

# On the Oregon Health Authority's Recent Ban on Elective Surgery for Smokers with Medicaid: An Ethical Analysis

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**Abstract:** Starting January 1, 2017, the Oregon Health Authority (OHA, henceforth) made a sweeping decision that no elective surgery is to be performed for Medicaid recipients who smoke tobacco. The authors of this paper investigate the administrative procedures behind the OHA's decision, explore some possible ethical arguments for and against the decision, and render our ethical verdict about the ban and our suggestion for the OHA. Meanwhile, since this issue involves the problems of smoking-related addiction, the agent's autonomy which may be understood in the light of moral freedom and rationality/irrationality, and our society's perception about obesity and cigarette smoking; the paper engages in a deeper philosophical debate about the problems beyond the legal purview of the ban.

**Keywords:** Cigarette smoking, addiction, obesity, rational autonomy, moral freedom, Augustine, Robert Goodin, *libertas*, *liberum arbitrium*.

## I. INTRODUCTION

Starting January 1, 2017, the Oregon Health Authority (OHA) made a sweeping decision that no elective surgery is to be performed for Medicaid recipients who smoke tobacco. It is considered the OHA's deliberative effort to make sure that the health care budget is most efficiently utilized in the way that the best health outcomes obtain. However, why the cigarette smokers? Materials from the meetings leading up to the decision to withhold payment for such procedures document that consideration for this action had its genesis from a smoking task force.<sup>1</sup> Initially, the Oregon committee reviewing the proposed action considered requiring smoking cessation counseling prior to elective surgeries, but considered this action too difficult to implement. They instead decided to deny payment for elective surgeries for all members who smoke unless they can demonstrate that the smoking has been abstained from for 4 weeks. It is true that the costs and the complications of elective surgery are often higher for smokers than for nonsmokers. However, it seems ethically unjustifiable to deny medical care simply because it is costlier. As we know well, it is tremendously expensive to take care of, for example, a patient who was born with Down's syndrome or someone with a clotting disorder or an individual experiencing renal failure due to years of alcohol abuse. Should the care for these groups of people be denied because

<sup>1</sup>"Health Evidence Review Commission's Value-based Benefits Subcommittee" [Date File], Oregon Health Authority, August 11, 2016: 312-330, accessed Dec. 1, 2017, <http://www.oregon.gov/oha/herc/CommitteeMeetingMaterials/VBBS%20Materials%208-11-2016.pdf>

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their cost of medical care is too high? If not, why can we, as a society, not carry a portion of the extra burden of care accrued when smokers undergo elective surgery?

The proponents for the OHA's ban may say that the regulation is not just about the cost but about greater post-surgery complications as well. They may also argue that we do not have moral duty to act in ways to relieve suffering and improve quality of life of those who actively choose to harm their own health, given the assumption that the smokers have voluntarily and rationally chosen to harm themselves. The authors of this paper will carefully examine these questions and arguments.

The essay is organized in such a way of, first, looking into the administrative process behind the OHA's decision on the ban to inquire if there were any visible ethics violations during the process; second engaging in medical analysis to make sure of the relationship between smoking and elective surgeries. Then, we will move to the main part of the essay, which is deeply philosophical. We will examine and explore ethical arguments for and against the decision, as we touch upon the problems of smoking-related addiction, the agent's autonomy which may be understood in the light of moral freedom and rationality/irrationality, and our society's perception about obesity and cigarette smoking. Our own position is that the OHA's ban in its current form is not ethically justifiable and thus, if to be ratified and implemented (which is largely a political decision), its existing content should be modified. As we render ethical verdict on the ban, we will suggest how its content be improved while making its core intact.

## II. THE OHA'S DECISION ON THE BAN

The OHA's ban has three exceptions; they allow for reproductive, cancer-related, and diagnostic procedures to be performed on smokers. All other requests for elective surgery on Medicaid recipients who smoke cigarettes will be denied. In order to be considered elective, a procedure must meet the condition of being flexible in its scheduling, which the OHA further defines as not posing imminent threat or requiring immediate attention within one month. To obtain authorization for lung volume reduction surgery, bariatric surgery, erectile dysfunction surgery, or spinal fusion, patients must demonstrate smoking cessation for 6 months. For authorization of all other elective surgery, a patient must obtain the objective proof that they have stopped smoking at least 4 weeks prior to the date of surgery. The ban mainly focuses on two elective surgeries, *total joint arthroplasty* and *spinal fusion surgery*.<sup>2</sup>

The genesis of the decision, as it is traced, is as follows. The issue originated with Oregon's Coordinated Care Organizations (CCOs), among which are the local community action council (L-CAC) and regional community action council (R-CAC), and subsequently their associated task forces. The noise from these task forces led the Oregon Health Authority's Value-based Benefits Subcommittee (VbBS) and ultimately lead the Health Evidence Review Commission (HERC) to review the potential benefits of requiring smoking cessation prior to elective surgeries. It looks as if they considered two options, that is, requiring smoking cessation prior to elective surgery and smoking cessation therapy prior to elective surgery, but went for the former, believing that it was easier to implement and more cost-effective than the latter option.<sup>3</sup>

## III. A PRELIMINARY ETHICAL EXAMINATION

The OHA's ban on elective surgeries for smokers, presented in the case above, seems *prima facie* a political brainchild of the anti-smoking task forces rather than the result of cogent ethical discussions among all possible stakeholders. However, this fact does not make the ban unjustifiable unless there are found ethics violations in the policy development process. As a deontological ethical evaluation applies, there should not be nefarious ulterior motives behind or in the process. On the other hand, as a consequentialist concern is raised, the future-oriented aim should be justifiable in accordance with the utilitarian cost-benefit analysis.

