PROFESSIONAL ETHICS FOR COLLEGE HEALTH SERVICES

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By

Dessa Mrvos

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_____ Gerard Magill, Ph.D. The Vernon F. Gallagher Chair Professor of Healthcare Ethics (Dissertation Director)	_____ Joris Gielen, Ph.D. Director, Center for Healthcare Ethics Associate Professor of Healthcare Ethics (Committee Member)
_____ Joris Gielen, Ph.D. Associate Professor of Healthcare Ethics (Committee Member)	_____ Peter Ikechukwu Osuji, C.S.Sp., Ph.D. Assistant Professor. Center for Healthcare Ethics (Committee Member)
_____ Kristine Blair, Ph.D. Dean, McAnulty College and Graduate School of Liberal Arts	

ABSTRACT

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Dissertation supervised by Gerard Magill, PhD.

College Health Services are a unique and continually evolving entity of institutions of higher education with a rich history of how the field evolved, trends that influenced its development, and a strong national organization that contributed to its formation. Respective of institutional size and scope of practice, while aligned with institutional mission and recognized practice standards, college health centers can function as a small healthcare system through characteristics such as student centeredness, the impact of student health on achievement, and in terms of quality of services provided. Fundamentally, college health services contribute to disease prevention, health and wellness promotion and education, and toward student wellbeing through integration with counseling services and other campus partners.

Healthcare ethical principles and concepts apply directly to the practice of college health. This dissertation uses the ethical approach of principlism by the four pillars of autonomy, beneficence, nonmaleficence, and justice as the lens through which professional ethics are explored for college health services. General ethical concepts are further considered in their application to this particular context of clinical practice.

Professional ethics and professional practice are discussed in relation to character and virtue, as well as through the ethics of care and wellbeing in terms of organizational agency, accountability, and institutional practice standards. Moreover, a systems approach is applied in view of the ethical accountability of health care providers as regards high risk health practices and other public health challenges of young adults as the predominant population served by college health services.

DEDICATION

I dedicate this dissertation to my husband Rudley, my daughters Sara and Jelena, and to the sweet memory of my parents. It is also duly dedicated to my colleagues in Duquesne University Health Services, and to the many students served by our devoted staff. The collective experiences that I have had initially as a staff nurse and eventually as director served as my motivation for this project.

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Without the unwavering prayers, support, patience, and encouragement of my family and close personal friends, this achievement would not have been possible. In addition, my gratitude, admiration, and profound respect for Dr. Gerard Magill as my mentor, is unsurpassed. I first came to know Dr. Magill professionally because of co-appointment to a university committee, and by his gentle encouragement and tender patience, I enrolled into graduate studies, made it through one semester into the next, and finally to this point. A certain angel from the Center for Healthcare Ethics named Glory Smith must also be given her due as a stalwart supporter, encourager, and prayer warrior. Along this journey, I also encountered many scholars and authors in the fields of healthcare ethics and theology, several of whom share my Eastern Orthodox faith tradition. I acknowledge their wisdom and scholarship, and the guidance I received because of their generosity. According to the teachings of St. Seraphim of Sarov, when a man lives in peace, God reveals mysteries to him. May we all seek and find peace.

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Chapter 1. Introduction

College health services provide a crucial resource for campus communities in the United States, substantially affecting student health, safety, and wellbeing. The impact and quality of campus clinical services impact student life through varied approaches to the delivery of services, health innovations, and business models. The role that campus health services plays in dealing with risk mitigation is essential: well-established public health principles of disease prevention, health promotion, and health education are sustained and advanced by campus clinical health services. Aligned with institutional mission and promoting recognized practice standards, College health centers can function as a small healthcare system. Despite the widely recognized importance of College health services, there is very little literature on the contribution of ethics related to them, especially from the perspective of professional responsibilities.

Hence, to engage this significant gap in the field, the thesis of this dissertation seeks to present an approach to Professional Ethics for College Health Services (CHS). The layout of the argument is as follows. Chapter 1 presents a brief introduction to the dissertation. Chapters 2 and 3 present the context of CHS as a basis for the analysis in the dissertation. Chapter 2 describes CHS as an evolving field across College campuses in the United States. Chapter 3 discusses the relevance of prominent principles in healthcare ethics as a foundation for the development of an approach to professional ethics. The subsequent chapters present an approach to professional ethics by engaging pivotal themes that shape CHS. Chapter 4 explains the importance of quality and virtue in professional ethics for CHS. Chapter 5 considers the significance of care and wellbeing in professional ethics for CHS. Chapter 6 addresses the role of agency and accountability in professional ethics for CHS. Chapter 7 presents a brief conclusion. What follows is a brief summary of the analysis in each chapter.

Chapter two discusses College Health Services as an evolving field in terms of ever-changing needs of the students that are served by them, and truly function as mini-healthcare systems.

2.A. A Historical Perspective

This section examines how campus clinical health services evolved to their current status.

2.A.i. A Look Back

The first sub-section provides a historical perspective through a look back at the very origins of health and hygiene practices on college campuses in a young nation, and the progression of ideas, concepts, and practices that followed. There is early evidence of colonial institutions recognizing the importance of the physical health of its students by formalizing physical education programs and developing infirmaries analogous to those within military academies. In the nation, there was growing awareness of public health concerns with increasing understanding of communicable diseases as history progressed. Further progress of medical services at educational institutions included attention to mental and other personal health concerns. Eventually, national surveying and data collection advanced the standardizing of certain practices.

2.A.ii. Evolving Trends Influences, and Development

The second sub-section discusses evolving trends and influences, including historic conditions, cultural shifts, and political tides that shaped the practice of medicine in the U.S., directly affecting and overtly improving campus health offerings. Ongoing advancement of the practice of college health became evident through correlating academic success with overall personal health. The incorporation of national health initiatives fostered continuing progress. Subsequent developments evolved from influences such as enrollment demographics, technology, resources, and cultural competency in light of increasing student diversity across multiple dimensions.

