FACULTY OF PUBLIC HEALTH

ASPHER
The Association of Schools of Public Health in the European Region

EUPHA
EUROPEAN PUBLIC HEALTH ASSOCIATION

# Variability in public health ethics education across Europe

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# Contents

# Abstract

***Introduction:*** Public health professionals face decisions that have far-reaching ethical implications. Despite this, the field of public health ethics is relatively new, and teaching and training in ethics for public health professionals is *"highly variable in quantity and content"* (Doudenkova et al. 2017). Building on a prior body of research, surveys of ASPHER and EUPHA members were undertaken to explore current levels of ethics education.

***Methods:*** Online surveys were distributed to ASPHER and EUPHA members with the aims of a) exploring the current status of ethics education in public health courses in ASPHER institutions and b) understanding the ethics education of individual public health practitioners in EUPHA. The ASPHER survey was completed by teaching staff at 35 different institutions between June and August 2019, whilst the EUPHA survey was completed by 230 professionals between October 2019 and December 2019.

***Results:*** Of the 31 ASPHER institutions with at least one master's degree, 39% (n=12) had one or more master's degree in which no ethics was taught, whilst only 47% (n=13) of institutions had someone who was formally qualified to teach ethics by virtue of holding a PhD, master's and/or further academic role in ethics. Fifty-one percent (n=118) of EUPHA respondents had not received any ethics education or training in the past five years, and 21% (n=48) had never had any education or training in ethics.

***Discussion:*** Key messages from these surveys are that 1) ethics is an optional extra for some Schools of Public Health, 2) there is an ethics training gap in continuing professional development, 3) public health ethics education is a poorly defined field, 4) there is a lack of ethics expertise and support, but 5) public health professionals perceive they have a good understanding of, and response to ethical dilemmas in their professional lives.

***Conclusion:*** To ensure ethically reflective and sensitive public health practitioners, access to ethics education should be available to all public health professionals.

# Foreword

The professional discipline of public health is driven by its values. Public health is not just a technical discipline concerned with statistics or facts. Our norms, values, beliefs and the way we see the world, as individuals, communities and institutions which serve us, do matter and fundamentally affect our decisions, behaviours, policies, and practice. The ability to be aware and reflect on norms and values when taking decisions, is a decisive professional virtue in public health practice.

Public health ethics is a core cross cutting competency for good public health practice. It enables us to systematically explicitly identify, analyse and consider ethical issues inherent in public health practice and research through application of principles, norms and tools to guide practice.

Many scholars in the field of both, public health and ethics, and most practitioners of public health do value ethics as a skill and space for reflection, but ethics has not been widely taught in schools of public health or other training spaces.

There is evidence that despite the need and demand for education and training in public health ethics by public health practitioners and policy makers, it is variable, often inadequate, and defaults to clinical ethics rather than considering population perspectives and issues of social justice.

The UK Faculty of Public Health (FPH), European Public Health Association (EUPHA) and the Association of the Schools of Public Health in Europe (ASPHER) have been collaborating to advance the discourse, scholarship and practice of public health ethics. We strongly support efforts to improve education and training in public health ethics – laying the foundation for better and more explicitly justified decision making and professional practice. A joint working group has been set up on Education and training in public health ethics and law, chaired by Dr Farhang Tahzib, to take forward activities to build competence and capacity in public health ethics and law in public health workforce in Europe.

This reports outlines findings from a survey conducted by FPH, EUPHA and ASPHER as part of ongoing efforts to better understand education and training in public health ethics. This research focussing on individual professionals in a European and international perspective is complementary to and building upon research with a focus on experience from education in ethics within the UK public health work force[1] and a survey among ASPHER schools[2].

What this research and other research clearly highlight is that while majority of public health practitioners regularly encounter ethical issues, they have little or no education and training in public health ethics, and question whether they have dealt with the ethical issues encountered in practice in the best way. These results demonstrate that there is a clear need to develop and support wider public health ethical capacity in the public health workforce.

We are happy to present these findings and making them available for further scholarship and capacity building.

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# Background

Public health professionals will face decisions that have ethical implications during their careers. As public health is intrinsically practiced on a population scale, decisions made can have wide ranging consequences. Despite this, the field of public health ethics is relatively new, and teaching and training in ethics for those working in public health is variable.