To take up, first, the consequentialist ethical evaluation, it seems important to understand the unique financial considerations that play into this case. Complications from surgery, infections, failure to achieve the desired outcome, and delays in healing add to the cost of treatment when compared to a successful operation on a healthy, compliant patient with positive outcomes. Patients who undergo total joint arthroplasty are at increased risk for joint infection for a number of months after surgery. The estimated

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<sup>2</sup> "Prioritized List of Health Services" [Data file], Oregon Health Authority (2017), accessed Dec. 1, 2017, <http://www.oregon.gov/oha/herc/PrioritizedList/1-1-2017%20Prioritized%20List%20of%20Health%20Services.pdf>

<sup>3</sup> "Health Evidence Review Commission's Value-based Benefits Subcommittee."

cost of treating the joint infection from a total joint arthroplasty is \$50,000.<sup>4</sup> When covered by Medicaid, it is paid by the government budget. If so, the consequentialist ethical slogan for distributive justice – the greatest benefit for the greatest number – may buttress the OHA’s decision. It does not seem as if the decision was made in favor of the interest of a certain group against that of all citizens in the state. The OHA’s decision to no longer approve elective surgery for the smokers who are Medicaid recipients is considered a way of achieving a consequentialist interpretation of distributive fairness for all citizens in the state through the effective allocation of the tax-funded medical resources.

In the deontological ethical evaluation, the stipulation that the ban is lifted if the patients have abstained from smoking for 4 weeks demonstrates reasonableness and objectiveness. In addition, no ostensible ethics violations are found, such as falsifying data, bribery, etc. However, a possible conflict of interest for the hospitals and surgeons is observed. In Oregon, as in the case of many other U.S. states, hospitals/surgeons earn flat fees for performing procedures. Most procedures do have global periods during which additional care may not be charged to the insurance. For example, the surgery fee has a 30-day global period. Any follow-ups in the office within that time is intended to be covered under the fee paid for the procedure. Thus, when the patient needs follow-up cares more than normally expected from the hospital/surgeon’s financial deliberation, it hurts the hospital/surgeon financially. It is Medicaid that lowers reimbursement to hospitals for having complications and infections. However, it is not the case that the hospital/surgeon is always selective depending on the insurance status of the patient. It is normally assumed that the hospital/surgeon is just trying to stay in good graces while the hospital/surgeon, in general, does not wish to perform complicated and time-consuming revision surgeries.<sup>5</sup>

In sum, the purported consequentialist aim of the OHA’s ban is justifiable, and its developmental process does not exhibit ethics violations in the eyes of the deontological ethics watchdog. Meanwhile, the conflict of interest for the hospitals/surgeons that perform the surgeries is a possible concern, yet without providing a strong case of ethics violation. We turn to a medical analysis to make sure of the correlation between cigarette smoking and its related medical complications when the smokers receive elective surgery.

#### IV. MEDICAL ANALYSIS: ELECTIVE SURGERY AND SMOKING

It is known to us, as shown the U.S. Surgeon General’s warning signs on cigarette packages, that smoking causes cancer. Also, the smoking-related diseases include heart and lung diseases. Furthermore, smoking has been linked to several adverse factors that affect surgical outcomes, including perioperative cardiac, pulmonary, and wound healing complications.<sup>6</sup> Reasons for these poor outcomes may include reduced blood supply and the anti-inflammatory effect of nicotine.<sup>7</sup>

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<sup>4</sup> H Senderovich, “The Ethical Responsibility of Health Care Providers to Provide Treatment to Smokers,” *Annals of Long-Term Care*, December 18, 2015, accessed Dec. 1, 2017 <http://www.managedhealthcareconnect.com/article/ethical-responsibility-health-care-providers-provide-treatment-smokers>

<sup>5</sup> It should be noted that Oregon does not run the same system as North Carolina. In North Carolina, “most doctors [nowadays] continue to be paid in a fee-for-service system, which means they’re reimbursed for each appointment, test or procedure. Perversely, they make more money if a patient has complications and requires extra care. In Charlotte, some surgeons who perform spine surgery and knee and hip replacements have begun using a ‘value-based’ system that means accepting a single ‘bundled payment’ for each patient encounter. This gives doctors an incentive to provide the best care for each patient. If all goes well and care is delivered for less than the contract price, the doctor or hospital keeps the savings. If there are complications and the patient needs more care, the doctor or hospital absorbs the extra cost. So, operating on smokers, with potentially expensive complications, could hurt the bottom-line for physicians. At OrthoCarolina, doctors have agreed that “all patients who register for the bundled payment plan must go through surgical optimization” so that all patients are as healthy as possible before surgery. “At some point, insurance companies may even begin to refuse to pay for elective surgeries on smokers.” (Karen Garloch, “Doctors are Refusing to Operate on Smokers in Some Cases. Here’s Why the Trend Will Grow,” *Charlotte Observer*, February 22, 2017, accessed June 1, 2017, <http://www.charlotteobserver.com/living/health-family/karen-garloch/article134223889.html>).

