have a lot of means, then I feel that my demeanour changes a bit. Because ultimately why we are in public health is that we want to make sure that everybody has equal services, especially those people who might not have the means. But, when you have people who have the means, and are accessing your services, that's not really fair."

She elaborated further by saying:

"Well, I'm always concerned because then you have people who are accessing your services who do have the means that could take their children to the dentist; that's taking funding away from possibly other people who have no means. That's still accounted in your budget. If they said, "we want to cut your budget", well I could tell you which half to cut."

The participant shared additional details of her experience by stating:

"They just have to sign [the permission form], and to me it's a moral signature. Again, it would be parental ethics to say, we're going to have to find the money somewhere. We find it for Triple A hockey; we find it for this; we find it for that. That's a different dilemma. That's on the onus of our clients."

The ethical conflicts described by these public health professionals are struggles balancing the rights and needs of individuals with the rights and needs of the community. Most of us expect people to voluntarily cooperate by only using services they require which ensures programs and services are always available for those in need. However, these personal ideals can sometimes conflict with professional obligations which in the case of public health are to provide services to anyone who indicates a need, even a perceived need. Moreover, the public health professionals experienced personal moral conflicts in everyday practice when they found themselves in situations where they may have to report parents for negligence knowing the family was experiencing accessibility issues. One participant shared an experience she encountered by saying:

> *"Well, at the end of the day you have to have parent consent but then you have to override and look at, and you go sort of into your responsibilities for reporting and that as well too, so you have say, is there neglect here? And at what point is it considered neglect? So, if a child really needs services and the parent refuses and is aware of it, then that's the point where it is neglect so then you have to decide where you go from there."*

Some people may believe that there is only one way to handle a situation such as the one described here. They may see the solution as being straightforward and simple and the obvious decision is to report the parent for neglect. However, for the public health professional who shared this experience, these decisions did not appear to be straightforward. It was not clear to participants if there was neglect as they were not privy

to the complete story of the family's situation. Thus, to decide whether to report the parent for neglect or give the parent another opportunity to help their child is an everyday ethical dilemma that public health professionals experience.

Another challenge the public health professionals reported dealing with was the range of emotions projected at them from the families who they desired to help. The public health professionals discussed situations where they wanted to offer and provide public health assistance to a family, but the family did not want support from public health. A participant described her experience with this issue by saying:

> *"One of the challenges that I think we often face is kind of the relationship with the families that we serve. The relationship with the child, I guess, to begin with but for preschoolers, to be effective, we really need the buy-in of the families and the parents. It's constantly something that we're striving to do and the challenge is to help the parents support their children in that. There's the full range, but the more challenging families are those when the parents aren't really buying into the need or don't really understand what their role can be and how crucial it could be. You might get resistance, you might get anger, you might get the whole gamut of human emotion and responses. Parenting is always a very personal and sensitive thing for people, and so we work with that, we touch that, and I think that's challenging."*

The dilemma experienced here as outlined by the public health professional is one of personal discomfort. The conflict the public health professional is experiencing is one of trying to do their

job the best way they know is possible, while balancing the negativity being projected toward them. Stress being felt by a client in other areas of the lives projected at others is a common dilemma for people in many different professions who work with the public. Many people will not take another person's anger personally and try to be empathetic, but displays of negativity can create emotional upset that is difficult to overcome.

Furthermore, the public health professionals experienced an ethical and moral conflict in their work when they realized there was an abuse of their services or when clients were not forthright with the information they provided. This involved situations when there was not disclosure of parental consent or when child care providers or parents were looking to use services as a way to manipulate others (e.g., trying to prove a parent or ex-spouse was not providing adequate care for the child). Two participants shared their experiences with these difficult situations:

> *"When a family comes in for a screen, you may have tried five or six times and then they get there, they haven't disclosed things so you are about to screen and you realize you don't have the legal guardian's permission so you don't have consent. So you have to look at things there; do you go ahead and screen or do you not screen because really you can't screen. There are a lot of so-called dilemmas in our programs"*

> *"An example is a screening was done with a child in a childcare centre. So they were having issues with the parent, but it wasn't really a result of the screening so it wasn't the disciplines that we deal with specifically. But because it overall is*

affecting the child, they wanted to use the screening as a tool to get what they wanted but it really wasn't the appropriate thing. The other thing we get a lot, which is sad, is when there's a divorce going with the family, so the one parent wants to take the child in for a screening and use it against the other parent, saying they aren't doing a good job because look, the child needs this, and this, and this. So we really have to watch who we are releasing, like just because you're a parent doesn't mean that we can necessarily release the information to you."

The public health professionals who shared these experiences appeared to struggle with situations where there was a lack of transparency. This lack of transparency conflicted with their ability to seek informed consent while maintaining privacy and confidentiality. From the public health professional's perspective, clients must be open and honest about their background, health conditions, and family circumstances to ensure that services are provided and designed to appropriately meet their needs. An ethical conflict arises when a decision must be made to provide public health services or not because information is missing that may cause a person to be excluded from receiving the service either due to the harm it may inflict on them or the legal consequences that may result.

A lack of respect and stigma were everyday ethical dilemmas the public health professionals also identified. The public health professionals shared several experiences in working with dental health professionals in their community who showed no interest in providing care to those in need. These health professionals reported financial limitations as the reason they could not

provide service to public health clients. The public health professionals found these reasons unfounded as two-thirds of the cost for the service was covered by their public health program. A negative view was expressed by the public health professionals toward these other health professionals as they were seen as stigmatizing those who were in need of their services. The public health professionals also expressed animosity toward these health professionals as it seemed they were not willing to absorb a fairly minimal cost and to donate their time to assist constrained members of their community.

Internal angst was felt by the public health professionals because of the negative attitude they expressed toward certain individuals in the health profession and the view that these individuals were being immoral. The public health professionals made comparisons to doctors or nurses such that if these health professionals were to turn down a person in need there would be public outrage. But, the same outrage would likely not be as prevalent for a dentist who would not accept a person as a patient in need of care. The public health professionals felt that negative perceptions and stigma toward people who need dental care and who access services from public health created a learned helplessness for some people. One participant described the following situation:

> *"You're always feeling like you're up against some else's ethics. They [the dental health professionals] turn away people in need because some of them won't accept our program. It is morally wrong as a professional to be able to pick and choose who their clients are. That's wrong. But, that's not our ethics. Our ethics as a health unit are we want to provide as much service as we can for our clients. But, we're up against the wall with that."*

Another participant elaborated by saying:

> *"We only have so many [dental health professionals] who take our clients without question, so there is this vast percentage that they're only getting [paid a certain] percentage and they seem to be ok with it. But, if we had every [health professional] take two or three clients in a year, it would make a huge difference."*

The public health professionals who shared their experiences as described above appeared to identify a conflict they felt managing issues associated with the principle of distributive justice. Their focus was to ensure that benefits and burdens were distributed fairly among the communities they serve, but the autonomous decision making expressed by the health practitioners to decide who they would take on as clients conflicted with principles of balancing benefits and burdens.

Moreover, the public health professionals expressed concern about situations where the perception was that people were failing if they did not follow public health directives. The concern was that some programs may be stigmatizing people by giving the message they are not a good person or they are harming their child because they chose not to breastfeed. One participant shared her views:

> *"I think the messaging has adapted a bit but it's almost like - we can potentially cause harm in a lot of our messaging because it's like we constantly tell people what they should be doing so then if people aren't doing those things for whatever reason, then you feel bad about yourself. Like if you're not able to breastfeed your baby for whatever*

reason, okay, then you're not as good of a mom as someone else, or whatever. I'm just using that as an example."

This participant elaborated by saying:

"And if you look at it organization wide, you have an organization full of dedicated hardworking people who are trying so hard to get their message out there that people are just bombarded with these messages that if I don't do all of these things and I'm not this person, then I'm failing somehow."

The situation described by this public professional demonstrated the decisional balances that are evident in public health practice. In their everyday work, public health professionals must balance the benefits of providing services and programs with the unanticipated harms that may arise leading some people to believe their parenting methods are inadequate.

The public health professionals also reported challenges in learning how to handle their own personal feelings and emotions along with identifying when their personal values conflicted with that of others such as co-workers, community partners, supervisors, or clients. Several participants shared their sentiments on these liberty and autonomy by saying:

"That's something where we have to kind of give them [client] both options and kind of put your beliefs and values sort of aside so you can talk to this person about certain things."

"Try not to preach as opposed to giving information and letting them [client] make their decision with that information."

"Because I'm the first person and they tell me everything, for me it's after they're gone - just trying to work through that. You know, not being judgmental if it's not something that I would believe in or support."

Two other participants shared the following:

"It's interesting because you have your own personal moral thoughts and beliefs about things in life and whatever, but it's interesting at work because you have to separate that and we're very much trying to be evidence-based here. I had the opportunity to be a part of creating the [health unit program] strategy and so that was particularly interesting because you have people from all the different pillars working together to come up with recommendations, and some people their thoughts about specific things are very much morally based and it doesn't matter if there's evidence to support that; they just believe that."

"Like what does it mean to be respectful, what does it mean to listen, what does it mean to be non-judgmental? Well, if you want to be respectful, it means you actually have to listen and that means really listening, which isn't something we're necessarily very good at or I'm very good at. And so, in a way it can be really tough to be ethical because it goes against, I mean, it's almost like this, you know, I just described when I started this interview how busy I am. I've got all

these staff. I've got all these mandates. I've got all this multiplicity of roles and it's all about getting as much cleared and done as quickly as you can. At the same time, our mandate work, it's all about taking the time to listen. It's about the time to build relationships. It's all about sharing on a personal level."

One of these participants further shared her feelings on this issue by conveying:

"Well, I think just another ethical dilemma in public health is sometimes, you know, I mean if you work for the provincial government over a long period of time, you're probably going to be in the middle class and you'll have a certain lifestyle. Your life expectations will be framed by that. And again, often you need to interact with people who are really quite poor and face issues such as hunger. And, I think that, well, it's not necessarily an ethical dilemma, but it's a reality. But, you have to be really careful, again, about raising expectations, being respectful, because sometimes people who are really struggling, who don't have a lot of money – like they're in pretty vulnerable situations and you have to proceed with caution."

As outlined above, a conflict of values can also arise in everyday public health practice. The public health professionals in this study described situations where their own values sometimes conflicted with that of others, and where professional and empathetic values conflicted with process values. The personal struggles the public health professionals experienced also involved dilemmas with respect to accountability and following directives. One participant shared her specific experience by stating:

"The recommendations, whether it's for fluoride or sealants or a child to have their teeth cleaned, all come from Ministry, so that everyone's uniform because you want all health units to be recommending based on this criteria. We have the criteria from the Ministry, that's what we make the recommendations on. Now if we choose to go into more schools in order to provide that service, that's something we get from our director. If we say it's really needed, look at how many we recommended, then we get that support and we apply to the Ministry to do that."

This participant further elaborated by sharing these thoughts:

"[Our priorities are based on] Ministry standards and then we – you have a read of your community. It's a gut feeling too. It's not one person makes the decision. It's all a discussion. And then it could be that your director or manager says we don't have the time, we don't have the manpower, is there some other way we can do this? And you look at it."

Another participant conveyed concern by saying:

"I'm not sure how anyone else feels, but as a public health professional and we've been at it a long time, I feel I'm very accountable to the public whether it's my time, everything. You take it on as a personal role which I think is an ethical thing to do. So then you're reading in the Globe and Mail that other ministries have procured limousines and highfalutin' lunches, I'm thinking there's got to be, like there's a moral obligation to our public to make sure that what my wage tells me, what I am paid, is I am providing service. So when you read about those

things, you're wondering what ethics they were bound by. How could you morally say in a financial constraint time that you going to Hawaii on the ministry card is warranted. I mean, that's not right. So then it shines on other aspects of the government. So then people might question your role or whatever. It just doesn't make sense."

6.1.3.2 Professional Relationships

The public health professionals reported that the professionalism they expressed and showed toward their community partners was crucial in maintaining good relationships in their everyday work. However, some of the dilemmas they experienced in maintaining professional relationships were finding ways to ensure that personal agendas did not hijack the focus of mandated public health initiatives. A lack of communication concerning priorities was also a significant dilemma they encountered. They found it difficult, at times, trying to find ways to ensure the priorities identified by their community, or clients, aligned with the public health unit's mandate. Redirecting the community or client to focus on a public health mandated issue was crucial from the perspective of a public health professional as there can be a disconnect to what public health was mandated to accomplish and the help the community was looking for public health to assist them with or to advocate for them. One participant described their experience by saying: *"People are coming to the table with an agenda and you want to make sure that what they're doing is in the spirit of what they're supposed to be doing and not just a way to access money for either themselves personally or for their project."* Another participant shared the following:

"But there are certain conditions to the kind of work we can do. I mean, again, when you start doing community engagement often it's not pure community development work because we're not just there to entertain any idea or notion the community might want to do because we can't – it's under our accountability mechanisms. If I went out tomorrow and engaged a community, we probably need to be up front about what we're engaging them about because it really has to be within, you know, something related to the standards. So I can't just go in, and sometimes the community wants us to, you know, work on some of their really pressing issues. But you can't".

The participant outlined more details of the dilemma she experienced by sharing:

"If you go out and engage the community, maybe I was engaging them on some kind of smoking cessation strategy and they said 'Well, I'm super stressed about housing and the fact I might lose my house.' Well, you can't, really, you're mandated to do the smoking cessation. You're not there to be their housing support person. But, ethically, you're in a relationship with these people and they might feel let down by your inability to really respond to them where they are at that moment."

These experiences demonstrated how the public health professionals valued the relationships they established as they felt they may lose the trust of the community group or the public at large if they did not continue to engage them in some way. The public health professionals felt it was unethical if they did not continue to enhance the capacity of the community over time and this

could impact other work being undertaken or launched by public health in the community. Moreover, the public health professionals expressed concerns related to stewardship and being professionally responsible and how this conflicted with other priorities. One participant described their dilemma by saying:

> *"So we did go into a partnership with some other community agencies and we got the money to do the ethno-cultural outreach. And there was a huge energy amongst the constituency and they want us to continue to work with them. Well, that's to my mind, we have to continue to work with them now. You can't just go out and do an ethno-cultural outreach strategy, write a report and say goodbye to the people, because they have volunteered. They've answered questions. They've answered our surveys. They've come to community meetings. They've given us a lot of ideas. They've given us new direction. So I have to be sure – as sure as I can be – that I can continue to support those endeavours after the initial outreach strategy, because otherwise I think I'm being unethical in my own mindset."*

This participant elaborated further by saying: *"Because my ethical standards is if I'm engaging these people, I'm getting into a relationship with these people, and they have expressed certain vulnerabilities to me and I need to respect that by continuing to work with them."* Moreover, the public health professionals reported that one of their ongoing struggles was to continually reach out and expand their initiatives to new partners. They felt it was essential to always be searching for new partner interest and engagement to be able to reach, grow, and expand public health services for those in need in their community especially to those partners who may not initially see themselves as have an impact on health. These dilemmas meant the public health

professionals were juggling their empathetic values of respect and welfare with their professional obligations to meet established goals and objectives. One participant shared their experience by conveying the following:

> *"Being systematic because sometimes we also, when we evaluate what we are doing, we again go back to those who we have seen and ask them for their opinion. But we don't ask who hasn't. I mean, we don't ask the question, well, who have we not seen in our interventions; and how can we get there?"*

The public health professionals also struggled with situations where they had to juggle the involvement of multiple partners. One participant shared her experience working with numerous partners on a public health initiative and the struggle she experienced trying to find processes that would not only ensure certain partners were recognized as leaders in their community but also endorse the involvement of everyone who contributed to the initiative. This public health professional described a situation where several community groups collaborated on a health initiative and these groups made up what the public health professional called a coalition. The dilemma the public health professional experienced was ensuring that all partners were given the appropriate recognition for the work they put in to the health initiative. However, they had to balance ownership issues with recognition to ensure that certain groups felt their involvement was appropriately recognized. This participant shared her thoughts:

> *"And, you know, that's the kind of thing that gets back to the recognition piece, right? Because if you have three organizations that are working on a project, you want to make sure that there is appropriate recognition. So obviously, if you have,*

say, a school board and public health and a non-profit organization working together, you want the recognition for those organizations. But then, you know, the Ministry is funding it and public health is administering it; and it's under the umbrella of the coalition. And so how do you make sure there's appropriate recognition for what's happening and that? And what has happened is, in the newspaper you'll read about a project and it's attributed to a school board or it's attributed to public health. It's a coalition; and the coalition is all of those organizations, not just one. But sometimes the face of the person who's talking about it, then people associate that as the organization who's doing it."