A small body of literature has so far attempted to quantify progress in this area, both by surveying institutions and public health practitioners. A 2003 survey found that public health ethics was taught in 75% of medical schools and 52% of institutions providing postgraduate education, but that in both locations the content and nature of the education was *"patchy and often minimal"* (Kessel, 2003). In 2012, a screening survey profiled ethics teaching in the Association of Schools of Public Health in the European Region (ASPHER) found that although 95% of programmes include ethics content in some form within their public health programmes, this was highly variable in format and intensity, with respondents wanting more support in this area (Aceijas et al., 2012). In the United States, an evaluation of ethics instruction at schools of public health found that only half of postgraduate courses surveyed required an ethics course for graduation (Thomas, 2003), whilst a separate review of syllabi noted that a large number of schools do not offer a specific course on public health ethics, but integrate it into other modules (Simón-Lorda et al., 2015). A Spanish study identified only 50% of master's of public health courses taught ethics according to their online profile, and this was always taught with other aspects of public health (Burón and Segura, 2019). Literature on practitioner perspectives is scarcer. A Canadian survey (non-peer reviewed) found that a significant minority of public health practitioners had not received any postsecondary training in any ethics, let alone public health ethics (Keeling and Bellefleur, 2018) whilst a 2019 survey of the UK Public Health workforce found that one quarter of respondents reported not receiving any public health ethics or public health law courses as part of their formal training, and of these, 17% also reported not receiving any training in these areas since entering the public health workforce (Viens et al., 2020).

It is therefore unsurprising that a summary of public health ethics education in the US, Canada, Europe, UK and India concluded that the "only certainty in PHE [public health ethics] education…is that it is important, highly variable in quantity and content, and that there is still significant room for improvement" (Doudenkova et al., 2017). Given this variability in prior research and the lack of recent European-wide research, this project aimed to survey institutional members of the Association of Schools of Public Health in the European Region (ASPHER) and practitioner members of the European Public Health Association (EUPHA) to explore the current status of ethics education in formal education and professional practice. This will be used to increase understanding of current ethics education, advocate for closing gaps and utilising opportunities for improving ethics education in the future.

# Methods

## ASPHER Survey

The survey was designed and tested between February and March 2019. The survey builds on and expands the Aceijas et al. questionnaire to help ensure comparable data longitudinally (2012). To ensure the survey was not too burdensome to those completing it, it was designed to be completed within 15 minutes using the online Survey Monkey software. Responses were collected between June and August 2019[1]. In total there were 45 responses from 35 different institutions. All institutions that responded, even if outside the European area, were included in the analysis as ASPHER does not limit membership to Europe. In all but one of the incidences of repeat responses from the same institution, earlier responses were incomplete and there were minimal discrepancies between answers, likely indicating the same individual had started the questionnaire but not finished it, before coming back at a later date to finish it. These incomplete responses were excluded from analysis. In the remaining institution, two responses were received from different individuals, with slightly different responses. In this case when the answers conflicted, the higher response was used (e.g. the higher estimated number of hours of ethics teaching).

1. The survey link was sent out by email on 13/06/2019, with a reminder on 12/07/2019. It was also included in wider ASPHER newsletters in June and July 2019.

## EUPHA Survey

The survey for members of EUPHA was designed and tested between June and September 2019. Like the ASPHER survey, this built upon the Aceijas et al. questionnaire (2012), aimed to be completed in under fifteen minutes, and used the online Survey Monkey software. The key difference from the ASPHER survey was that this survey focused on practitioners' personal experience of ethics education and experiences in the workplace. Responses were collected between October and December 2019[2]. There were 230 individual practitioner responses received. All responses were included in the analysis irrespective of country the respondent was working in, as EUPHA includes global membership as well as European membership.

## Ethics and data governance

This was an operational service evaluation of institutions and practitioners, in which no personal or sensitive data was collected. As per the UK NHS Health Research Authority definition of research, this would not be considered research as it does not involve an intervention and results cannot be extrapolated beyond the survey results. All EUPHA individual survey responses were anonymous with no personal identifiable data collected (including no internet protocol addresses). Names of institutions in the ASPHER survey were collected to allow identification of duplicate answers but were removed to anonymise data prior to analysis. The surveys were distributed by ASPHER and EUPHA representatives on behalf of the survey authors and as such the survey authors did not have access to, or store, the mailing list data. All questions were voluntary, with skip logic enabled to hide irrelevant questions. This means that the total responses for a specific question is less than the total number of responses in some cases. Where a multiple-choice answer option was chosen by very few respondents, or respondents gave specific answers when including free text for an 'other' response, this was not included in the analysis if this could potentially reveal recognisable information about an individual or institution.