2.A.iii. Formation of a National Organization. The third sub-section considers how advancing the practice of college health was heavily impacted by the formation of a national focal organization. The continuing advancement of a national presence of leadership occurred through the initiative of annual gatherings, formation of a college health journal, and publications of guidelines for preventative health practices. Further development of national leadership occurred in terms of both research and advocacy by means of scholarly enquiry specific to college health, consistently applied assessment strategies and surveys, as well as increasing access to professional development and networking.

2.A.iv. Where We Fit In. This fourth sub-section looks at where we fit in today in campus health centers. There are vast differences yet common similarities that unify the contributions that campus health centers provide to their institutions. The purpose and value of campus clinical services became prominent through developing trends for health promotion and socioecological approaches to wellness, as well as the importance of outreach and collaboration across campus sectors. Today, campus health services are associated with the transformation of culture, being integrally connected to institutional mission, core values, and all-encompassing wellbeing practices throughout the institution.

2.B. College Health Services as a Healthcare System

In this section, college health services are identified as a valuable resource to the campus community by substantially affecting student health, safety, and wellbeing and functioning within the campus community as a mini-healthcare system.

2.B.i. Student-Centeredness. The first subsection discusses the importance of student-centeredness to emphasize how campus clinical services support student learning and achievement, despite broad differences across institutions. Also within this subsection, various

emerging healthcare delivery innovations, resourcing, and business operational models are considered.

2.B.ii. Impact and Quality. The second subsection examines the impact and quality of college health services for risk mitigation, threat assessment, and other strategic processes. College health services provide a vital role in addressing safety, assault, and violence issues on campuses as well as risk-inducing factors. Also explored is the importance of fostering quality improvement of all processes as a systemic necessity.

2.B.iii. Prevention, Promotion, and Education. In subsection three, key public health principles of disease prevention, health promotion, and health education and literacy are presented as being crucial for college health services. The significance of health promotion standards as a collaborative effort of the institution with college health services in the lead, also informs students as future consumers of healthcare.

2.B.iv. Integrated Forces. Subsection four challenges traditional models of health systems by considering the need for integrated forces to foster a culture change toward a culture of wellbeing. As a healthcare system, college health services rooted in a purposeful institutional mission and adherence to practice standards will drive strategic action.

Chapter three discusses ethical principles and concepts for college health services. The following two sections each introduce foundational principles of healthcare ethics in application to college health services, first through principlism, and then by general ethical concepts.

3.A. The Ethical Approach of Principlism for College Student Health Services

This offers an introduction to the four basic principles of healthcare ethics, autonomy, beneficence, nonmaleficence, and justice in application to college health services.

3.A.i. Autonomy. In subsection one, autonomy is tied to developmental considerations of wellness, especially as regards the transition to young adulthood and of self-care. How students gain the capacity for decision-making in terms of their health, as well as a multitude of influencing factors are also evaluated in light of vulnerabilities and health risks.

3.A.ii. Beneficence. Subsection two addresses the principle of beneficence as regards the potential for campus health services to positively influence the health of college students through illness prevention and health-related education. With regard to the college environment, stressors and challenges experienced by students are considered in context of the positive impact that clinical health services can have on student coping and adjustment.

3.A.iii. Nonmaleficence. The third subsection details the principle of nonmaleficence through the perspective of various harms that college students may encounter in relation to their health and wellbeing, such that campus health centers are in position to educate students while also treating their medical needs. Upholding clinical care and professional practice standards as an expectation of college health services to sustain the credo of "first, do no harm" pertains to all, regardless of size or scope of service.

3.A.iv. Justice. In subsection four, the principle of justice is reflected upon as it correlates to student wellbeing and academic potential. Access to health care services, elimination of barriers, and equitable provision of services that compliment a productive living, learning, and work environment is vital for student achievement.

3.B. General Ethical Concepts for College Health Services

In this section, general ethical concepts are examined as they apply to the college health setting.

3.B.i. Common Morality and Virtue. Subsection one probes the topic of common morality contrasted with particular moralities, relating morality and virtue to campus clinical health services. Moral excellence and ideals apply to this niche of medicine when considering the patient/provider relationship.

3.B.ii. Vulnerability and Discrimination. The next subsection identifies vulnerability and discrimination as two areas of concern for college health professionals, in that college students are a particularly vulnerable population. Avoiding intentional or unintentional discrimination by means of disparities or other limitations is of universal concern.

3.B.iii. Professional Patient Relationship. Within the third subsection, key ethical concepts are discussed in terms of imparting information considering developmental stages and maintaining faithfulness and trust. As such, the topic of confidentiality is explored in the context of the college health setting.

3.B.iv. Consent and Surrogacy. The fourth subsection considers consent and surrogacy while evaluating the importance of informed decision making for student-patients of campus health services. Surrogate decision making is discussed as regards legally binding agreements as well as general standards for surrogacy.

Chapter four discusses professional ethics through quality and virtue. Professional ethics for campus health services are considered from the perspective of practice and quality and from the perspective of character and virtue.

4.A. Professional Practice and Quality

In this section, moral underpinnings of professional practice standards as well as patient trust, interdisciplinary collaboration, and quality improvement are applied to college health services.

4.A.i. Professional Morality and the Caring Professions. The first subsection addresses healthcare professionals as being of the caring professions and how moral theories, norms, and virtues apply to the practice of college health: universal and particular moralities are discussed. It also discusses sources of moral authority to consider what motivates one's moral functioning in the context of professional practice.

4.A.ii. Patient Trust and Professional Practice. This subsection looks at the patient-provider relationship as affected by information technology and social media. Student-patient perceptions and perspectives are considered in terms of thematic questions and corresponding professional virtues.