<sup>6</sup> D. Khullar and J. Maa, “The Impact of Smoking on Surgical Outcomes,” *Journal of the American College of Surgeons* 215 no. 3 (2012), accessed June 1, 2017, [http://www.journalacs.org/article/S1072-7515\(12\)00412-7/fulltext](http://www.journalacs.org/article/S1072-7515(12)00412-7/fulltext)

<sup>7</sup> W. Deardorff, “Reasons to Quit Smoking Before Spinal Fusion,” *Spine-Health* (2008), accessed June 1, 2017, <http://www.spine-health.com/wellness/stop-smoking/reasons-quit-smoking-spinal-fusion>; E. H. Tischler, K. L. Matsen, A. F. Chen, M. G. Maltenfort, J. Schroeder, and M. S. Austin, “Smoking Increases the Rate of Reoperation for Infection Within 90 Days After Primary Total Joint Arthroplasty,” *Journal of Bone and Joint Surgery* 99, no. 4 (2017), accessed June 1, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/28196031>

On the other hand, elective surgeries most commonly cited in the medical literature with regards to smoking as well as related to our case here are *total joint arthroplasty* and *spinal fusion surgery*. The OHA's ban focuses mainly on these two categories of procedures, so the focus of our investigation will be on the two. In general, smoking hinders bone growth and wound healing which in turn has an impact on bone fusion procedures. Also, smoking increases chances of infection. The problem of infection may be significant because surgeries leave incisional wounds as many common surgical procedures have varying levels of dissection, length of wound, etc. The worst case of the common surgical infections are deep joint infections.

Concerning the elective surgeries (except in the case of emergent spinal fusion surgery which usually is not considered elective, thereby not pertaining to this discussion), they are not naturally life-saving therapeutic measures. Their main purpose is to decrease pain and improve function. On the other hand, the surgeries do the patient's body some amount of harm to bring about a desired effect, and not all patients recover from this harm. Degree of healing, speed of recovery, complication, and functional improvement vary from patient to patient and depend on a host of variables.

As mentioned, cigarette smoking inhibits and delays healing wound because it decreases blood flow. Thus, it can be said that smokers do not do well after having spinal fusion surgery and joint replacements. One study also suggests that smokers who got joint replacement surgery had a significantly a higher chance of requiring repeat surgery than nonsmokers because of complications from infection. According to a research published in the *Journal of Bone and Joint Surgery*, the retrospective analysis of 15,264 patients was made to evaluate the risk of reoperation within 90 days after a total joint arthroplasty for smokers, former smokers, and nonsmokers. And the smokers are found to have an 82% greater odds ratio for reoperation due to infection.<sup>8</sup>

In the case of an infected joint following total knee arthroplasty, the common remedy is a two-stage revision procedure. Both stages require surgery, and both surgeries are in addition to the primary arthroplasty procedure. Stage one involves repeating the incision from the primary surgery, opening the joint capsule again, removing cemented total knee implant components as little of the patient's remaining bone stock as possible, cleaning and irrigating the joint capsule, and the application of an antibiotic-infused cement product to the exposed bone surfaces before reclosing the wound. Between stage 1 and stage 2, patients usually must keep their knees in the fully extended position and are instructed not to bear weight. After several weeks, stage 2 can take place. During stage 2, the wound is reopened, the cement product is removed (with additional opportunity for loss of healthy bone through the chiseling process), and new total joint implants are cemented into place. Due to bone loss and the condition of other stabilizing factors, revision-type implants may be used. These typically extend into the intramedullary canal of either or both the distal femur and proximal tibia. The joint is then closed once again. Thus, there is a significant amount of harm that occurs as the result of an infected total joint. Knowing that a patient who smokes is at greatly increased risk for loss of good bone stock, may require multiple corrective procedures, may need to spend months without the ability to use their limb with copious amounts of antibiotics, it seems reasonable to believe that it is best not to let smokers have the surgeries.

Also, the outcomes of spinal fusion surgery are poor when the patients are smokers. Despite the rods and screws that could be part of a spinal fusion procedure, achieving stability is dependent on fusion of bone segments. Without fusion, the procedure is not deemed a success. The rate of nonunion in smokers has been found to be nearly double (26.5% versus 14.2%) that of nonsmokers. In addition, one well-designed and pivotal study found the rate of being able to return to work after spinal fusion surgery to be 71% for nonsmokers but only 53% for smokers.<sup>6</sup>

In brief, the success rate of the elective surgeries for smokers is relatively significantly low, compared to that for non-smokers. The adverse effects and complications which make the surgeries prone to failure include, above all, the increased possibility of reoperation due to the high risk of infections, which eventually results in patient suffering and the waste of valuable medical resources.

## V. SOME POSSIBLE ETHICAL ARGUMENTS FOR THE CURRENT BAN

### A. *The Ban is Justified because Beneficence/Non-maleficence and Distributive Justice are Violated Otherwise.*

In favor of the OHA's ban, the proponents, first of all, may point out the fact that there were no visible ethics violations as the deontological ethics watchdog has been keeping an eye on the legislative formation of the ban, shown in the preliminary analysis

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<sup>8</sup> S. D. Glassman, S. C. Anagnost, A. Parker, D. Burke, J. R. Johnson, and J.R. Dimar, "The Effect of Cigarette Smoking and Cigarette Cessation on Spinal Fusion," *Spine* 25 no. 20 (2000), accessed June 1, 2017, [http://journals.lww.com/spinejournal/Abstract/2000/10150/The\\_Effect\\_of\\_Cigarette\\_Smoking\\_and\\_Smoking.11.aspx](http://journals.lww.com/spinejournal/Abstract/2000/10150/The_Effect_of_Cigarette_Smoking_and_Smoking.11.aspx).

above. Then, they may apply the standard bioethical principles and argue that the medical analysis above indicates the violation of the deontological principles of non-maleficence/beneficence (the patient suffering addressed) and that of the consequentialist principle of distributive justice (wasting the tax money) if the smokers are allowed to have the elective surgeries. Therefore, the ban is ethically justifiable.