## Limitations

A key limitation of these surveys was the low response rate for ASPHER, which may limit the utility of the results. It is likely that both surveys were subject to two types of response bias, namely participation bias and social desirability bias. Participation bias may have occurred as those who chose to respond were likely to be more interested in public health ethics than those who did not respond. Social desirability bias may have biased responses to questions about the perceived importance of ethics education, as respondents may have wanted to affirm their interest in this area, for which the survey authors were interested. Despite this risk of social desirability bias, it was still perceived by researchers that there was utility in asking respondents about their opinions on ethics education, in combination with factual questions that had a lower risk of bias (such as qualifications in ethics).

2. The survey link was sent out by email to the a) on 18/10/2020 to the EUPHA Governing Board Members representing all public health associations and institutional members (99 institutions with two persons representing each institution), b) on 18/10/2019 to the 1620 members of the EUPHA section Ethics in Public Health on 18/10/20 with reminder emails sent to this section on 17/11/2019, and 12/12/2019 and c) on 31/10/2019 it was included within the European Public Health Association Newsletter sent out to approximately 5000 members.

# ASPHER Results

## Respondent characteristics

There were 35 institutional responses from institutions in 21 countries (32% response rate[3]). Whilst the majority of responses were from Europe (n=26, 74%), a significant minority came from Western Asia (n=7, 20%) and Northern America (n=2, 6%). Half of the respondents (n=18, 51%) filling out the surveys were the programme director of the master's and/or bachelor's degree(s) at their institution, whilst 17% (n=6) were designated ethics leads, and 31% (n=11) had other roles including director/ dean of institution or researcher.

**Table 1** Region and country of Schools of Public Health responding to ASPHER survey

| UN Region* | n | (%) | Countries |
|---|---|---|---|
| Northern Europe | 9 | (26) | n=1 for Denmark, Finland, Norway and Sweden, n=5 for United Kingdom |
| Southern Europe | 8 | (23) | n=1 for Portugal, Malta and Serbia, n=2 for Italy, n=3 for Spain |
| Asia | 7 | (20) | n=1 for Lebanon, n=2 for State of Palestine, n=4 for Israel |
| Eastern Europe | 5 | (14) | n=1 for Czechia, n=2 for Bulgaria and Poland) |
| Western Europe | 4 | (11) | n=1 for Austria and Netherlands, n=2 for Germany, |
| Americas | 2 | (6) | n=1 for Canada, n=1 for United States of America |
| Other** | 4 | (2%) | |
| **Total** | **230** | | |

* Classification from United Nations M49 standard country or area codes for statistical use. Wider area classification used for all areas except for Europe.

3. Based on available information that ASPHER has "over 110 members" (https://www.aspher.org/contact.html), although this may have varied since the questionnaire was distributed

# Master's degrees

The majority of respondents (n=31, 89%) of respondents were from institutions with one or more master's degree. Of these 31 institutions, 19 (62%) taught ethics on all of their master's degrees, whilst 39% (n=12) had one or more master's degree in which no ethics was taught.

