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PERSONAL AND SOCIAL RESPONSIBILITY IN OBESITY

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Abstract

The health of a population is a social asset. The individual and the society contribute to it through biology and behaviour, environment and health systems. An ethical and responsible conduct from all parties is expected but difficult to legislate while seeking to respect personal and collective rights and freedoms. Out of all chronic diseases related to lifestyle, obesity is the best example to give when discussing if individuals are the only ones responsible for engaging in healthy behaviours or not, or whether environmental factors undermine their ability to act in their best interest and erode their freedom. It is still a controversial issue if the heath systems resources could be distributed according to the personal responsibility for health. The aim of this article is to review literature data about personal and social responsibility in relation to obesity.

key words: *Obesity; Personal responsibility for health; Health policies.*

Introduction

At any given moment, when people choose their directions in life or decide to take a different path, they often realize that there is a fine line between what their fellows and their environment are able to offer them and what is entirely up to them to provide. People's ability to distinguish between these two poles and their determination to pursue their own goals ensure their professional success, irrespective of their domains of activity. The foundation of this successful enterprise is called ***responsibility***, which is often considered a burden, an obligation, an imposed chore or a duty. However, the highest form of responsibility is ***self-responsibility***, which is our major step towards freedom and control. Recently, there has been increasing interest in medical research for the personal responsibility for health and how this concept could be used by health policies. The aim of this article is to review literature data regarding personal and social responsibility in relation with obesity.

Responsibility as a burden. Our society teaches us that we have responsibilities towards our parents, the elderly, our teachers, our country or God. We are expected to develop our good personalities and socially acceptable behaviours in order to become respectable members of our community. As adults, we acquire further values that imply various types of responsibilities, such as our responsibility towards our husband/wife, children, parents, employer or employees, or even organization or team members. A responsible person is expected to display certain attitudes and to be able to distinguish between right and wrong, at least in his/her own cultural environment. ***Common sense*** implies fulfilling the expectations of others and complying with

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social norms that often face opposition from the *irresponsible*, who think and act differently than most people. When responsibility becomes particularly burdensome to people, it invites forms of resistance. Thus, in order to protect our self-esteem, we often blame others for our own failures. Often regarded as a form of protest, *blaming* is equally self-destructive, because complaining implies that life is seen in a dark light. Finding excuses is another way to elude personal responsibility, but this leads to only setting prudent goals or, worse, to developing a victim mentality (being overwhelmed, helpless, unhappy or pitiful). Victimisation is the opposite of taking responsibility; it means giving up all control over one's life, and it can become a way of life (self-taught helplessness).

Responsibility as a blessing. Responsibility is the key ingredient of our human lives and authentic ways of living. When people assume their own responsibilities, they allow themselves to change, to overcome stagnation, weakness, mediocrity, disease and to feel physically, mentally and spiritually strong. "A man must be big enough to admit his mistakes, smart enough to profit from them and strong enough to correct them" [1].

Responsibility as freedom. Every decision has its consequences. Our choices create our success or failure and tell everything about us. Just as we have the liberty to blame, protest and find excuses, we are also entitled to take risks and wittingly respond to any life challenge. The will and need to make life decisions, the belief that we have control over the events, as well as the acknowledgment of effort-driven control constitute the essence of our internal control. When people strive to change their ways of thinking, they eventually bring about modifications to their own lives and foster their self-esteem.

A key element in health care, **personal responsibility** has proven its usefulness in many directions. Thus, most patients who take responsibility for their well-being often lead autonomous lives and strive to comply with their own decisions of bringing major vital changes into their lifestyles. The concept of determinism, namely the influence of the environment (including the state) over the individual, should be part of any health equation. As long as the state and its citizens fulfil their responsibilities, both personal freedom and collective freedom are protected.

Why should we be concerned about the idea of personal responsibility?

