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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians and Researchers in Government Respond to Threats to Their Offices?

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Abstract

During the COVID-19 pandemic, clinician policy makers have faced unprecedented challenges. This commentary responds to a fictional case of a clinician policy maker who heads the Office of the Surgeon General and must ponder the answers to these questions: (1) What does it mean for a clinician or researcher to responsibly hold government office? (2) When good governance is thwarted by apathy about facts and cultural sympathy with false information, how much personal peril should government clinicians and researchers be expected to endure to maintain and model allegiance to evidence as a basis of public policy? (3) How should government clinicians navigate legislative, regulatory, or jurisprudential curtailment of their authority or roles in promoting public health and safety?

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Case

As the US Surgeon General, Dr SG is also vice admiral of the US Public Health Service (USPHS) Commissioned Corps, overseeing thousands of uniformed public health professionals in federal health service clinical and governance roles, each of whom are widely regarded as top clinicians and researchers in their fields. Dr SG recently testified before a congressional committee looking to restrict USPHS personnel members' discussion, in the course of their duties, of politically contentious topics (eg, gun violence, needle-exchange programs, contraception), regardless of these topics' evidence base or relevance to public health and safety.

Legislators cite a recent poll revealing that 56% of Americans disapprove of the US Department of Health and Human Services Office of the Surgeon General (OSG) and another poll indicating that 43% of Americans distrust science and health information released by the OSG. OSG press agents have also been struggling to manage confusion about science and health recommendations published by the Centers for Disease Control and Prevention that don't fully accord information on the OSG website. Atop those frustrations, OSG press agents have also tried to manage some media channels'

portrayal of Dr SG as "part of a science elite on a mission to instill enough fear to justify curtailing Americans' civil liberties." Since becoming the US Surgeon General, Dr SG and family members have frequently received threatening correspondence and now retain security personnel for public and even some personal events.

Dr SG's testimony to the congressional committee reiterates that the OSG's accountability is to best available science, not to public opinion, and not to extremist distortions of facts. Nominated by the US President and confirmed by the US Senate, Dr SG underscores that the OSG has always been an important expression of government balance of powers. Dr SG also emphasizes that OSG independence and credibility are compromised by politically motivated congressional restrictions of OSG staff members' speech, actions, and other standard means of engaging stakeholders—including the public—on critical health and safety matters.

After a grueling day of testimony, Dr SG confesses to a colleague, "I'm nearing the end of my 4-year term, but the stress gets to me. I wonder whether I should resign." This colleague urges Dr SG to remain in office and fulfill the term, emphasizing that resignation could mean that the OSG would be at risk of crumbling under less skilled leadership. Dr SG continues, "I expected to confront doubters and skeptics in my many roles as a public servant, but good health and science communication in this age of apathy about facts makes this impossible. My skills might be put to better use if I start a media company."

Dr SG considers what to do.

Commentary

The clinician policy maker is a health professional who helps formulate government policies. Examples of clinician policy makers include clinicians who hold political office, such as congresspeople, or those who lead governmental agencies, such as Dr SG. In this article, the clinician policy maker will broadly refer to a medical doctor in charge of leading a governmental agency.

Due to the COVID-19 pandemic and a growing distrust of government exacerbated by the rapid spread of misinformation through social media, the clinician policy maker is frequently asked to make choices based on not only the evidence but also ethical considerations. Making decisions about the rights and duties of individuals, communities, and government and accepting responsibility for protecting and maintaining health is a deeply complicated task. Dr SG is at a professional crossroads in terms of whether to continue holding office and, if so, how to lead. Traditionally, clinical policy makers have used public health or medical ethics frameworks to guide decision making on how to best improve the health of populations. However, a public more prone to apathy towards facts and to cultural sympathy with false information has altered the feasibility of relying on these traditional moral and ethical frameworks. New guidelines for clinician policy makers who serve in government need to be debated and developed that are practical, prudent, and persuasive—a more population-based approach to medical ethics.