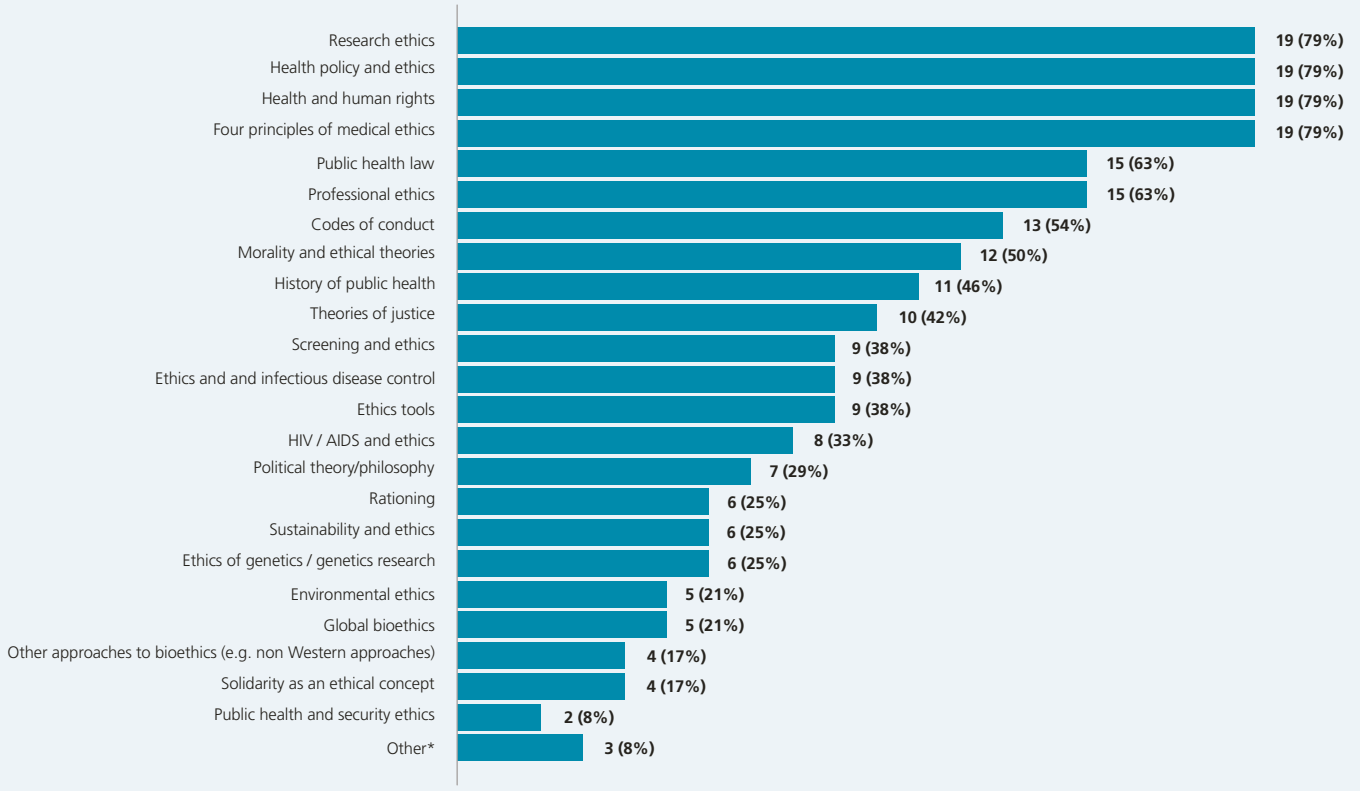
For the 27 institutions in which details of ethics teaching was provided, 70% (n=19) had a specific module on public health ethics (with or without further teaching in other modules) and this ethics module was a core course (as opposed to elective) for 11 courses (58%). Other master's degrees 22% (n=6) taught ethics across other non-ethics modules (n=6, 22%) or taught ethics via an alternative strategy 7% (n=2). For the 24 institutions that had ethics teaching across other modules (as well or instead of an ethics module), the majority taught ethics across some of their other modules (n=20, 85%), with a minority teaching it across most modules (n=3, 12%) or all modules (n=1, 4%). The estimated minimum amount of mandatory taught or facilitated ethics education a student would receive had considerable variation with 42% of respondents (n=11) estimating more than 16 hours, 15% (n=4) 10 to 15 hours, 31% (n=8) 4 to 9 hours and 12% 1 to 3 hours.

Most institutions used more than one method to teach ethics (n=19, 79%), with a minority (n=5, 21%) using one method only. The most common method of teaching ethics remains a traditional lecture (n=23, 96%), followed by workshops and small group work (both n=10, 42%), then other methods (n=8, 33%) for which some respondents specified online learning, then problem based learning seminars (n=6, 25%), and lastly tutorials (n=3, 13%). Seventy-seven percent of institutions assessed ethics (n=20) with at least some summative assignments which contribute to the final degree, whilst 23% (n=6) had only formative or no ethics assessment. The most common method of ethics assessment was at least one short answer question during a timed examination (n=7, 27%) or an ethics essay, written report or other coursework (n=7, 27%).

Assessments also took the form of other question formats under timed examination (essay question n=5, 19%, multiple choice question n=5, 19%, or ethics as a component part of a wider public health question n=5, 19%), other coursework (in which ethics is a component part of a wider public health assessment (n=5, 19%), oral presentation partially or wholly concerning ethics (n=5, 19%)), or other methods (n=3, 12%) which included an example of an reflective diary. A further question looked at the most common aims of the teaching, using Bloom's Taxonomy to categorise the aims hierarchically from gaining knowledge, comprehending, applying, analysing, synthesizing, and evaluating ethics (see additional files for full questions). The most common aim was to apply ethics (students can apply concepts or theories knowledge to concrete situations) (n=10, 42%), followed by gaining knowledge of ethics (students can remember previously learned information) (n=9, 38%). No respondents chose the two higher level aims of synthesizing or evaluating ethics.

