Discussion Paper

Living Virtues of Public Health

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June 2012

**Participants in the IOM Public Health Virtues Discussion Paper Challenge*

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Living Virtues of Public Health

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INTRODUCTION

Harvey V. Fineberg, MD, PhD
President, Institute of Medicine

In a discussion paper published in January 2012, a group of us at the Institute of Medicine (IOM) put forward some ideas about the "deadly sins" of public health. At the end, I suggested six initial candidates for the counterweight, public health's "living virtues": (1) **moderation,** (2) **prevention,** (3) **preparedness,** (4) **empathy,** (5) **science,** and (6) **service.**

I invited others to suggest what they would choose for the seventh living virtue, whether a personal attribute (such as "mindfulness") or social value (such as "equity"). Among the dozen submissions received, three relate to the idea of working together (collaboration and partnership), another three stress thinking of the other (selflessness, altruism, and the golden rule), and the remaining half cover an array of others—idealism and leadership, prudence and evaluation, honesty and patience. See which of the following virtues appeal to you.

COLLABORATION

Richard F. Southby, PhD
Distinguished Professor of Global Health and Executive Dean Emeritus, George Washington University

Collaboration as a public health virtue means that public health professionals must collaborate horizontally not only with other colleagues, health and non-health, within their own agencies and departments, but also with health professionals, governmental and non-governmental organizations, and citizens in the larger community in order to promote health and prevent disease.

There must also be vertical collaboration among the numerous levels of the health system so that the community's health needs are supported by sensible health policies, which in turn reflect real collaboration among federal, state, and local levels of government and the larger society.

Collaboration must be embedded into the "health professional culture" from the outset of professional education through multi-professional classes, community health internships, and cross-disciplinary research. This collaboration, in research and practice, will be further advanced

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[1]Participants in the IOM Public Health Virtues Discussion Paper Challenge.

by the expansion of clinical epidemiological research, which has the potential to bring together professionals who focus on individual health and those with a population health perspective.

Ultimately, collaboration could be a transformative experience leading to convergence in which the end result is not simply combining the best aspects from all participants, but better evidence-based outcomes overall.

SELFLESSNESS

Anila Naz, MD, MPH
Program Associate, Emory University Rollins School of Public Health

Holly Patrick, MA
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Selflessness lies at the heart of many of the herculean efforts that have been made to eradicate disease and relieve suffering around the world. Public health workers have to confront head-on the conditions of poverty, violence, and prejudice that both create and perpetuate poor health, and this often requires sacrificing their own comfort and security. But selflessness in the context of public health is more than just risking one's own well-being in the struggle to bring about positive changes in people's health. It is also about the willingness of those who work in the field to sacrifice their own ideas about what is best for others and abandon planned programs and interventions in the interest of meeting the needs that communities have identified for themselves. This requires courage and patience, and means investing time and effort to truly understand a community's concerns and priorities, whether or not they match neatly with an individual or organization's predetermined goals and objectives. By practicing this type of selflessness, health workers can help build an atmosphere of trust and cooperation, which in turn strengthens the willingness and capacity of partners to think, be ready, participate, and work for mutual benefit and progress. The overall and long-term outcome of practicing this virtue is reflected in the targeted communities' progress toward achieving their goals.

CONTINUITY AND COLLABORATION

Yan Xu, BSc
Medical Student, Queen's University, Ontario

The virtues of continuity and collaboration occur most often in clinical translation of efficacious public health research. Continuity describes the ability to sustain a public health intervention or policy through time and political changes, while collaboration emphasizes the partnerships, often interdisciplinary, among all players involved in public health. For many years, brilliant concepts from experienced teams of clinician-researchers have revealed promising results, but the proposed interventions are rarely expanded or translated into routine clinical practice until decades later. More recently, however, the turnaround time for research findings to become incorporated into public health practice and policy is shortening. A successful translated project can be attributed to a variety of criteria. First, successful projects often have adequate, long-term funding, and commitment from investigators to conduct larger studies that evaluate encouraging preliminary results. Second, the culture of knowledge translation is increasingly recognized by both funders of health research and academic institutions in their promotional structures. This in turn incentivizes investigators to pursue wide-scale implementation work beyond publication of

trial results in prestigious academic journals. Third, the emerging interdisciplinary and collaborative nature of academic centers fuels partnerships with other institutions with favorable initial findings, creating a catalyst for efforts aimed at expansion of an existing project—rather than each local center working in silos—thereby avoiding resource wastage from "reinventing the wheel." Finally, with advocacy from the public health community and increased recognition of the expanding health care burden, governments no longer wish to maintain the status quo and are more willing to support large-scale implementation of efficacious public health initiatives and the overhaul of ineffective care delivery structures.