In addition, not only were the public health professionals challenged with finding ways to expand their community partnerships by developing coalitions focused on specific issues, but they found that some organizations were already committed to other community partnerships and coalitions. As a result the public health professionals were often competing with other programs, efforts, appeals, campaigns, and causes. One participant expressed this by saying:

"I think because they were coalitions on their own, so they had many partners come in together to address their issue – for example, community gardens or neighbourhood markets, or those sorts of things. They already had a coalition, so they were kind of a coalition within a coalition. So they didn't really have a need to be part of this other coalition because they already were a coalition. So that was maybe one of the things that we would've needed, like we needed to look at, is I think there was lots of value to expanding our membership by connecting with existing coalitions. But one of the things that we didn't account for was, how

does that work into the structure of our coalition and what are the changes we needed, and how does it align? Because we came from somewhere very specific and then by reaching out to those groups, it really changed things. And I don't think we expected some of that and we didn't really work through all of that."

Thus, finding ways for community partners to be committed beyond just their individual interests was a critical issue for the public health professionals. Although they sought to find ways to ensure the partner organizations aligned their values, conflicting values and diverse beliefs were often hard to coordinate. Moreover, they struggled with trying to determine who was responsible for providing specific services and struggled to find ways to minimize the conflict and the overlap of services among organizations. One participant shared their dilemma by saying:

"So we have to decide too where, say, it's our responsibility versus when is it their responsibility. And we have to watch, sometimes they try to pull you into something that really isn't yours so you have to sort of gauge when is it something where we say "you guys deal with it within your organization" versus where is it where we should be giving you the guidance."

Community engagement is a critical part of public health practice. Although public health professionals may be focused on collaboration and cooperation, the dilemmas identified above described how expectations can collide with voluntary cooperation and freedom of choice. Moreover, when expectations are spelled out certain groups and organizations who become involved in multi-jurisdictional community health initiatives may feel the required activities to be coercive and may choose alternative actions that can go against the mandate of the allied group.

The public health professionals also reported it was important for public health as an organization to find balance within its own mandate for addressing health inequities in communities. Concerns were raised about spending resources to deliver mainly universal interventions rather than designate some available resources on the delivery of interventions that addressed specific issues for people who were disadvantaged. For example, the public health professionals needed to balance priority requests from organizations and groups they regularly work with and their own need to address provincial mandates. This included providing services that reach those who may not be seeking help but need help the most. The dilemmas they experienced were balancing priorities with interests, finding quick wins, and focusing on those in need even though these may not be the groups they are mandated to target. One participant described her experience readjusting priorities:

> *"And when we tried to get people together to focus on a certain priority, we often spun our wheels and we didn't get stuff done; and then it was a bit of a struggle. When we took the approach that, you know, knowing that this is what the priorities and needs are for our community and we looked at what people wanted to do and geared our programming around where there was an interest and capacity, we were much more successful at what we did. But what I think the dilemma was that we might not necessarily have been doing the things that were most needed or the most priority in our community."*

The public health professionals also described instances where they felt they were, at times, placing the public health initiatives they were implementing at risk by not always engaging the

community or clients, or seeming too aggressive and demanding. One participant shared her experience:

> *"In one of the playgroups we used to go to, I'd actually have to go the week before and it's not like you could go and just do a little presentation on what [the program] was. I'd just sit there and play with the families and then they would kind of call you off to the side and ask "well, does there have to be a concern". And, we explain that "no, it's for everybody and if there isn't a concern that's a good time to go because then you can just see where your child is at".*

The dilemma outlined above appeared to be a struggle in balancing the value placed on obligations to meet certain ends (i.e., service provision) and showing empathy and concern toward others. Both were equally important for the public health professional who shared her experience. Focusing her efforts on empathy and concern was deemed to be the best way to address the needs of the clients she served and this aligned with her values of doing what she could for the greater good.

The public health professionals felt strongly that they represented their community in the work they undertook and not their own personal desires or ambitions. This became a professional struggle that they experienced. One participant expressed this by saying: *"Just because you might be in the majority, so to speak, or the way you work is the way your organization works, it doesn't mean that that's the way your community works."* Another participant shared these thoughts:

"If there is one thing that's still not, sort of, realizes the potential is maybe creating a greater impact among key stakeholders in public health, even among health units, looking at where we create cumulative impact or influence on population health and maybe optimizing resources a little bit towards that or having consolidated policy advocacy on a few issues, you know, that are of particular interest. And when it comes back to those issues of health in all policies, kind of deciding well, which ones would we want to pursue in a consolidated fashion and kind of having one voice behind it, creating perhaps greater acknowledgement and agreement around what those most important issues are."

As mentioned, public health professionals strive to work collaboratively and cooperatively. They value working in partnership with communities, schools, clients, and volunteers as these are the people who support public health programs to achieve the best outcomes. Sustaining initiatives is another challenging dilemma as it is important from a development perspective that communities take ownership for the initiatives that will impact their everyday life. For public health to take the sole responsibility for initiatives would be contradictory to the foundational principles of most community development and mobilization models. One participant shared her challenges by outlining the following experience:

"We often had challenges of getting leadership for the coalition [our partnership of organizations]. And so I know at one point our chair left because they moved to a different city. And so we had a real challenge in terms of trying to get someone else to step forward to take on that chair leadership role. And I know

that we had a facilitator in and, you know, we had lots of challenges for awhile. As the coordinator, I took on that chair role until we could find someone."

This participant elaborated by saying:

"Our steering committee wasn't as functional and we just didn't have a strong leadership. So it was made up of organizations in the community, like non-profits hospital, schools. But I think because it was about the coalition as whole, nobody saw that as really their responsibility. They were happy to come and sit around the table and participate and help. But I think they really saw it as public health as the leader, because public health was getting funded. As public health was required to provide a coordinator in kind, and so I think that they really felt that as the coordinator you knew what was going on and you were the natural leader. And so they just deferred to you for a lot of things. And I think they were more than happy to come around and participate in the decision making, give opinions, provide input. But nobody felt like it was theirs, and so nobody wanted to step forward and actually be the leader. And when they were the leader, they were very dependent on the coordinator for providing that leadership. And so that was a struggle we had all the way through; and that they would take on the chair role in name. But they weren't really leading the coalition. I mean, they would chair meetings and they would send out emails. But they weren't the champion. The coordinator was really the champion; and I don't know that we ever really resolved that. And we didn't want public health to be the chair because we didn't want it to be seen as [just] a public health program."

Moreover, the public health professionals reported they felt obliged to regularly reflect on what was important to others as part of their community engagement process. They reflected on why it was important to be have a focus on maintaining relationships, being accepting, understanding, and supportive especially when a community decided they did not wish to be involved cease involvement in a particular health initiative or program. A few participants shared their experiences by stating:

> *"I know a challenge for my program is that in our program we are mandated to work with schools, but on the other hand, schools are not mandated to work with us. So you feel sometimes that you're just trying to do your job but they're not interested in working with you. That's a common challenge that they find. Things are changing now because people are becoming more aware of the importance of a healthy lifestyle so schools are becoming more willing to work with us. But when I first started, it was just "no, we're not interested" and that's it. So there's no way to get past that initial meeting with the principal because they're not interested and they are not mandated to work with you."*

> *"A lot of times, and hopefully, they will come to us to discuss so that we can sort of guide them from our program's perspectives. But because they are volunteers but they work for other organizations, they also have their own ethical guidelines that they have to follow as well too. So we have to make sure that, if they're from a [organization], that they're still following the guidelines from there in addition to what we feel is ethical and appropriate as well."*

"So it's making sure and just accepting that, you know, it's okay for people to come and go and then, you know, there is some natural kind of turnover and that you will lose partners because mandates change or priorities change. But then you will gain other partners, and that kind of bit of transition of people leaving and coming is okay. You always feel really bad when people leave. But sometimes it's the right thing and it's okay for that to happen."

6.1.3.3 Organizational Relationships

Organizational relationship dilemmas were identified by most public health professionals who took part in this study. Some public health professionals felt the leadership within their organizations was, at times, a roadblock to providing adequate programming for communities and clients. This caused the public health professionals to sometimes feel negatively toward the leadership in their health unit. This was not their true feelings as the public health professionals were devoted to their work and mandate, but at times, felt there was a lack of transparency. Staff reported they felt their opinions, based on their experience in the communities with which they work, were not being appreciated, and perhaps were even being misunderstood by the leadership and others in the organization. This resulted in issues of low staff morale. Several participants expressed this concern by saying:

"There's sort of a gap that says that 'that's off limits'. That's my interpretation anyway."

"It's like we weren't sent the memo. There's something going on, but we're not allowed to get that memo."

"You feel a bit lesser than your provincial counterparts."

"Some of this is having a very negative impact on staff morale which is impacting a lot of other things, including programming. You get to the point where it's just, "You know what? I just don't care anymore."

The public health professionals also identified practical dilemmas they experienced such as administrative barriers and things they found to be bureaucratic. Chain of command communication structures, restrictive policies on use of social media in programming, and staff not being responsive were other dilemmas they felt contradicted their values of good customer service, transparency, and good practice, and limited the accessibility of public health's services. Three participants commented:

"We have to jump through these hoops to do the simplest little thing. You're just wasting time for no reason."

"I'm not getting information that other people are getting, and then you're constantly trying to play catch-up to figure out what's going on."

"Some of my challenges have just been other people. With respect to accountability and transparency."

One of the participants above elaborated further by saying:

"I just think it's 'we always do it that way'. So you kind of get locked in that type of thing, and it's not a bad thing but sometimes when someone new comes in with

these ideas, it's hard to see how they're going to benefit. So that's sort of been my challenge."

Several others participants shared the following views:

"When you want folks with lived experience around substance abuse to come to a focus group. It's very difficult, you know, even to pay them to do it because for finance, you need to have a signature, like their name, like a receipt. And, that violates their confidentiality and I think ok, hang on a second here."

"It's just hard for me to watch people sit back. There's been a lot of things that have gone on and sometimes things haven't been dealt with properly or things that could've been done haven't been done. There's been points where I have made it known and I've had to resign from being involved because I didn't agree with how things were being approached."

Two participants further elaborated by sharing a specific experience:

"In getting phone calls transferred too, it's very important because if the person has been frustrated from the beginning or has been bounced around, by the time they get to you it can make for a good experience or a bad experience. It depends how they've been treated. We had the other day somebody came in and they thought that maybe they were with us, so started with us, so I went down there and by the time we worked it all out it was a totally different program but the person came in, they didn't know who they were supposed to see or why they were really here. It just had something to do with the survey and a grocery coupon. So

that could be a number of things that were going on, so trying to work through it. That's very important because if it's not dealt with correctly at the front, like I said by the time they get to us it could exasperate a situation or make a situation that should have been good into a bad situation, or it could go the other way where it's a bad situation and it could be a good situation by the time they get there."

"And then there's things that I've been able to do now that I wanted to do a couple of years ago, but only because legislation came in saying we want this done now. Before, I almost had to do a business case and do all the work in advance to show how much of a good idea it was before I got approval to go ahead. And now I'm getting, okay, now we have to get this done. But those ideas were already in place a couple of years ago. So those are some of the constraints that I have, some of the challenges."

The public health professionals also shared concerns about the evolution and establishment of organizational silos. They felt this discouraged departments and teams from working collaboratively and viewed this as an unethical way to provide public health services. The public health professionals appeared to indicate that this forced them to search for the path of least resistance. At times, they were willing to sacrifice certain individuals' interests for the greater good and to accomplish the stated goals for their program in the name public duty. Moreover, they wondered if it was ethical to feel committed to the work that one does but not necessarily the organization as their values and those of their organization sometimes felt misaligned. One

participant commented: *"If we can't get together to make a plan then how is that going to be useful? It's just going to build more and more silos."* This participant elaborated by saying:

> *"I'm just going to focus on what I'm doing at the frontline level, work with my provincial and national counterparts, and get more work done that way. That's more of an impact. It's more work to try to not work in silos within your own organization because you don't have that larger plan."*

Another participant expressed the following views:

> *"I'm still committed to the – like I'm proud to work for [the health unit] – and I think that the work that a lot of us do that's positive actually makes the [health unit] look good and what makes me laugh is that they want us to work together as frontline workers to do things for our own programs, but what we're doing in our own programs has an impact organizational wide, so why are we not working as an organization in the first place. Like what I'm doing is sort of showcasing our organization, nationally and provincially".*

These ethical dilemmas seemed to create confusion among the public health professionals with respect to their priorities and obligations. Two participants shared their thoughts by saying:

> *"We're supposed to be public servants and listening to direction from our elected officials, but we're getting a huge push from the community to advocate on their behalf."*

> *"We've got the ideas. It's just that we're not getting the support to move in that direction. And it's just like, okay, here we go again."*

The public health professionals reported they were conflicted as they did not seem to appreciate and understand the directions and goals of their organization's leadership. They felt this limited their potential to accomplish more within communities as these struggles created limitations in providing services. Moreover, the public health professionals felt, at times, the goals of the organization were restrictive which meant they were unable to provide certain services or activities to encourage healthy living. Several of the public health professionals identified dilemmas associated with what they felt was resistance from the public health unit administration to focus on the long-term needs of their communities and clientele. They felt this resulted in the delivery of programs and services that only met some, but not the most, important health issues and concerns of the community and their clients, which seemed contrary to the foundations of public health. One participant stated:

> *"Doesn't allow us to get at the big issues where we could probably do a lot more good. And, I think with the expertise we've got here, we're ready to take a lot of stuff to that next level because we are very good at working together internally across different departments and divisions, as well as with our external partners and at a provincial level too."*

Moreover, a lack of communication and transparency seemed to be the factors why many public health professionals identified this as a dilemma. One participant stated: *"we're never told what the reason is".* Another participant stated: *"it's just odd that here we are*

trying to get at these [health] issues that really do rattle chains, but we're not allowed to rattle chains".

6.1.4 Achieving Impact and Effectiveness

In most communities, public health is a long-standing entity. However, to be able to compete with the impact being made by the growing commercial sector, several of the public health professionals were emphatic that their programs and services need to be different and innovative and this was a challenge they strived to overcome every day. One participant expressed the following:

> *"Well, public health, I think, has very lofty, great goals, but is in a competition with some really strong sectors such as the commercial sector and particularly when it comes to sending out messages to the public. So I think, generally, that's the biggest issue for public health practitioners. We have only modest resources in comparison to those very strong other sectors who are sometimes giving or most of the time giving opposite messages and attracting public in the ways that are going against the principles or against the goals that we have."*

Another participant shared their view on this issue by saying:

> *"I think a big ethical dilemma for us is to actually be open to relevant sources of evidence; taking something that somebody else developed and just dumping it here and thinking that with minor modifications, and on that basis we could be able to do something, is really misleading. We've created, really, some quite*

distorted programs using that logic and that's not really how things need to be done."