The most popular topics taught by institutions included research ethics, health policy and ethics, health and human rights and the four principles of medical ethics (all taught by 46% of institutions, n=11), but there was a wide variety of subjects taught (Figure 1). Many respondents used guidance documents to structure their teaching (n=16, 67%), but with the exception of several institutions using UNESCO documents, most of these guidance documents were different. Only 44% (n=12) institutions had someone who was formally qualified to teach ethics by virtue of holding a PhD and/or further academic role in ethics, 3% (n=1) had someone with a master's in ethics, 37% (n=10) had someone with some ethics training (e.g. summer school) and 15% (n=4) had no staff with any ethics training. Forty-four percent of respondents (n=12) thought they had too little ethics teaching on their master's degree with the rest thinking the level was 'about right'. No respondents thought their master's degree contained too much ethics.

**Figure 1** Ethics and law topics taught by ASPHER institutions




*Respondents specified for other topics ethics and obesity substance abuse and ethics

# Bachelor's degrees

Only 10 out of 35 total questionnaire respondents (29%) confirmed that they had one or more bachelor's degrees in public health at their institution. All these institutions taught ethics on their bachelor's degree (100%). Further analysis of the ethics teaching was not undertaken due to the small number of respondents meaning a risk that individual responses could be deducted from the cumulative data.

# Qualitative feedback

When respondents (of both bachelor's and master's degrees) were asked to specify any support they may need to further develop and/or implement the teaching of ethics in their programme, the responses were varied and included the need for training materials (e.g. case studies and syllabi), staff training and more dedicated staff in public health ethics, methods of overcoming structural factors in degrees (e.g. not being seen as core and needing funding), and the suggestion of sharing of material/collaborations with other ASPHER members.


# EUPHA Results

## Respondent characteristics

There were 230 respondents working in 41 countries (response rate estimated 5%[4]). Ninety percent (n=207) of respondents were working in Europe, with Portugal (n=28, 12%), Italy (n=24, 11%), and France (n=19, 8%) having the most respondents (see Table 2). The majority of respondents worked in the same country they did the majority of their public health education and training in, but 19% (n=42) were now working in a different country. Of these individuals, the most common education and training locations were the United Kingdom (n=13, 30%) and the United States (n=8, 19%) in the United States. Thirty-three percent of respondents (n=75) had worked in public health for more than twenty years, with 12% (n=28) working for 16-20 years, 11% (n=25) working for 11-15 years, 17% (n=38) working for 6-10 years, 21% (n=25) working for 1-5 years and just 7% (n=16) new to public with less than a year's work in this area. The most common background respondents had was a medical background (n=99, 43%), followed by research or academia (n=32, 14%), those that had always trained or worked in public health (n=19, 8%) and nursing (n=15, 7%). Respondents were highly educated with 44% having a PhD or further post-doctoral training as their highest level of study (n=102), 24% (n=39) had a master's degree, 19% (n=44) a medical degree, 8% (n=18%) a habilitation and 2% (n=5) a bachelor's degree.

The most common area of public health that respondents were working in was academic public health (n=96, 42%), followed by public health in a healthcare setting (n=25, 11%). Less than 10% of respondents worked in health policy or administration (n=20, 9%), community health (n=20, 9%), health promotion or improvement (n=18, 8%), global health (n=15, 7%), or health protection / control of infectious diseases or non-infectious hazards (n=12, 5%). Twenty-four respondents (10%) worked in other areas of public health, which included occupational health, digital public health, and academic ethics as well as other further diverse areas. Given that academia was the most common area of public health that respondents worked in, it was unsurprisingly that 45% respondents (n=104) worked in universities, with 13% (n=29) working in local government or local public health departments, 12% (n=27) working in a hospital or healthcare organisation, and 9% working in a non-profit or non-governmental organisation (n=21) or a national public health department (n=21).

4. Estimated based on approximately 5000 members of EUPHA who would have received the link to the survey in the newsletter (including members of the ethics section and governing board of EUPHA, who also received further email reminders).

**Table 2** Region and country of work of EUPHA survey respondents

| UN Region* | n | (%) | Countries |
|---|---|---|---|
| Southern Europe | 73 | (32%) | n=1 for Albania and Serbia, n=3 for Croatia and Greece, n=4 for Slovenia, n=9 for Spain, n=24 for Italy, n=28 for Portugal |
| Western Europe | 58 | (25%) | n=2 for Belgium, and Luxemburg, n=6 for Austria and Switzerland, n=11 for Netherlands, n=12 for Germany, n=19 for France |
| Northern Europe | 53 | (23%) | n=2 for Finland, n=4 for Ireland, n=5 for Sweden, n=9 for Norway, n=10 for Denmark, n=23 for United Kingdom |
| Eastern Europe | 23 | (10%) | n=2 for Czechia, Hungary, Russia and Slovakia, n=3 for Romania, n=12 for Bulgaria |
| Asia | 5 | (2%) | n=1 for Georgia, Israel, India, Qatar, Malaysia, |
| Southern America | 5 | (2%) | n=5 for Brazil |
| Northern America | 4 | (2%) | n=2 for Canada and United States of America |
| Africa | 3 | (1%) | n=1 for Democratic Republic of the Congo, Nigeria, Tunisia |
| Oceania | 2 | (1%) | n=2 for Australia |
| Other** | 4 | (2%) | |
| **Total** | **230** | | |