LEADERSHIP

Vikram Khanna, MHS, PA
Health Consultant, Clinical Exercise Specialist, and Cancer Exercise Trainer,
Vikram Khanna Health Consulting

Tumultuous times present unique challenges for public health leaders—both individuals and organizations. Leaders whose primary approach to strategy is convention will succeed in the short term, because their proposals will seem familiar and comfortable to both internal and external audiences. They will eventually fail, however, because others will rightly conclude that their vision is myopic and insufficiently daring. Over the long term, success accrues to those who lead unconventionally and fearlessly (although not recklessly). This pattern appears repeatedly in American industry (see, for example, the crumbling of pre-bailout General Motors and Chrysler, versus the sustained, never-been-bailed-out success of Apple). It is an algorithm that is lacking in U.S. public health, as the field has no equivalent to Steve Jobs and Apple—no people or organizations around which a message-consuming public can coalesce.

The history of public health in the United States is one of achievement, but the field is now plagued by convention and confusion about what it should do, at what cost, and in which manner. Americans are justifiably nervous about whether public health efforts, which typically utilize the power of the state, can draw reasonable and respected lines between the needs of the populace and the constitutional imperatives of individual freedom and state prerogatives. If public health professionals treat this concern with disdain, they will find increasingly fractured and resistant audiences for their messages.

Leadership in public health must drive toward innovative strategies that showcase its ability to be iconoclastic in the pursuit of change. Further, clear and consistent expression will tell Americans that clarity of thought is the source of critical public health messaging and frameworks. Public health leaders must foment change with an eye toward the most important and compelling form of leadership, which allows people to follow consensually and with understanding, instead of under duress or out of anxiety and fear. Leaders must also transparently live their values, rearranging their own personal health strategies (and the dynamics of the organizations that they run) so that they align with the imperatives communicated to the rest of the population. Hypocrisy is neither a leadership trait nor a public health value.

Finally, public health leaders must respect dissent, opening their doors and minds to the views of skeptics. People and organizations that lead with compassion and respect for their opponents will find that the thoughtful people inclined to follow them will do so with even greater devotion, and that those initially disinclined may leave themselves open to suasion, recognizing that public health leadership is committed not to a cult of personality, but to the creation of a culture of positive, health-promoting change.

EVALUATION

Jillian Penrod, MPH, CPH
Research Coordinator, Public Health Law Research, Robert Wood Johnson Foundation

As both an art and a science, public health cannot be described without extolling the virtue of evaluation. This virtue concretizes the field into a dazzling web of measurable, time-sensitive, and specific objectives and holds public health accountable in creating bodies of research and generating an evidence base. Bidirectional and inclusive, evaluation epitomizes the democratic and pluralistic ideal of program development, implementation, and sustainability. Without this virtue, we, as public health professionals, would miss crucial dialogue with the community, lessons learned from ineffective implementation, and the rhythms of our stride when we conquer unforeseen obstacles. Evaluation reminds public health that it is not a wide-eyed child earning a merit badge in a silo of well-wishes; public health is a social science mechanism that must simultaneously hold its own and act reflexively within the ever-changing fabric of our towns, states, regions, nations, and world.

HONESTY

Edward Mberu Kamau, PhD
Technical Officer, World Health Organization

Honesty on the part of public health practitioners and advocates allows them to accept and openly declare when their recommendations or interventions fail or do not work as intended. Honesty, unlike arrogance, encourages a paradigm shift in public health that recognizes individuals and communities as engaged, empowered participants in their health care and not just recipients of information and prescriptions. An honest public health practitioner will actively engage individuals or communities as partners by sharing information and learning about their experiences while identifying the key drivers, incentives, and roles for them to participate—a genuine engagement that can engender trust and the sense of being valued as members of a team. Honesty encourages practitioners to identify vested interests, including personal interests that may be underlying the push for a particular intervention or tool. It allows public health practitioners to search for new ways to be truly transformational in their engagement with those they seek to serve. And I quote: “Only those who will risk going too far can possibly find out how far one can go” (T. S. Eliot).

PRUDENCE IN ACTION

Elizabeth McGean Weist, MA, MPH, CPH
Director, Special Projects, Association of Schools of Public Health

Prudence in action—rational discernment of the role one should take as an individual versus the action that may need to be considered as a collective unit—is a critical public health virtue. In some cases, the choice of action versus inaction is best left to personal decision making. To do otherwise is to risk both meddling and jeopardizing positive perceptions of the role of public health leaders and, by extension, the institutions they represent. The latter is of particular concern in sustaining trust in the social contract between those who govern (inclusive of political,

corporate, and other entities) and the people under their purview. However, when the scope of the problem is so large or the safety and health of groups of individuals are determined to be at risk based on science and evidence, then it is fitting that the scope of action shift to the appropriate collective body. In these situations, prudent public health leaders must consult with appropriate parties representative of the affected groups. Good judgment is called for in taking a particular course of action in preventing, preparing for, responding to, and recovering from public health challenges, and restraint and caution are advised when inaction or a less-than-bold action is preferable. In all situations, drawing from the best that science and research have to offer is critical. Additionally, prudence in action involves sensitivity, respect for personal liberties, courage, inclusivity, humility, creativity, shrewdness, the ability to move and change course quickly, and long-term thinking.