It is important to differentiate the complex concept of *personal responsibility* from the concept of *making people responsible* and to consider the introduction of certain measures aimed at limiting the access of patients to available treatment resources. The use of *personal responsibility* in health care policies has practical limitations. Education, social status and the co-occurrence of diseases in one and the same person influence the extent to which patients can be made responsible for their poor health and accountable for their self care decisions. In healthcare, the idea of *personal responsibility* is inseparable from that of *social responsibility*; this symbiosis accounts for the fact that there are environmental factors that influence people's responsibilities and that most prospective patients need reliable healthcare knowledge and information.

What are the values associated with the concept of responsibility in health? [2]

One value is ***self-determination***. Individuals decide for themselves how to live their lives and how to make appropriate life choices. Our self-trust includes our commitment to make appropriate choices that impact upon our existence and quality of life. Hence, self-determination is tightly related to responsibility

and may be considered as a valid criterion for the distribution of health funds.

Another value is ***solidarity***, which is best understood as ***reciprocity***. As members of a community, we owe each other some things. This means that when we make choices in life, we take into consideration how they affect others. If our choices imply that we use a larger share of the health system resources, reciprocity means that we should cover that part of the costs that reflects our own choices. The idea of applied reciprocity would represent our concern for how our choices have come to impinge upon other people; moreover, it should also precondition, at least morally, (free) medical assistance. If people do not act in a way that includes reciprocity, they may lose the opportunity of being treated on a par with their peers and they may even become liable to pay for their own treatment.

The third value is the ***reward*** or ***requital*** and it generally includes considerations over whether people deserve the situation they end up in. This value could support a system in which unwise people pay more than others. The 'reward' could be viewed as a rationalising criterion that considers the virtue in people's choices and allows for their fate to vary in a way that reflects their choices.

The forth value is ***fairness***. This implies that the distribution of resources is fair only if it reflects the way people have made their choices in regards to one another. This idea could be used to advocate for personal responsibility in healthcare; thus, individuals who have taken actions that negatively affected their health are compared with those who happen to suffer from the same illnesses although they have not acted against their well-being.

Gerald Dworkin noticed the difficulty of establishing rules and norms when responsibility is involved. He stated: "it is more difficult to distinguish clearly in the area of responsibility than it is in any other field of moral philosophy" [3]. There is still the question whether we can maintain a balance between personal and social responsibility. Daniel Wilker claimed that "individuals are responsible for their health", but this statement should be nuanced. On the one hand, in traditional holistic medicine, the control over one's health is a personal matter (i.e. the body is your own) and responsibility is only a moral matter ("role responsibility"); on the other hand, in modern medicine, people's life conduct and decisions can make them ill and personal responsibility embraces causality ("causal responsibility"). Furthermore, when people's ways of life and decisions get translated into health care costs, responsibility becomes a duty based on liability [4].

The World Health Organisation defines health as "a state of complete physical, social and mental well-being", including therefore social responsibility. Health is, on the one hand, a characteristic of life, but on the other hand, it is also a measuring tool for the quality of life. Health is a resource for everyday life. It is determined by intrinsic factors (genes, behaviours, culture, habits and lifestyle) and extrinsic forces (the health system alongside social, economic and environmental factors) [5]. Social responsibility should always come first in healthcare matters although sometimes it is the moral stand that empowers people to take personal responsibility for their health [6]. We may find it hard to imagine how a network of human relations could exist and function without a set of rules, no matter how simplistic they may be. "*Ubi societas, ibi jus*" is a famous Latin saying which points to the idea that the *law* and *community* are two inseparable and complementary notions. Every society has treated human beings as its most valuable *source* or *resource*. In any democratic society, the law

must protect each and every individual, regardless of his/her citizenship, ethnical background, or religion; consequently, societies flourish and individual freedom is guaranteed. Any excessive intervention from the state narrows individual freedom and leads to "*salus populi suprema lex esto*" – (i.e. "the health of the people shall be the supreme law").