4.A.iii. Interdisciplinary Collaboration. The third subsection considers benefits of and barriers to collaboration amongst the broad range professionals in college health services because of variability in staff composition and institutional characteristics. College student mental health needs continue to spiral upward, and the corresponding need to combine forces by integrating clinical and psychological services as foundational to interdisciplinary collaboration is also discussed.

4.A.iv. More on Quality Improvement. Subsection four considers the uniqueness of the college health setting and the need for moving the concept of continuous quality improvement to realistic quality care. Along with this charge, the question is of whether quality improvement is

essentially functional research is posed with regard to how it applies to implementing change in clinical settings of campus health services.

4.B. Professional Character and Virtue

This section introduces notions of virtue ethics and other reflections on character and conscience for healthcare professionals in college health settings.

4.B.i. What are Virtue Ethics and Why Bother. The first subsection provides insight into various philosophical foundations and historic roots of virtue ethics that serve to inform the college healthcare professional. Moral excellence and exemplarist virtue theory further the notion of the virtuous life as being developmental along with professional growth.

4.B.ii. Virtue Practiced. Within the second subsection there is an expanded look at classic virtues for healthcare professionals as relates to the college health setting. Certain objections and criticisms of virtue-based ethical theories are also considered from several perspectives.

4.B.iii. It Begins with Character. Section three addresses professional character and the empathetic encounter, particularly significant to the setting of campus clinical health services and clinical scenarios with college-student patients. Defects of character such as attitudes, biases, and compassion fatigue are also considered with attention to professional conduct.

4.B.iv. Accounting for Conscience. The fourth section examines the eternal question of what is conscience, focusing on self-reflection of actions through moral discernment. Conscientious objection is discussed relative to morally challenging situations encountered in the practice of college health.

Chapter five is discusses professional ethics in terms of care and wellbeing. This section further discusses professional ethics as regards both the ethics of care in correlation to the practice of college health, as well as expanding the discussion of wellbeing as necessitating a holistic approach and that it is an institutional concern.

Chapter 5.A. Professionalism and Care

Within this section, an overview of care ethics is examined through various theories, challenging viewpoints, and complimentary findings that provide a direction to caring as well as alternative approaches in application to the practice of college health.

Chapter 5.A.i. Care Ethics: Roots & Origins. This subsection analyzes the roots, origins, and theories from which care ethics are derived, namely through that of Gilligan and Tronto, each with a distinct underpinning of moral relevance. Other theories from Noddings and Tong both consider the inter-relational aspect of care, while Tong clearly fuses her theory with virtue ethics.

Chapter 5.A.ii. Care Ethics: Challenging Viewpoints. Challenging viewpoints in criticism of the ethics of care are examined in this subsection in that some regard care ethics as lacking normative and descriptive content. Still other critics contend that an ethic of care does not provide adequate or definitive moral guidance in evaluation of the relational aspect of care.

Chapter 5.A.iii. Complimentary Findings: A Direction for Caring. This subsection evaluates complimentary and associated concepts that pertain to practical application through the work of Galvin and Todres "lifeworld" approach to "humanizing care." It also examines a nursing theory by Watson referred to as a caring-science model, with relevance to college-health practice.

Chapter 5.A.iv. Complimentary Findings: Alternative Approaches. Within this subsection, the personalist approach to care ethics is considered through the writings of Janssens and Selling as

being multidimensional and relational. The Christian inspired ethic of care concludes this section from the foundation of Christian moral teaching as depicted through Pellegrino and Engelhardt.

Chapter 5.B. Professionalism and Wellbeing

This section introduces the concept of wellbeing for healthcare professionals in college health services as regards a culture of wellbeing on campus as well as ethical structures of wellbeing. It considers various perspectives of happiness as well as holistic wellbeing as an institutional concern, with emphasis on a health related quality of life.

Chapter 5.B.i. Overview: Wellbeing and Ethics. Wellbeing is examined in this subsection as central to all aspects of care services on college campuses, both clinical and psychological, and correlates to all aspects of higher education. Ethical structures of wellbeing are examined through multiple theories, concepts, and principles as also contributory to a justice-promoting environment.

Chapter 5.B.ii. Perspectives of Happiness. This subsection analyzes studies on happiness from various perspectives in correlation with the concept of human thriving. Critical viewpoints are raised in terms of contemporary cultural paradigms and an increasing prevalence of mental health disorders.

Chapter 5.B.iii. Holistic Wellbeing: an Institutional Concern. Within this subsection, the notion of institutionalizing wellbeing is examined through several models of holistic wellness as correlates to student success. Further, overarching mobilization strategies for campus communities are considered with college healthcare professionals being influential for the movement.

Chapter 5.B.iv. Health Capability and Health Related Quality of Life. This subsection pursues individual self-care in the context of environmental influences, health-seeking, and self-efficacy. It ends with a glance at spiritual wellbeing as a component of total wellbeing, joy in contrast to happiness, and the presence of meaning in one's life.

Chapter six furthers the discussion on professional ethics in respect to agency and accountability. This section examines professional ethics by means of organizational moral agency, intuitional mission and commitment to campus health services, and by organizational identity and accountability. A systems approach for clinical ethics are applied to high risk practices of young adults.

6.A. Organizational Ethics: Practice Standards of Institutions.

Within this section, the function of college health services as a health system bearing its own moral agency is examined through stakeholder theory, institutional commitment, and adherence to mission and vision. Organizational culture and identity are discussed, along with general applicability of an ethics infrastructure, as well as accountability and performance practice standards.

6.A.i. Organizational Moral Agency. This subsection discusses the concept of moral agency as applicable not merely to individual healthcare professionals, but to the college health service as an organized healthcare system bearing its own moral obligation. The strategic importance of stakeholder theory to student health services is examined in terms of a related priorities.