They speculated that one of the reasons their counterparts in other regions of the province were making significant inroads, being influential, and achieving success with hard to reach populations was because they were taking chances, being creative, controversial, and innovative with their approaches. Some of the public health professionals, however, questioned whether public health can be innovative. They commented that public health is not known for taking risks with their programming or being controversial for fear of creating backlash among clientele and communities. This hesitation appeared to create an ethical disagreement among the staff as some were willing to take risks to shock or stir up positive controversy in communities whereas others preferred a less contentious approach to public health programming. The public health professionals wondered if the safe approach was a possible explanation for why certain public health outcomes were not being met within specific communities. They wondered if this fear was inhibiting the creation of a healthy community. One participant expressed the following:

"Another big ethical dilemma, I think, in relation to this for us is to move, actually. I've seen this even before coming to public health. We seem to be quite comfortable with being in that awareness-raising mode of being aware of diversity issues, health inequities, social determinants of health; but very reluctant to translate actually that into our practice, you know, so that we can really practice what we preach. And that means transformation of how we do things so that we can be more relevant, perhaps, and address these issues better."

Being innovative to achieve the greatest impact was a dilemma the public health professionals described because this seemed to create a tension among the staff. The tension that arose appeared to be a conflict between the principles of distributive justice and evidence-based practice. Distributive justice refers to being fair and ensuring equality. The public health professionals expressed concern that they were being unfair to their communities by not providing these new and innovative services that other health units were implementing because others were unsure if their programs and services were effective.

Moreover, the public health professionals identified that initiatives focusing on promoting healthy decisions with respect to lifestyle, eating, and addictions, such as tobacco use, are initiatives that are not short-lived. They reported that the timelines in which to be able to demonstrate changes in a community or within a certain client population takes many years or decades before positive outcomes can be seen. One participant conveyed this by saying:

> *"Most of these take a very long time and eventually when change happens, you know, it feels like oh, okay. It happened. But it takes, actually, a long time to develop it. Such as, for example, the tobacco policies and the smoking by-law. It took years, right, to get to that stage."*

Another participant shared:

> *"The timelines are so long it's very hard to get a result. In public health basically, you're trying to improve the overall health of the population, like we're talking about 20, 25 year time. Sometimes you're working as hard as you and*

you're just hoping that 5 years down the road, the data is going to support what you are doing."

The public health professionals also outlined that they felt pressure for public health interventions to be far reaching, to do more, and be more effective. However, it seemed that most of this pressure was coming from the public health professionals themselves. One participant stated: *"I wish that we could reach and serve more people that actually need our services than we actually do. And so that is a little bit discouraging, or a lot discouraging."* Effectiveness of programs to ensure reach, impact, and positive outcomes was a serious concern for the public health professionals. This was described by a participant:

"Were we successful? Are we relevant? Are our messages the right messages? You know, how do we ensure that we have a consolidated voice as public health practitioners in the eyes of the public? Because they don't look at us in this compartmentalized way that we are organized – you know, huge inter-prevention. Here's this. Here's that. You know, a variety of topics, but rather as one. And then the issues of how do we really work towards influencing others; and maybe that's not direct work with the public. It's actually work with other stakeholders, with decision-makers, with other sectors to actually influence how health is affected by their decisions. Right? So it's pretty much that concept of health policies. I mean, health is an outcome and so far, I mean, of course public health is very focused on working with people and directly. But I'm not sure that we are achieving as much with these kinds of interventions as we would have been able if we were more successful at influencing other policies."

These dilemmas seemed to relate to the feeling among the public health professionals that their goals to ensure full access of public health services to all members of their community were not adequately being met. They appeared to struggle with accepting the reality that there may be limits to what public health programs and services can achieve. The public health professionals seemed to sometimes struggle with finding the professional balance of achieving the greatest good for the greatest number of people and doing one's best as public health's mandate of improving the health of community is being achieved.

The public health professionals also experienced struggles in finding the most appropriate way to handle conflicting information, best practices, and evidence-based recommendations. One participant shared his experience in being obligated to implement a program even though the program and initiative was not applicable to the region due to the geographic and structural differences of a rural community to that of a more urban community. This dilemma identified a competing obligation for the public health professional. He believed the program had no value for their community and therefore felt it was unethical to implement such a program as it would be a waste of resources. The harm of providing the program (i.e., waste of resources) seemed to outweigh any possible benefits. The participant described his experience:

> *"There are 7 regions in Ontario and often we'll say we don't really think that this issue is as important for [our] region as it is for the rest of the six, but somehow we are roped into doing what everybody else is doing. And we try to push for regional priorities, but every now and then we do get sucked in."*

The participant elaborated further by saying:

"Something like multi unit dwellings is a big issue provincially which is drifting smoke in-between apartments. It might be a big issue in Toronto but it might not be in, say, [community] because they don't have any. So we kind of have to say, do we want to commit so much time and effort to this? It isn't something that they really push really on us right now, but it comes up every single year - that topic and other things like that."

The public health professionals reported there were several instances where they were unsure of the correct or most appropriate response with respect to a particular health concern and what public health should communicate to the community and clients. One participant shared their thoughts by saying: *"I work in a program and we have measurable data which is really good but then also sometimes we don't agree with what the Ministry is saying that the data tells us. And we're saying, no, it's this way."* The public health professionals further indicated they felt it was important for public health professionals to stay focused on their goals and mandate and follow their professional code of ethics. But, they also felt conflicted with procedural justice and finding solutions that will accommodate other ways of working even though these ways may stretch their comfort level (i.e., moving into action, transforming how things were done, being relevant, and finding ways to better address issues). One participant described their views:

"But it's mostly critical thinking, right? And, asking some good questions. What am I not seeing here? What might have we missed with this inquiry? Who is excluded from this decision-making? What did we miss in terms of reaching out to and validating what our intentions are? And the whole issue of engagement in general – have we really engaged who need to be around the table – the

stakeholders? And are we systematic about that? Are we evaluating what we're doing, or are we doing all that we can?"

This participant further elaborated by saying:

"And, I mean, just acknowledging that there are many different ways to arrive at an optimal outcome. And one big thing had recently surfaced for me; and that's that there is no such thing as absolutely knowledge or the knowledge that is so firm and so valued, you know, or evidence that it cannot be disputed."

And, the participant continued by outlining:

"So the academic evidence is not the ultimate evidence really, because it may not be grounded in the reality. And unless it's grounded in the reality, it has no relevance. Often times academic evidence is not relevant enough for us, so we need to gather some other forms of evidence. But just by virtue of going through that process and having a conversation of engaging stakeholders or doing some focus group or whatnot, we are actually creating evidence that's as legitimate as the other formal type."

6.2 Negotiating and Resolving Dilemmas

This section describes how the public health professionals who took part in this study negotiated and resolved the ethical dilemmas they experienced. The specific mechanisms and how they were used varied depending on the circumstances of the specific dilemma, struggle, or challenge. These mechanisms related to the following themes:

- Managing mechanisms,
- Collaborating mechanisms, and
- Innovating mechanisms.

These mechanisms focus on various realms of the public health professionals' practice. Managing mechanisms focussed on their roles and organization. Collaborating mechanisms focussed on their relationships with external organizations and how they worked with other groups. Innovating mechanisms referred to ways of being with and working with the general population and enhancing the scope of public health's impact.

6.2.1 Managing Mechanisms

When the public health professionals were asked how they negotiated and/or resolved the ethical dilemmas they experienced in everyday practice, they described various ways to manage dilemmas. They described activities such as finding ways to control, administer, direct, oversee, steer, and influence those who were causing or bringing about the struggle or challenge being experienced. Managing mechanisms were ways that they found to take charge of their roles and succeed in their initiatives. Some of the mechanisms used for managing dilemmas involved establishing priorities, and at times, juggling priorities and setting limits with clients and community groups to prevent misunderstandings. Other managing mechanisms used included outlining roles and responsibilities, open communication, and transparency. Concerns and issues around expectations, mandates, and the use of resources were other dilemmas the public health professionals reported they were able to negotiate and resolve through a managing process. This

process for negotiating and resolving dilemmas using a managing mechanism was conveyed by one participant:

> *"The community is truly making the decisions and that you might be guiding them. You're ensuring they have all the information they need. You might be making recommendations or suggestions, but then there is a process set up and that there is a, you know, a system so that whatever the community decides is what actually gets implemented and that there isn't any organization vetoing it or trumping it and changing that decision, and that it truly is a kind of community development model and community mobilization model. And I think we were always really clear with the community around, "These are the parameters. These are the things we can do. Here's the things we can't do." If the community was going down the road of making decisions around things that were outside of our scope or mandate, that it was my role to call them on that and to bring them back into the box of, "This is what we can do", so that any decision that they made that was within the scope of what we can do could be then respected."*

Another participant shared her experience with a misalignment of priorities and managing the dilemma was the mechanism that aided with negotiating the dilemma toward resolution. This participant described her experience as follows:

> *"You can give people as much money as you want. But if they don't have the people hours to actually do the work, then that's not going to happen. I think one of the other dilemmas we often had was that, you know, we might have factual information that says, this is what the priorities are for our community or this is*

what the needs are for our community. But what we actually did was based on who came around the table and what they were interested in doing. Because we had tried before to say, "Well, these are priorities. Let's focus on them". And when we tried to get people together to focus on a certain priority, we often spun our wheels and we didn't get stuff done; and then it was a bit of a struggle. When we took the approach that, you know, knowing that this is what the priorities and needs are for our community and we looked at what people wanted to do and geared our programming around where there was interest and capacity, we were much more successful at what we did. But what I think the dilemma was that we might not necessarily have been doing the things that were most needed or most priority in our community. But we were doing things where there was the most community organizational interest or capacity to do them. So just bridging those two."

Managing mechanisms also provided the public health professionals with ways to command, influence, and deal with the issues and dilemmas they were experiencing. As described in the dilemmas section, public health professionals struggled with finding the most appropriate way to communicate to community partners that they had the necessary resources to provide programs and services, and to support their coalition initiatives, but that public health resources, although hearty, are finite. Annual planning was a strategy that one participant indicated they used to aid with managing resource expectations:

"And I think we also had a process. Yes, there was annual planning. We did long-term plans, so a vision for what we wanted to do for four years. But we did

annual plans. And we also set up our coalition so that we were always able to respond to any kind of emerging opportunity, so that was really good. And what we found was that people or groups would request money. And when our steering committee looked at it, the work groups that put requests for money in always requested way more money than we had. Our steering committee always allocated less money than we had. And it usually worked out that the money that groups got and the activities that they were approved to do, they were accomplished. And then we always had money left over that when a group accomplished what they had been approved and they had capacity to do more, they could apply for more. Or if something came up throughout the year that you didn't anticipate and we wanted to be able to respond to that, that we would have some resources set aside to be able to facilitate community partners doing."

This participant also outlined:

"Then we were able to respond to that and not have to say, "Well, you have to wait for our next year plan". So we always had a little bit of resources available so that we could be responsive like that and take advantage of opportunities. And so I think that helped with priority setting as well because then, you know, if something became a priority throughout the year. And I think it reassured the community partners, right? Because they felt that they could respect the decisions that were made around what the priorities and the activities were that we were going to focus on, knowing that there was opportunity to bring things

forward as they came up and that they could just respect the process and they knew that they had opportunity still, right?"

Two other participants shared the mechanisms they used for managing the resource dilemmas they experienced by outlining:

"And so, really making sure that what we said we were going to do was geared to the capacity of our community to do it. Because money is one thing and you can give people as much money as you want. But if they don't have the people in house to actually do the work, then that's not going to happen."

"We do fund a community-based site, I mean, it's a basic thing; but at a certain point we went and received a significant increase in the funding envelope and moved a lot more money into administration for the program, just to ensure that the sites in which we are funding these programs had the money. You know what I mean. If we were asking to do all this work we significantly increased the admin component so they would be able to have the support to do it. And, that's the most cut and dried idea that I've had."

Moreover, the public health professionals felt it was important to ensure their clientele, the public, viewed public health, a government service, as being fiscally responsible. This was all done while trying to ensure the public did not feel their lives were controlled by what they viewed as the government. Thus, communication was a key managing mechanism that several participants described:

"So when you're sitting around the table with a community group, if you're not really clear up front, there's often the expectation because you're a paid staff person that you can do all the minutes and you can do all the background work, and you can provide the snacks. And, sometimes you can, but you need to be really clear with people up front about what you're bringing to the table. Because I find there's a supposition that if you don't say otherwise that you're going to be doing everything, or there can be. And, I think it's really important to be clear up front about what your role is in that particular group."

"I think you have to be really transparent and my staff team and I go through this all the time. I think sometimes because we have a lot of resources in Public Health compared to others – I mean, I don't want to give you the idea that it's, you know, just, you know, over. We have limited resources."

"We're talking not only program-wise, but certainly financial-wise and every other wise. The transparency has to be there. People have to be able to see what you're doing and see that you're doing it properly, not just that you're doing it properly but it has to be obvious to everybody and available to everybody and available for everybody. Confidentiality is obviously important but at the same time, they have to be able to see what you're doing and be able to see that you're doing it equally and fairly and consistently."

"Because I find there's a supposition that if you don't say otherwise that you're going to be doing everything, or there can be. And, I think it's really important to be clear up front about what your role is in that particular group."

Several other participants expressed their thoughts on managing expectations through open communication with community groups by stating:

"You need to be really clear and transparent."

"You've got to negotiate up front with people and tell them what you can do and what you can't do"

"Clarify around what outcome you're looking for, because people will get frustrated because they come to the table wanting a decision and then not getting it, and so being really clear."

Another mechanism described by the public health professionals was the process of managing several things at one time and knowing how to deal with crisis situations yet trying to address immediate needs and not lose sight of long-range issues. One participant outlined how they managed these dilemmas by using a juggling strategy:

"So no matter what health promotion project you're working on, if you have a mom who is crying because she's having an issue or a family is in crisis, you fit that into your day which sometimes means juggling around, getting your team

members to cover off for you while you're doing other things, who can do this visit, can you go to this meeting, you work through your lunch hour, you stay late. So that definitely sets priorities in our work. Those would be to keep things."

Moreover the public health professionals described dilemmas where they had to balance the needs that a parent identifies for their child and the needs (or priorities of needs) that public health may identify for the child. The public health professionals, in some situations, wanted to provide service for a child, but the guardian did not give permission and this resulted in a dilemma for the public health professionals to make a decision whether to provide service for the child or not. One participant shared their experience using a managing strategy to negotiate and resolve the dilemma:

"Well, at the end of the day you have to have parent consent but then you have to override and look at, and you go sort of into your responsibilities for reporting and that as well too, so you have to say, is there neglect here? And, at what point is it considered neglect? So, if a child really needs services and the parent refused and is aware of it, then that's the point where it is neglect so then you have to decide where you go from there."

In this example, speech problems were identified when the child began school but it was too late for public health to provide programs and services for the child as the public health speech development program was for preschool children only. As a result, the public health professionals were not able to provide direct service and only able to help the family by giving guidance on navigating the health care system such as providing information about services as their child no longer meets public health's criteria for direct service.

Priority setting was another managing mechanism the public health professionals used to negotiate and resolve the dilemmas they experienced. Several participants described their experiences in priority setting with the community groups they worked with or with the clients who resided in the communities they served. The public health professionals described various mechanisms they used to balance the priorities with that of the people and organizations for whom they worked with and that of their own. One participant described the process she used:

> *"So what we tried to do then is build our coalition work around where our community was at. But then one of the just dilemmas was just balancing it again. What is the priority in our community and the needs? And what are all the different priorities and mandates for all of the different organizations around the table? Because that's going to be very different too."*

This participant further detailed her experience balancing the priorities of multiple stakeholder groups:

> *"So people would come forward as their organization and talk about the priorities based on what they're mandated to do. We would present information from the community, like from the Canadian Community Health Survey and all the different, other data that was out there that basically painted the picture of our community to say what the needs and priorities were. So we kind of had that factual information of what we know about our community. And then we'd have all the organizations in terms of what their mandate is to work on; and then we'd determine what the priorities were for the coalition based on that. So, you know, if we didn't have people from a certain sector around the table or from a certain*

topic area, then that wouldn't be as high priority for our coalition, even if it was a high priority for the community. So I think the dilemma was just balancing different organization and community priorities, and then what the focus of the coalition was going to be. And you only have so much capacity, right? And then you have your Ministry priorities that are mandated to us that we have to work with us in a certain scope, right? So balancing all of that."