IDEALISM

Kristi Fossum Jones, MPH
University of Wisconsin

Idealism is in many ways the foundation of public health, since the central goal of public health—improving population health—is idealistic. Since the beginning, when there were efforts to improve sanitation to reduce illness in communities, idealism has been a virtue of public health. It continues to be a virtue today, as we explore how genetics and environmental factors intersect and as we develop new medical therapies and broader interventions to improve health. Idealism has multiple implications for public health. The most fundamental of these is the belief that health is a basic human right, one that all humans deserve. Example: believing that it is possible to provide all Americans with health insurance coverage so they can have access to the health care they need, and then working to make this a reality.

Idealism means always believing that there are solutions to public health problems, no matter how bleak the environment or economic situation, no matter how partisan the political scene, no matter how major the public health problem. It means always believing that the status quo can be improved. Example: believing that we can eradicate polio, discover genetic bases of disease, and effectively respond to the obesity epidemic. Idealism means believing that it is possible to make a difference in health everywhere in the world, in rich countries or poor countries, whether with complex or simple interventions. Example: believing that the United States can reduce infant mortality and that Haiti's cholera epidemic can be addressed.

Idealism means believing that our world can, should, and will be a healthier place.

PARTNERSHIP

Tara McCoy
Research Assistant, Mayo Clinic

Partnership has been defined as a relationship between individuals or groups that is characterized by mutual cooperation and responsibility in order to achieve a specific goal. Partnership is a necessary virtue of public health and is especially relevant to the patient-practitioner relationship.

As patients become more informed and empowered through increasingly accessible health information, a patient-practitioner partnership becomes increasingly important. Enhanced

patient knowledge brings patients into the health care setting with a stronger ability to participate in their care and to advocate for their health. Simultaneously, patient buy-in and investment in their care has become more important than ever. As rates of preventable chronic illnesses rise due to adverse lifestyle choices (e.g., obesity), patients must become active participants in their health care and strive to create healthy behaviors.

Practitioners often deliver care according to a prescriptive model in which patients are overlooked as partners or participants. The traditional top-down model of care must be reexamined and shifted to a model based more on partnership and collaboration and less on paternalism. If patients do not feel connected to the treatment processes initiated with practitioners, it less likely that they will adhere to treatment outside of the doctor's office.

Increased partnership in the patient-practitioner relationship allows for better access to each patient's unique health goals and values, which allows for the determination of solutions that better fit the individual or population. This has the power to greatly improve health and empower patients to create the positive behavior changes which are often so difficult to achieve.

A true partnership is paramount, as both parties contribute vital information that if overlooked or misunderstood could lead to suboptimal results. Ideally, patients encounter their health care provider with knowledge of their health and with a willingness to share vital information about lifestyle, values, and goals. Practitioners arrive at the encounter with a willingness to provide expertise on the best practices and treatment options available.

With both sides of the story, the best solution can be found for the patient. This will require practitioners to cultivate the tools and skills that facilitate open conversation, flexibility in the clinical model, and creativity in identifying treatments. More emphasis on a model based on partnership has the potential to assist in creating behavior change, improving health literacy, and bettering health outcomes through this shared decision making.

ALTRUISM

Emily Ann Miller, MPH, RD
Associate Program Officer, Institute of Medicine

Public health often calls us to serve populations of socioeconomic status lower than our own. Particularly in global public health, the populations we serve may differ markedly from ourselves in terms of resources and lifestyle. Though some may regard these populations or their practices with disdain and condescension, the task of improving the public's health would be better executed if these populations were regarded with compassion and served out of a sense of altruism. The motive for altruistic service is genuine concern for the welfare of others, rather than expectation of compensation or recognition. This is appropriate for agents of public health, because many of the people we serve can provide little more than their gratitude in return for what they have received. Improving the public's health may involve sacrifice of our comforts, particularly if travel to an impoverished country or an undesirable region of a developed nation is required to administer an intervention or provide services. Altruism persists even when such sacrifices are involved.

Humility often underlies the virtue of altruism. While many think of humility as the downplaying of one's accomplishments, a better way to frame it would be not to think less of yourself, but to think of yourself less. Adoption of this way of thinking is a first step in

cultivating a true concern for the welfare of others. This altruism is an antidote to the selfishness, conceit, and arrogance that have been put forward as sins of public health.