6.A.ii. Institutional Mission & Commitment. The next subsection deals with mission and vision through related ethical principles of stewardship and integrity as regards campus health service's strategic importance to the institution. Regardless of institutional size or scope of practice of

campus health services, how they are resourced suggests institutional commitment to their sustainability as an essential service.

6.A.iii. Organizational Identity. The third subsection considers organizational culture within the facility of campus health centers in terms of functional conditions within the practice, how values are integrated with practice standards. Having an effective ethics infrastructure for campus health centers correlates daily practice with ethical awareness and core values that guide decision-making.

6.A.iv. Organizational Accountability & Practice Standards. This subsection examines the public health strategy of health literacy as a standard for student-patient skill development in consideration of overall quality performance of the health center. Due to the complexity of health care needs specific to college students, effective managerial leadership of the campus health center is critical to upholding established practice standards and facility accreditation.

6.B. Ethical Accountability of Healthcare Providers: High Risk Health-Related Practices of Young Adults.

This section captures the essence of why healthcare ethics can be applied to the practice of college health in that it addresses public-health challenges of this predominant age-category by examining root causes. It also offers a systems approach for ethical accountability of healthcare providers in college health services, with a nod to the future in terms of high-risk health concerns exacerbated by the study of genomics.

6.B.i. Rationale: Public Health Challenges of Young Adults. This subsection addresses public health-related challenges of young adults since they comprise the majority of students at most institutions of higher education. It examines particular high-risk health behaviors and resultant

consequences influenced by the social script of young and emerging adult students. The consideration of cultural context clearly demonstrates an impact upon how healthcare providers in college health services support the health of young adults.

6.B.ii. Root Causes: The i-Words. (The prefix "I" connotes "internet" – such as in iGen). Subsection two introduces the impact that technology has had on college-aged young adults as among the root causes of a palpable generational shift. This subsection also examines distinct contributing influences contextual to the college environment.

6.B.iii. Systems Approach: Capacity, Understanding, Agency. The third subsection correlates the challenges of high-risk behaviors with neurobiological complexities unique to the young adult developmental stage. It concludes with the ethical precept of veracity as pivotal to college health professional's interaction with students toward empowerment of them as individuals, regardless of particular vulnerabilities and high-risk behaviors, toward improving health outcomes.

6.B.iv. Systems Approach: Precision Medicine and Epigenetics. Moving from high-risk health challenges of present-day college students, this subsection examines that further high-risk concerns may be exacerbated in the burgeoning arena of genomics and precision medicine. Today's young adult population must consider the true and present risks of environmental impact on the human genome and potential effects on DNA of future generations as it relates to epigenetics.

Chapter 2. College Health Services: An Evolving Field

Within this chapter, the first section will provide a historical perspective of how college health evolved, while the second section considers how college health services function as a healthcare system.

2.A. A Historical Perspective.

Many are familiar with the Rudyard Kipling oft-quoted phrase "if history were taught in the form of stories, it would never be forgotten."[1] As regards the history of the practice of college health medicine, there have been but a few 'stories' written on the topic, yet for those of us who work in this vastly unique field, we should indeed be cognizant of the evolution, formation, and advancement of our profession. Of the various articles and publications that are written on this topic, *The History and Practice of College Health*, a book written by H. Spencer Turner and Janet L. Hurley in 2002, is a preeminent resource and treasure of all-things college health.[2] Their work credits influential texts by pioneers in the field and over time by other contributors and authors, and provides a keen perspective on not only the origins of our practice, but also offers topic-specific overviews and guidance on a comprehensive list of ever-pressing concerns from an impressive panel of experts in the profession. When a field-specific journal was eventually conceptualized, it provided a pivotal forum through which college health professionals could read about a multitude of topics related to research and developments in the field, in addition to providing a format for discussion of controversial issues, and continues to be an outstanding resource.[3] Various noteworthy articles in other journals and periodicals throughout the latter half of the 20th century through present day have also provided insight and perspective about not only the development of but also the growing sophistication of the practice of college health.[4] A work from 2007 by Heather Munroe Prescott entitled *Student Bodies, The*

Influence of Student Health Services in American Society and Medicine offers a somewhat different approach as she parallels the connections between university health centers and the evolution of American health and medicine, addresses changing student issues in terms of context and era, and within this book offers an insightful perspective that continues to be current.[5] In respect to all of those scholars whose works are referred to throughout this essay, what remains relevant is that we continue to lift up the value of what we do, honor the significance of our profession as fundamental to the success of the students we serve, and strive to sustain the excellence that has resulted from the rich history that preceded.

At various touch-points along the time continuum, college health has intersected with other historic events, has been impacted in many ways by legislation, and has realized not only its own specificity for the health and wellbeing of college students, but also its relevance to and parallel with public health, in general.[6] To reach back to its very beginnings, we find ourselves amidst the 19th century when our nation, although very young, did have over forty established universities including military institutes and academies that came to develop infirmaries after various infectious disease epidemics resulted in student deaths.[7] Early programs incorporated university faculty physicians to also provide care to ill students, along with teaching physical education and hygiene courses, serving as a lasting approach until discoveries in the biological sciences replaced such hygiene based theories.[8] Over time, further progress in the 20th century along with emerging trends and theories also expanded the nature and scope of what college health services were becoming, inclusive of federal initiatives and funding for campuses to control infectious disease spread.[9] In the early 1900s, interest groups started to form as practitioners of college health began to contact one another to share information, eventually leading to the formation of a national organization in 1920 dedicated to the field of college

health.[10] This was monumental for the advancement of the practice through establishing a professional network, facilitating exploration and expansion, and providing a forum for advocacy.

Maintaining perspective through an understanding of the history of our specialty and the multitude of influences throughout the decades of our development will enable ongoing progress as both a unified and unique subspecialty of medicine. The broad range of health care and other professionals that make up this family of college health specialists surely recognize the exclusive opportunity that distinguishes us to make significant contributions that affect the health of a very important population that we have the privilege of caring for.