Moreover, this participant elaborated further by outlining the process she undertook to balance the dilemmas and situations where it was, although difficult, had to be acceptable for a community group to decide they no longer wanted, or needed, to be part of the public health initiative. The decision to no longer be involved in the initiative may have been the result of organizational changes, priority shifting, or a reformation of their organizational mandate. This participant described the following:

"I think sometimes we did [resolve the issue]. I think sometimes, as I talked about, you had organizations leave because it wasn't a right fit for them because you couldn't resolve it for whatever reason, right? Like either their mandate was out of the scope of our mandate or we didn't have the capacity to work on a project that they wanted to work on. And so where we couldn't resolve the issue I think sometimes the outcome was that we lost partners. But I think, as I said, part of that's okay. In other cases, we gained new partners. I think that over the time that I worked on the project, priorities in our community changed. Organizational priorities changed. Ministry priorities changed. So there was opportunity. Things didn't stay the same and so there was always opportunity to change things as we

went along. So it wasn't static, so I think that helped to resolve things because if it wasn't a priority in Year One, it might've been in Year Five. So decisions only held for a year, and so we were able to re-visit those decisions every year and relook at the situation and the people around the table and the information that we had. And so I think that was good, right? Because people could live with the decision for a year knowing the next year that they had the opportunity to discuss it and look at it again."

Establishing certain procedural practices was another mechanism used by the public health professionals to manage the dilemmas they experienced. One participant outlined this practice by saying: *"Policies and procedures and they can be written or unwritten, just practices that you follow with timelines established throughout the year that sort of guide your work and how you do things."* Another practice, or mechanism, the public health professionals used was collecting information such as data and statistics to aid with negotiating and resolving the challenges they experienced. This practice of looking internally to learn about what one knows about his or her own program and using these evaluative findings and recommendations to improve the work the public health professionals undertook with their communities and clients seemed to be a critical element to managing some of the dilemmas the public health professionals experienced. By the same token, looking at the practices of others, also known as better practices, was a managing mechanism the public health professionals adopted. Several participants outlined other managing practices they established:

"And it's cool because numbers can be measured. And so we keep a lot of stats and we keep a lot of data. But some programs, it's kind of hard to measure that.

It's very difficult and you know in your gut that you're doing a great thing because you see it but the data sometimes doesn't support that in your program."

"In our program, we fill out a report called the [name] report. So, by filling them out we're accumulating all our data, qualifying what we're doing by Ministry standards, and anything that we do up and beyond we have to submit a narrative and reason why. If we as a department with our manager behind us and director figure that what we're doing, sealants for example, that's a measurable thing that we do and if we wanted to push for more [services] based on recommendations, then we can tell the Ministry that's what we're looking at doing."

"So I think sometimes we're doing over and above the Ministry guidelines, but we're all good with that. It adds resources plus there's an evaluation component with all of those research projects which is really helpful for our program planning and it keeps us on the evidence-based. We have implemented other best practice guidelines which again have been over and above, and have been in part due to some other health promotion projects that we've received funding for. So those are all a little bit over and above what are mandated programs would be although they're very related to the work that we do and we have to use those guidelines. I think those things set the priority for the work as much as the mandated programs."

"What we look at is our regional stats. For example, in our region, our youth tobacco rates are higher than the rest of the province, and then also tobacco rates for Aboriginal people, and for men working in trades sorts of employment. So for our regional action planning, we'll focus in looking at stats for region and see who has the highest rates and try to do programming around that."

The keystone elements of managing mechanisms for the public health professionals related to several underlying values and principles. The root of these values and principles appeared to consist of several practice-based actions and processes such as being a steward of resources, setting limits and establishing common goals, using evidence for decision-making and focusing on good practice. Other elements germane to the negotiation and resolution of everyday ethical dilemmas from a managing point of view appeared to include establishing priorities and roles and responsibilities and transparent decision-making. Moreover, the ideals or values the public health professionals seemed to identify as imperative when negotiation and resolving everyday ethical dilemmas were setting limits and open communication.

6.2.2 Collaborating Mechanisms

A second mechanism the public health professionals who took part in this study used when negotiating and attempting to resolve the dilemmas they experienced in everyday practice was collaboration. To be able to negotiate and resolve some of the dilemmas the public health professionals experienced a collaborative strategy required them to work jointly with others through teamwork and establishing partnerships. Collaboration also required the public health

professionals to create alliances and work cooperatively with their clients and community groups to negotiate and resolve certain dilemmas. Collaborating mechanisms referred to their relationships with other groups and people. This collaborating mechanism was often used by the public health professionals when working through dilemmas where they needed to educate citizen groups on how to make collective decisions. This mechanism was also used when the public health professionals sought ways to provide resources to the groups they viewed as their partners in the community to ensure the public health initiatives that were needed could be implemented. Three participants shared their view on collaboration by stating:

> *"[We do] community capacity-building by funding folks to get together and identify these issues and work together."*

> *"There is a power in a collective voice."*

> *"[We] really value the capacity-building approach, give it core funding on an ongoing basis."*

Another participant outlined the following:

> *"It's about building relationships and working on the issues, and doing right things at the right time. Taking advantage of opportunities, of course, when they arise. But also spending some time building, collecting evidence, and working on building relationships is always helpful."*

Moreover, the collaborating mechanism was used during times when the public health professionals were compelled to establish partnerships. Specifically, the public health

professionals discussed several requirements to establish partnerships, such as with schools, due to new regulations that had been placed upon the schools. One participant shared her specific experience while negotiating and attempting to resolve a dilemma using a collaborative mechanism with schools. This participant outlined the following example:

> *"Well, they were always mandated to do the daily physical activity but all they have to do is say that yes, we've done it. I think what's really changed now is that there is that new policy for healthy eating so there's nutrition standards that have come through the Ministry of Education, along with the public school board has created their own policy so that, yes, definitely has generated a lot of partnerships. So our school dietitian has been very involved with schools because they are looking to us for resources and that knowledge. So for sure, when policy starts changing, we definitely become a lot more involved in schools."*

Negotiating and resolving dilemmas through collaboration resulted in the public health professionals, in some instances, having to establish trust and build confidence within the community. The public health professionals knew that for many public health initiatives to be successful the community had to take ownership for the initiative and act in a leadership role. This required patience and cooperation to be established and maintained. One participant shared this example of a collaboration mechanism when negotiating and resolving a partnership dilemma:

> *"But it took a lot of work; and I think a lot of negotiating in my role as the coordinator between public health and between the community so that the*

community would trust public health and public health could let go of that power and let the community decide. And it took many examples of things working and being successful for both sides to kind of embrace that. But eventually they did and we were very successful in having that kind of model."

This participant further elaborated by outlining:

"And so, it took a long time for the health unit to be comfortable with me representing myself in that capacity. So even though I was a public health employee, my role was to coordinate this coalition; and I wanted to represent myself as the coordinator of the coalition so that I wasn't seen as a public health employee. Because that's not what my role was. So, you know, that's kind of an example of how, you know, as they saw things working, they were comfortable letting me represent myself that way, knowing that I understood what my responsibilities were as a public health employee and I was implementing those as part of my job, but that I didn't need to have that label of an employee in order to do that, right?"

The public health professionals also described the mechanism of collaboration when negotiating and resolving the dilemmas they experience as finding ways to reach out and expand their work. This involved actions such as findings ways to stretch resources in ways they may not have considered previously. One participant shared the following example:

"I do a lot of the Train the Trainer sessions with those organizations so that they can know what the issues are and they can kind of work with their clients in terms

of addressing those issues. Doing that sort of thing will impact their clients. So we're not directly going one-on-one with those clients, but we're doing something for their clients. There's a perception sometimes that we're only doing middle class. I was sitting on the access to services committee and they're like,"Well, we're not providing services; they're not coming here at the health unit." It's not just about them coming to the health unit. There's a lot more to it. In the example I gave, we are doing something with the group."

Another participant described the processes she undertook using a collaborative mechanism to cope with and reconcile the dilemmas she experienced while working with numerous community partners. She outlined processes of finding ways to leverage resources to be able to continually support the initiatives of the community partners yet recognize the involvement of all players and the collaboration they established collectively together. Although the participant felt she was not able to resolve the dilemma she experienced, it appeared from her experience she felt she had negotiated the dilemma in the best way possible, even though it was not to her complete satisfaction. The story she shared of her experience is as follows:

"And there was two very different types of groups. There was groups that emerged out of [the coalition]. Without [the coalition] they would never have existed. They primarily came together as part of the coalition. They got funded just from the coalition and that's the work that they did. But then partway through our work, we were trying to expand our membership and we wanted to reach out to existing groups and try and leverage what they were doing versus starting things from scratch because we felt we'd have more success. But by

doing that, we had all of the - like half of our groups in the coalition were groups that existed before [the coalition]. They had their own identity. They got funded by other funders as well. And so there was different challenges with each because almost with the ones that had other funders, they were used to acknowledging their funder. So [the coalition] got acknowledged as a funder, right? So we funded this part of the program. This organization funded this part of their program. But they didn't really feel part of the coalition the same way because they just felt like we were a funder. Then the ones that were just limited to [the coalition] they felt part of the coalition, but really got acknowledged as just individual organizations, but really didn't think of us so much as a funder. So that was one of the other, I'd say, ethical dilemmas we face is that, what are we trying to accomplish. And part of what we were trying to accomplish wasn't just giving money to the community. But it was establishing a coalition that had come together for a common purpose and was trying to work towards that common purpose in the community and that not just an opportunity for people to get money from us."

Analogous to the story of the participant above, another participant shared a story in finding ways to negotiate and resolve the dilemmas they experienced in working with multiple community partners. The collaborative mechanism they undertook focused on findings ways to maintain partnerships by looking for unique ways to establish continued funding for the programs and services provided by public health and the community. Her story was as follows:

"I think there's a real problem with the short-term nature of funding. And, this one I would never have thought of until I was in [name of city] the other day, but I mean there is a lot of talk in the literature of public health – the literature about community capacity-building. And, then I bumped into a colleague at [name of health unit] and, you know, when I see the resources in [name of health unit] that go into community-capacity building, I mean, literally, they're quite specific. They fund 19 community entities. They're not organizations. They're quite grass roots, so to get people together in communities to identify issues that are important to them, but they provide them ongoing core funding simply for the process of getting together and raising issues. And, I thought wow, that's a really neat model and we don't have anything like that. And, [name of health unit] are quite explicit that that's not something that can come from [name of health unit]".

Other collaborating mechanisms used by the public health professionals involved actions that required them to adjust their way of working. This included recognizing that their own morals and standards may not be equivalent to that of others however hiring and working within a diverse group of individuals was one way the public health professionals were able to resolve this dilemma. Having the ability to speak with colleagues or supervisors to discuss challenges and concerns was another collaborating mechanism used by the public health professionals. One participant expressed their experience negotiating these dilemmas by saying: *"We have an interdisciplinary group, as I mentioned. We're somewhat diverse in terms of ethno-cultural makeup. But everybody has different experiences than I have. And, also we're a bit*

demographically mixed, which I think is really helpful too." Several other participants shared the ways they reconcile these similar dilemmas:

> *"I have a good relationship with my manager, and I can talk to her. That's kind of now who I turn to because some of the other girls I work with, we don't necessarily share the same beliefs so turning to them wouldn't help me any, really."*

> "*Well, you have to know how to de-stress yourself too, and take time off, and recognize burnout, and book vacation, and I'm lucky as I get to do a compressed workweek so I get every other Friday off even though I work full-time."*

> *"For dilemmas that I've been in, I know that I always have a colleague because we work on a team with 6, so a lot of times we have weekly meetings and we discuss things. So using that as a debrief, an opportunity to have input and suggestions on how to deal with it. That's mostly how I think I deal with dilemmas that are not easily resolved or I don't know what to do with them. So I think just finding support from my colleagues."*

> *"Along with my manager who, if I'm ever in a dilemma, she is very approachable and very easy to talk to and she generally does give you guidance as to how to go about solving those kinds of issues and supporting you along the way. So those are probably the two ways that I deal with my dilemmas."*

"As far as my team goes, we have a number of kind of built-in structures like our programming meetings. Our general, really informal relationship with each other I think is really important to discuss the ongoing issues. So we have kind of an informal relationship that's very strong. We have our program meetings. We have the broader based several agency group, the [program] communication services, that meets once a month. We're constantly talking about these things and occasionally we make some really good changes that I think addresses it. "

Moreover, additional collaborating mechanisms included using alternative methods for improving their work such as focusing on experiential learning rather than relying strictly on the usual textbook ways of doing things. One participant described this by saying: *"I don't think it's so well suited for textbooks or more traditional kinds of learning, reading case studies. I think it's more practice-based learning."* Another participant conveyed their unique way of finding an alternative method of learning by sharing the following:

"If we're systematic, that means we really need to examine our environment and see what would be suitable in that department, and then look at what's available out there and how it could be adapted to really meet those specific needs, rather than bringing in to the managers and say, "Okay. We have an answer. Let's see where we can plant this intervention because somebody else was successful."

Collaborating mechanisms also included identifying the appropriate training needed by staff to adequately develop and maintain the relationships within the community. The public health professionals felt that providing training and mentoring on networking, liaising, and building

alliances was critical to the success of public health initiatives. One participant outlined her strategy for negotiating these dilemmas by describing the processes she put in place to ensure collaboration is a mechanism used by public health professionals in her department. This public health professional described her negotiation and resolution strategies by stating:

> *"You don't want to send someone out who's completely clueless. Because really, some people do not know how to do this stuff. And again, ethically, you don't want to send them out to certain groups because from no fault of their own, they're probably going alienating to those groups of people, and that's not something that I would be, I am concerned about that. So I think that you can put people in observer roles if you have the staff to watch people who have some real skills in this area. And, then debrief, because I think that's good learning. I think you can get together as groups. But, really the best thing is somehow or other to get into some of these cross-cultural processes and perhaps be given a bit of a charge before you go in about what you might expect. I mean, you can never predict in advance. And then, again, debrief after the fact."*

The public health professionals also discussed ways they cope with what were viewed as moral dilemmas experienced in everyday work. Although these moral challenges were issues the public health professionals wished they could resolve, unfortunately, many of these moral dilemmas were issues the public health professionals realized they could not completely reconcile and had to accept that most could not be solved. Ultimately, the public health professionals had to focus on ways to negotiate the dilemma in the best way possible and in the most honorable and

collaborative way for the client. Several participants outlined their processes for negotiating these dilemmas:

> *"And I think, okay, probably not the right thing but at some point you kind of go, okay, well at least the kid is getting treatment. And you say, okay, this mother was obviously not going to find the money anywhere; she smokes or whatever, has something else that is more important, so at least she has brought the kid in and at least it's getting looked at."*

> *"Like we're helping people access services. Lots of people are very resourceful, they know where the food banks are, but they're young women expecting babies or hocking their Twilight videos at the pawn shop because they don't have money to buy the crib that if they aren't prepared for their baby, they're really afraid that their child is going to be apprehended. So those are really huge dilemmas that you can't rationalize like the advertising thing, that was a simple thing. These are huge things. So you just keep going and you do the best you can. You help them access what they need at some point but only to a certain degree."*

> *"You might carry it into your personal life in terms of you think twice. Like, I haven't had a yard sale for years; you know what, I'll just give it to an association or [organization] or all those things, because you know your clients access that. So at a personal level you think, oh my gosh, I don't need it; someone else might."*

Collaborating mechanisms were also associated with several keystone elements and underlying values and principles. These mechanisms appear to be associated with the principles of reciprocity, and procedural values such as cooperation, ensuring a collective voice, capacity building, relationship building, trust and confidence. Other critical elements for effective collaboration included providing leadership, leveraging resources, acknowledging and supporting others personally and professionally, and giving guidance. Experiential knowledge, learning through observation, acceptance, and finding other ways to help were additional actions and values germane to effective collaboration.