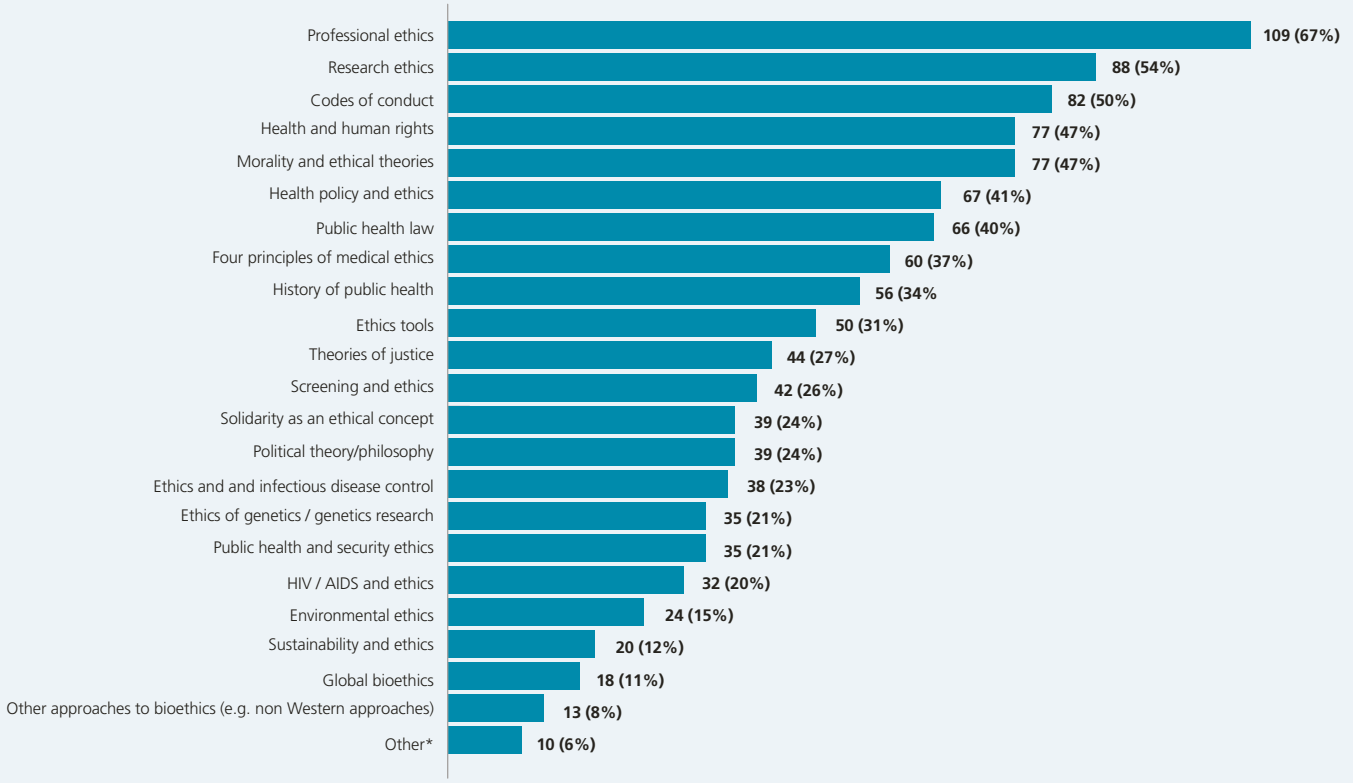
* Classification from United Nations M49 standard country or area codes for statistical use. Wider area classification used for all areas except for Europe.
** Didn't specify or worked in more than one setting (e.g. Pan-European)

# Ethics training

Fifty-one percent (n=118) of respondents had not received any ethics education or training in the past five years. Many of these had had ethics training prior to this (n=70, 30% of total respondents) but 21% of total respondents (n=48) had never had any education or training in ethics. Other respondents had received ethics education within a non-degree course or within professional training (n=62, 27%), within a degree or diploma (n=27, 12%) or within both of these (n=21, 9%).