2.A.i. Look Back

A Growing Concern for Health and Hygiene. To value the legacy of college health is to also gain a sense of perspective of the general history of higher education in America, beginning with the founding of the first college in the American colonies, instituted by the Massachusetts Bay Company in 1636, taking on the name Harvard in 1638 after the endowment of colonist John Harvard.[11] The College of William & Mary is considered to be the second-oldest, with the original plans from 1618 predating those of Harvard, having been disrupted by an "Indian uprising."[12] As colonial America continued to grow prior to the Revolutionary War, multiple other institutions were established until resistance to British rule became active in some, while the presence of Loyalists affected the climate of others.[13] What is known today as the University of Pennsylvania was the outcome of a formal Proposal written in 1749 by Ben Franklin who acknowledged the importance of health, asserting that so as to keep students healthy they should "render active their bodies and be frequently exercised."[14] Although many of the colonial colleges were conceivably disrupted during the war, some original "Royal" founding charters

were converted to "state" granted charters, and several other colleges were founded even during those turbulent times.[15] Despite the turmoil that ensued and the growing pains of a new nation, by 1830 over 40 major universities were established, followed by nearly doubling that number by 1860.[16] The propagation of American colleges in a new democracy recognized the European ideal of "a healthy mind in a healthy body," and several of these early institutions were developing infirmaries by the latter half of the 19th century.[17]

Throughout the literature, Amherst College is lauded as having established the first college health service with the novel creation of a "Department Of Physical Education and Hygiene" which stipulated that medical examinations were conducted on all entering students, a course in physical education was developed, care of ill students was provided for, and annual reports were to be compiled to track statistics of student illnesses.[18] Because of concerns raised by the President of the university regarding the "breaking down of the health of students especially in the spring of the year," Amherst charged Dr. Edward Hitchcock, a physician, with the task of advancing the health of students through physical fitness.[19] Hitchcock's career spanned 47 years during which he not only developed the program, but utilized the standard of anthropometric measurements, cared for sick students in rooming houses, petitioned for the building of an infirmary, also provided lectures to freshmen students known affectionately as the "smut lectures," and was known to spend a great deal of time counseling students.[20] Hitchcock was truly beloved, and is thusly referred to as the "Father of American College Health."[21] His legacy was powerfully sustained by Thomas A. Storey, who further exerted tremendous influence in advocating for hygiene to be taught to college students, especially as the fields of microbiology and immunology advanced.[22]

It is of interest to note, however, that the actual precursor to campus-based college health services were early military academy programs and their hospital and infirmary facilities.[23] Dr. William A. Christmas, noted ACHA (American College Health Association) historian, personally undertook intensive archival research about the history and origins of college health and discovered that prior to 1860, not only did at least 78 higher education institutions have buildings on their campuses for the sole purpose of caring for ill students, but that military academies such as the Virginia Military Institute, the U.S. Naval Academy, and West Point U.S. Military Academy each had dedicated facilities.[24] Epidemic occurrences of illnesses such as typhoid, influenza, and mumps at these various institutions often potentiated the establishing of such clinical facilities.[25] The University of Virginia, founded by Thomas Jefferson in 1819, also experienced several serious typhoid outbreaks in the early 1850's, resulting in multiple student deaths, prompting the authorization of the construction of an infirmary due to student and parent concerns.[26] When constructed, the building was "state-of-the-art" for the time, equipped with centralized heating, a ventilation system, louvered windows, and cisterns for the collection of rainwater for redirection to bathrooms.[27]

From the mid-nineteenth century on, health-related services for students across institutions continued to increase, commonly emphasizing physical education, instruction in personal hygiene, and concern for healthful living environments; eventually coming to include the ever-increasing component of organized collegiate athletics.[28] As the concept of student health services gained momentum through the second half of the 19th century, so too did the opportunities for nurses to care for the ill students in these settings, directly paralleling the vigorous development of the nursing field, particularly with that of Florence Nightingale's principles for educating nurses that addressed "ventilation, cleanliness, light, and chattering

hopes (to patients)."[29] The infirmary concept prospered with attention to isolating sick students amidst epidemics, even further impetus for the formation of complete medical programs, with Princeton and the College of William and Mary being the first to open men-only infirmaries in the 1890's, followed several years later by U.C. Berkeley surpassing all with instituting one of the most comprehensive programs for college student health.[30] Likewise, women with medical degrees were often employed by female-only colleges in the late 19th century, which became a proving ground for achieving improvements to the overall physical health of female students during time spent in college along with improved disease prevention as compared to their male counterparts.[31]

Origins and Progress. With the turn of the century, one of the most influential historic events that affected the continued development of campus health services was the First World War, with pre-induction physical examination requirements to determine suitability for military service, the concept of which spilled into college health programs as many institutions then began to conduct physicals and implement screenings to identify medical problems that would interfere with academics.[32] Another military-college health parallel occurred in 1915 with the involvement of the student health director of Stanford, Dr. William F. Snow (a colleague of the aforementioned Thomas A. Storey), as a founding member of the American Social Hygiene Association, assigned to combat venereal diseases in the military through federal funding that also earmarked funds for distribution to colleges and universities for venereal disease prevention efforts.[33] Through the remaining early decades of the 20th century, increased standardization of college health practices grew out of other government initiatives and conferences aimed at infectious and communicable disease prevention with the first National conference on College Hygiene held in 1931, followed in the same decade by an international assembly held in Athens,