GOLDEN RULE

Rev. Robert W. Hamilton
Teaching Elder, Presbytery of the Twin Cities Area, Presbyterian Church (USA)

After reviewing the paper “Deadly Sins and Living Virtues of Public Health,” I decided it would make a good subject for theological reflection, and two quotes stood out to me: Sable’s statement—“When we allow our culture to tolerate behavior with no empathy and accept proclivities toward exploitation, we undermine our ability to care for the underserved and the vulnerable”—and Fineberg’s statement on the virtue of empathy—“the ability to regard the plight of others as your own, with a sense of compassion.” These reminded me of Karen Armstrong’s statement:

> I’ve become acutely aware of the centrality of compassion in all the major world faiths. Every single one of them has evolved their own version of what’s been called the Golden Rule. Sometimes it comes in a positive version—“Always treat all others as you’d like to be treated yourself.” And equally important is the negative version—“Don’t do to others what you would not like them to do to you.” [2]

Empathy is the spiritual resource which gives rise to the Golden Rule. This essay will reflect on Christian scriptural resources and how to articulate the Golden Rule in light of public health issues.

There are three accounts in the Gospel that speak of the Golden Rule: Mark 12:28–34, Matthew 22:34–40, and Luke 10:25–37. Matthew and Mark are similar in their narrative structure. The lawyer asks Jesus, “What is the greatest commandment?” Jesus gives a two-part response. The first part of the summary of the law is *love your God with all your being*. The second part of the summary of the law is *love your neighbor as yourself*. However, Luke’s narrative structure is different. The lawyer asks, “What is required to inherit eternal life?” Jesus responds, “What is written in the law?” Then the lawyer restates the law giving the two-part summary as in Matthew and Mark. The second part, or the Golden Rule, which seems most critical for this essay, comes from Leviticus 19:18. Leviticus 19:18 says not to hold a grudge against people but to “love your neighbor as yourself.” These texts command one to see others’ suffering in relation to their own suffering and to sympathetically respond to that suffering. This builds a relationship of care in which one mitigates pain and maximizes life’s potential in body, mind, and spirit.

Out of this insight come four acts I call the Caregiving Discernment Process. First, with the client, name the suffering. Second, communicate to the rest of the care team the reality of the individual’s suffering. Third, state the ways that the individual and the care team can grow to minimize suffering. Fourth, reflectively implement and grow so that the suffering is lessened. These four acts foster empathy by following the Golden Rule, which leads to building a relationship of care.

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[2] http://www.ted.com/talks/karen_armstrong_let_s_revive_the_golden_rule.html.

PATIENCE

Tiffany Cloutier, LNA
St. Joseph Hospital, Nashua, New Hampshire

Patience should be the seventh public health virtue because it is essential for our patients' comfort, staff support, and ultimately the entire care plan. The "time is money" approach to health care promotes little more than mistrust in a health team.

A patient on the Med-Surge floor of St. Marguerite Hospital, where I work as a nurse assistant, needed some patience one afternoon as she pushed her call button repeatedly. I entered the patient's room for the third time that day knowing that two other nurse aides had been there as well. The patient was anxious because she was discharging after 2 weeks. In her handbag were orders to treat her new diagnosis, diverticulitis. She wanted to know when she could leave, what she should do when she got home, and who she should call if she had any problems. I had already asked her nurse these questions and provided the patient with the details. This time, I took a minute to ask her some questions, beginning with how she was feeling. "Well," she replied thoughtfully, "I feel better than when I got here, that's for sure. But I don't know how long that will last." She exhaled that last part out as though she'd been hanging on to it and it was heavy. "What did the doctor say?" I asked. At this she looked confused and then irritated as she answered, "I don't really know what he said, to tell you the truth. He was in and out of here so fast all I can remember is that he said good luck." I nodded. This was not the first time I'd heard this. This patient was a member of our World War II generation. She came from a time when a patient considered her doctor a friend. The members of this generation seem to have more difficulty adapting to the distance of today's patient-physician relationship.

The advancements made in health care have contributed to much success in health care today. Computer programs designed to promote electronic medical records allow doctors, nurses, specialists, and pharmacists to communicate *about* their patients. At the same time, much has been lost in the way of communicating *with* their patients.

Patience also cradles the other six virtues. Adding patience to empathy, science, preparedness, and moderation is part of providing great service and ensuring prevention of mistakes. Patience also goes a long way to prevent that awful taste a patient gets in her mouth when she feels she hasn't been handled with any.

CONCLUSION

Harvey V. Fineberg

One overarching impression from this paper and the last is that public health encompasses more than seven deadly sins and seven living virtues. With everyone taking part in the effort, we can ensure that the power of the virtues will overcome the burden of the deadly sins.