

THE MORAL OBLIGATION TO PROMOTE YOUR OWN HEALTH

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Abstract

The intersection of health and morality have been debated for ages. In this thesis, I argue that health is in fact part of morality and, further, that we are morally obligated to promote our own health. I show how the moral obligation to promote one's health can be derived from two classical ethical theories, Aristotle's virtue ethics and Kantian deontology. Despite the stark foundational differences in these theories, both focus on self-perfection, produce moral obligations to the self, and create moral burden that admits of latitude – all characteristics that I argue are true of the moral obligation to promote one's health.

Perhaps most alarming is that we cannot, based on the current structure of our society, be held morally responsible for promoting our health because we have insufficient control over our health-related behaviors. I use the food environment as an example of the consumer's lack of control over her food choices. In the final section of this thesis, I argue that we as a society have a collective responsibility to create the conditions necessary for individuals to be held morally responsible for promoting their own health.

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The Moral Obligation to Promote Your Own Health

Many people try to be healthy at least some of the time. Just turn on the television and you will see numerous commercials about weight loss regimens or smoking cessation techniques. Our society even moralizes health and healthy behavior. Think of junk food, for example, and how it has a reputation as evil and those who consume it sinful. But are health and healthy behaviors matters of morality? I believe they are. In this paper, I will argue that individuals have a moral obligation to promote their own health and that this obligation is inward-facing. Even though there are outward-facing obligations of health, such as not being a burden on society, people owe it to themselves, first and foremost, to promote their own health.

First, I will provide a definition of health that is compatible with my argument that we have a moral obligation to promote our own health. Then I will defend my argument by situating it in Kant's and Aristotle's ethical theories, and by providing a historical analysis to highlight commonalities in thinking during the times these theories were developed. From Kant's theory, the moral obligation to promote our health can be derived from the duty to cultivate one's own natural powers of the body, spirit, and soul, while this moral obligation can be derived from the virtue of temperance in Aristotle's theory. Next, I will highlight some aspects of the moral obligation to promote your health that can be seen in both Aristotle's and Kant's theories, including self-perfection, a moral obligation to oneself, and moral burden that allows for latitude. After establishing my argument, I will respond to some obvious objections, such as that health is an obligation to others and that attributing moral responsibility for health causes shame and blame. Finally, in recognition of the opposing views as to how we can pursue health and who is responsible for pursuing such an end, I argue that for an individual to be held morally

responsible for promoting her own health, the conditions necessary for her to pursue this end need to be created and we have a collective responsibility to create such conditions.

First, I must address what health is. The traditional medical definition of health as the absence of disease seems too narrow a conception to capture all that health is. The World Health Organization recognized that this definition was too narrow and defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (100); this is the definition of health that I adopt for my argument. It is important to recognize that health is not an endpoint, nor a certain set of conditions that one must meet to be considered healthy. While not all people start off at the same base level of health, everyone can engage in behaviors to promote their health. Thus, I have framed my argument as a moral obligation to *promote* one’s health, rather than a moral obligation to *be healthy*.

I have held the idea of health promotion in mind while creating this argument. Health promotion is “the science and art of helping discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health” (O’Donnell iv). Health promotion evolves as our understanding of health expands. As Cheek pointed out, “being healthy increasingly means embracing a range of lifestyle choices and technologies that once would have been considered at the periphery of health, if indeed part of it at all” (975). Cheek gave the examples of cosmetic surgery and sexual enhancement drugs to demonstrate activities that are not traditionally lumped into the category of health but are now acknowledged as health promoting activities (975). With a definition of health and health promotion in mind, I can move on to my main argument that we have a moral obligation to promote our health. But first, it may

be helpful to briefly overview Kant and Aristotle's theories to help ground the moral obligation to promote your own health.