Greece, of seventeen countries (including the U.S.) which deliberated and prioritized a statement of views on college student health practices.[34] Progressive for its time, this assembly paid particular attention to prevention of tuberculosis, encouraged the proper training of physicians and staff inclusive of specific skills to care for college students, urged the importance of keeping statistics and health records, and suggested reconvening every four years – which unfortunately never ensued.[35] Other concepts were also explored at these early meetings, such as stipulating requirements for professional nurses in student health to "be a registered nurse and graduate from a recognized school of nursing with hospital experience…have a pleasing personality... experience in laboratory technique…membership in professional organizations…broad interests and educational viewpoints," seemingly an early rendition of a professional practice standard, much of which continues to be applicable today.[36]

Although it is ostensibly cliché to state that history repeats itself, during the early decades of the 20th century our country was working toward a national healthcare plan to finance healthcare for all, but due to its failure the private insurance industry exploded, so college health centers relied primarily on tuition, general funds, or collected fees to assure constancy of operations, despite the instability of healthcare financing in the public sector.[37] Not all colleges and universities adopted the model for on-campus student health services, but when the momentous influenza pandemic of 1918-1919 resulted in the deaths of countless young adult males, many were then initiated.[38] Despite this stark reality, some opinions of college health services were unfavorable. There were physicians from the private sector who viewed campus-based student health centers as an unfair monopolies, evidenced by an editorial in an AMA (American Medical Association) Bulletin from 1925, referring to college health services as "a most obnoxious form of contract practice," contending that institutions of higher education were

"under no more obligation to supply medical care than they would be to supply clothing, food or any other necessities."[39] Fortunately, a rebuttal to this published opinion was offered by a Penn physician who claimed that universities had the "in loco parentis" duty toward students' health and wellbeing, affirming the "positive moral duty of the educational authorities" and "to provide as promptly and conveniently as possible competent medical care and advice for sick students."[40] Even further objection to negative criticism was articulated by physicians at historically black colleges and universities, asserting that campus services were indeed necessary due to racial discrimination and segregation in off campus medical treatment facilities.[41]

A substantial development of the 1920's that is prophetically relatable to current practice was the recognition of a need to establish mental health "hygiene" programs on college campuses, citing the "retention of intellectually capable students," "forestalling of failure from nervous and mental diseases," and other profound testimonials stated in an address presented by a college health physician at a landmark gathering of college health professionals.[42] Concerns for the mental health needs of college students were recorded as early as 1910 at Princeton University due to student attrition because of "emotional and personality issues," as well as behaviorally related programs being developed throughout that decade at other institutions.[43] A national committee was also formed in the early '20's for youth in schools and colleges due to increasing prevalence of mental health issues including depression, suicide, and alcohol abuse.[44] Despite this acknowledgement, incorporating mental health services was not widely practiced, and by the latter half of the 1930's, a survey was conducted of over 400 schools, indicating overwhelmingly that 93% of the participants viewed mental health as an important need, yet just over 40% already had psychiatric services, with just under 50% reporting that they intended to establish psychiatric consultations.[45]

Fortunately, by the mid-1940's and post WWII, attention was given to further organize and standardize the practice of college health by reviewing the progress and status of existing centers, identifying major health problems of college students, delineating administration responsibilities, suggesting adaptable programs with specific provisions, and cultivating a plan to publish these and other recommendations as a guide for those in the practice of college health medicine.[46] Even greater critical analysis of the profession took place in 1953 when Cornell University staff issued a vast and comprehensive college health services survey issued through personal interviewing by means of letters to over 1,100 college and university health service directors, resulting in comprehensive data that provided guidance on standardizing practice, staff composition, funding, the need for publishing periodicals specific to college health practice, and other pivotal conclusions.[47]

The subsequent decades of the latter half of the 20th century proved to be times of unparalleled growth in higher education, with attention to increasing standards of performance of college health services, further development of journals, increased awareness of women's health issues and the health needs of minority and underrepresented groups, in addition to many other topics.[48] One primary example was due to the emergence of the "free sex" movement, the push for free speech and other topics of civil unrest, most notably at Berkeley and elsewhere by students in the early 1960's which led to quantum changes in offerings at campus health services relative to sexual health.[49] The subsequent decades of the latter 20th and early 21st centuries have been replete with substantial change and rapid sophistication of the profession, in line with public health and ambulatory care practice criteria for acute and chronic illness management, disease prevention, health education, and student advocacy. To fully recapitulate all that unfolded from mid-last century through present day would fill entire chapters, while this review

is intended to merely portray a snapshot of the primary historic progression by which college health services evolved from its earliest entities to now being regarded as a valued partner in fulfilling educational missions of higher education.

2.A.ii. Evolving Trends, Influences, and Development

Across Decades and Generations. College health was and continues to be influenced by external events and affected within by various trends, concepts and circumstances, with each decade delivering its own inimitable conditions. One such primary event occurred after the Second World War, when during 1946-47 over 3 million babies were born, known commonly as the start of the Baby-Boom.[50] As those very babies would enter college by the mid 1960's, it was realized that not only would there be a need for expanding higher education, but the need for equally expansive student services would also rise precipitously, along with determining methods of financing college health services and incorporating creative solutions such as with the advent of physician extenders, or Physician Assistants and Nurse Practitioners.[51] Also during this era, the notion of a person as a "consumer" and not simply a "patient" began to surface, along with use of the term "provider" replacing "doctor," inferring a social relationship that moved power from the clinician to a shared relationship with individuals who possess both rights and responsibilities.[52]

In this climate and timeframe, a major development occurred in American health care with the approval of the birth-control pill by the FDA in May 1960, which levied a culture shift on many levels, as well as potentiating activism on college campuses and students pressuring administration to allow institutionally employed health care providers to prescribe the pill to any coed requesting it.[53] Given this upsurge of the student voice, ACHA created a student task force and eventually the Student Section to welcome their participation, creating the pathway for

student advocacy and direct involvement in campus health centers.[54] Another organizationally supported endeavor was a call to the use of preventive medicine and health education as a model for campus health centers, leading to the creation of a statement of recommended standards and practices for a college health program by the ACHA, aiding institutions who sought to establish or improve their student health centers.[55]

However, there continued to be tension between opposing schools of thought with regard to the importance of campus-based health services such that some valued higher education as being simply concerned with the cognitive and intellectual development of students, while others regarded a more integrated association between academic growth and personal, psychological and sociological factors.[56] Despite this theoretical challenge, the practical reality was a mounting need for college health program expansion, which was addressed at a conference sponsored by the Josiah Macy Jr. Foundation in the late 1970s, noting the issue of limited national funding and institutional support for budgeting health services (clearly an issue that has sustained over the generations), confronting crucial concerns such as staffing, special needs of minorities and women, and the relationship of campus health services with administration.[57] In spite of these challenges, campus health centers continued to survive and progress.