Of the respondents that did have ethics education or training within the last five years, for 58% (n=56) at least some of this was compulsory and for 39% (n=38) this was optional. Forty-seven percent (n=46) of the respondents that had had some ethics education or training in the last five years estimated that this was more than sixteen hours, whilst 23% (n=23) estimated 10-15 hours, 15% (n=15) estimated 4-9 hours, and 13% (n=13) estimated three or less hours. The most common topics that respondents had studied anytime in their career included professional ethics (n=109, 67%), research ethics (n=88, 54%) and codes of conduct (n=82, 50%), but there was a wide variety of subjects respondents had received education or training in (Figure 2).

**Figure 2** Ethics and law education or training of EUPHA respondents by subject




*Respondents specified for other topics ethics and obesity substance abuse and ethics

Responses were divided when asked to state their agreement or disagreement with the statement *"I've found it easy / think it would be easy to find and attend training in public health ethics".* Thirty-six percent (n=75) agreed or strongly agreed, 38% (n=78) disagreed or strongly disagreed, and 27% (n=56) were neutral. Those who disagreed or strongly disagreed with this statement found or thought it would difficult to attend training in public health ethics because they perceived that there wasn't much or any available (n=65, 82%), that they don't have the time (n=20, 25%), that the training is expensive (n=18, 23%) and that their organisation was not supportive (n=12, 15%), that their supervisor/ manager was not supportive (n=4, 5%) and other reasons, which included they would not know where to find courses or be assured of their quality (n=5, 6%). No one suggested that they did not want to do this type of training.

# Ethics in practice

When asked on average, how often they encounter ethical dilemmas, 30% (n=63) thought this was on a monthly basis, 25% (n=53) thought on a weekly basis, and 23% (n=49) thought on a daily basis. Few respondents thought they only encountered ethical dilemmas on a yearly basis (n=20, 10%), or less than yearly basis (n=13, 6%) or were unsure about this (n=11, 5%). The last ethical dilemma that respondents perceived they encountered was related to confidentiality, privacy or data protection for 28% respondents (n=56), a conflict between their sense of what is right and their organisations in 20% of respondents (n=39), balancing individual freedom versus public good in 11% of respondents (n=22), decision making around health inequalities or inequities in 11% respondents (n=21) and resource allocation in 9% respondents (n=18), with other responses including professional conduct, consent or capacity decisions, research ethics, or 'I'm not sure', or other dilemmas all chosen by less than 10% of participants.

Respondents were confident that they could identify ethical dilemmas in their work when using a slider bar to identify where they felt between not confident (0), neutral (50) and confident (100) with a mean value of 74 (standard deviation (sd)=22). When asked how they would resolve ethical dilemmas at work, respondents favoured discussion with colleagues (n=143, 71%), personal reflection or reasoning (n=110, 55%), discussion with their manager or senior colleagues (n=103, 51%) or seeking advice from an ethicist or ethics committee (n=89, 44%). Less popular answers included seeking advice from a legal expert (n=59, 29%), discussion with friends or family (n=37, 18%) or other methods (n=18, 9%) which included those who turned to guidance, literature, or legal documents. Just over half of respondents (n=107, 53%) rated themselves as feeling OK about making ethical decisions, but sometimes worry if they have made the right decision, whilst a minority enjoy the challenge of these decisions (n=47, 23%) or felt anxious about these decisions (n=23, 11%). Very few were unsure about how they felt about these decisions (n=12, 4%), thought they didn't realise they were making decisions about ethical dilemmas (n=8, 4%) or really dislike or avoid making these decisions (n=4, 2%). The respondents perceived influences on ethical decision making included their professions norms and values (n=147, 73%), their own ethical reasoning abilities (n=139, 69%), their intuition or conscience about what is right or wrong (n=107, 53%), and their own study or training in ethics (n=103, 51%). Religious or spiritual beliefs (n=26, 13%) or other influences including reactions or pressure from senior colleagues (n=9, 4%) was were only chosen by a minority of respondents.

The institutions that respondents worked in had varying ethics tools or processes. Sixty percent (n=121) had access to a research ethics committee, 59% (n=118) had a code of conduct that included ethical principles, 40% (n=80) had access to legal advice and 34% (n=69) had access to an ethics framework or set of principles. Access to an ethics (in practice) committee, ethics consultation or training in public health ethics was less common (n=51 25%, n=45 22%, n=34 17% respectively). Very few respondents did not have access to any of these (n=11, 5%), were unsure about their access (n=17, 8%) or had access to other ethics tools or processes (n=6, 3%). Nearly all respondents agreed that ethics is very useful (n=135, 67%) or useful (n=60, 30%), with very few respondents thinking it was a little useful (n=5, 2%) or not useful (n=1, 0%) to their everyday work. There was a split between respondents who thought the amount of ethics training for their professional role was too little (n=101, 50%) and about right (n=98, 49%). Only 1% (n=2) of respondents thought they had too much ethics training.

