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COMMENTARY

Mandating Health Behaviors – How Far Should It Go?

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ABSTRACT

Using Smoke-Free and Tobacco-Free policies on college and university campuses as an example this article discusses these initiatives in the context of the role of health educators and health education programs. Issues raised are ones that health educators need to consider in any intervention effort. While the importance of intervention is well recognized, what interventions to implement are less clear and raises important philosophical, ethical and practical questions relating to issues such as individual freedom, personal autonomy, beneficence, paternalism and collective good. This article attempts to identify and discuss these issues within the context of ethical principles and the Responsibilities and Competencies for Health Education Specialists and the Health Educator Code of Ethics. It also extends the discussion to another area of concern – obesity.

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Background

Major chronic diseases and illnesses such as cardiovascular disease, cancer, diabetes, cirrhosis, Alzheimer's/dementia. are a major public health challenge. By definition, chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention and/or limit activities of daily living or both.[1] Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US. They are also leading drivers of the nation's $3.5 trillion in annual health-care costs in 2017.[2] In 2014, 60% of Americans had at least one chronic condition, and 42% had multiple chronic conditions.[3] Ninety percent of the nation's annual health expenditures are for people with chronic and mental health conditions.

Health-damaging behaviors, particularly tobacco use, lack of physical activity, and poor eating habits, are major contributors to the leading chronic diseases.[4] The importance of interventions to address these health-damaging behaviors in an effort to prevent or delay the onset of major chronic diseases is well recognized since "Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear."[5]

Philosophies guiding educational interventions

There is no one definition of health education. Rather, Health Education has been defined in many ways by different groups, authors and experts. The World Health Organization defines Health Education as "any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes."[6] Green defines Health Education as "a combination of learning experiences designed to facilitate voluntary actions conducive to health."[7]

A variety of approaches are available to health educators involved in intervention efforts. Often the preferred method is a reflection of a person's philosophy[8] or the organization for which they work. Welle, Russell, and Kittleson conducted a study and identified five dominant philosophies that emerged over the past half-century.[9] These included 1) a behavior change philosophy using goal setting, behavioral contracts, and self-monitoring to encourage a person to adopt a healthy behavior instead of an unhealthy one, 2) a cognitive-based philosophy focusing on the acquisition of accurate factual information, 3) a decision-making philosophy by having the individual develop skills emphasizing critical thinking to analyze and address health-related decisions, 4) the freeing functioning philosophy proposed by Greenberg[10] as a reaction to traditional approaches of Health Education that run the risk of "victim blaming" for engaging in health behaviors that were either not in their best interests or out of their control. The emphasis of this philosophy is to free people to make the best health decisions for themselves that do not harm others based on their own needs and desires and not that of society, and 5) the social change philosophy

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that emphasizes the role of Health Education to create, social, economic and political change that improves the health of individuals, groups or communities, such as no smoking in bars, restaurants or public places, mandating helmets for motorcycle or bicycle riders, or airbags or child restraint seats in cars.

An interesting finding from the study was that, in many cases, respondents changed their philosophy depending on whether it was a school, community, worksite or medical care settings.

A key question for health educators is whether the intended behavior is based on voluntary or mandated compliance. All of the above philosophies are based on voluntary compliance with the exception of social change, where the emphasis is on improving health through mandating behavior via rules, regulations or laws including some level of enforcement. This creates some interesting issues, especially when the affected behavior is one limited to the individual and causes no immediate or direct harm to others. For example, smoke-free laws directed at preventing harm to others due to second-hand smoke or mandating car child restraint seats to protect children are consistent with preventing harm to others. However, the situation is less clear when the intended program outcome is directed at the individual. A case in point is the implementation of Smoke-free or Tobacco-free initiatives on college campuses and elsewhere. This article discusses Smoke-free or Tobacco-free initiatives in the context of the role of health educators and Health Education programs. Issues raised are ones that health educators need to consider in any intervention effort.

While the importance of intervention is well recognized, what interventions to implement is less clear and raises important philosophical, ethical and practical questions relating to issues such as individual freedom, personal autonomy, beneficence, paternalism and collective good. This article attempts to identify and discuss these issues within the context of roles and responsibilities of health educators, as well as ethics, using smoking and tobacco use on college/university campuses as an example.