It is rather controversial whether personal responsibility may be successfully employed as a rationing criterion in health care policies. In any health care system based on the equality of chances and solidarity, people should be expected and justified to take responsibility for their health and well-being [7]. Nowadays, being healthy represents more than a personal goal, which brings success, more attractiveness and longevity. Health symbolises self-control, hard work, ambition and a successful life. Interestingly enough, in its turn, self-control governs our health and induces not only a deep sense of responsibility, but also a considerable amount of stress, even within the context of some larger social responsibility [8]. If healthy people are generally held in high esteem, those who become ill or whose bodies are not exactly the epitome of perfection are generally regarded as self-indulgent, irresponsible and even immoral, although it is evident that it is our biological reality that governs all our decisions and efforts to stay healthy [9].

In the domain of health care, the notion of personal responsibility implies that if we have a healthy lifestyle and if we are "good" patients, we will have our rewards, namely we will feel better and spend less money. Nevertheless, there are two questions that still need to be asked: *What measures have already proved efficient in promoting patients' responsible behaviour? Doesn't the coercive nature of these measures actually obliterate any expected positive outcome?* A thorough understanding of what personal responsibility implies in health care is of vital importance when health care policies and goals are established. Liberal regimes give people with antagonist ideas about welfare and a better life, the possibility of enjoying some form of conviviality whose terms and conditions are agreed upon by everybody [10].

One of the most prominent contemporary normative traditions – liberal egalitarianism – presents one way of making people responsible for their choices and avoids most of the problems signalled by most critics [11]. Cappelen suggests a plausible interpretation of responsibility and health care within the liberal egalitarian paradigm and evaluates reasonable counter-arguments [12]. A society is just if the distribution of its primary goods among different social positions complies not only with the principle of a just placement of rights and liberties, but also with that of the power system and prerogatives.

The **liberal egalitarianism** founded by J. Rawls stipulates the principles of the fair distribution of fundamental rights and duties, as well as the social and economic advantages in a society with free and equal men [13]. The Rawlsian principles are: the principle of *fair equality of opportunity* (applying one adequate system of basic liberties, equal to all) and the principle of *difference* (the socio-economic inequalities should give an advantage to the underprivileged) [14]. To evaluate the just distribution of the social basis for self-esteem is a complex task because it requires that individuals should be capable to evaluate their own life goals first and then to start comparing them to those of other people. This is granted, among other things, by the two principles of justice and their public recognition [15].

Also focussing on distributive justice, ***luck egalitarianism*** is worth discussing when health care policies are involved. Luck egalitarianism

states that the fundamental object of equality is to compensate less fortunate people, namely people who are born with disabilities, people whose families are in serious distress, people who have been involved in accidents or who suffer from serious diseases. However, if people face poor physical health due to their own fault, then societies need not be compelled to offer them health care services. The basic proposal of luck egalitarianism is that "inequalities deriving from un-chosen features of people's circumstances are unjust and therefore should be compensated for" [16].

The health status of a population is a social asset. Health care professionals and researchers are generally expected to offer patients safe and trustworthy solutions especially through their effort to gather relevant scientific knowledge that matters for public health and through their commitment to pursue health driven goals and put all their knowledge into practice [17]. They initiate communication campaigns in public health in order to raise people's awareness about the risk of various diseases and to promote the adoption of appropriate treatments. Successful communication strategies employed in marketing have been transferred to public health. Ethical issues in public health communication refer to the following subjects: "directing" and "creating" public health messages for certain population segments; gaining the equivalent of an informed consent; the use of persuasion techniques; messages that increase patients' responsibility for their actions, messages that make patients be blameworthy, or harm reduction messages. An ethical analysis should be applied at every step of the communication process in public health in order to identify moral dilemmas and prevent the harmful effects of miscommunication and misunderstandings. Communication is not a risk-free activity especially when people decide to use stigmatising terms and stereotypes, when they verbalize or keep reminding us about the existence of social differences and when they promote health as a virtue [18]. Although personal responsibility has become a major challenge in health care, there are very few conceptual tools to help us identify its subtle manifestations. Guttman presents a framework which contextualizes some potentially paradoxical consequences behind personal responsibility campaigns, which can be explained through the medieval allegory "The tragedy of the Commons" – a psychological attribution theory, and public health concerns regarding "blaming the victim" [19]. Written in 1968, Garrett's famous essay proposes a social dilemma: several individuals acting rationally and independently in their own interest end up destroying a common resource, although they were perfectly aware of the fact that their line of action eventually served no one's interest (when the rational behaviours of individuals are summed up, the result is ruinous for each participant). "The population problem has no technical solution; it requires a fundamental extension in morality" [20]. An attribution is a designation of responsibility to the person or to the situation [21]. Finding the cause and the responsibility connected to it plays a leading role in negative attribution [22]. The theory of attribution provides the theoretical framework for justifying the negative traits attributed to obese individuals (lazy, unmotivated, and lacking willpower). Hence, the terms ***negative attribution*** and ***stigmatising attitude*** are used to describe the mechanism that eventually leads to discrimination.