6.2.3 Innovating Mechanisms

The third set of mechanisms identified by the public health professionals who took part in this study were innovating mechanisms. Innovating mechanisms referred to ways of working with the general population and expanding the scope and impact of public health. The public health professionals shared the view that historically public health was known for being conservative and not necessarily known for being a trendsetter. They also discussed how public health initiatives were competing against corporate and sponsored health programs and services. The public health professionals felt that to be able to negotiate and eventually resolve some of the dilemmas they experienced in providing services they needed to catch the public's attention and make them interested and engaged at findings ways to improve their health. The public health professionals expressed that public health initiatives must be designed and implemented in ways that the public sees these initiatives as being appealing, interesting, and state-of-the-art. They also felt that public health programs needed to be inventive, original, and contemporary, as well as effective. One participant shared their reasoning process when delivering programs:

"Well, certainly the best experiences are the ones where there is an opportunity for creativity and innovation in developing something new or understanding better our context – those big ah-he's around what's new and what are some of the issues that we may want to address and how would we tackle those issues, and what are some of the newer creative strategies we could go about dealing with. Bringing meaning to some of the things would be routinely, so I have that opportunity with this program because it informs how we strategically approach some issues. So those are definitely highlights for me."

The public health professionals also felt that for public health to be cutting-edge, their programs and services needed to be radical and revolutionary to make effective change that will improve the health of communities and populations. Thus, the public health professionals were always trying to find innovating mechanisms to negotiate and resolve the dilemmas they experienced. This included focusing on mechanisms that were accomplishing such as always following through on plans they set out to achieve and gearing plans to the capacity of the community to attain what they want to achieve. One participant described her experience trying to always focus on innovative strategies that seek to accomplish initiatives that will ensure success:

"You might be able to say that the thing that's most needed in our community is to get kids in schools eating healthy. But then, if the school boards aren't interested in working with you and you can't get into the schools to do it, you can organize and plan any initiative you want. It's not going to be successful because you don't have the players on board; and that's what we originally ran into was trying to do things that we knew were needed and would make a difference, but

not having the players that we needed or the doors opened that we needed, and then just struggling. But then if we looked at, okay, here's 10 priorities and maybe the ninth priority is around – I'm trying to think of something – around creating a workplace program. And we have six workplaces who want to sit around the table with us and are willing to pilot things in their workplace and work on plans. Then, you know, we have the opportunity to be really successful because we have who we need around the table. And even though it isn't one of the top priorities, we're going to be able to demonstrate success and show people, because that's where the interest in our community is."

The public health professionals also struggled with the expectations placed on them and the expectations that community partners place on themselves. They felt it was important to ensure that communities did not place too many demands on one another and their goals were achievable and geared to the capacity that was available. One participant shared their thoughts on the mechanisms she used to manage these expectations by saying:

"So one of the dilemmas I think we often had was capacity in the community to do things, right? So community partners are very enthusiastic. They want to do a lot and I think they often thought that they could do more than they actually could. And, so my concern or my feeling was always that I don't want to set people up to not be able to accomplish what they wanted to accomplish."

This participant elaborated further by stating:

"So I would always approach it by trying to get them to limit what they were going to do and then have ideas on the back burner that, if they accomplished that, then they could move onto the next thing so that we could really set them up for success and accomplish what they planned to accomplish versus having them have six things on the list and, you know, just through experience knowing they're never going to accomplish those six things. And then at the end of the year they feel like they didn't accomplish what they wanted to do; or they feel like they failed."

Although the public health professionals felt that the mechanisms for managing and limiting dilemmas needed to be made less complex, they also felt it was critical for communities to be able to take ownership for their own health initiatives and be their own champion. The public health professionals worried that clients may become dependent on public health; therefore they felt it was critical they worked hard to encourage and educate citizen groups on how to make collective decisions and collaborate with other sectors. For example, they felt citizen groups must get their voices heard by politicians so positive changes can be made to their own lives and their community. The public health professionals also identified that one way they could manage theses dilemma was to help communities continue on with programs in a more independent fashion by ensuring there was ongoing funding for programs. One participant shared their view by outlining the following:

"It's almost like there's a recognition that community engagement done by the community is where there is funding, the core funding, so the community can

count on that in the long term which, for me, would be the answer to this ethical dilemma."

The public health professionals identified that to be able to meet expectations they needed to act in a fair and cooperative manner. Although the public health professionals may have felt the community was ready to move forward on their own, if the community did not feel they were ready for this independence, the public health professionals did not feel they could walk away from the community. Thus, they felt they needed to continue to work in partnership with community. One participant expressed this by saying: *"If I'm engaging these people, I'm getting into a relationship with these people, and they have expressed certain vulnerabilities to me and I need to respect that by continuing to work with them."* This participant further shared the following views negotiating the dilemma and attempting to resolve the issue they struggled with by stating:

"There's now some expectation we're going to follow-up, so I need to know ahead of time and be willing to strategize and pull resources to follow-up. Because you don't go out, I mean, you have to be ethical I think. So we did go into a partnership with some other community agencies and we got the money to do the outreach. And, there was a huge energy amongst the constituency and they want us to continue to work with them. Well, that's to my mind, we have to continue to work with them now. You can't just go out and do an outreach strategy, write into a report and say goodbye to the people because they have volunteered. They've answered questions. They've answered our surveys. They've come to community meetings. They've given us a lot of ideas. They've given us

new direction. So I have to be sure – sure as I can be that I can continue to support those endeavours after the initial outreach strategy, because otherwise I think I'm being unethical in my own mindset"

As noted, a dilemma identified by most of the public health professionals was associated with health inequities. Clients who were struggling with finding services to deal with their health issues and members of their community who felt victimized, isolated, and alienated due to their health issues resulted in the public health professionals looking for ways to be innovative in the way services were provided. Various innovating mechanisms were used by the public health professionals to negotiate and resolve the dilemmas they experienced. This was conveyed by one participant in their comment:

"[We need to be] understanding how a variety of strategies compare in public health and maybe stepping up policy development of public health, working in the domain of policy development as opposed to awareness-raising and teaching, education and so on."

Another participant elaborated by saying:

"Taking it to another level and being much more deliberate than we have been, using more upstream strategies to get there. And the other very important issue for me is the whole shift - paradigm shift - from so-to-speak blaming the victim or looking at the individual and the lifestyle changes versus looking at the environment and the changes in the environment. And that's, you know,

something that I'm very interested, both when it comes to the social environment and the physical environment and how those factors affect public health in general and people's decision-making around actions that contribute to their health."

The public health professionals also felt it was important to work in ways that some may view as unique to accomplish their goals and mandate. They identified that in some cases they needed to be persistent by finding the path of least resistance and thinking outside of the box. There was the feeling that they could no longer do things the same way they had been doing things. They needed to be creative. One participant expressed this method of negotiation and resolution by saying:

"If I can phone someone else that I know will help them, I'll do that. Or usually I'll take their information and personally try to make sure that someone actually phones them back. I'll give them a phone number to call too, but I try to assure them that I've heard what you want and I'm going to take it upon myself to try to help you get that service."

Another participant shared their experience by stating:

"Well, you still are going to refer because two years later is better than none. So what we do is we have an executive, so we bring that to our executive and we try to deal with it. And we've had situations where, because we're a community partnership so the service providers sit on the executive, and so as our group we really advocated against ourselves, so what we did is we sent out a letter to each

service provider letting them know the concerns about the ethics of the wait lists and to try and provide support for them if they need it, some application for funding, those sorts of things, and that we really needed to get that wait lists down. So in doing that, we've internally taken on some evaluation and it's really nice. We actually have a hired program evaluator here. So he's been able to provide us with assistance and that's something that we really struggled with, we really wanted to do, but when you look at your priorities of timelines and availability of time, that sort of always got put on the back burner. So that's really helped because not only are we saying through this evaluation on wait times, we're going to see where we're at and decide what's acceptable, but there's been the unintended consequences that have come out of it. All of a sudden, their wait times have seemed to have gotten a little bit less. But that's what we're trying to say, it's not like we're trying to say you're a bad service provider. We're trying to help you so that you have actual stats to bring. So that's the way that we approach it."

Two other participants outlined their strategies for being innovative:

"I also sit on the [provincial organization] working group where there's a lot of policy advocacy going around that. We don't have the frontline capacity to work on those projects because [name of health unit] has tons of research analysts and policy analysts who work on that, so we actually sit on those conference calls, sit on those committees, to piggyback onto what they're doing so that we have a say as well and are able to do something."

"In our little team, there's three or four of us who are on working groups at a provincial level and that allows us to work towards the policy piece of the mandate without stretching the capacity in-house. We find that quite effective."

Staying focused and following standard practices was another mechanism the public health professionals used in their everyday practice to negotiate and resolve the dilemmas they experienced. Although processes like following standard practices may not be viewed as an innovative mechanism, how the public health professionals implemented these processes and practices to ensure clients received the best service as possible was, at times, a judgement they had to make based on the particular circumstances for that client. This required them to be somewhat ingenious and inventive. One participant described their decision-making process by reporting:

"We have some general practices that we follow. The wait list that is the longest is for weekly therapies. Our other programs are programs that are finite and they don't involve assignment of a therapist for that individual, so the child and the family will go through that program and then other recommendations will be made. So it's less intensive in terms of our relationship with the families. So it's that weekly therapy wait list that's the longest. Things that we follow are that we place clients on that wait list in terms of their original referral date, no matter what that is. So, that's kind of how they get on that wait list. There's some exceptions to that. If stuttering is the issue and it's a fairly severe case of stuttering, then they will be prioritized right up at the top of the wait list because that's a clear case of prevention. So that's an exception. As we have room in our

caseload to pick up new clients, we follow principles. We work within a certain number on the top. We look at things like how long has that family gone without service, have they received any other service. Use a lot of different kind of judgment calls in terms of who we pick up next. We might informally talk to other people or approach or supervisor, that kind of thing. That's basically how I make those decisions."

Critically analyzing the activities they conducted and regularly reviewing their own internal processes and procedures were other innovative mechanisms the public health professionals discussed. One participant detailed her experience and the actions taken by the community partners she worked with to negotiate and resolve the dilemmas they experienced by stating:

"I guess for me it goes back to that community, because the work I've been doing is community work and looking at those dilemmas that exist between the community and public health in the coalition work, right? So you know, for example, because we're giving resources to groups to do something, you know, making sure that the resources aren't going to an organization or an individual to do the work that they're doing, that it's truly for a project. Because you know people are coming to the table with an agenda and you want to make sure that what they're doing is in the spirit of what they're supposed to be doing and not just a way to access the money for either themselves personally or for their project. So that kind of thing. At a steering committee level when people are making decisions, you know, it's certainly some of the ethical dilemmas are around what is your association with some of these projects and ensuring that

people are declaring conflict of interest so that, you know, decisions can be made. Or if a steering committee member participates in one of the groups that they're not part of that decision-making process around whether that group gets money or gets approval for doing things. So that whole, how decisions are made and who participates in those decisions, that what the conditions are around that decision-making and what the conflicts are. So that's one of the other things that we addressed a lot and talked about in terms of what I would think of as kind of an ethical dilemma."

This participant elaborated further by outlining:

"And then just mandates. Organizational mandates on what they're doing around the table; what their agenda is; and how that's influencing the work that they're doing. And again, sometimes getting back to the conflict piece around, it's hard when people are representing an organization and that's what they're supposed to be doing, but working as part of a coalition. Right? And this is one of things that when people would go out into the community, they would represent themselves as their organization; and we were really trying to move people to say that they were representing the coalition, not just their organization."

The participant who shared her experience above also described various strategies she undertook with the groups in her community using an innovative critical thinking-type strategy. This involved the community partners asking themselves a series of probing questions about the services or program they were looking to implement in their community. The participant outlined the process they undertook by reporting:

"So I kind of looked at it twofold. So when partners came forward and said, "We want to do this program at [location]", they were able to, again, use this list of criteria to see if it was in line with what we wanted. Is there a way to sustain it? Do they have steps in there to sustain it? Is it collaborative? Is it primary prevention? Is it on one of the topics of our risk factor? What are the organizations involved? How does it fit into our priorities? Is there other people in the community already doing it? And so what we did is we had principles and guidelines and values in our terms of reference."

This participant also outlined an evaluative action the community partners undertook to aid them in their planning activities and ultimately in their decision-making to resolve the dilemmas of what services to deliver to address the health needs in their community. She elaborated by saying:

"And we did a survey with our community partners a number of times – every couple of years – again, looking at what is the experience they're getting out of participating. What's the value? Does it meet their mandate? What are their challenges? What do they want to see as the priorities of the coalition and that kind of thing? So that again we could have a way to get feedback from them; keep them engaged; make sure that it was a valuable experience for them; making sure we were getting from them what we needed."

Another innovative mechanism the public health professionals indentified was what might be more appropriately identified as a learning mechanism. The public health professionals outlined

that knowledge is not finite as knowledge is always evolving and new knowledge is learned each day. However, they also discussed that even though some knowledge may be widely accepted, certain facts, observations, and comprehension, can be disputed. The published academic evidence was viewed as not necessarily being the gold standard as other forms of evidence, such as experiential knowledge, can be just as valuable and legitimate when making decisions regarding public health programming. One participant outlined their views associated with learning and how this impacts decision-making in public health:

> *"Being an evidence based organization and striving to be more of an evidence based organization, and for me evidence isn't just quantitative, peer reviewed research unlike it is for some people. For me, evidence includes qualitative research. I did some schooling at another university somewhere else where qualitative research is very much treasured, and I'm finding now that that's not happening here these days. So, I take issue with that. So I'm finding things a little unbalanced right now. But for me, those are both very strong. Also the needs of the community, so what you're hearing from the target population that you're working with, your community partners, all of that stuff. And to me, all of that comes together to guide your work. So I would say that's probably my approach to my practice."*

Several public health professionals shared experiences where their focus to be innovative led them to find ways to diversify their work. These diversifying strategies caused the public health professionals to use different actions to positively influence the public's health such as promoting policy change. Diversifying also meant the public health professionals needed to

digress from their usual ways to be able to transform how they influence people to make healthy choices. This, in some cases, meant seeking the support of politicians and other influential champions in their community to try and make significant capital alterations to neighbourhoods. This deviation from what was seen as the norm took the public health professionals away from what some viewed as their comfort zone and down avenues that caused them to explore approaches they had not considered previously. One participant outlined the diversifying mechanisms she had considered to promote health in her community:

> *"Well, a specific example would be environment policies – you know, policies where people would be allowed to live in built environments where they could actually spend their time walking to a destination, you know, to a store or to a bank or to a doctor, rather than sitting in a car and driving. Then we wouldn't need to tell them that they need to go to a gym 30 minutes a day, right? Because this would be part of their day. It's integrated into their day-to-day life, right, and these messages would be much more meaningful in their eyes. At this point we're still saying, you know, "Thou shall spend this much time in physical activity" and I'm sure that most of the people are actually laughing at us thinking, "And when would I find that time to do that?" Well, the time is the time that actually needs to be built into our lives elsewhere. It could be like two times 15 minutes, walking to a destination where they're walking for a purpose. So it's the shift from recreational walking to walking to a purpose. How do we get there? Well, the power of physical environment is different and we don't have exclusively a residential or exclusively a commercial neighbourhoods then we would definitely be able to do that. Who needs to make those decisions? Well, policy makers and*

planners. What can planners do about this when they're faced with pressure from the developers? Well, you know, these are the kinds of things we need to talk about. And the same would be with, I don't know, violence; and I'm sure, you know, alcohol policies and injury and you name it. I mean, decisions are made elsewhere, outside of the health sector. How do we become more relevant?"