Smoke-free and tobacco-free issues on college/university campuses

Most local and state Smoke-free laws do not include college or university campuses, although some states do include state schools in their Smoke-free workplace laws. There is strong public support, including among smokers, of the need to protect employees and students from exposure to secondhand smoke. According to a survey from CVS Health, there is strong public support for smoke- and tobacco-free campus policies.[11] Results show that three in four Americans (73%) and eight in 10 current U.S. college students (78%) indicated support for policies that prohibit smoking and other tobacco use on college campuses.

This has led many campuses to eliminate secondhand smoke exposure which also may ban "vaping" or the use of electronic cigarettes that emit nicotine vapor instead of smoke. Other intended outcomes of Smoke-free policies are to facilitate social norm changes around smoking that harm others as well as to encourage preventing smoking initiation and promoting cessation. Many campuses going Smoke-free also have included programs to assist smokers wanting to quit. Of the roughly 20 million college and university students in the United States,[12] more than 1 million are projected to die prematurely from cigarette smoking.[13,14]

Given the damaging effects of tobacco and the fact that 99% of smokers start by age 26, prevention efforts focused on youth and college students are crucial.[15,16] Smoke-free initiatives on campuses and elsewhere generally have been well-received[17] with high compliance and minimal enforcement. Given the realization that tobacco use and not just smoking tobacco is the leading cause of preventable deaths in the United States via cancer, lung and heart disease and stroke, many campuses have gone further and instituted tobacco-free policies. While encompassing all the elements of smoke-free, tobacco-free includes all smokeless tobacco products from chewing tobacco to dissolvable tobacco "orbs" and strips. The ban would apply to students, faculty, other employees and visitors to campus, as well as any tobacco use, including smokeless tobacco, in private vehicles parked on campus property. There are now at least 2,279 100% Smoke-free campus sites. Of these, 1,910 are also 100% tobacco-free, 1,886 also prohibit e-cigarette use, 960 also prohibit hookah use, and 386 also prohibit smoking/vaping marijuana.[18] Aside from the practical difficulty of how a tobacco-free policy will be enforced, given that smokeless tobacco is less visible than cigarettes or e-cigarettes, there are a number of fundamentally more important issues that need to be considered. These include the following.

Autonomy

By definition, personal autonomy is, at minimum, "self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."[19] Simply stated, autonomy is the freedom to act or function independently without external controlling influences.

Personal autonomy is widely and highly respected in our and many societies.[20] Recognition of its vulnerability in health-care contexts led to the inclusion of respect for autonomy as a key concern in biomedical ethics.[21]

Respect for autonomy is one of the fundamental commonly accepted principles of health-care ethics.[22] This includes allowing or enabling patients to make their own decisions about what care they receive or not receive.[23]

However, autonomy is not without limitations. Under certain circumstances, restrictions can be justified.[24] Some believe that there can be justifications for violations of the principle of autonomy. Known as the Harm Principle, it was first articulated by John Stuart Mill when he said, "That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[25] An example would be confining a person with a highly contagious disease against their will. Other justification for violations of the autonomy principle would be intervening to stop a suicidal person from self-harm against their wishes (Paternalism Principle), prohibiting or requiring behavior based on society's collective judgment of whether it is moral. Examples would be mandating children to be immunized over their parents objections, or anti-gambling or anti-prostitution laws (Legal Moralism Principle) or fluoridation of public water supplies for the benefit of the community against the objections of some residents known as the Welfare (Social Benefit) Principle.[26]

Application to smoke-free and tobacco-free

Smoke-free laws, policies or rules impose limitations on smokers due to the demonstrated risk and harm caused ***to others*** from secondhand smoke in workplaces, public buildings, restaurants and bars, and cars with other people, especially children. Because of the potential harm, smoke-free policies in these and similar settings, there is strong public support[27] and high voluntary compliance by both smokers and non-smokers. However, Tobacco-free is not consistent with personal autonomy when imposed in the absence of demonstrated harm **to others** such as using chewing tobacco or smoking alone in a vehicle. Tobacco-free rules implemented to protect the user alone are not only inconsistent with autonomy but are weakly supported by other justifications for violations of the principle of autonomy.