A 1979 publication by the federal government, "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention," established five measurable goals for disease prevention and health promotion.[58] This seemingly was even further impetus for many college health centers to incorporate "health educators" in their staffing so that health education efforts for the campus community and in clinical practice could be implemented.[59] National initiatives that identified health prevention topics such as drug and alcohol use, nutrition, sexuality, and stress management were parallel topics for health educators on college campuses,

some of which were federally supported as with the Fund for the Improvement of Post-Secondary Education, focusing on alcohol abuse.[60] By 1987, nearly 27,000 college health professionals were employed nationally in the 3,400 institutions recognized at that time, with enrollment at approximately 12.5 million, estimating 20-30 million annual visits to college health centers.[61] During the 80's, the worldwide recognition of AIDS prompted the ACHA to establish a Task Force on HIV Disease, leading to the production of special reports and prevention materials for use in College Health as well as offering institutional grants.[62] Along with these various advances, the role of professional nurses as integral to the practice of college health took a giant leap forward with the publishing of the "Standards of College Health Nursing," by the American Nurses Association in the late 1980's, succeeded by a companion document "A Statement of the Scope of College Health Nursing Practice," serving to define and standardize college health nursing.[63] With these changes through the '70's and '80's, student health care laid forth the opportunity to favorably alter risk factors for many causes of premature morbidity and mortality in a continually renewing cohort of young adults, with potential to influence the health of future generations.[64]

As the 20th century drew to a close and with start of the new millennium, several geo-political factors impacted ongoing maturation of the practice of college health. Nationally, the cost of medical care was trending upward for a multitude of reasons among which was increasing use of technology, a plan for national healthcare was being debated by legislators, and college health centers were examining not only cost-efficiency, but how best to care for un-or-under insured students.[65] Further, the traditional college student was being redefined with population birth rates having fallen through the 1960s, thereby lessening the number of high school students available to enter college and twisting the focus onto non-traditionally aged,

international, and graduate students.[66] The interplay between campus health and general population health continued to become more pronounced due to complex sociocultural factors, repeated cycles of economic boon and fail, the expansion of a global marketplace, and the prevailing health concerns of alcohol and substance use, smoking, sexually transmitted diseases, and others – further evidence that academic success is only achievable with functional health status.[67]

Expanding Scope. The twenty-first century is now nearly two decades old, and college health services have untold potential to influence the cultivation and sustenance of healthy behaviors in the college student population of today, amidst a setting that is altogether a living, learning, and work environment – yet many college students continue to engage in behaviors contrary to wellbeing.[68] Although much of what we offer in our collective student health centers is an extension of traditional practice over time, the breadth and depth of our services continues to expand amidst the broad spectrum of types, sizes, and affiliations of college health services throughout the equally wide spans of institutions of higher education. Toward our common mission of caring for and educating the students that we serve, college health personnel should be cognizant of how the backdrop has changed. Since the early 2000s, enrollment in higher education in the US has increased more than 20%, female students comprise at least 57% of enrolled students, and the percentage of American college students who are Hispanic, Asian/Pacific Islander and Black has continued to increase, while international student enrollment has also increased precipitously to over 1 million through 2016-17.[69] Additionally, utilization data of college health centers suggest that primary care visits comprise 60% and mental health visits 13% from research done by the College Health Surveillance Network (CHSN).[70]

The ACHA produced "Framework for a Comprehensive College Health Program" in 2016, replacing several previous renditions of "Guidelines for a College Health Program," which addresses fundamental elements for a functional college health center such as medical, specialty, and ancillary services; mental health; public health and safety; administration and leadership; funding; staffing; cultural competence; practice management and use of technology; insurance; and facilities.[71] This compilation of relevant information clearly sets forth topic-specific principles regardless of institutional size, setting, surrounding community resources, or institutional commitment; and offers guidance for resourcing and funding, student involvement, cultural competence, and program assessment. Additional data from the CHSN provides that each year, at least 16% of all enrolled students are seen at least once for prevention-related clinical services, jumping to 35% of younger coeds, and students at private schools seeking out services more often than their public institution counterparts, along with females under age 18 and aged 22-29 as having the highest visit rates for primary care and mental health.[72] With today's student, regardless of practice size or scope, even episodic visits (which are typically brief and focused) to campus health centers for an acute illness provide opportunities for education on illness and prevention, as well as possibly providing a chance for screening for anxiety and depression, substance use, healthy relationships, and health practices.[73]

In addition to primary or episodic care, the odds that health services will care for students with general chronic conditions is increasing because of better survival rates of these students, who comprise over one fifth of young people in the US, so support for and capacity to provide care to these students is warranted.[74] Apart from chronic physical conditions, mental health co-morbidities are increasingly more common as evidenced by the National College Health Assessment, indicating that students are arriving to campus with psychiatric diagnoses and

psychotropic prescriptions already in use, and as established students are experiencing hopelessness, suicidality, depression, and anxiety at record levels.[75] Due to this reality and new norm, the theory of integrated care has gained popularity in terms of behavioral services being provided alongside and in partnership with medical services, a model widely practiced in community settings.[76] The integrated care model attains three goals that work in favor with the college health setting: integrated services produce healthier patients, promotes fiscal efficiency (such as to reduce need for psychiatry services when primary care clinicians collaborate with psychology), and removes barriers to access given the convenience and offers less stigma when such services are associated with primary clinical care settings.[77]