Public Health Ethics vs Medical Ethics

Public health, broadly speaking, is the art and science of protecting and improving the health and well-being of populations and encompasses multiple disciplines, including epidemiology, disaster prevention, and pandemic preparedness.[1,2] Public health ethics,

as defined by the Centers for Disease Control and Prevention, is a "systematic process to clarify, prioritize and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders, and scientific and other information."[3] Public health ethics employs a utilitarian moralist framework by aiming to do the most good for the greatest number of people, even if this goal at times is furthered at the expense of individual liberties.[4,5,6] The American Public Health Association has defined 6 core principles of public health: professionalism and trust, health and safety, health justice and equity, interdependence and solidarity, human rights and civil liberties, and inclusivity and engagement.[7]

In contrast, medical ethics refers to the values, principles, and code of conduct that health care professionals should uphold to protect the health of individuals. Medical ethicists generally employ a deontological framework, whereby clinicians have certain moral obligations and patients have certain immutable rights or privileges that clinicians should not infringe upon, even if the consequences of doing so might benefit the public good.[4,5,6,8] Beauchamp and Childress have defined 4 key principles of medical ethics: (1) autonomy (patients' right to self-determination and consent to medical procedures), (2) beneficence (clinicians' obligation to do good), (3) nonmaleficence (clinicians' obligation to do no harm), and (4) justice (the obligation to distribute limited health resources in a way that is fair).[9] The American Medical Association (AMA) *Code of Medical Ethics* provides guidance to clinicians on their specific duties and responsibilities.[10]

In order to responsibly hold office, clinicians in government, such as Dr SG, need to extend the goals of individual patient care to the broader community. While the AMA *Code* does not explicitly discuss the ethical duties of clinician policy makers, it does contain sections on physicians and the health of the communities they serve.[11] These sections discuss the ethical use of quarantine and isolation,[12] health promotion and preventive care,[13] and ethical physician conduct in the media.[14] To fulfill their ethical duties, clinicians are advised to use a patient-centered approach,[15] promote appropriate vaccinations and screenings,[13] and advocate for "their patients' welfare,"[16] which includes advocating for healthier school, work, and community environments for their patients and for community resources to better promote patient health and well-being.[13] Dr SG has a moral imperative to promote the health of communities even if the object of that health promotion is contentious, such as contraceptive use or means to end gun violence. If that activist role involves participating in the media, clinicians must remember to first and foremost uphold the values, norms, and integrity of the medical profession,[14] which requires that any medical information clinicians provide is "accurate … inclusive of known risks and benefits … commensurate with their medical expertise … [and] based on valid scientific evidence and insight gained from professional experience."[14] In order to gain public trust, especially in rapidly evolving crises such as the COVID-19 pandemic, Dr SG must be forthcoming about the limitations of current knowledge and impress upon the public that information on the new disease is iterative and rapidly evolving. Dr SG is also bound to confine the medical advice he gives to his areas of expertise and maintain the highest levels of patient confidentiality when discussing patient care.

A Population-Based Approach to Ethics

Although the goals and intentions of both public health and medical ethics frameworks continue to be important and relevant for clinician policy makers, modifications are needed. A framework based on principles of total population health that bridges public health and medicine and incorporates social, political, and economic factors may be the

most appropriate place to start. Such an approach was taken in 1999 by Dunn and Hayes, who defined population health as "the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services."[17] Five years later, however, Kindig and Stoddart redefined public health in purely population terms as the "health outcomes of a group of individuals, including the distribution of such outcomes within the group."[18] There is growing consensus that to deal with ethical challenges of being a clinician policy maker, elements of the utilitarian moralist framework of public health must be combined with elements of the deontological framework of medicine.[5,6] This more practical approach will allow public health practitioners to stay true to the evidence (by avoiding the utilitarian framework's risk of overgeneralization) while also espousing the utilitarian framework's outcomes orientation with the understanding that all governmental health activity is based on authority and funding provided through a political—whether executive, legislative, or judicial—decision-making process. This approach will also enable clinician policy makers to understand that the process of health outcome improvement involves multiple determinants at multiple levels—from the individual, to the community, to the state or nation as a whole. The idea of embracing total population health, which encompasses geopolitical rather than geographic areas,[19] is critical to clinician policy makers performing their job ethically, morally, and successfully.