This participant elaborated further by saying that diversifying is a critical mechanism to be able to make an impact on the public's health. If direct services are not changing people's behaviour to make healthy choices, then helping people navigate the system in ways that will cause them to choose the path that will positively impact their health may be the necessary mechanism. This participant described her experiences by saying:

"Well, I think working with decision-makers in the health sector and working with other decision-makers, is the way to go. I mean, this really needs to happen in the very high level before, you know, we on the ground have an opportunity to do something. But it does happen, actually, also through policy advocacy. So when we work with the community and the community raises their voices and goes to the council meetings, and councils approve it or give certain direction based on the public pressure, so we working with citizen groups and helping them learn how to advocate for themselves is also a good strategy. And trying to make some small steps on our own. So, for example, in our regional government we do try to work with planners on, you know, developing a good plan. You know, we are learning how to work together. So a variety of ways."

Overcoming barriers to provide requisite health services is another dilemma the public health professionals experienced everyday in their work. Finding solutions to these barriers has meant searching for alternatives. It has also meant, in some instances, the public health professionals being accommodating to those who were the gatekeepers for the clients who were in need of public health services. Discovering better ways to address health issues and transforming how things are done were other mechanisms the public health professionals identified they used. Several participants outlined how they had to be innovative in their work by finding solutions they once had not thought was possible:

> *"Because we found that us going in to present to students is not really effective so using those peer champions to deliver the message is the most effective way for them to receive that information and it gives them a good opportunity to become leaders themselves."*

> *"To work around it is to find somebody in the school that's passionate about it so they value a healthy lifestyle themselves and so then you kind of work with them - a teacher or a parent. Just trying to make those connections with people who are interested. Just because the principal is not interested, doesn't mean that the other people within the school are not interested as well. So it's networking with those people that are passionate about it is really how we work our way around it. And everything we do, we get board approval. If the principal doesn't approve it, we have already received the approval from the board. They're in support of it so we are not doing anything wrong; we're just finding our own avenue into it."*

Solution finding also meant for the public health professionals finding better ways to address the health issues people were experiencing. The public health professionals used various innovating mechanisms that went beyond the usual service provision and program implementation methods. These mechanisms involved sharing their own personal experiences with clients, using their own network of personal and professional contacts to aid members of their community who are struggling, and sharing the luxuries they enjoyed with those who may not be able to afford the same benefits. Two public health professionals identified unique solution finding mechanisms they used to advocate for their clients and to be proponents for their community. These are described below:

> *"I think just in terms of how we try to accommodate despite offering different modes of delivery of service, so if somebody can't come into the clinic, we offer home visits or telephone support. We'll meet clients at the coffee shop if they're not comfortable in their own home, at a [health unit community location]. So we do try to break down some of those barriers. Transportation and childcare are always issues for clients, as is access to food. I think we could do more with our resources that way. We have a food voucher program for clients in financial need on the Healthy Babies, Health Children home visiting program. We have loans of breast pumps. We give out some breastfeeding equipment if it's necessary to clients if they are in financial need and can't access a pump. We'll write letters to Ontario Works to get them electric pumps. We do try to advocate. So, I think we do a lot but we probably could do more to break down those barriers for access to service."*

"I guess it's just such a part of our daily routine that you do try to connect families with organizations that do community gardening, cleaning, community kitchens, stay with them, let them use your cell phone so they can call for emergency food services, but you don't have so much time to do the big picture stuff in our program. I think advocating at whatever level possible for community work in that area would be really helpful as an organization. It's working with the other departments, our nutrition department that is working on food security. I don't know, it's really hard to walk away. You try to find some donations for people."

Another participant shared a specific experience by describing a unique solution to explain to new mothers the conflicting evidence and information known about safe sleep for infants:

"A couple of weeks ago, I went and did a presentation on safe sleep with an Aboriginal group. It was a drop in thing, so I had no idea who was going to be there. It was a small group, maybe 10 people with their babies, and it was a tough topic because we're telling people, don't put them on their stomachs; don't put them on their sides; you should be breastfeeding; don't bundle them anymore; don't overheat them. It goes on and on and on such as make sure your rotating so they don't get warped heads. I mean, there's so many messages now. So I went in and said, "Look, this is a really hard topic to talk about because what I'm going to tell you may not be what you're doing. It doesn't mean you're a bad parent", and whatnot. And for a couple of things, I said, "I'm not sure what the right answer is going to be, what the recommendation will be, because right now

there's a disjoint between the coroner's office and the breastfeeding community in terms of sleeping with your baby." So we walked through it and we talked about it, and at the end one of the mom's said, "Thank you for coming and not preaching to me. You made this real. I don't feel like a bad mom now. You given us all the information and there isn't always a right answer, and that's okay." And she said thank you for that. And I really left there feeling, okay, I just did my job. And I told her, even with my little one there's some things I do that aren't completely what's recommended. There's other things I'm very strict about and whatnot. And I said, "You need to make the best decisions for you." And I said that what I say six months from now might be totally different because in terms of liability, I might be told what I have to say."

The public health professionals highlighted several keystone elements related to using innovative mechanisms to negotiate and resolve everyday ethical dilemmas. Being engaging, creative, strategic, and focusing on successes and listing accomplishments were values actions that supported innovation. Finding alternatives, being deliberate, unique, and persist were other germane elements of innovative mechanisms. Moreover, building capacity, using one's best judgment, planning ahead, sharing, critical thinking, giving feedback, along with advocating and solution finding were all ways the public health professionals felt that public health could be transformational and not static.

The health of groups and communities is one of the primary concerns of public health professionals as the practice of public health was founded on the belief it is a societal

responsibility to protect and promote the health of the population. The public health professionals who took part in my study clearly outlined that public health initiatives are driven by the collaborative actions of many individuals such as groups, organizations, and communities to help people live in a healthy way. It was also evident from the public health professionals that I spoke with that the ethical issues they experienced as public health professionals in their everyday work were quite dissimilar from those issues experienced by medical professionals. Moreover, the ethical and moral dilemmas encountered in the design, and delivery, of public health initiatives were quite unique in comparison to the dilemmas the public health professionals felt were experienced by other health professions.

Subsequently, the public health professionals I met while conducting this study appeared to work hard to determine the most appropriate and ethical way to negotiate and resolve the dilemmas they experienced in everyday practice. These actions were based on their association with what I believed to be internal and external contributing factors that drove their decision-making process for dilemma negotiation and resolution such as their relationships, values, and work style. As outlined, the various strategies the public health professionals used to negotiate and to reconcile everyday practice dilemmas should be more appropriately described as *mechanisms*. Historically, public health ethics is a field that has received little attention in the published literature and in the education and training of public health professionals. However, as was evident by the public health professionals with whom I met, ethics has increasingly become an area of interest and importance for those working in public health practice.

7.0 Discussion

Ethics is new territory for many who work as public health professionals. Public health ethics is an area that I felt intrigued to learn more about because it is an area that appears to be understudied. I am not sure why this is the case but perhaps it is due to its uniqueness and the fact that public health ethics blends bioethics, social justice, human rights, philosophy, and law. Although Nancy Kass (2001), and others, developed frameworks to aid public health professionals with the identification of ethical issues they may experience, the published literature is somewhat lacking in describing the everyday ethical dilemmas that public health professionals experience in practice. More so, there is little published literature outlining the dilemmas experienced by Canadian public health professionals.

An area of research that Childress et al. (2002) felt needed more attention was how ethical dilemmas experienced by public health professionals can be resolved. They also felt more attention was needed to understand the processes public health professionals undertake when negotiating the ethical challenges being experienced and can these be made more specific to guide decision making in practice. As described in an earlier section of this paper, the authors for whose research I reviewed attempted to categorize the ethical dilemmas experienced by the public health professionals. However, they did not intimately explore how the public health professionals negotiated and resolved these ethical dilemmas. Thus, the rationale for my thesis research came about not only because of the lack of published literature identifying the types and nature of everyday ethical issues faced by Canadian public health professionals, but also the scarcity of literature that aspired to identify how public health professionals approach, negotiate, and resolve such issues. Therefore, I pursued this line of research to investigate how the public

health system in Canada manages everyday ethical challenges. I chose to address this absence of knowledge by using grounded theory to identify not only the dilemmas experienced in public health practice but, also the approaches that Canadian public health professionals working in public health units used to negotiate and resolve everyday ethical challenges.

Ethics is a discipline and guiding philosophy dealing with right and wrong and moral duty, by definition (Miriam Webster Dictionary, 2012). Ethical dilemmas arise when two or more ethical principles are in conflict. Based on research conducted to date, it appears that public health professionals working in public health units in Canada encounter not only ethical dilemmas in their everyday work, but also numerous issues and challenges which in their perspectives are also ethical dilemmas. Although in some instances it may be obvious for a public health professional to identify which everyday public health concerns are a conflict between two or more ethical principles or a struggle between right and wrong or moral duty, in other instances this distinction may not always be straightforward and obvious. Therefore, when discussing the challenges and concerns they experienced in their everyday work I aimed to let the public health professionals frame the ethical dilemma in their own way even if this was different from how an ethicist or an academic studying ethics would frame an ethical dilemma. It quickly became clear that the terms ethics and ethical dilemma meant different things to different people. However, to appropriately report on ethical dilemmas experienced by those working directly in the field, I felt it was important to validate their experiences based on their own definitions of ethical dilemmas.

I felt it was critical that I try and understand the everyday ethical dilemmas experienced by public health professionals working in public health units as they reported them and to not dismiss their perspective of an ethical dilemma in everyday practice because it did not conform

to a definition of a conflict in principles or obligations. It was clear that although there were difficult situations mentioned by the participants, they thought about these difficult and challenging situations in ethical terms, imbued with ethical dimensions. Indeed, how participants thought about ethics in their day-to-day work was complex, and involved both individual interactions with clients as well as larger population-based issues.

Although I will not claim that I have replicated word-for-word the views of the study participants, I did attempt to use my time while in their work life to describe the practices and experiences they used while making decisions concerning the everyday ethical dilemmas they experienced. I attempted to let the data take over so as to not restrict the possibilities that arose in the pursuit of a comprehensive understanding of the dilemmas they experienced. I also attempted to describe the processes that were undertaken to negotiate and resolve the dilemmas from a population and public health perspective. Moreover, I will not claim that I have looked at the practices and decision-making processes of the public health professionals with whom I met with in an objective manner since I was not just a passive recipient of information. I believe my observations and perspectives aided with the construction of new questions or in finding ways to seek clarification of ideas or information provided by one or more study participants. As noted by Charmaz (2006), the collection of data guides the theory that is expected to evolve from the information shared by the study participants.

The issues identified by the Canadian public health professionals interviewed for my research focused mainly on challenges associated direct service delivery and problems experienced in everyday practice. The issues, challenges, and problems identified by the public health

professionals that I interviewed may have been as a result of the positions held by the individuals who took part in my study and the fact that, for most, their portfolio involved direct service delivery and the delivery of health interventions and programs. It may also be a consequence of the mandate and structure of the public health units, the directives of management, and the public health professionals own belief and value system.

I found that the everyday ethical dilemmas experienced by the public health professionals I spoke with to be categorized into four themes. Even though these themes aligned with the dilemmas identified by authors for whose research I reviewed; Baum et al., Rogers, and Bernheim, there were several notable differences. The dilemmas identified by the Canadian public health professionals I interviewed included *making choices when resources are finite* with resources referring to time, people and money. They also dealt with challenges associated with *health inequities* which included dealing with the belief, that addressing a person's short-term health needs will also improve their needs in the long-term. Moreover, this included changing the mindset that individuals are responsible, and to blame, for living unhealthy.

The public health professionals also struggled with *balancing and accommodating relationships.* This included not only dealing with one's own personal internal ethical and moral struggles, but also professional relations with co-workers, supervisors, and community members and organizational relationships with leadership decisions and actions that impact service delivery and programming. Finally, the public health professionals with whom I spoke with experienced ethical dilemmas associated with *achieving impact and effectiveness* of public health initiatives

to be able to make a difference in the lives of those in the community that public health is directed to serve.

The everyday ethical dilemmas identified by the public health professionals in my study were challenges that were not necessarily unique to one specialized area of public health professional or one singular individual. Many of the public health professionals grappled with the same issues. As noted, one of the main purposes for my research was not just to identify the everyday ethical dilemmas experienced by the public health professionals, but to also outline how the public health professionals negotiated and resolved these dilemmas and how they approached such issues. Fundamentally, I found there were several common actions as to the way the public health professionals handled and reconciled everyday ethical dilemmas. These actions can be best described as mechanisms. The three mechanisms that I delineated public health professionals used when negotiating and resolving the dilemmas they experienced in everyday practice were: *managing mechanisms*, *collaborating mechanisms*, and *innovating mechanisms*.

How each of the mechanisms were used by the public health professionals was unique in that *managing mechanisms* were used to find ways to control, oversee, steer, or influence those who are part of the struggle being experienced. Collaborating *mechanisms* were processes the public health professionals used to be successful in working jointly with others such as cooperation, teamwork, and building partnerships. The third set of mechanisms, *innovating mechanisms*, were used as a means that the public health professionals put in place to ensure effective public health initiatives and interventions by designing, and delivering, interesting and state-of-the-art programs and services.

I was able to find only one published research study conducted by Canadian researchers outlining ethical dilemmas experienced in public health practice; however the study focused on one specialized group of public health professionals; public health nurses. In reading the work of Oberle and Tenove (2000), it became clear to me that the public health nurses who took part in this study focused mainly on patient autonomy whereas the public health professionals that I interviewed tended to be more population focused. This research by Oberle and Tenove was valuable to the field of public health ethics as they identified three types of moral and ethical problems experienced in Canadian public health practice; moral uncertainty, moral dilemmas, and moral distress which can aid public health professionals to cope with and/or reconcile the dilemmas they experienced. An element of Oberle's and Tenove's research that I found particularly intriguing was their supposition that most existing ethical frameworks seemed to represent the ethical decision-making process as a step-wise or linear approach. As they noted, and similar to what I found in my own research, is that the "ethical issues in public health [nursing] are so rooted in context, and so interwoven and complex, that they are seldom amenable to this type of analysis" (p. 435).

The utility of the mechanisms I identified also did not ensue in a logical or linear fashion such that a mechanism used to resolve one specific dilemma may be used to negotiate another type of ethical dilemma. The processes used for dilemma negotiation and resolution also appeared to be similar to a mediation process where the goal may be to find a compromise or settlement. The public health professionals, in some instances, were able to negotiate the anticipated dilemma quickly or resolve it immediately but in other instances they appeared to require a period of renegotiation or reconciliation. The public health professionals, in some situations, also needed

to implement multiple actions, draw from an array of experiences, and juggle the feelings, beliefs, and judgments of many in their assessment of the potential impact of the dilemma. Essentially, the public health professionals used numerous mechanisms to negotiate the dilemmas they experienced. They also used numerous mechanisms to resolve dilemmas. The specific mechanisms used varied depending on the circumstances of the specific dilemma, struggle, or challenge.

Based on what I heard from the public health professionals with whom I spoke, there did not appear to be a situation where a dilemma they experienced could not be negotiated or resolved in some way, albeit not always without some discomfort in the resolution. However, it is conceivable that a resolution may not be possible in some instances. It seems that in most situations the public health professionals always attempted to find an appropriate resolution to the dilemma. However, it may be that the resolution determined to be adequate in one instance on one particular day, may not be adequate in another instance on another day. Each dilemma must be assessed independently, especially if new information becomes available.