***B. The Seeming-Discrimination Against Smokers included in the Ban is Ethically Justifiable because the Smokers Have Voluntarily and Rationally Chosen to be Discriminated Against.***

Second, the proponents can add that it is morally justifiable to care less about the health of the people who voluntarily and rationally chose not to maintain good health in pursuit of certain pleasures. In this day and age, at least in the West, the habitual smokers belong to that category. After the Federal Cigarette Labeling and Advertising Act was enacted in 1965 (Public Law 89-92) which required the warning "Caution: Cigarette Smoking May Be Hazardous to Your Health" to be placed in print on each cigarette package,<sup>9</sup> we witness the plethora of the same kind of visible warnings everywhere. Hence, it difficult not to believe that the smokers have voluntarily and rationally chosen this path for the sake of the pleasure cigarette smoking excites. If true, why should the liberal democratic state waste tax dollars to interfere with the voluntary, rational will of the citizens? Accordingly, the seeming discrimination against the smokers included in the OHA's ban is not discriminatory in essence, but honoring the will of the patients. Besides, the ban's mandate that patients can get the surgeries when they stopped smoking for four weeks demonstrates not only reasonableness but also the state's will to respect patient autonomy. The four-week secession is relatively an objective measure that shows the patients' voluntary, rational will to prioritize their own health over smoking-related pleasure. As the patients display the will for healthy living in this manner, the state will provide the elective surgeries in honor of the will.

## VI. OUR OWN POSITION ABOUT THE CURRENT BAN AND SUGGESTION FOR THE OHA

***A. The Proponents' Claim about the Violations of Beneficence/Non-maleficence and Distributive Justice is Found Problematic Because Their Ethical Reasoning is Based on an Unjustifiable Bias against the Smokers.***

However, we raise counter arguments as follows. First, it should be pointed out that the OHA's policy is the result of an unjustifiable bias against smokers; it seems difficult to deny that the policy reflects the social vilification of smokers ubiquitous in the U.S. If we follow the logic of the proponents' argument addressed above (i.e., smokers are a group of people who do not wish to take care of their own health), those who do not exercise regularly, people enjoying salty food, (red-meat) steak lovers, and ice cream binge-eaters belong to the same category. However, our American society is much tolerant towards those groups than the smokers. Some point out that the hostility to smokers is beyond a reasonable level in the U.S. Smokers are banned from buildings and restaurants and driven on to "pavements, street corners or doorways where formerly down-and-outs could find a decent refuge."<sup>10</sup> And certain universities do not even allow smokers to enter their campuses. Take, for example, the college town of Oxford, Mississippi, "where no blacks were allowed [in the past]. Now Oxford, Mississippi, is acquiring a new sort of fame in another crusade. This time, the victims of discrimination are smokers. . . [T]here are plenty of unbanned sources of far [more] noxious fumes than a passing cigarette can yield - cars, trucks, incinerators, air-conditioning plants and students' incredibly smoky, smelly barbecues. The reasons for the [smoking] ban have little to do with health and a lot to do with culture."<sup>11</sup> The OHA's ban shares the cultural bias.

<sup>9</sup>"Smoking and Tobacco Use," Centers for Disease Control and Preventions, [https://www.cdc.gov/tobacco/data\\_statistics/sgr/2000/highlights/labels/](https://www.cdc.gov/tobacco/data_statistics/sgr/2000/highlights/labels/)

<sup>10</sup> Felipe Fernández-Armesto, "Smokers are Subject to the Sort of Vilification That, in the Past, Usually Heralded Vicious Oppression," *Times Higher Education*, September 14, 2007, accessed June 1, 2017, <https://www.timeshighereducation.com/comment/columnists/smokers-are-subject-to-the-sort-of-vilification-that-in-the-past-usually-heralded-vicious-oppression/310460.article>. "Some criticize the hypocrisy. The paradox of the federal government vilifying smokers while profiting from their addiction is hardly new. Cigarettes are the only consumer product invented purely to capture permanent public usage through chemically managed addictive ingredients. In the past decade, US smokers became unwitting consumers of genetically modified Brazilian tobacco that contains up to 50 per cent higher levels of nicotine. In mid-2009, US President Barack Obama finally signed legislation giving the FDA full regulatory powers over cigarettes' ingredients. This should have made headlines throughout the world, but the epic victory in the protection of American smokers passed with little comment" (Jane Rankin-Reid, "Morality Lost in a Cloud of Smoke," *Tasmanian Times*, Dec. 8, 2013, accessed June 1, 2017, <http://tasmaniantimes.com/index.php?/article/morality-lost-in-cloud-of-smoke/>)

<sup>11</sup> Felipe Fernández-Armesto, "Smokers are Subject to the Sort of Vilification."