There is a question whether we are to be held accountable when we become ill because we did not manage to fulfil the responsibility of caring for/maintaining our health. Some argue it is immoral to blame the victim. It is important to

encourage people to accept some part of the responsibility but at the same time to avoid destructive forms of guilt [23]. Those who embrace a morally therapeutic perspective usually recommend the reduction of guilt to a minimum, yet it would be equally unreasonable and unadvisable to ignore it. The ambiguities of personal responsibility in health care should be discussed within four major contexts: (1) in preventing disease; (2) in managing the costs of health care; (3) in making sense of human suffering; (4) in the interaction with medical professionals [23].

Personal and social responsibility in obesity

In the case of obesity, we should avoid "blaming the victim"; at the same time we should acknowledge the central role of healthy behaviours in maintaining healthy weight. There are two approaches:

The medical model focuses on treatment; individuals are approached in such a way as to determine the personal behaviours that made them become obese. One basic hypothesis is that individuals, as independent agents, make informed choices. Hence, most interventions involve giving information and motivating individuals to modify their behaviour.

The public health model focuses more on prevention and sees the roots of obesity in an "obesogenic" environment, which makes individuals engage in harmful health behaviours. Therefore, most interventions aim at altering the environment through social policies.

A social justice perspective facilitates a synthesis of the two models. The concept of **behaviour justice** is proposed to convey the idea that individuals are responsible for engaging or not in healthy behaviours. However, they should be held liable only if they have adequate resources to do so. This perspective gives control and responsibility both to the individuals through their behaviour and to the society which should offer an environment able to promote health [24].

Lifestyle diseases are associated with the way in which an individual or a group of individuals lives. They are also called "diseases of longevity" or "diseases of civilization" although these two terms are not totally interchangeable. These diseases include: atherosclerosis, heart diseases and stroke, obesity and type 2 diabetes, pollution-related diseases, smoking, alcohol addiction and drug abuse. Non-communicable diseases (NCD), also known as chronic diseases, are incurable but controllable most of the times. A chronic disease "is permanent, may be accompanied by handicap, is caused by irreversible pathological alterations, requires specific patient training for rehabilitation or assumes a long period for control and care" [25]. The four main types of NCDs are cardio-vascular diseases, cancer, chronic respiratory diseases and diabetes mellitus. Interestingly enough, obesity is neither overtly included nor explicitly mentioned in this category, where it should normally belong to. According to WHO, obesity is a disease that involves the presence of "excess fat with health consequences", being often described as an epidemic and urging for celerity in finding medical means to tackle it [26].