Kant and Aristotle's Ethical Theories

Kant's Deontological Theory. Kant created a theory of right action based on his Categorical Imperative, which he described in three formulations known as universal law, humanity as an end in itself, and the kingdom of ends. For the sake of my argument, I will focus on Kant's second formulation which states, "So act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means" (qtd Timmons 212). This formulation of the Categorical Imperative focuses on "protect[ing] and promot[ing] one's own humanity and the humanity of others" (Timmons 214).

Two general duties can be derived from the Categorical Imperative: the duty of self-perfection and the duty to promote the happiness of others. We have a duty to perfect ourselves because, as humans with the capacity to set ends (i.e. autonomy), we need to "develop certain powers that would enable us to effectively set and pursue ends of our choosing," which is essentially perfecting ourselves (Timmons 214). From the derived duty of self-perfection, Kant derives more specific duties to oneself regarding one's self-perfection; these are broken down into duties to promote our natural perfection and our moral perfection. Duties to perfect oneself as a natural being include the duty to not commit suicide and the duty to cultivate one's natural powers of the spirit, soul and body. The first example to not commit suicide represents a perfect duty because it must be obeyed in all situations, while the second example to cultivate one's natural powers is an imperfect duty because it admits of some latitude in how an agent acts on that duty (Timmons 216). So, for this imperfect duty, it is up to the moral agent as to which ones,

how, and to what extent he wishes to cultivate his natural powers. A general pursuit of health falls under the category of cultivating one's natural powers of the body. Therefore, it is through the imperfect duty to cultivate one's natural powers that the obligation to promote your own health can be derived.

Aristotle's Virtue Ethics. Aristotle's *Nicomachean Ethics* states that every action is done for some end or good. These ends are arranged as a hierarchy such that lower ends are pursued for how they contribute to higher ends, and higher ends are things that are pursued as ends in themselves (Aristotle 3). The highest end, however, is "an end for which all other ends are pursued, which is pursued for itself, and which is never pursued as a means to any other end" (Timmons 270); Aristotle argued that this highest end is eudaimonia (Aristotle 5), commonly translated as human flourishing, because it is unconditionally complete and self-sufficient (Timmons 270). Humans can achieve eudaimonia through an understanding of our purpose; in other words, by knowing the function of a human being, we can understand what we are supposed to do (Aristotle 10). Aristotle wrote that "the function of man is an activity of soul which follows or implies a rational principle," since our rationality is that which sets us apart from other living things (11). Furthermore, the actions that man engages in should be "performed in accordance with the appropriate excellence," thus, "human good turns out to be activity of soul in accordance with virtue" (11). In this way, Aristotle linked virtue as essential to achieving eudaimonia.

Aristotle defined moral virtue as "a state of character concerned with choice, lying in a mean.... between two vices, that which depends on excess and that which depends on defect," while virtue is the intermediate (27-28). For example, courage is a virtue because it falls between rashness (excess) and cowardice (deficiency). Virtues are developed through practice,

i.e. we develop the virtue of courage by acting courageously (Aristotle 21). Much of the rest of *Nicomachean Ethics* is spent discussing particular virtues, but I will be focusing on temperance for the purpose of my argument.

Aristotle defined temperance as “a mean with regard to pleasures” (Aristotle 49). This virtue is unique because the corresponding vices typically happen in only one direction, the excess – over-indulgence. Aristotle focused on bodily pleasures, i.e. food, drink, and sex, (as distinct from pleasures of the soul) as the main forms of over-indulgence. He considered these particularly depraved because they are pleasures shared with animals (50); in other words, men over-indulging in these actions are not behaving as humans but as non-rational animals (Hughes 84). Aristotle believed that the virtue of temperance is important to maintain one’s health, particularly in terms of food, drink and sex. He said the temperate man will desire food, drink, and sex that “make for health or good condition... and also other pleasant things if they are not hindrances to these ends” (Aristotle 52). This is not the only example where Aristotle tied temperance to health, for example, earlier in *Nicomachean Ethics* he stated, “drink or food which is above or below a certain amount destroys the health” (22). It is through the virtue of temperance that it is possible to derive an obligation to promote your health. Aristotle might not have considered health itself a virtue, but he clearly considered it an important end.