After all, the OHA's ban clearly reflects the egregious bias against smokers in the U.S. If true, the proponents' claim that allowing for the smokers with Medicaid to have elective surgeries violates beneficence/non-maleficence and distributive justice is philosophically suspicious. It is admitted that the medical analysis above rightly shows the post-surgical complications for smokers. However, the same or similar types of the post-surgery adverse effects can exist for the people with unhealthy lifestyle. The obesity problem is a good example. Though obesity has been one of the major health problems to be compared on a par with smoking in the U.S., the OHA is completely reticent about it.

American culture has been extremely generous about obesity mainly because the fast-food industry has played a central role in building the socio-economic structure of our society. According to the 2017 U.S. Bureau of Labor Statistics, the fast-food industry "has been one of the biggest sources of job growth since the recession. More than 4.3 million people are now dipping fryer baskets and flipping hamburgers, a 28 percent increase since 2010 that is almost double the increase in the overall labor market."<sup>12</sup> Accordingly, how we Americans eat has been determined. There is no doubt that American food is fast food, and the powerful fast food corporations want to make sure of it through a highly sophisticated media bombardment. As a result, it is unlikely that obesity is portrayed as nefarious on media.

However, our cultural perception about obesity is changing, though at a slow pace. Today, many doctors and public health officials warn against the obesity problem in the U.S. Especially, childhood obesity is at an alarming level. According to a recent 2017 CDC report, "the percentage of children with obesity in the United States has more than tripled since the 1970s. Today, about one in five school-aged children (ages 6–19) has obesity."<sup>13</sup> The experts call the obesity problem a major public health crisis in America and find its cause in Americans' fast-food eating habit.

On the other hand, we witness a powerful, yet very subtle resistance against the nation's war on obesity. The so-called "body advocacy" or "body positivity" movement has gained substantive support in recent years. Their motto is to stop demonizing a body shape (any body shape) and embrace your own. A unique feature about the movement is that, although the body advocates call for acceptance of any body types of yours as positive and beautiful as long as you feel healthy, their primary purpose is to affirm the idea that being obese and healthy (though you may be extremely obese) is good, not that being extremely thin and healthy is good. Thus, the body advocacy movement is synonymously called the "fat acceptance" or "fat liberation" movement, which the advocates feel, not at all, offended by.<sup>14</sup> In recent years, the success of the body advocacy movement is quite visible. In the American music and film world, singers like "Adele, Nicki Minaj, Meghan Trainor, Beyoncé and Lady Gaga have spoken out about body acceptance." And the Hollywood film makers are looking for the role of "fat girls." In the fashion market, big and pretty-faced models for trendy plus-size clothing line are sought for.<sup>15</sup> However, regardless of their intention, either ethically or politically praise- or blame-worthy, the socio-psychological impact of the movement on the American general public is clear. The cultural message it gives off is that it is all right to be obese or even extremely obese, which is detrimental to the society's effort to fight the current obesity crisis.

To further investigate philosophically, the body advocates' claim that being obese and healthy is good is problematic. Unless they provide a further clarification in meaning, the slogan commits the fallacy of equivocation and possibly of red herring. It can be said that being obese and healthy is *medically good* insofar as the body can operate in functional excellence. However, as a strong scientific evidence proves as well as a common human experience tells us, it is highly doubtful that the person in the body mass can continue to sustain excellence in health and movement as the person ages. The advocates may present some exceptional cases. However, forming a social movement based on exceptions is fallacious in and of itself, for the case the movement points to must be a generalized form of truth.

On the other hand, being obese to be aesthetically good is a strange claim for many reasons. First of all, apart from how an individual person feels about it, we have never heard of any society or culture that has praised an obese body, not a glamorous body, as beautiful. In fact, whether the standard of beauty is objectively given or socially shaped is a perennial problem of philosophy, so

<sup>12</sup> Rachel Abrams, "Why Aren't Paychecks Growing? A Burger-Joint Clause Offers a Clue," *The New York Times*, Sep. 27, 2017, accessed Dec. 10, 2017, [https://www.nytimes.com/2017/09/27/business/pay-growth-fast-food-hiring.html?\\_r=0](https://www.nytimes.com/2017/09/27/business/pay-growth-fast-food-hiring.html?_r=0)

<sup>13</sup> "Childhood Obesity Facts," Centers for Disease Control and Prevention (CDC), accessed Dec. 10, 2107, <https://www.cdc.gov/healthyschools/obesity/facts.htm>

<sup>14</sup> Jes Baker, "6 Things I Understand About the Fat Acceptance Movement," *The Huffington Post*, June 24, 2014, accessed Dec. 10, 2017, [https://www.huffingtonpost.com/jes-baker/6-things-that-i-understand-fat-acceptance-movement\\_b\\_5200650.html](https://www.huffingtonpost.com/jes-baker/6-things-that-i-understand-fat-acceptance-movement_b_5200650.html)

<sup>15</sup> Brooks Barnes, "In a Body Positive Moment, Why Does Hollywood Remain Out of Step?" *The New York Times*, Aug. 16, 2017, accessed Dec. 10, 2017, <https://www.nytimes.com/2017/08/16/movies/in-a-body-positive-moment-why-does-hollywood-remain-out-of-step.html>; Maya Salam, "Why 'Radical Body Love' Is Thriving on Instagram," *The New York Times*, June 9, 2017, accessed Dec. 10, 2017, June 9, 2017 <https://www.nytimes.com/2017/06/09/style/body-positive-instagram.html>

any intellectual consensus on the topic is not to be expected. The only truth about the subject is that we do now know the answer. We do not know what metaphysical nature the notion of beauty has (despite Plato's grandiose system in his *Symposium*) and why two different cultures and individuals' aesthetic preferences are sometimes different from each other. But what is philosophically interesting is the fact that, despite all these cultural and subjective atheistic variations, we cannot entirely dismiss the possibility of objective beauty. Go to a remote place in the world and ask the villagers who the most beautiful woman is there. Then, find that girl! We are sure that you will *understand* why the girl is found beautiful.