Beneficence

Beneficence refers to all forms of action intended to benefit or promote the good of other people, including often by preventing or removing possible harms.[28] Beneficence can include protecting and defending the rights of others, especially vulnerable populations such as children, disabled, and people in abusive relationships, homeless, immigrants or incarcerated. It also can include assisting or rescuing persons who are in danger from natural or man-made causes such as floods or fires. In clinical application, health-care providers not only are expected to refrain from causing harm, but they also have an obligation to help their patients. Examples of beneficent actions by health educators would include assisting smokers to quit, a nutrition program to promote more healthful eating or weight loss, encouraging people to improve fitness through an exercise program, increasing helmet use for motorcycles and bicyclists, speaking to the community about opioid prevention, or working with a park district to develop increased opportunities for citizens to exercise, such as paths for walkers, joggers, and bicyclists. With respect to smoke-free and tobacco-free, health educators or other advocates can explain and justify their actions on the basis of beneficence since their efforts are intended to benefit others based on the demonstrated harm of tobacco use and second-hand smoke.

Balancing autonomy and beneficence

Difficult ethical issues arise when a person's autonomous decision conflicts with the health educator or health provider's beneficent duty to act in the person's best interests. For example, a patient who has had a heart bypass or lung cancer surgery may want to continue to smoke or a patient with pneumonia may refuse antibiotics. An obese person may not be receptive to dietary modification or participating in an exercise program. In these situations, the autonomous choice of the individual clashes with the health educator or health provider's beneficent responsibility, and following each ethical principle would lead to different actions. As long as the person meets the criteria for making an autonomous choice (the person understands the decision and is not basing the decision on delusional ideas), the person's decision should be respected regardless of the educator or provider efforts to educate and encourage the person to do otherwise. With respect to smoke-free, beneficence trumps autonomy since the second-hand smoke poses a harm to another individual. However, with respect to tobacco-free, one could argue that **autonomy surpasses beneficence** in instances where the potential harm of smokeless tobacco or smoking alone in a person's automobile is limited to the individual.

Paternalism and autonomy

Another ethical issue relevant to smoke-free and tobacco-free efforts arises between the concepts of paternalism and

autonomy. Paternalism is the policy or practice on the part of people in positions of authority of restricting the freedom and responsibilities of those subordinate to them in the subordinates' supposed best interest. It can be an action performed with the intent of promoting another's good but occurring against the other's will or without the other's consent.[29] Violations can range from admonition, fines, loss of privileges, expulsion or incarceration. Paternalistic actions can be based on norms or policies backed by formal or legal rules and regulations.[29] Paternalism is not based on the action itself but by the justification given for the action. It restricts a person's freedom against their will "for their own good".[30] In contrast, respect for autonomy prohibits such interventions because they involve a judgment that the person is not able or willing to decide for themselves how best to pursue their own good.

Examples of paternalism are abundant in everyday life and include laws that require seat belts, wearing helmets while riding a bicycle or motorcycle, not using a cell phone while driving and banning certain drugs. With respect to the latter, states treat the same drug differently. For example, in some states marijuana use is a crime. In others, it can be used for medically approved conditions, while others allow recreational use.

Putting it altogether

It is easy for health educators to advocate for and support smoke-free efforts on campuses or elsewhere based on the demonstrated harm to others of second-hand smoke. However, the same does not appear to be justified with respect to supporting mandated tobacco-free policies. While supporting tobacco-free is consistent with the principles of beneficence and the Welfare (Social Benefit) Principle, it also is paternalistic and inconsistent with autonomy. As one university student non-tobacco user who supports a smoke-free but not tobacco-free campus said, "Smokeless tobacco is dangerous but the toxins do not reach anyone in the university. Banning something with no real negative impact on the community is paternalistic."[31] Moreover, except for the social change philosophy, it is inconsistent with other Health Education philosophies, and especially the freeing functioning philosophy proposed by Greenberg[10] that are based on voluntary action by the person.

Applying ethical principles to another situation

Strong public support for smoke-free and tobacco-free policies is, in part, due to the fact that the vast majority of the public are currently non-smokers. Smokers represent a declining minority of the population. In 1965, just after the release of the first Surgeon's Report on Smoking and Health, 42.4% of the adult population (51.9% of males and 33.9% of females) 18 years and older smoked.[32]

Recent data from the CDC's National Center for Health Statistics (NCHS National Health Interview Survey (NHIS)) indicate that among U.S. adults ages 18 and older, the U.S. adult smoking rate reached an all-time low of about 14% in 2017. An estimated 14% of U.S. adults (34 million) were current ("every day" or "some day") cigarette smokers in 2017 – down from 15.5 in 2016 – a 67% decline since 1965.[33] Thus, given the dramatic reduction in smoking, it is easy to see why not only smoke-free but also tobacco-free would have public support. However, does that justify health educators advocating for that policy instead of advocating and developing policies based on voluntary compliance when the harm is to the individual user and not the population?