Historical Analysis of Health. The moral obligation to promote our own health can be situated in both Kant’s and Aristotle’s ethical theories. For Kant, this obligation derives from the imperfect duty of self-perfection, and for Aristotle, from the virtue of temperance. From a historical analysis of ancient Greek culture and Enlightenment ideas, one can see that it is possible for an obligation to one’s health to fit into these two theories.

The ancient Greeks recognized the value of health. One of the earliest mentions of *hygieia* (good health) was in Greek poetry. Theognis, a Greek poet who lived during the 6th century BCE wrote, “The fairest thing is the most righteous, the best thing health, and the sweetest to have our heart’s desire” (Bartos 17). Aristotle mentions a version of this poem inscribed at Delos: “Most noble is that which is justest, and best is health; But pleasantest is it to win what we love” (Aristotle 13). The Greeks honored good health in the form of the goddess Hygieia, who was seen as “good health personified”; worshipping Hygieia was tied together with the pursuit of good health (*hygieia*) in Greek culture (Wilkins 136). Bartos described the emerging value of health in the 6th century as “one of the most appreciated and widely accepted values of human life, and once its value was recognized its validity remained more or less unchallenged throughout antiquity” (17).

The concept of health as *hygieia* from ancient Greece carried over into the Enlightenment with the expansion of the medical branch of hygiene. According to Vila, “Medical writers sometimes promoted hygiene as a means of attaining greater enlightenment” (206). In other words, the emphasis on hygiene was seen as a way in which individuals could achieve greater perfection (Purnell 46). For example, a general theme in two Enlightenment works, *Medicine of the Mind* and *Essay on the Means of Perfecting Humanity*, was that “human beings were perfectible in mind and body, and they could therefore be transformed into healthier, more virtuous and more intelligent beings” (Vila 206). Some Enlightenment thinkers even thought the perfection of man was infinite (Condorcet 4).

Both ethicists were creating their moral theories during times when health was a prominent value, so it is reasonable to conceive that Aristotle and Kant placed a similar value on health. The obligation to promote one’s own health can be derived from these two drastically different

theories developed centuries apart and may fit into other ethical theories as well. Regardless, a historical analysis of health can shed light on nuances of health and how it is understood in connection to morality.

Aspects of the Moral Obligation to Promote your Health

Self-Perfection. The basis of the moral obligation to promote your own health is self-perfection. Kant's and Aristotle's theories lend themselves well to my argument because both theories generate an ethics of self-perfection, even though they do so differently.

Aristotle's virtue ethics is considered a perfectionist value theory. Perfectionist theories establish "an objective account of the good" and then create "an account of ethics and/or politics that is informed by this account of the good" (Wall). Aristotle's objective good is eudaimonia or human flourishing (Aristotle 5). The way to achieve this good life is by developing our human nature (Wall), which is done through the use of "the rational part of the soul" (Dorsey 62) "in accordance with virtue" (Aristotle 11). Thus, one can achieve self-perfection by developing their virtues, and, as I have argued, the obligation to promote your health can be derived from the virtue of temperance.

Kant, on the other hand, created a theory with self-perfection as a main component. According to the humanity formulation of Kant's Categorical Imperative, respect for persons as ends in themselves is the "supreme principle of morality" (Timmons 211), and for each duty that Kant discusses he "appeals to considerations of respecting one's own humanity" (Timmons 216). Kant wrote that, for duties toward oneself,

It is not enough that the action does not conflict with humanity in our person as end in itself; it must also harmonize with it. Now in humanity there are predispositions to greater perfection, which belong to ends of nature in regard to the humanity in our

subject; to neglect these would at most be able to subsist with the preservation of humanity as end in itself, but not with the furthering of this end. (Kant 48)

Therefore, a person who acts to increase her self-perfection, one aspect of which is health, is actually respecting herself.