Beauty cannot be entirely a subjective or culturally insulated concept, which in turn makes the body advocates' arduous attempt to change the public's perception of beauty futile. How an individual or a culture evaluates a certain feature to be beautiful is not entirely relative as well as not something to be achieved by force or insistence, for how one sees something beautiful is inherently passive. We do not stop to evaluate whether a certain type is beautiful or not. We just find it beautiful or ugly. In other words, it *is* found or seen or evaluated to be beautiful or ugly though we may not know why that person or culture does so. In the end, the body advocacy movement has never been medical or atheistic or ethical, but purely political.

The body advocacy is a political movement trying to gain social power so that they could wield it to achieve what they desire, though no one's perception or view about health and beauty can be changed. What they want immediately is apparent from a socio-psychological perspective. As any group of like-minded people would do in a liberal democratic society like the U.S., the group's voice of strong solidarity gives off the signal that whoever blames them or name-calls them will not be tolerated. In this way, they safeguard themselves from any possible blames or stigmas presently attached to them for a long time. Thus, naturally, only the socially underprivileged group creates such an alliance because the privileged do not need to protect themselves. However, too often, their attempt to protect themselves easily falls prey to the carefully manipulated deception by various corporate industries. Obese people had been stigmatized for lack of self-control, laziness, unattractiveness, and self-caused health problem (whether they true or not). But they have been able to safeguard themselves from all the blames through the fraternal, combatant solidarity. But business corporations find a great opportunity to exploit the movement.

The entertainment industry, always looking for something new and interesting to sell, turns their activism into commodity. For viewers, it is fun and interesting to watch something they have never heard of. Clothing companies find an opportunity to sell a variety of products because being obese is beautiful from now on and thus the beautiful, obese people should try many different fashionable items, just like a slim and pretty fashion model does. What comes worst is that many of the group members have come to believe that their political activism has indeed changed the society's view about the beauty and health standard. We deplore this tragedy. Obesity is America's public health crisis. The body advocacy has caused a serious harm to America's war on obesity.

Near the end of 2016, the United Kingdom, the country where the social stigma of smoking is less prevalent than in the U.S., has enacted a policy on some elective hip and knee surgeries. The U.K.'s National Healthcare System (NHS), the British equivalent of the OHA (considering the UK and Oregon two independent political states), announced that it would ban such surgeries not only for patients who smoke but also for those obese. The NHS, different from the OHA and other state health authorities in the U.S., operates to provide a universal social healthcare for all citizens and legal residents, for in the U.K. healthcare is considered a universal human right rather than a privilege or positive right. That being said, it is ironic that the OHA, whose policy is in no way near providing the universal healthcare, seems to believe that the ban targeting one particular group, the smokers, is seeking distributive justice in health care.

In the U.S., obesity and smoking have been two major health problems. We suggest that, if the OHA's ban is politically a necessary measure, the OHA should extend the ban to include those with obesity problem, just in the case of the British NHS' program. In so doing, the OHA can achieve the following two. First, the state can demonstrate that it is free of cultural partiality towards obesity and against tobacco smoking and thus *en route* to procedural justice. Second, the state can contribute to America's war on obesity by giving a powerful message that obesity is as a serious problem as smoking.

***B. The Ban in Its Current Form is Guilty of Suspicion of Violating Procedural Justice as It Unfairly Discriminates Smokers Based on the Erroneous Assumption that All Smokers Have Freely Chosen to Acquire the Smoking Habit and Retain the Autonomous Choice to Stop Smoking.***

The second reason against the ban concerns procedural justice. The OHA's ban is based on the erroneous assumption that the smokers have freely and rationally chosen to initiate their smoking habit, despite all the warnings, and that they retain the rational, free choice to stop smoking. However, it is unclear if this is the case. To further examine, however, we need to approach the case from the perspective of two different sides of the agent's moral will, that is, the conative and cognitive. For the autonomous decision is referred to as the activity of the conative partition of human mind which includes desires, wills, intentions, volitions, etc. as well as deemed as that of the mind's cognitive partition such as reason, deliberation, speculation, etc. Let us start with the former.

**i. Whether smokers do have VOLUNTARILY chosen to start smoking and retain the same VOLUNTARY WILL to quit smoking, and how the OHA's ban is guilty of violating procedural justice in that regard.**

An individual's propensity for addiction to smoking is based on many factors some of which are outside the patient's control, such as exposure to secondhand smoke and genetics. Moreover, the degree of addiction and difficulty of cessation is not the same for all smokers. A 2011 report published by the Centers for Disease Control (CDC) shows that, while 52% of smokers had tried to quit smoking in the previous year and 32% had received counseling and/or used medication to try to quit smoking, only 6.2% successfully quit smoking.<sup>16</sup> Particularly in the U.S., those who smoke are routinely being denied for many public services that their non-smoker peers are allowed to have. Among the elective treatments rejected are those whose overall cost of care are high. Yet, some smokers are known to make their best efforts to quit but fail, which makes them disqualify for the surgeries. The reason for the failure is due to addiction. If the smokers cannot fully exercise the free, voluntary choice of the will, due to addiction, the smokers, alongside people with obesity problems, should be assisted with medical aids to quit.