The mechanisms for dilemma negotiation and resolution used by public health professionals with whom I spoke with appeared to function as revolving elements. Although the mechanisms, in some fashion, acted as a cohesive unit to aid the public health professionals with finding ways to cope with and reconcile the dilemmas they experienced, the public health professionals often considered multiple mechanisms as part of the process for negotiating or resolving the challenge they were experiencing. Moreover, the public health professional's decision-making processes appeared to always be evolving where dilemmas were appraised, contemplated, examined, and

re-evaluated. This decision-making process also emerged over time, and with more experiential knowledge, decisions were made with greater ease. In other words, the public health professionals did not appear to be immediately decisive on one way to negotiate or resolve the dilemma they experienced.

The public health professionals also relied on their values and ideals to guide their ethical decision-making in an attempt to mitigate any ethical dilemmas that could occur in practice. They outlined that their *personal values*, *process values, and empathetic values* as guiding how they practice. These values, I conjecture, helped drive the choices, and ultimately, the decisions regarding mechanisms for dilemma negotiation that the public health professionals needed to make in their everyday practice. Each of the actions, mechanisms, and values that public health professionals considered in their decision-making process was an integral part of the negotiation course of action and each of these worked collaboratively together. The cohesive function of the negotiation process appeared to aid the public health professionals in a comprehensive fashion when dealing with the everyday ethical dilemmas in practice.

Another gap in our knowledge of public health practice is the identification of the ethical principles used in public health practice. Although each of the published papers described in the earlier sections of this paper implied that public health professionals inherently based their work on ethical principles, the authors of these papers did not focus on this as an element in their findings nor did they identify the principles used. However, work conducted by Upshur (2002) published in the *Canadian Journal of Public Health* identified a set of principles for public health professionals to consider, and to use as a guide, when designing and delivering

interventions and to justify public health actions. The ethical principles Upshur (2002) identified as aiding public health professionals included: the harm principle, the principles of least restrictive or coercive means, the reciprocity principle, and the transparency principle. It became clear that the public health professionals I interviewed did not use any one specific ethical principle in their everyday practice as they did not make the distinction between what would be everyday ethical (or practical) dilemmas. Their work was population-based and client-driven which results in them using what would be seen to us as academics as being an array of practices framed by people's experiences. If I were to ask the public health professionals to identify the ethical principle to which they based their practice, they might consider this view as thinking too narrowly for the delivery of public health services.

Public health is not driven by one main ethical principle. The public health professionals who took part in this study were very clear that the practice of public health needs to consider the entire inventory of ethical principles to find the one that is relevant for the dilemma being experienced. However, with that being said, the professionals I spoke with not only identified most of the ethical principles identified by Upshur (2002), but also other foundational principles used to aid them in their work negotiating and resolving dilemmas. These included the fundamentals of community development, program development and evaluation, and better practices. Other values included human rights, social justice, voluntary cooperation, serving the greater good, distributive justice, building and maintaining trust, experiential knowledge, and liberty.

My research revealed that there were two key approaches for how public health professionals addressed the dilemmas they experienced in everyday practices. One of these approaches was a proactive way and the other was a more reactive way. The proactive approach can be described as *practicing in an ethical way* and the reactive approach can be described as *ethics in a practicing way*. For example, the approach *practicing in an ethical way* was used to negotiate dilemmas where it was known what to do such as how to handle issues associated with finite resources and achieving impact and effectiveness. Moreover, *practicing in an ethical way* meant that ethical dilemmas were anticipated. When ethical dilemmas were anticipated, the associated value conflicts and risks and harms could be mitigated reducing any possible negative impact of the public health initiative for clients or the broader community. *Practicing in an ethical way* also involved the public health professionals knowing, perhaps instinctively, that there was a dilemma they needed to negotiate and they, through their own knowledge and experience, knew in a practical way how to proceed with negotiating the issue. This may have included planning programs and services taking into account ways to mitigate the potential any risk or negative impact on a family's privacy and confidentiality, developing standard operating procedures, consulting with colleagues or a supervisor, or following better practices.

The approach, *ethics in a practicing way*, was the approach used to resolve issues. In most cases, these were issues that were new or unknown to the public health professional or issues that were unexpected, unanticipated, and unintended to have a negative impact on their clients or the broader community. Dilemmas associated with health inequities and balancing and accommodating relationships were dilemmas that were approached in this way. The *ethics in a practicing way* approach meant that the public health professionals were not able to know,

speculate, or anticipate all of the risks or harms to clients or the broader community. There was no way to know in advance that there would be an ethical dilemma to resolve as the dilemma was something that came about unexpectedly or was not predicted. Examples included issues associated with organizations that were part of a collaborative community health intervention and deciding to terminate their partnership early, and issues associated with the unforeseen alienation and isolation of children who were taking part in a healthy lunch program. The public health professionals through their own experiential knowledge had to determine the best way to resolve the ethical dilemma they were experiencing. This may have included making a decision to no longer provide a particular program or service or terminate a partnership with a community organization.

The theoretical concepts as to how I viewed public health professionals approached the negotiation and resolution of ethical dilemmas are outlined in Figure 1. Using this schematic, I have attempted to show how the everyday ethical dilemmas being experienced impacts how a public health professional approaches the process for negotiation or resolution of that dilemma; is it *ethics in a practicing way* or *practicing in an ethical way*? Moreover, the values held by the public health professionals impacted their determination of the mechanisms they used to help them in negotiating and resolving their dilemmas; it was either; *managing mechanisms*, *collaborating mechanisms*, or *innovating mechanism,* or a combination of one or more. This schematic outlining the grounded theory that I proposed, although somewhat abstract, surmises the complexity of the processes undertaken by public health professionals when approaching the ethical dilemmas they experienced in everyday practice.

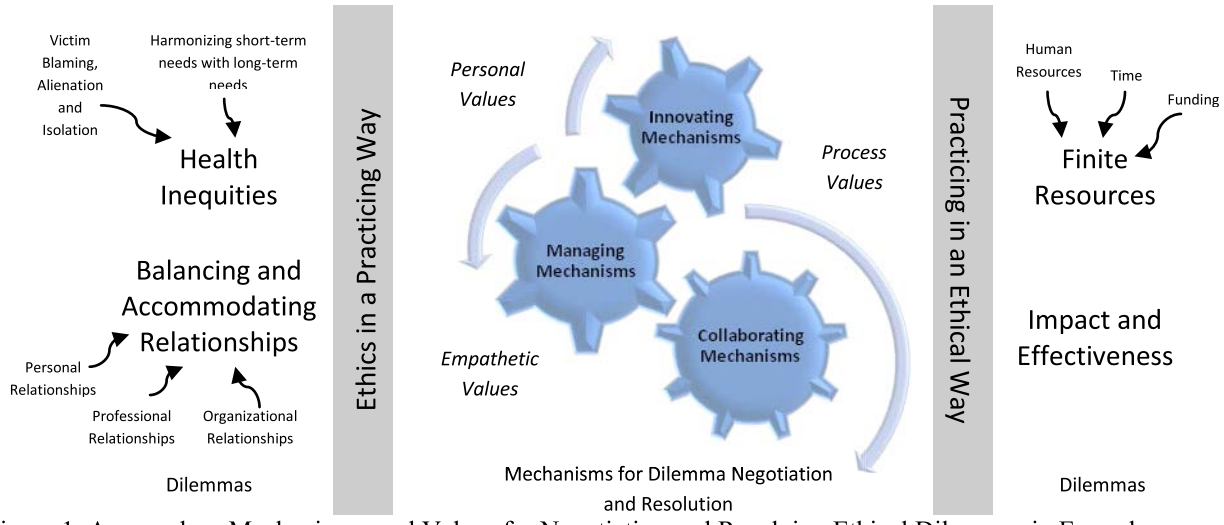

Figure 1. Approaches, Mechanisms, and Values for Negotiating and Resolving Ethical Dilemmas in Everyday Public Health Practice.

Because of their practice-based and population-focused profession the public health professionals who took part in my study appeared to express no deliberate thought about the ethical principles they used to direct their actions or decisions, such as reciprocity, do no harm, or transparency. The terminology used in the profession of public health does not inherently include language from ethical philosophies and principles. But ethical principles implicitly guide the work of public health professionals. It is important to note that regardless of the dilemma they experienced, the public health professionals who took part in this study were not unethical in their practices. They attempted to find the most appropriate way to address the dilemma they were experiencing. As outlined by Baum et al. (2009), the resolution of dilemmas in public health practice is a complex process because of multiple factors that must be considered, and for many, the public health policies and practices they use may at times run counter to their professional principles or deeply held values.

The ideals of ethics in health care, medicine, and medical practice have predominated since the 1940s because of violations against human dignity by those under the influence of the German Nazi command. These atrocities characterized a desperate need for ethical standards to be established making an enormous impact on the future practice of health care, medicine, and medical research (Bayer & Fairchild, 2004). However, since this time, little attention has been given to the ideals of ethics in public health practice and the ethical dilemmas of everyday practice in public health units (Callahan & Jennings, 2002; Roberts & Reich, 2002). However, more recently Stephen Holland (2007) identified that public health professionals encounter distinct ethical challenges and not just moral problems which are usually seen in medical ethics and bioethics. Moreover, Holland (2007) described public health ethics as being "an offshoot of medical ethics, but distinctive from bioethics because of the nature of public health itself" (p. vii). Many in the field of health care and medicine have come to realize that public health initiatives are broad and the focus is not typically on one particular individual but rather to address the needs of a specific group, family, community, or the population at large (Callahan & Jennings, 2002; Upshur, 2002). The findings from my research are consistent with the statements made by Holland (2007) such that the ethical dilemmas experienced in everyday public health practice are fundamentally different from those experienced in medicine or medical practice. Consequently, the mechanisms for negotiating and resolving dilemmas in public health are also fundamental to public health practice and systematically different from how dilemmas should be negotiated and resolved in medicine or health care.

7.1 Implications for Practice and Future Research

Knowing the everyday ethical dilemmas experienced in public health practice along with the approaches, mechanisms, and ethical principles used in dilemma negotiation and resolution can have a positive impact on the development of practice-based public health initiatives. The theoretical concept of *practicing in an ethical way* or *ethics in a practicing way* may provide guidance to public health professionals when planning, designing, and implementing programs and services. A consideration of the ethical implications should be integrated into the planning and design stage of the proposed initiative. Moreover, it is important for public health professionals to know that in many instances there is no right or wrong decision or one way to do something in practice. Furthermore, knowing there is more than one way to approach an ethical dilemma can relieve the conflict that public health professionals can sometimes encounter as the values held by an individual are intimately integrated into the mechanisms they choose for negotiating and resolving dilemmas experienced in public health practice.

Even though most public health units have no formal process in place for the ethical review of programs and services that do not involve research, knowing the everyday ethical dilemmas experienced by public health professionals and the approaches and mechanisms used for negotiating and resolving dilemmas, can aid with the design and delivery of future public health initiatives. This knowledge may be beneficial for a public health ethics committee to establish guidelines and processes and give public health professionals a place to ask questions and debrief about challenges and issues being confronted. This committee could assist throughout the planning and design of services and programs which is the approach *practicing in an ethical way* for negotiating dilemmas, but also during the delivery and evaluation of these initiatives. This

would be the approach *ethics in a practicing way* for dilemma resolution. The outstanding issue however is what expertise may be needed to constitute such a committee. This is something each individual public health unit would need to determine.

An understanding of the everyday ethical dilemmas, values, approaches, and mechanisms used in practice may also provide direction for public health ethics education initiatives. Public health professionals may benefit by knowing there are two approaches to managing everyday ethical dilemmas and neither of these approaches are better than the other. Learning from the experiences of others will advance the field of public health practice through processes of knowledge sharing. Workshops, special lectures, and webinars that discuss everyday ethical dilemmas and ways to resolve these challenges will teach public health professionals how to approach the dilemmas they experience either in an *ethics a practicing way* or *practicing in an ethical way*.

Further research in public health ethics is absolutely necessary in Canada. A plethora of investigation into the everyday ethical dilemmas experienced by public health professionals in our country is desperately needed. The scope of my research was fairly small in that I interviewed public health professionals from just two public health units and both of these were focused in the province of Ontario. Thus, there is likely to be numerous other everyday ethical dilemmas that public health professionals have experienced in Canada. However, not only do we need to be able to identify the everyday ethical dilemmas being experienced in Canadian public health practice but we also need to more broadly identify the mechanisms and approaches used when negotiating and resolving ethical dilemmas. There are likely additional mechanisms or

approaches yet to be discovered. More importantly, work is needed to determine the specific decision making processes used by public health professions when faced with an ethical dilemma. Are these processes deliberate or instinctive? Understanding how the decision making process is undertaken by public health professionals could ultimately lead to the creation of a decision-making toolkit. This toolkit could aid all public health professionals by giving them direction and guidance on how to negotiate and resolve the ethical dilemmas they face in their everyday practice.

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Appendices

Appendix A: Recruitment Letter for Interviews

Lakehead University

[Date]

[Name and Address]

My name is Julia Joza and I am a graduate student in the Master of Public Health program at Lakehead University. This letter is an invitation to you and your staff to participate in a research project entitled "Ethical Dilemmas Experienced in Public Health Practice and the Mechanisms and Principles Used to Aid with Dilemma Negotiation and Resolution: A Qualitative Study". I am conducting this project under the supervision of Dr. Elaine Wiersma. This letter will provide you with more information about this project and what your involvement would entail if you and your staff decide to take part.

Public health ethics is a relatively new field and it is an area that warrants further study due to its uniqueness and the blending of bioethics, social justice, human rights, philosophy, and law. Although there are frameworks that have been developed to aid public health professionals with the identification of ethical issues they may experience when working to provide population health initiatives, there has been little attention given to the process public health professionals undertake when negotiating and resolving the ethical dilemmas being experienced in everyday practice. Furthermore, little is known about the decision-making process used by public health professionals to identify the ethical principles they consider when attempting to justify certain practices. The objective of this study is to describe the concepts and mechanisms public health professionals use to approach, negotiate, and resolve ethical dilemmas.

Participation in this study is voluntary. The study involves an interview of approximately one to one and a half hours in length to take place with members of your staff in their office or a meeting room in your workplace. The interview questions will focus on identifying and describing the ethical dilemmas experienced and how public health professionals go about negotiating and resolving them. Your staff may decline to answer any question they wish. Further, they may decide to withdraw from this study at any time by advising myself or my supervisor.

With permission, we would like to audio-record the interviews to facilitate the collection of data, and to be able to transcribe them for analysis. Shortly after the interview has been completed, if requested, we will send each staff member a copy of the transcript to give them an opportunity to confirm the accuracy of our conversation and to add or clarify any points. All of the information collected for this study is considered completely confidential and no one will be identified from these summarized results. To ensure the confidentiality of the information collected for this study, each person will be given a study code or pseudonym known only to myself and my supervisor. There are no known or anticipated risks associated with participation in this study.

The data collected from the interviews will be coded, analyzed and securely stored on a password protected computer in my office at my residence. After completion of the study these

records will be stored at Lakehead University in my supervisor's locked office for 5 years. After that time, all paper records will be confidentially destroyed and all electronic files erased. The consent forms will be kept in a file separate from the study results in order to maintain each person's confidentiality. Only researchers associated with this project will have access to any of the information collected and the consent forms. A summary of the study results will be shared with you and your staff when the study is completed in the Fall of 2011. Study results may be presented at seminars, conferences, and through papers and publications. Names or any other identifying information will not appear in any work or presentation resulting from this study.

If you have any questions regarding this study, please feel free to contact me at 519-888-4567 ext. 38535 or 519-590-9871 (cell) or by email at jjoza@lakeheadu.ca. You can also contact my supervisor, Dr. Elaine Wiersma at 1-807-766-7250 or email ewiersma@lakeheadu.ca. If you have any comments or concerns about this study, please contact Lakehead University Research Ethics Board at 1-807-343-8283.