Moral Obligation to Yourself. The moral obligation to promote your own health is an obligation to yourself. Obligations to oneself “have to do with the ways in which a person comes to a realization of his own self-worth. It is the understanding of his own nature as the source of moral worth that lies at the root of a person’s duties to him/herself and which makes morality possible” (Paton 233). While the use of the word “duty” evokes Kantian language, moral obligations to oneself are characteristic of perfectionist ethics (Wall) and fit into Kant’s and Aristotle’s theories as a way of respecting oneself and as a way of living one’s best life, respectively.

For Kant, duties to the self “cannot be established on the grounds of our moral interaction with others...nor can they be reduced to considerations of the agent’s own long-term well-being” (Timmermann 508). While health is one sense of a person’s well-being, the promotion of one’s health can be raised to the level of a moral obligation since its promotion “foster[s] the realization of one’s worth as an autonomous being” (Paton 232). Pursuing health, then, is one way in which a moral agent can respect herself.

For Aristotle, the goal is eudaimonia or human flourishing, which is achieved through living in accordance with virtue. “Virtues of character are necessary to lead such a life on the grounds that certain other goods are made possible as a result of the virtues... as such, virtues are both part of the best life for any human, and also a means to certain further features of that life” (Grant 161). One example of a good brought about by virtues is health. Thus, the virtuous life is one of self-perfection, which includes optimal health.

Moral Burden. Components of both virtue ethics and Kantian deontology create moral obligations with similar moral burden. In particular, both theories provide the agent with leeway in regards to how he or she can act in certain circumstances or pursue certain ends. The moral obligation to promote one's own health has the same moral burden in both views, such that you do not have to take every opportunity to engage in health-promoting behaviors.

Kant's deontological ethics includes a system of duties that is composed of perfect and imperfect duties. Whereas perfect or narrow duties include specific actions that we must refrain from doing in all circumstances, imperfect or wide duties are less precise and "require that agents adopt certain ends as general guiding objectives in life" while giving the individual latitude in how to pursue those ends (Timmons 216). As I argued earlier, the obligation to promote your own health can be derived from the imperfect duty to cultivate one's natural powers, which means an individual can choose how and when to promote their own health.

Virtues generate a similar latitude as imperfect duties. Since virtue ethics is an agent-centered theory rather than action-centered, there is no direct line from virtue to action; in determining the rightness or wrongness of an action, we must look to facts about the virtuous agent. Actions are *obligatory* if a virtuous agent would not fail to perform an action in a particular circumstance, and actions are *optional* if a virtuous person might perform an action in a particular circumstance (Timmons 276). From the virtue of temperance, we can arrive at a moral obligation to promote our own health, but this virtue does not generate a strict obligation to act in a certain way. Rather, a temperate person will use her proper judgement to determine when it is appropriate to indulge and when she ought to act to promote her health.

Moral and Personal Responsibility

I have laid out my argument that we have a moral obligation to promote our own health based on Aristotle's virtue ethics and Kant's deontological theory. This obligation is based on self-perfection, is inward-facing, and has a moral burden that does not generate a strict obligation but admits of latitude in how one chooses to promote their health. Since morality has to do with an agent's character or actions, it is the agent who is responsible for his or her moral obligations. For an individual to be held morally responsible for promoting their own health (or failing to do so), they must be able to control their actions.

Moral Responsibility. Discussions about moral responsibility are often confused because they fail to distinguish between distinct types of responsibility. When I use the phrase moral responsibility, I simply mean an agent is morally accountable for doing x ("H. L. A. Hart" 443). Other types of moral responsibility are role responsibility, such as a parent being responsible for their child's welfare; liability responsibility, meaning a person is responsible for the consequences of their action (or lack of action) (Cane 280); and the type of moral responsibility that generates blame for not doing x action (Eshleman).