A Clinician Policy Maker's Perils

With growing political polarization in the United States, there are many threats to the physical and emotional safety and well-being of the clinician policy maker. The vignette describes threats to the life of Dr SG and his family members, including a need for increased security personnel, which raises the question: When is personal strife too much for the clinician policy maker? This question is particularly concerning, given the growing mental health crisis among health professionals. In a meta-analysis that collated data on over 17 000 resident physicians from 18 countries, Mata and colleagues found high rates of depression and depressive symptoms (29%) among residents.[20] Other studies have corroborated that physicians experience higher rates of poor mental health compared to age-matched members of the general population.[20,21] Poor clinician mental health is strongly associated with poor health outcomes for both patients and clinicians. For example, it has been found that physicians who are depressed are 6 times more likely to make medication errors than healthy staff.[22] Clinicians who experience burnout—a clinical syndrome characterized by high levels of emotional exhaustion, cynicism, and feelings of being ineffective due to "workplace stress that has not been successfully managed"[23]—have been shown to have higher risk of absence for mental or cardiovascular disorder, higher rates of traffic accidents and all-cause mortality, and reduced productivity and early retirement than healthy clinicians.[21]

Given these adverse outcomes, effective measures to assess physician mental health are imperative at the individual, organizational, and systemic levels. As in the case of Dr SG, a thorough assessment of clinician policy makers' mental health—including screening for anxiety, depression, posttraumatic stress disorder, or other mental health disorders—is essential. If Dr SG's continuance in office poses an elevated risk of burnout, suicide, or other mental trauma, then it would be acceptable for Dr SG to resign, knowing that severe mental stress and burnout are detrimental to his personal

health and safety and to the broader US population affected by policies developed and communicated by Dr SG.

Taking Action as a Clinician Governor

Applying the following guidelines, adapted from Edward Hunter,[24] would help clinician policy makers promote public health and safety, as well as deal with conflicts between various governmental agencies:

- *Recognize the factors affecting policy decisions*. Clinician policy makers need to be sensitive to other factors beyond health and science that influence policy decisions.[24] Incorporating other perspectives, such as those of diverse population groups or other governmental agencies, and acknowledging the consequences of public action would help clinician policy makers craft recommendations with more achievable outcomes. This approach includes focusing on common goals between and within government agencies.

- *Educate the public on the scientific process*. The scientific process is supported by guardrails, such as peer review and expert committees, to ensure accuracy and proper interpretation of information. However, science changes and adapts as new information and more robust evidence accumulate. Clinician policy makers must educate the public that knowledge is ever-changing and that new questions and conclusions can emerge.

- *Communicate evidence objectively*. Clinician policy makers need to present unbiased and impartial data, research, and evidence and to be truthful about what they do not know. Efforts need to be taken to "avoid the reality or perception of selectively highlighting evidence that supports a predetermined political position."[24]

- *Avoid partisanship*. Clinician policy makers need to not only be aware of past bipartisan successes[24] but also uphold views that follow the aforementioned preexisting ethical guidelines, irrespective of the political views of their superiors. This nonpartisan approach should be communicated to political leaders before clinician policy makers accept public positions.

Conclusion

This framework will not make the job of clinician policy makers easy. The challenges of political polarization and disinformation and misinformation, as well as anti-science sensibilities, will create complexities that clinician policy makers will have to navigate. However, their goal and responsibility must remain improving the health of populations. The population-based framework proposed here would enable clinician policy makers to do their best to achieve this aim while upholding the ethical responsibilities of their profession.

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