I hope the results of this study will benefit public health professionals both in Canada and abroad by mobilizing them with new knowledge. The desire is for the findings of this study to aid with the decision-making process that public health professionals need to undertake when attempting to negotiate and resolve the ethical dilemmas they face in everyday practice.

Finally, I would like to thank you for your consideration of support for including the [name of public health unit] in this study. I will call or email you in a few days to answer any questions you may have and to inquire if you and your staff are interested in taking part in this study. I very much look forward to your participation in the study and thank you in advance for your assistance in this project.

Yours Sincerely,

Julia Joza
Graduate Student
Masters of Public Health (Health Studies)
Lakehead University
jjoza@lakeheadu.ca
519-888-4567 ext. 38535
519-590-9871 (cell)

Appendix B: Information-Consent Letter for Interviews

Lakehead University

[Date]

[Name and Address]

This letter is an invitation to participate in a research study entitled "Ethical Dilemmas Experienced in Public Health Practice and the Mechanisms and Principles Used to Aid with Dilemma Negotiation and Resolution: A Qualitative Study".

I am conducting this study as part of my Master's degree in the Department of Public Health at Lakehead University under the supervision of Dr. Elaine Wiersma. I would like to provide you with more information about this research and what your involvement would entail if you decide to take part.

Public health ethics is a relatively new field and it is an area that warrants further study due to its uniqueness and the blending of the frameworks of bioethics, social justice, human rights, philosophy, and law. Although there are frameworks that have been developed to aid public health professionals with the identification of ethical issues they may experience when working to provide population health initiatives, there has been little attention given to the process public health professionals undertake when negotiating and resolving the ethical dilemmas being experienced in everyday practice. Furthermore, little is known about the decision-making process used by public health professionals to identify the ethical principles they consider when attempting to justify certain practices. The objective of this study is to describe the concepts and mechanisms public health professionals use to approach, negotiate, and resolve ethical dilemmas.

Participation in this study is voluntary. The study involves an interview of approximately one to one and a half hours in length to take place in your office or a meeting room in your workplace. The questions will focus on identifying and describing the ethical dilemmas experienced and how you go about negotiating and resolving them. You may decline to answer any question you wish. Further, you may decide to withdraw from this study at any time by advising myself or my supervisor.

With your permission, the interview will be audio recorded to facilitate the collection of data, and later transcribed for analysis. If you wish, shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points. All of the information collected for this study is considered completely confidential and you will never be identified from these summarized results. To ensure the confidentiality of the information collected for this study, each person will be given a study code or pseudonym known only to myself and my supervisor. There are no known or anticipated risks to you as a participant in this study.

The data collected from the interviews will be coded, analyzed and securely stored on a password protected computer in my residence. After completion of the study these records will

be stored at Lakehead University in my supervisor's locked office for 5 years. After that time, all paper records will be confidentially destroyed and all electronic files erased. The consent forms will be kept in a file separate from the study results in order to maintain your confidentiality. Only researchers associated with this project will have access to any of the information collected and the consent forms. A summary of the study results will be shared with you when the study is completed in the Fall of 2011. Study results may be presented at seminars, conferences, and through papers and publications. Your name or any other identifying information will not appear in any work or presentation resulting from this study.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact me at 519-888-4567 ext. 38535 or 519-590-9871 (cell) or by email at jjoza@lakeheadu.ca. You can also contact my supervisor, Dr. Elaine Wiersma at 1-807-766-7250 or email ewiersma@lakeheadu.ca. If you have any comments or concerns resulting from your participation in this study, please contact Lakehead University Research Ethics Board at 1-807-343-8283.

I hope the results of this study will benefit you and be of future benefit to other public health professionals both in Canada and abroad by mobilizing them with new knowledge. The desire is for the findings of this study to aid with the decision-making process that public health professionals need to undertake when attempting to negotiate and resolve the ethical dilemmas they face in everyday practice. I very much look forward to your participation in the study and thank you in advance for your assistance in this project.

Yours Sincerely,

Julia Joza
Graduate Student
Masters of Public Health (Health Studies)
Lakehead University
jjoza@lakeheadu.ca
519-888-4567 ext. 38535
519-590-9871 (cell)

Consent Form

I have read the information provided in the letter sent to me about a study being conducted at Lakehead University by Julia Joza, Graduate Student, Masters of Public Health, under the supervisor of Dr. Elaine Wiersma on "Ethical Dilemmas Experienced in Public Health Practice and the Mechanisms and Principles Used to Aid with Dilemma Negotiation and Resolution: A Qualitative Study".

My signature on this sheet indicates I agree to participate in the study and that I understand and agree to the following:

1. I have received and read the explanations about the nature of the study, its purpose, and procedures and agree to participate.
2. I am aware that my participation in this study is voluntary and I can withdraw from the study at any time by advising one of the researchers of this decision.
3. I am aware that I may decline to answer any question asked in the interview.
4. I am aware there are no known or anticipated risks or harms (physical or psychological) associated with my participation in this study.
5. I am aware there may be no direct benefits to me by participating in this study at this time however I am aware there are future benefits to others such as future public health professionals.
6. The information or data I provide for this study will be securely stored at Lakehead University for five years.
7. I will receive a summary of the study results, if I request one, following the completion of the research.
8. I will not be named, or identified in any way in any seminars, conference presentations, reports, or papers published as a result of this study.
9. I may contact the Research Ethics Board at Lakehead University at the number provided if I have any comments or concerns resulting from my participation in this study.

Name of Participant (please print)

Signature of Participant Date

I wish to receive a summary of the study results. Upon completion of the project, please send the summary to me. YES NO

(Please circle your choice)

Appendix C: Appreciation Letter for Interviews

Lakehead University

[Date]

[Name and Address]

Dear [Name],

I would like to thank you for your participation in my thesis research. As a reminder, the purpose of this study is to identify the ethical dilemmas experienced in public health. The data collected from the interviews will contribute to a better understanding of the mechanisms used for negotiation and resolution of these dilemmas in everyday practice.

Please remember that any information pertaining to you will be kept confidential and you will not be named or identified in any papers or presentations. Once my final paper has been approved, I may share the results from this study with the research community through seminars, conferences, presentations, and perhaps even a journal article. When I have completed my thesis paper, I will send you a copy. My paper is expected to be completed by Fall 2011.

Please contact me at either the phone number or email address listed at the bottom of the page if you have any questions. You may also contact my supervisor, Dr. Elaine Wiersma at 1-807-766-7250 or email ewiersma@lakeheadu.ca. Should you have any comments or concerns resulting from your participation in this study, please contact the Lakehead University Research Ethics Board at 1-807-343-8283.

Yours Sincerely,

Julia Joza
Graduate Student
Masters of Public Health (Health Studies)
Lakehead University
jjoza@lakeheadu.ca
519-888-4567 ext. 38535
519-590-9871 (cell)

Appendix D: Information-Consent Letter for Focus Groups

Lakehead University

[Date]

[Name]

Dear Potential Participant,

The purpose of this letter is to invite you to consider participating in a study that we are conducting on ethics in public health titled "Developing a Code of Ethics and Ethics Framework: Using a Participatory Action Research Approach in Public Health". This research is being conducted by Dr. Elaine Wiersma, Lakehead University, Dr. Jaro Kotalik, Lakehead University, and Dr. David Richards, Lakehead University for the [name of health unit]. In addition, Julie Joza, an MPH student, will be using the initial focus groups for her Master's thesis as part of her Master's of Public Health degree at Lakehead University under the supervision of Dr. Elaine Wiersma. We are doing this research to help to develop a code of ethics and an ethics framework for the [name of health unit].

Your participation in this research project will include participating in focus group that will last approximately 60 to 120 minutes. The focus group will be conducted at a time and place to suit your preference and convenience. You may decline to answer any of the interview questions if you so wish. Ideally, we would like to audiotape our conversations so we can better understand experiences and have an accurate record of our conversation. All information gathered throughout this study, including the audiotapes of the focus groups, will be kept strictly confidential and will only be accessed by the researchers and research assistants involved with this study. The [name of health unit] will not have access to any identifying information of participants and to audio-recordings and transcripts of focus group interviews. Any identifying information will be removed in the final report and publications that may emerge from this research. All information pertaining to the study will be kept in a locked filing cabinet at Lakehead University for a minimum of five years, after which time audiotapes will be destroyed and electronic transcripts with no identifying information may be kept indefinitely. If you choose to participate in the focus group, given the group format of this session, we will ask you to keep in confidence information that identifies or could potentially identify a participant and/or his/her comments. If you have any questions about participation in this session, please feel free to discuss these with the facilitator, or later, by contacting Dr. Elaine Wiersma (Lakehead University) at (807) 766-7250**.** The findings of the research will be prepared for publication at professional conferences and journals. The electronic transcripts with no identifying information may be used for additional analysis in the future by the researchers.

We do not anticipate that the nature of the conversation may be difficult, but your facilitator will be sensitive to this. If you decide to give your consent to participate in this study, we will be asking you to sign a consent form formally stating your consent to participate in a focus group. Participation in this study is completely voluntary and you may choose not to participate. You may also choose to withdraw from this study at any time. Any decision not to participate or to withdraw from the study will have no impact on your experiences or employment at the [name of

health unit]. All information pertaining to you (i.e., tape recordings, focus group transcripts) will be removed from the research and destroyed.

This study has been approved by the Research Ethics Board at Lakehead University. This office is available for any concerns and comments pertaining to this study and can be reached by contacting (807) 343-8283.

Should you have any questions about this study, please feel free to contact Elaine Wiersma at (807) 766-7250 or ewiersma@lakeheadu.ca.

Thank you for your interest and considering to participate in this project.

Sincerely,

Elaine C. Wiersma
Assistant Professor
Master of Public Health Program/Centre for Health Care Ethics
Lakehead University

INFORMED CONSENT

I have read the information letter provided by Elaine Wiersma, Assistant Professor, Master of Public Health Program, Lakehead University and the research team describing the purpose of their study. I understand that I will be asked to participate in a focus group of my choosing regarding ethics in public health practice. The focus group, should I choose, will last between 60 and 120 minutes and will be tape recorded with my permission.

My consent to participate in this research project is made under the following conditions:

1. That I have read and understood the information in the study cover letter.
2. My participation is completely voluntary and all data collected will be used solely for teaching and research purposes.
3. All information will be kept strictly confidential, accessed only the researchers and research assistants involved in the project. Pseudonyms for all participants involved will be used on all documents pertaining to the study and in all oral and written reports of the project. My name will never be used. Any identifying information will be removed.
4. I may withdraw from the study at any time by simply notifying the researchers or research assistant, and may refuse to answer any questions during the interview or ask to have the tape turned off at any time. All information pertaining to my participation, including audiotapes and focus group transcripts, will be destroyed. My withdrawal from the research will have no impact on my experiences and access to present or future services in my community.
5. Given the group format of this session, there may be a possibility of identifying a participant or comments within the group. Participants will be asked to keep information in confidence shared in the focus group.

6. It is not anticipated that I will experience physical or psychological harm.
7. The findings of the research will be prepared for publication at professional conferences and journals. The electronic transcripts with no identifying information may be used for additional analyses in the future by the researcher.
8. Data will be published in aggregate form, and no individual participants will be identified in published results without their explicit consent. Any identifying information will be removed from the final report and any publications that might arise from this research.
9. All data will be securely stored in a locked filing cabinet at Lakehead University for a minimum of five years. Files linking interview transcripts to any identifying information will be kept for five years at which point they will be destroyed. Audio tapes will be kept for five years. Transcripts containing no identifying information will be kept indefinitely in electronic format on a password protected computer for future review/analyses.
10. I may request an executive summary of the findings upon completion of the study. These will be available through Lakehead University in winter 2012 by contacting Elaine Wiersma at (807) 766-7250 or ewiersma@lakeheadu.ca .

This study has been approved by the Research Ethics Board at Lakehead University, and may be contacted at (807) 343-8283 .

Name of Participant_____

Signature of Participant_____

Date _____

I consent to having the focus group audiotaped.

Signature of Participant_____

Date _____

Signature of Researcher _____

Appendix E: Interview and Focus Group Guide

Opening Instructions: *"I am trying to understand how public health professionals perceive the dilemmas they face in everyday practice and how they go about negotiating and resolving these dilemmas. If there are any questions you are uncomfortable answering, please tell me and we can move on. If you would like to stop the interview at any time, please tell me and we can continue at another time if you wish. If at any time you do not want to continue with participation in this study, you just need to tell me (or my supervisor) and we will remove all of the data that pertains to you."*

"The questions I ask may be followed up with some open-ended questions that seek as much depth and detail as possible. For instance, I may sometimes ask questions such as: Tell me more about what was happening there? Who was involved? What were you thinking? Can you give me an example?"

Interview Guide

Context

1. How long have you been working in public health?
2. How long have you been working in this division?
3. Do you work full-time or part-time?
4. What training or experience have you had that helps your work here?
5. What is it like to work here?
6. Tell me about your day to day work. What are some of the best experiences you have had at work? The worst?
7. What is most important to you in your work?
8. What values and principles are important to you in guiding you in your work?

Understanding Dilemmas

9. What issues or conflicts (i.e., dilemmas) have you experienced in your day-to-day work? How do/did you feel about this?
10. Did you resolve this conflict or struggle (i.e., dilemma)? If so, how?
11. Have you had a conflict or struggle (i.e., dilemma) with the work you do/clients/colleagues you work with? Can you tell me about the situation? How did you feel about this?
12. Did you resolve this conflict or struggle (i.e., dilemma)? If so, how?
13. Have you ever had an issue, conflict, or struggle that hasn't been resolved? Is there a reason why you think this is? How do you feel about this?

Understanding Ethical Dilemmas

14. When we talk about ethical dilemmas in public health, what do you think about? Would you say that you face ethical dilemmas in your work? Can you describe some of them to me?
15. Are there certain guidelines or principles that help/guide you or help you in making decisions?
16. Is there anything that helps you (i.e., mechanisms, guidelines, principles) make the decisions that you need to make?
17. What things influence the ways in which you make decisions to deal with these conflicts or struggles (i.e., ethical dilemmas)? Are there specific factors?
18. Are there things (i.e., mechanisms, guidelines, principles, policies and procedures) that would help you to ***negotiate*** these conflicts or struggles (i.e., ethical dilemma)? If so, what are they?
19. Are there things (i.e., mechanisms, guidelines, principles, policies and procedures) that would help you to ***resolve*** these conflicts or struggles (i.e., ethical dilemma)? If so, what are they?
20. What mechanisms (i.e., processes, best practices, policies and procedures) exist, or should exist, for public health professionals in dealing with ethical dilemmas?
21. What has been your experience as to how your division/department normally negotiates and resolves dilemmas? How are these coordinated within your role as a public health professional in your health department? How are these coordinated within the broader organizational structure?
22. How do you think public health professionals should be supported in resolving ethical dilemmas?
23. What are your thoughts/opinions/concerns about how the ethical dilemmas being faced by you on future will/can impact future public health practices?
24. Is there anything further you would like to say about anything we have talked about today?

Focus Group Guide

1. Tell me about your work.
2. What does "ethics" mean to you?
3. What are your priorities in the work that you do?
4. What philosophies guide your work?
5. What values are important to you?
6. What values guide your work?
7. What are some of the challenges you face in your work?
8. What kinds of ethical dilemmas or situations do you face either most frequently or that would be characterized as most difficult?
9. What are some of the challenges you face in your work?
10. Is it important for you to have an ethics framework and code of ethics in your workplace? To guide your work specifically?
11. What does the organization do to support ethical decision making and ethical practice?
12. Are there things that could be done to better support ethical decisions and practice?