Many studies reveal a direct and significant relationship between obesity and all-cause mortality, as well as between obesity and cardio-vascular mortality [27]. It is discouraging to notice how mass media keeps constructing messages that constantly imply that obesity is a matter of personal responsibility; moreover, they often mislead viewers into accepting that both the causes of obesity and the solutions to be adopted lie with the individual [24]. There are a lot of factors that contribute to the development of obesity and some of them are beyond the

individual's control. Besides genetic and biological factors involved in weight regulation, there are also numerous social and economic factors that impact most "obesogenic" environments. Seng Lee notes: "We created a mismatch between biology and environment, so that the weight adjustment mechanisms are no longer able to evolve fast enough to keep pace with environmental change" [28]. Apparently, the more one eats and the less he/she exercises, the more weight one gains. Even scientific articles have stated that the origin of overweight and obesity is "gluttony" or "sloth" [29]. Therefore, in essence, in order to lose weight, one should just eat less and exercise more. The energy balance equation has become the major means of fighting obesity; it implies that as long as people focus on counting the calories in and calories out, they are healthy, happy and slim. Nevertheless, it is indeed debatable whether the prevalence of obesity can only be explained through this energy balance equation and metabolism. "The rate of increase in obesity occurs in a relatively constant gene pool and therefore in a constant metabolic background" [30]. When people become obsessed with the energy balance equation, they are likely to disregard other significant factors such as *behaviour*, *psychology*, *emotions*, and *self-esteem*. Most people do no longer pay attention to what they think about eating and food or to what they feel about eating and the food they choose. People start eating excessively because they are sad or lonely, because they feel frustrated or unaccomplished, or because they are angry or hurt. Just like obesity, anxiety and depression are rising among today's people and there is one simple answer: *we cannot have what we really want, yet food is not really what we want* [31]. Some scholars have even demonstrated that overweight or obese individuals can truly benefit from psychological interventions and cognitive-behaviour interventions [32]. According to Cohen, one way to conceive of obesity in terms of an epidemic is to consider that people are influenced by the forces residing in their environment rather than by their own will and self-control. Even more scholars seem to agree to the idea that most environmental changes are essential to people who fight obesity [33]. Globally open, the chronic care model requires constant and continuous interventions that quite often involve ambulatory care and treatment. Under these circumstances, medical teams are expected to perform their duties in well-organized medical networks within a broad framework including communities and societal structures. It is expected that patients with chronic diseases understand and acknowledge their medical diagnosis, that they come to terms with the incurable nature of their condition, and that they eventually admit that a good control of their disease is generally associated with an improved life expectancy and quality. Moreover, any person diagnosed with a chronic disease should be willing and able to manage his/her disease by adopting modifications to improve his/her lifestyle, by self-administration of treatment and self-monitoring and through a permanent connection with the care team (not only for managing the disease, but also for psychological and social support).

As *lifestyle diseases* impose a huge burden on health care costs, more and more professional voices consider that people should take responsibility for the kind of life they lead and should account for their unhealthy lifestyles. The adoption of a *forgiving attitude* towards those who regret their harmful lifestyle often ends up in a moral hazard. Generally, most regulating authorities are rather indifferent to whether people genuinely regret their previous choices or merely pretend to do so in order to benefit from

the compensations promised to those who show remorse. Some scholars believe that health systems should offer opportunities beyond any moral hazard and that the redistribution of resources should be conditioned by lifestyle changes and adjustments for which there is enough proof or evidence [34]. Recent public opinion surveys reaveal that the view on obesity has changed considerably. In early 2000s, only 2 to 3% of the population regarded obesity as one major medical problem [35], while at present most people would agree to the fact that obesity is a serious matter of public health [36]. In his 1968 entitled *The Stigma of Obesity*, Cahman noticed with surprise that obesity was scarcely mentioned in the writings of sociologists and in those approaching social deviance although in a modern world driven by succes and welfare overweight people were not a pretty sight and their condition was both a disease and a disgrace [37]. Bayer also noticed that in the last decades of the 20th century, the stigmatization of those already weak and easy to suffer damage or harm created the context for the spreading of diseases and the exarcerbation of morbidity and mortality [38]. Puhl and Heuer reported that overweight-driven stigmatizations may trigger contrary effects; the probability among stigmatized people to display unhealthy behaviour is much higher and threatens to affect ongoing treatment schemes, as well as alternatives methods of weight control and reduction [39].