For argument sake, let's agree that it does. Then consider the following situation for the same health educator. Just as the campus has recently gone tobacco-free, should a health educator support a mandated program proposal to reduce obesity for students and staff on campus? Clearly, obesity (BMI of 30.0 or higher), like tobacco use, is well documented as a significant public health problem.[34] A 2017 *Journal of Nutrition Education and Behavior* report found that during four years of college, the percentage of students overweight or obese rose from 23% to 41% – a 78% increase.[35] Given its prevalence in the population, it could be an even greater health problem than tobacco use. Health risks associated with obesity include heart disease and stroke, high blood pressure, diabetes, some cancers, gallbladder disease and gallstones, osteoarthritis, gout, and breathing problems such as sleep apnea. As such, for example, should campus residence halls, using accepted measures to determine obesity, mandate nutritional protocols such as how much food and what foods are allowed for obese individuals regardless of their expressed desires? Should caloric, fat, sugar, vegetables and meat and dairy targets be determined and enforced? Should obese people be banned from desserts? Should the campus be beneficent by offering educational programs to promote healthy eating? More importantly, should obese people be enrolled in mandatory educational programs aimed at promoting healthy eating and activity programs? Should there be weekly or monthly monitoring such as mandatory weigh-ins? What corrective action, if any, should be implemented? Control of quantity or types of foods? Fines for non-compliance? Probation for repeat offenders? Given the concern for a healthy campus environment, should these mandates be expanded to include employees, since employees are a vital component of

a health campus community? Should mandated education or fines be instituted? Should there be pay reduction for non-compliance? Suspension or loss of job? How well would that mandate be received by the student or staff population?

Nonsense you say. Quite possibly. But the example above is presented solely to generate discussion by health educators and others on policies and programs which, while may be well intentioned, mandate behavior focused on harm caused only to the individual while discounting the importance and respect for personal autonomy.

Health educator code of ethics and responsibilities and competencies for Certified Health Education Specialists

In considering the above issues, it may be helpful to do so in light of the health educator Code of Ethics and Responsibilities and Competencies for Certified Health Education Specialists. The Code of Ethics provides a basis of shared values that Health Education is practiced. According to the Preamble of the Code of Ethics, the responsibility of all health educators "is to aspire to the highest possible standards of conduct and to encourage the ethical behavior of all those with whom they work."[36] Responsibility to the public is clearly spelled out in **Article I: Responsibility to the public**.

> *A health educator's ultimate responsibility is to educate people for the purpose of promoting, maintaining and improving individual, family and community health. When a conflict of issues arises among individuals, groups, organizations, agencies or institutions, health educators must consider all issues and give priority to those that promote wellness and quality of living through principles of self-determination and freedom of choice for the individual.*

Additional insight can be found in the Responsibilities and Competencies for Certified Health Education Specialists. The core seven areas of Responsibilities along with their Competencies, and Sub-competencies provide a comprehensive description of the profession, illustrating the skills necessary to perform the daily tasks as a Certified Health Education Specialist. That document includes 11 references to the word ethical.[37] Key provisions include:

Area III: Implement Health Education/Promotion

3.1.5 Apply ethical principles to the implementation process

Area V: Administer and Manage Health Education/Promotion

5.5.10 Adhere to ethical principles of the profession

Also relevant is:

Area VII. Communicate, Promote, and Advocate for Health, Health Education/Promotion, and the Profession. Specifically,

7.2 Engage in advocacy for health and Health Education/Promotion

In conclusion, the purpose of this Commentary is not to provide a definitive answer. Rather, it is intended to raise the issue that health educators need to be aware not only of actions done with the intent of beneficence but also to be respectful of autonomy and avoid unwarranted and unjustified paternalism. It is also intended for health educators to consider any action in light of the Code of Ethics and consistent with the Responsibilities and Competencies for Certified Health Education Specialists. Health educators need to remember that, despite the best of intentions, they are educators, not moralists or missionaries.

Disclosure statement

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