Moral responsibility is predicated on the fact that an agent has control over his actions (Bobzien 85). This is important when it comes to one's health: some health outcomes are due to one's behavior and some happen randomly. Thus, a person is morally responsible for a health outcome that is due to their behavior (e.g. developing lung cancer from smoking for 15 years) but not morally responsible for a health outcome that occurs by chance (e.g. being born with a genetic disorder like cystic fibrosis). Many illnesses, especially in developed countries, are attributable to lifestyle behaviors (Resnik 444). Wikler described the global shift in illness from transmissible diseases to noncommunicable diseases as an "epidemiological transition... a milestone of development that puts lifestyles at the center of health concerns and that poses

unnecessary risks if the public is not alerted to the links between its living habits and its health” (“Who should be blamed” 54). It is unsurprising then that many people argue for personal responsibility for health, given the impact that lifestyle has on health. At the same time, attributions of personal responsibility for health have been critically assessed, including being critiqued as “healthism.”

Healthism. The concept of healthism was coined in 1980 by Robert Crawford, who defined it as “... the preoccupation with health as a primary – often the primary – focus for the definition and the achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help” (368). He noticed that society was undergoing a change in governance dictated by medicine rather than the church (Turrini 16). Healthism focuses more on lifestyles and their effect on wellness and disease prevention rather than medical interventions, and caused a shift in medicine toward a patient-centered approach, in which the patient becomes responsible for his or her own health. Greenhalgh and Wessely noted several historical and demographic changes that contributed to the rise of healthism, including an increase in life expectancy due to advances in medical technologies, an increase in the medicalization of all facets of life, and a “widespread commercialization of health, with heavy media interest in health topics – leading to a climate of insecurity and alarm about disease” (201). Much of medicine is still structured this way, because, as Chan points out, “patients are increasingly urged to become active and responsible consumers of medical services and products ranging from pharmaceuticals to reproductive technologies and genetic tests” (55).

While it sounds positive that people should be engaged in their own health, healthism has the potential to “distort public health priorities... increase health anxiety through media hype and risk inflation... escalat[e] demands for tests and referrals” (Greenhalgh and Wessely 199-200).

The biggest concern for healthism critics, however, is that morality becomes entrenched in health.

Objections to the Moral Obligation to Promote your Health

Objection 1: Moral Responsibility for Health Causes Shame. Crawford recognized that the phenomenon of healthism created a different relationship between health and morality, such that “individual responsibility entails a process of blaming which generates a new form of ‘moralism’” that equates good health to a good (and moral) life (Turrini 17). Due to the individual’s new-found control over their health, “agents can (and should) be held morally responsible for their health outcomes” (Brown 1).

Because of the relationship between health and morality created by healthism, many people disagree with this viewpoint as it can be used to justify stigmas, shame, and blame for those with less-than-perfect health. For instance, Roberts and Leonard described healthism as “discrimination on the basis of health status” (1) and Skrabanket argued that extreme forms of healthism “provide a justification for racism, segregation, and eugenic control since ‘healthy’ means patriotic, pure, while ‘unhealthy’ equals foreign, polluted” (15).

However, the shame that this health-morality relationship causes may not be as problematic as it may seem. While shame is predominantly considered “inherently maladaptive or pathological,” research by Sznycer et al. suggests that shame is an evolutionary adaptation (2625). Sznycer et al. described this evolution as “an emotion program that evolved to manage the evolutionarily recurrent threat of devaluation due to adverse information reaching others” (2625). Shame influences people to avoid behaviors that result in social devaluation (2626). For example, one study found that a smoking cessation advertisement that appealed to the shame

associated with smoking was effective in motivating smokers to quit smoking (Amonini et al. 441). Therefore, the shame associated with acts that do not promote one's health may be beneficial in the sense that it can motivate an individual to avoid health-harming behavior. Shame evolved as a consequence of our social natures, and, while the moral obligation to promote your own health is an obligation to yourself, health should also be considered as being affected by social conditions and having social effects.