On a scale of 0 to 100 with 0 as strongly disagree, 50 as neutral and 100 as strongly agree, respondents felt adequately prepared to face ethical dilemmas (mean 66, SD 24), but wanted more training in public health ethics (mean 73, SD 22) and to be able to access more resources in public health ethics (mean 75, SD 22). The resources that respondents would find useful include collection of ethics frameworks for public health (n=151, 75%), collection of practical cases or case studies (n=144, 72%), short documents that clarify ethical concepts, highlight issues and provide guidance documents (n=145, 72%), conferences, workshops or courses in person (n=116, 58%), online courses or modules to follow at your own pace (n=107, 53%), and collection of links to journal articles about public health ethics (n=105, 52%). The only resource option that had less than 50% of respondents chose it was interactive webinars (n=78, 39%), and very few participants thought that none of these options would be useful (n=2, 1%) or offered other resource suggestions (n=7, 3%).

# Discussion

## Key Messages

1. **Ethics is an optional extra for some Schools of Public Health**
   There is considerable variability in ethics education and training in institutions and the workforce. Whilst some schools have compulsory public health ethics modules or a substantial amount of ethics teaching integrated into other modules in a master's degrees, a minority appear to treat public health ethics as an extra rather than core content, with some schools having no ethics teaching, minimal ethics teaching integrated into other modules, elective rather than compulsory courses, or formative only rather than summative assessment of ethics. Although direct comparisons are difficult, given the low response rate, these results suggest that fewer ethics teaching in schools of public health has not progressed, and may have even deteriorated, since the previous ASPHER survey in 2012 (Aceijas et al., 2012), despite progress in developing model curriculums (See for example Schröder-Bäck et al., 2014)

2. **There is an ethics training gap in continuing professional development**
   Half of EUPHA respondents had not received any ethics training in the last five years. Those that had or thought it would be hard to do further training in ethics predominantly thought this because there is not much available, and respondents want more resources in this area.

3. **Public health ethics education is a poorly defined field**
   The ethics topics taught by schools of public health and that EUPHA members received education and training in include some topics that are more specific to medical ethics, rather than public health ethics, including the four principles of medical ethics. This may reflect that training in ethics for public health practitioners can be prior to their public health career, for example in medical or nursing clinical training. This is problematic, as public health ethics is increasingly defined as its own field with "values that differ in morally relevant ways from values that define clinical practice and research" (Kass, 2001) and not just an subfield of medical ethics.

4. **There is a lack of ethics expertise and support**
   There is a lack of staff qualified to teach ethics in the Schools of Public Health surveyed, with approximately half having no staff members with postgraduate qualifications in ethics. Many EUPHA respondents had access to a research ethics committee as would be expected given the high proportion of respondents working at universities, but other ethics tools or processes were less common. It was unsurprising therefore that over forty percent of ASPHER respondents thought there was too little ethics teaching in their courses and fifty percent of EUPHA respondents thought that they had too little ethics training for their professional role.

5. **Public health professionals perceive they have a good understanding of, and response to ethical dilemmas in their professional lives**
   Despite these gaps in ethics education and training, EUPHA respondents appreciate the importance of ethics in their practice, perceive that they can identify ethics dilemmas, and the majority identify as "OK" about making ethical decisions. This may be because many professionals that come into public health already follow ethical codes of practice of their prior professions, such as medicine, nursing, or other healthcare professions and may be confident in these. However, as not all public health professionals start from a clinical background, and decisions in public health include population level decisions with potentially major impacts (Potter, 2015), it cannot be assumed that this confidence indicates sufficiency in training.

# Conclusion

This survey presents a rich dataset that updates knowledge and understanding of ethics education and training in ASPHER organisations and EUPHA members. It highlights that there are wide variations in ethics teaching styles, volume, content and perspectives between institutions and individual practitioner experiences. There are opportunities for strengthening ethics education and training in master's degrees as well as a need for ongoing professional development in ethics, which can be achieved by working in partnership through organisations including EUPHA and APSHER. To ensure ethically reflective and sensitive public health practitioners, access to ethics education should be available to all public health professionals.

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