There are two major ethical issues that professionals need to consider in obesity interventions. The former issue comprises the following two questions: Is there any good reason for initiating a paternalist intervention to promote healthy lifestyles among people in a fit stat and who have no desire to be approached? What would be the most convenient time for such an enterprise? The latter issue is represented by the following questions: Is there any good reason to negatively affect the well-being of one person or one group so that others may benefit from our intervention aimed at promoting some common good? What would be the most convenient time for such an enterprise?

There are many examples of initiatives aimed at promoting personal responsibility. For instance, the World Health Organization is determined to deny the hiring of people who smoke and recruit people with healthy lifestyles. In USA, more companies than ever will not hire smokers and even consider to dismiss the employees who smoke. Some insurance companies offer more advantageous deals to non-smokers and perseverant weight watchers; their employees are likely to receive financial incentives if they enrol in health programs, fitness programs or quit smoking programs. A US national survey in July 2006 revealed an interesting fact, namely that 53% of the Americans believe that it is fair to demand of people who display unhealthy lifestyles to be charged more than the people who lead a healthy life; thus, it seems fair to make them pay higher insurance policies, higher deductible and co-pay medical insurance policies. In November 2003, the same type of survey revealed a much lower rate of only 37% [40]. An unhealthy lifestyle is necessary, yet not sufficent for the development of obesity [41]. Environmental conditions undermine personal responsibility and erode personal freedom. The notion of personal responsibility has been particularly useful not only in social, juridical and political studies, but also in those investigating obesity issues. Personal responsibility represents a valuable asset to be seriously considered in legislative and regulating proposals and decisions regarding the improvement of school food, the introduction of nutrition facts labels, the modification of industrial marketing strategies, as well as in promoting slightly controversial measures such

as the introduction of taxes and subsidies to encourage healthier diets and habits. It is generally considered that in this way people are likely to develop more responsible behaviors. At the same time such actions are expected to bridge the gap between individualism and collective responsibility [42].

While analyzing 60 action plans and policy proposals for obesity, ten Have et al. identified and discussed several ethical issues raised by most solutions: their direct influence on people's physical health may prove rather uncertain or unfavorable; some solutions or strategies may even trigger negative psychosocial effects such as uncertainty, fear, obsessions, guilt, stigmatization or unfair discrimination; inequalities deepen; the distribution of confidential, unreliable or damaging information; the social and cultural value of food gets disconsidered; the violation of people' intimacy; overweight is a demanding conditions that involves a complex set of responsibilities, often ignored or neglected; some interventions and action plans may infringe upon people's personal freedom involved in choosing particular lifestyles or raising children; some interventions and action plans may impinge upon people's freedom to take private decisions or adhere to various policies promoted by schools or organizations. Since most ethical incentives proposed to fight the obesity epidemic are not truly and entirely free from ethical constraints, professionals need to engage in further discussions and debates. At the same time, it is generally acknowledged that ethically solid developing programs may exceed their moral relevance and may prove helpful in the prevention and control of overweight and obese patients [43]. In spite of significant progress and improvement rates, the obesity epidemic is still far from being reversed. A recent article published in Lancet identifies high-priority actions that need to be taken in the fight against obesity. Moreover, the authors strongly condemn deeply rooted dichotomies related to obesity issues, as well as various barriers to action. Their discussions focus on the following aspects: personal responsibility versus collective responsibility for actions, individual versus environmental drivers to obesity, supply versus demand-type explanations for the consumption of unhealthy food, government regulation versus industry self-regulation, top down versus bottom-up drivers for change, treatment versus prevention priorities. Although it is normal for people to bear some responsibility for their health, environmental factors may either support or undermine people's ability to act in their self-interest. Consequently, the authors consider that obesity needs to be re-contextualized to accommodate a symbiotic relationship between the individual and the environment [44].

Moreover, it is also time for people to find new ways of fighting against the restricted ability or unwillingness of governments to implement policies, and to consider the absence of pressure from civil society for political action

Conclusions

As obesity has become an important public health issue, it is important to understand the responsibility of both the individuals and of society in creating and solving the issue, so that the fair and efficient measures could be taken.

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