Objection 2: Health is Solely an Obligation to Others. This brings me to the next objection: that the moral obligation to promote your own health is solely an outward-facing obligation to others. Some people simply object to the idea of duties to oneself (Timmerman 515), and others believe that one must promote their health because of the impact health has on other people.

In the world of philosophy, some argue that obligations to the self are absurd and non-existent. With duties to the self, the moral agent is both the subject and the object of the duty. Critics claim that the problem with duties to oneself is that, since the subject and object are one in the same, the agent can release herself from a duty (Hills 133). If an agent can release herself from a duty to herself whenever she desires, "that duty would not be a genuine normative requirement; it would not be a genuine duty at all" (Hills 133). People who believe this reasoning would argue that we cannot have an obligation to ourselves to promote our health because there are no obligations to the self.

That argument is flawed, however, and Timmerman provides two arguments against critiques of duties to the self. First, he says this critique begs the question because "it is hardly obvious that you *can* release yourself from any obligation that you impose on yourself. *If* there are duties to the self, you cannot" (516). But, Timmerman argues, even if you could release

yourself from a duty, “there remains the further question of whether you would be morally justified in doing so, i.e., whether the act of release is a *moral* possibility” (516).

His second argument is based on Kant’s belief of a dual self, “that the binding self and the bound are in some sense distinct” (Timmerman 517). We have a lower self that wants to give in to all our desires and a higher self that is rational and tries to regulate our lower self (518). From a dual-self perspective, the subject and the object of a duty to the self are not the same, therefore, one cannot release oneself from a duty. The philosophical objection to the inward-facing element of the moral obligation to promote one’s own health is flawed.

Now, the social objection, as I refer to it, that the obligation to promote one’s health is not inward-facing is based on the effects health has on other people and society. Howson claimed that “the individual pursuit of health forms a central aspect of the expression of social membership and good citizenry” (406). The main argument is that individuals “should keep themselves healthy so that they can avoid becoming dependent, and they must do whatever is in their power to prevent illness which could burden others with the costs of care” (Wikler, “Who should be blamed” 12). The financial strain on the healthcare system caused by people with lifestyle-related illnesses is the main motivation behind this argument (Wikler, “Personal and social responsibility” 47).

However, the causal relationship between a person’s unhealthy behaviors and the financial strain on the healthcare system and others members of society is not clear-cut. Wikler described how this relationship does not fit with the structure of our society:

In a system in which all citizens were covered by universal health insurance, and in which the decision to seek medical health through the national plan was mandatory, the relationship would be straightforward. If I take a risk with my health and become ill as a result, if I am made to see a doctor, and if you are made to pay for it, then my decision has affected your pocketbook. However, these conditions do not hold in our society. There is considerable social investment in health care institutions, and it might be true that less investment would

be required if everyone took care of themselves; but this makes the relationship between an individual's taking on health risks and another's becoming financially burdened much less direct than seems to be assumed in much of the literature. ("Who should be blamed" 18)

Individual risky behavior does not necessarily directly equate to others financing the cost of care associated with those risky behaviors.

Furthermore, the assertion that the moral obligation to promote one's health is an outward-directed obligation because of healthcare costs to others deals with a different sense of moral responsibility. Just because one may have liability responsibility, or responsibility for "the cost and other undesirable consequences of being sick" (Wikler, "Who should be blamed" 12), does not mean that the person has moral responsibility for their actions. As a philosophical matter, moral responsibility does not necessarily entail liability responsibility and vice versa (although the two notions may often be linked in people's minds).

Collective Responsibility to Create the Necessary Conditions for Moral Responsibility

I have argued that the moral obligation to promote one's health is an obligation to the self. As such, we do not have an obligation to promote another's health, nor can we compel another individual to promote his health. However, "we can work to ensure that others live under conditions that are conducive to their own self-[perfection]. Indirect promotion may be possible where direct promotion is not" (Wall). Unfortunately, our society is not indirectly supporting the promotion of one's health because our social environment is one that limits the control a person has over her choices. Therefore, I argue that we as a society have a collective responsibility to create the conditions necessary for people to have enough control over their health-related behaviors that they can discharge their moral obligation reliably.