Addiction is the problem of inner disposition from which one's freedom emerges. To be a free moral agent, one must have a sound inner condition to exercise one's autonomy. The first person known to us that explored this idea in the Western intellectual tradition is the 4<sup>th</sup> century theologian Augustine. As trying to explain the moral condition of humanity before and after the Fall, he puts forth two notions of freedom, *libertas* and *liberum arbitrium*. According to Augustine, "we are free" because we have the ability to choose, i.e., *liberum arbitrium*, as well as because we are in the condition where we can choose the good and right thing for us, i.e., *libertas*. In essence, the *liberum arbitrium* is neutral, for it signifies the capacity for free choices either good or bad while the *libertas* is something good because it is about our inner condition for making good choices. For Augustine, the theologian who coined the term "Original Sin," we are fundamentally different from Adam and Eve before the Fall in *libertas*. Augustine says, "How happy, then, were the first human beings, neither troubled by any disturbance of the mind nor pained by any disorder of the body!"<sup>17</sup> According to him, Adam and Eve in the Garden were in a far better condition than we are now in terms of *libertas*. After the Fall, however, they came to encounter the absence or death of *libertas* which makes them difficult to make not to sin.<sup>18</sup> For Augustine, this is the condition where we are all, as their descendants, currently situated. Due to the corruption of the inner condition, it is very hard for *liberum arbitrium* to make good moral choices.

Addiction may not be a sinful state of human mind. And it is not necessary for us to assume that the natural moral state of contemporary human person is depraved as Augustine believes it. However, it should be said that addiction is not a sound state of moral mind. The addicted state (*libertas*) has its own psychic pull which hinders the agent from exercising his/her free choice of the will (*liberum arbitrium*). In other words, habitual smokers do have the *liberum arbitrium* which is a neutral free choice of will, but lost good part of the *libertas*. Thus, their *liberum arbitrium* tends to make bad choices, which is the reason that makes the smokers so difficult to quit.

In policy-making, the state should treat all people equally or fairly under the principle of procedural justice. Thus, whether a certain group of people is denied certain public services must be justifiable by reference to the fair treatment of procedural justice. But the necessary precondition for procedural justice is that all citizens have the sound inner condition of freedom (*libertas*) to exercise their free choice of the will (*liberum arbitrium*). When an individual, out of the sound *libertas*, makes a free choice which he/she is blameworthy of, the state's denial of the service for the person is ethically licit. Due to the addiction, the smokers were not given an opportunity to freely quit smoking to receive the elective surgery. Therefore, the OHA's ban, unless complemented by a well-crafted medical aid to help the patients quit smoking, is guilty of violating procedural justice.

**ii. Whether smokers do have RATIONALLY chosen to start smoking and retain the same RATIONAL POWER to quit smoking, and how the OHA's ban is guilty of violating procedural justice in that regard.**

Turn to the cognitive concern, it should be noted that the philosophical approach to the issue from the cognitive and conative perspectives is only conceptual. We are not discussing two different moments or acts but rather two separate aspects of perceiving the same problem, the problem of addiction.

<sup>16</sup> "Tobacco Use Screening and Counseling During Physician Office Visits Among Adults — National Ambulatory Medical Care Survey and National Health Interview Survey, United States, 2005–2009," Centers for Disease Control Supplements 61 no. 2 (June 15, 2012): 38-45, accessed Dec. 11, 2017, <https://www.cdc.gov/MMWR/preview/mmwrhtml/su6102a7.htm>

<sup>17</sup> Augustine, *The City of God*, Book 16 Ch. 11.

<sup>18</sup> In Augustine's later writings, the *libertas* is portrayed as absent while it is dearth in his early writings.



In the Western intellectual tradition, the ancient Greek philosophers, Plato and Aristotle, believed that reason/intellect always has governing power over will. In Augustine, this line of thought is present as well, as he states that the divine eternal law is supreme reason which must always be obeyed by desires/wills. However, a fully developed version of moral psychology that explains how reason/intellect is in control of desires/wills is found in the 11<sup>th</sup> century theologian, Thomas Aquinas' *Summa Theologiae*. For Thomas, reason has supremacy over will. Therefore, in the Thomistic moral psychology, it is hard for smokers to quit, not because of the absence or dearth of *libertas* but because they are irrational. Hence, the addiction does not wreak havoc on *libertas* but on the agent's reason. Namely, smokers are irrational people.