A necessary condition for moral responsibility for an action, as I stated earlier, is that people must be able to have enough control over their actions that they can perform the action in question reliably. The conditions for appropriate control are not met in our society, thus people cannot be held morally responsible for promoting their own health. The food environment provides a useful example of the lack of control consumers have over their food choices.

People's food choices are affected by environmental cues (Thaler and Sunstein 3), such as package size, plate size, and even atmospherics like lighting, but many people are unaware of the environmental factors that contribute to their unhealthy eating habits (Wansink, "Environmental Factors" 456). For instance, environmental cues greatly influence our consumption volume decisions, in other words, how much we eat (456). Consumption volume is manipulated by consumption norms, such as larger packages, portions, and dining ware, that "suggest to us that it is more appropriate, typical, reasonable, and normal to serve and to eat more food than packages or smaller plates would instead suggest" (Wansink, "Mindless Eating" 455). Since people are influenced by environmental cues and are unaware of this influence, the ability to control their behavior in line with informed choices is undermined. Thus, people lack the relevant control over their food behavior to ground moral responsibility.

Given that our current environment is saturated with cues that push people in unhealthy directions and people are consistently unaware that these cues affect their behavior, these unhealthy cues are essentially limiting people's control by impeding them from making healthy choices. For example, many Americans have health-conscious attitudes and try to consume protein, fiber, whole grain, and vitamins and avoid packaged foods, sodium, sugar, and saturated fat, (International Food Information Council Foundation 36-37) but even with healthy intentions, overall consumption of fruits and vegetables has decreased by 7% since 2009 (Produce for Better

Health Foundation 5). The fact that people's eating behavior does not match their intentions suggests that these environmental cues undermine their control over eating behavior. Therefore, altering the environment to remove these unhealthy cues, possibly even converting unhealthy cues to healthy nudges, would remove an unhealthy influence over people's behavior and increase their control, allowing them to be held morally responsible.

Restructuring the environment to promote healthy behaviors would address personal behavior and support personal responsibility. Furthermore, these new healthy nudges would promote healthy behavior rather than restricting unhealthy behavior, adding to an individual's control. Once people are given the appropriate amount of control over the choices related to their health-behaviors, they can be held morally responsible for discharging their obligation to promote their health. It is part of our collective responsibility to ensure that people can carry out their moral obligations.

While health is impacted by social conditions and impacts society, the moral obligation to promote your own health is, at its core, an obligation to yourself. This is an imperfect obligation in that it admits of latitude when and how and individual can act to promote their health, and this obligation is based on self-perfection. Even though Aristotle's and Kant's ethical theories are drastically different, both create an ethics of self-perfection, generate similar moral burden, and give accounts of obligations to oneself. The moral obligation to promote your own health can be derived from both of these theories, and, given the historical analysis of health during the times when these theories were created, it is plausible that Kant and Aristotle considered health to be an important component of morality. Nonetheless, as with any obligation, a person must have control over her actions in order to be held morally responsible, and the apparent lack of control we have over our food behaviors, in particular, should cause concern over other ways in which

the social environment may be impeding our ability to be held morally responsible for our obligation to promote our own health.

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Biography

Cerra C. Antonacci was born in 1994 in the USA.

Cerra did her undergraduate work at Saint Louis University in St. Louis, Missouri, where she majored in psychology and minored in health care ethics. Her passion for health care ethics sparked a desire to learn more about the broader field of bioethics.

In 2016, Cerra began the Master of Bioethics program at the Johns Hopkins Berman Institute of Bioethics with an interest in food ethics. She was a research assistant on a food waste project lead by Roni Neff and Steve Harvey.