In contemporary Anglo-American philosophy, one of the best works that argues about the irrationality of smokers in relation to addiction may be found in the philosopher Robert Goodin's 2007 essay, "Smoking: Is Acceptance of the Risks Fully Voluntary?"<sup>19</sup> In his essay, Goodin, drawing on the utilitarian-liberal tradition of John Stuart Mill's anti-paternalism in which an individual citizen's autonomy is prioritized over state paternalism, argues that smoking is a substance that leads to the addiction which destroys the agent's rational capacity. Despite the ubiquitous presence of the objective data that cigarette-smoking harms nearly every organ of the body, causes many diseases, and significantly shortens the life of smokers in general, the smokers falsely underestimate the risks of smoking, which is the evidence of irrationality. Therefore, Goodin argues that the state should tighten smoking law so that citizenry should be able to exercise rational autonomy.<sup>20</sup>

Goodin's position that smokers are irrational has invited many critics. One of Goodin's formidable critics, Graham Oddie, raises the question if becoming a smoker is necessarily a bad idea. Then, he points out that "the chance of becoming addicted by itself does not constitute a reason for preferring one course of action to another."<sup>21</sup> In other words, there is no necessary logical connection between the possibility of being a habitual smoker and one's decision to knowingly start smoking or not. He argues that "there is no intrinsic disvalue to addiction, and each case of possible addiction will have to be examined for consequentialist values and disvalues before deciding what should be done."<sup>22</sup> Oddie recommends that what must be done is to "examine the nature of addiction, in particular the likelihood and severity of the bad cases it could generate," and concludes that "[i]n many cases, this [consequentialist deliberation] is enough to substantially shift the burden of proof, especially if we place a value on rational autonomy."<sup>23</sup> Alternatively put, Goodin's irrationality argument, for Oddie, is just out of moral context, if not strange.

Oddie is right that there is no conceptual, logical connection between the possibility of being a habitual smoker and one's decision to become a smoker or not and that the consequentialist deliberation of harm and benefit should be the guide to determine whether smoking (or use of substances which cause addiction) is ethically permissible. But we believe that Goodin's irrationality thesis is still relevant to the case of smokers, particularly today's smokers. As we all may agree, a certain degree of irrationality of this type exists virtually in any individuals who live the contemporary Western lifestyle which demands work-based efficiency. Drinking alcohol, gourmet food eating, binge-watching motives, etc. may be the same kinds of addictive behaviors which many of us rely on to help us work harder and more efficiently. But we do not talk about a strong government intervention to control the addictive behaviors to reset the possible irrationality. In the end, it is our value judgement whether a certain addictive behavior should be considered moral disvalue or not. We judge if a certain addictive activity is considered morally not acceptable and therefore not rational. Thus, another critic of Goodin, Daniel Shapiro, aptly writes that, if one allows oneself to form a certain addictive habit because "one wishes to be a certain kind of person or . . . lead a certain kind of life, [f]or these kinds of smokers, [Goodin's] irrationality argument fails."<sup>24</sup> In other words, some choose to become habitual cigarette smokers based on their own value judgements. If then, we cannot say that the smokers are irrational.

However, Shapiro should concede that, at least for most of us living in the contemporary West, choosing to become habitual smokers and retaining the habit are not decisions made out of their desire to be a certain kind of person based on their personal values. Most people start smoking when they were teens out of peer pressure or to show off to their peer or being manipulated by tobacco companies' marketing tactics. When they desire to quit in their 40s or 50s because of the apparent health concern, the

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<sup>19</sup> Robert E. Goodin, "Smoking: Is Acceptance of the Risks Fully Voluntary?" in *Principles of Health Care Ethics*, 2nd ed., eds. Richard E. Ashcroft, Angus Dawson, Heather Draper, John R. McMillan (Hoboken, NJ: John Wiley and Sons, 2007): 647-653, doi: 10.1002/9780470510544.ch88. The article is a re-published work listed in his own book, *No Smoking: The Ethical Issues* (Chicago: University of Chicago Press, 1989), 20–30.

<sup>20</sup> Robert E. Goodin, "Smoking: Is Acceptance of the Risks Fully Voluntary?"

<sup>21</sup> Graham Oddie, "Addiction and the Value of Freedom," *Bioethics* 7, no. 5 (1993): 398.

<sup>22</sup> *Ibid.*, 397.

<sup>23</sup> *Ibid.*, 398.

<sup>24</sup> Daniel Shapiro, "Smoking Tobacco: Irrationality, Addiction, and Paternalism," *Public Affairs Quarterly* 8, no. 2 (1994): 188.

addiction level is too high for them to quit. Being convinced that they may never quit, many of them irrationally justify their smoking habit by downplaying the objective scientific data, as Goodin describes it.

In addition, it can be said that rational moral agents do not choose to become habitual smokers to enjoy a certain lifestyle associated with smoking cigarettes when they fully understand the *harmful consequences of the actions*. One of the widely used criteria for patient competence at a hospital ICU is whether patients understand consequences of their choice for treatment decisions. When the patients do not, they are treated as incompetent, which requires legal surrogate decision-makers to decide on their behalf. Then, can incompetent patients be rational? The answer is obviously no. Of course, the smokers are not terminally ill people hospitalized in the ICU on the verge of losing competency. However, in theory, it is possible to argue that those who do not fully understand the harmful consequences of their own action can be considered “irrational,” if not incompetent.

In fact, Shapiro is against Goodin’s position that the government should ban the sale of cigarettes, not against the fact that irrational smokers do exist. But we argue that most habitual smokers in our day and age living in the West are irrational in the sense that we have described it. Hence, going back, the proponents’ premise that smokers have made a rational choice not to care for their own health is philosophically problematic. Accordingly, the OHA should provide an active medical aid to help the smokers quit smoking so that they would receive the desired elective surgeries. In this way, procedural justice may be respected with the ban.<sup>25</sup>

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<sup>25</sup> We, of course, argue that a comprehensive obesity prevention and weight-loss program should be introduced along with the ban as well. However, in this paper our focus has been mainly on smokers.

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