Campus health and counseling centers are challenged by limited resources to provide ongoing care for students with serious mental health issues and to balance the need to treat and intervene for students in crisis, as well as to make available services for other exceptional students, such as returning Veterans with PTSD.[78] Preparedness for life-threatening mental health crises including properly trained mental health staff, risk assessment strategies, and stringent administrative policies for mandated leaves are essential to the safety and wellbeing of the campus community.[79] Also, in addition to mass acts of violence against students that have occurred in recent times, individual students do report having personally experienced violence such as physical or sexual assault, verbal threat of violence, or physical conflict; thereby increasing the need to assess for violence and other trauma as campuses enroll more students with such life experiences.[80] Of utmost importance is that the mental health of all students, including specific demographics such as graduate and international students, also warrant attention and interest, along with overall institutional support through resource allocation and correlation to missional commitment.[81]

The prevalence of ADHD (or those who meet the criteria for the diagnosis and require treatment with psychostimulants) in college students adds to the preponderance of mental health related concerns, and has grown over the recent past, posing a complicated set of circumstances for college health clinicians as regards academic accommodations, the risk for prescription diversion and illicit use, and the presence of comorbidities in patients with ADHD and a variety of other mental and behavioral health or substance use disorders.[82] An estimated 2-8% of all US college students have ADHD, and the risk of poor treatment adherence can result in academic performance deficiencies, requiring stringent monitoring and management by integrated medical and mental health staff as well as keen awareness of risk versus benefit.[83]

Colleges and universities with student health facilities have developed an extensive variety of sexual health services including STI/HIV screening and all related treatment and education, as well as extragenital STI testing along with a broad range of reproductive services and/or related referrals at high frequencies for today's increasingly diverse college student, according to a recent article in the Journal of American College Health.[84] Concomitantly, many college students today no longer conform to terms such as straight, gay, lesbian, bisexual, or transgender to self-identify their sexual orientation or gender identity, and increased sensitivity and awareness by college health professionals regarding inclusiveness, health promotion and knowledge of associated health risk factors across the sexual spectrum is essential.[85]

These, as well as an ever-expanding list of "hot topics" that today's college health centers are confronting, including but not limited to: suicidality, sexual assault and intimate partner violence, homelessness and food insecurity, the impact and utilization of electronic communication and social media, the use of e-cigarettes and other devices, legalized marijuana, the care of students with addictions, changing practices toward trauma-informed care, honoring

diversity and inclusion, and being custodians for wellbeing across campus – the scope and reach of college health centers that has ensued has been astounding.[86]

2.A.iii. Formation of a National Organization

Advancing the Practice. As college health programs continued to develop throughout campuses across the country, the incipient need for leadership and direction by means of a national professional organization began to take root as college health staff administrators were having to attend meetings of other groups (such as the National Collegiate Athletic Association), however in 1920 a landmark meeting was held where in an agreement was reached to form a new association strictly dedicated to the field of college health, the American Student Health Association (ASHA).[87] Early gatherings of the ASHA achieved purposeful tasks, including the formation of a constitution and bylaws, as well as meaningful endorsement of the importance of health program interaction with other campus entities, establishing record keeping, adherence to sanitation in living quarters, and student mental health.[88] In the ensuing decades, many other pivotal developments occurred including the establishment of regional sections, the assignment of membership dues, and the formation of a national conference from which succeeded written guidelines and minimum requirements for a college health program, as well as affiliation with the medical journal *Lancet* for purposes of publishing not only meeting proceedings, but also scientific papers presented at the conferences.[89] In the late 1940s, the ASHA officially changed its name to the American College Health Association (ACHA) in an effort to avoid possible confusion with the American School Health Association, and to appoint a change to the set annual meeting time from late December (which conflicted with conference attendee's celebration of Christmas), to May – still in practice today.[90] By 1958, an official professional journal was established known

first as *Student Medicine*, later changed to *the Journal of the American College Health Association*, and eventually to its present form, the *Journal of American College Health*.[91]

Through the prudent structuring of regional ACHA "sections," designated affiliate region-specific associations were formed and eventually included the development of internal sections to address specific professional and special-interest groups, as early organizers realized the costs of time and money preventing many college health professionals from attending national meetings, and in the interest of promoting the association's objectives and common interests.[92] As the regional sections grew in membership, the potential for affiliates becoming increasingly independent of the national organization eventually became a prevailing concern, but by the 1980s under the leadership of the then ACHA liaison with the affiliates, major revision to bylaws took place, establishing six fixed regions (in congruence with an even early proposal from the 1930s) and guaranteeing six permanent seats as regional representatives of each affiliate region the national board of director's.[93] As medical technology and practice advanced exponentially after the post-war period, ACHA also realized that the annual meetings were no longer relegated to primarily directors and administrators, but that the organization was becoming an extensive network of interdisciplinary professionals of common interest in health care of academic communities, which led to the formation of a second publication, a periodic newsletter to cover trending topics of process and expanding clinical services, eventually named *ACHA Action*.[94]

Over time and by modeling other national organizations, the need for a process to evaluate health centers for accreditation and certification became evident, resulting in the development of an accreditation survey of several affiliate institutions, which tied into the development of *Recommended Standards and Practices for a College Health Program* due to the

efforts of several prominent physician-directors.[95] The national office was relocated nearer to the nation's capital, given ACHA's increasing prominence as well as its growing relationship with the federal government.[96] Other critical accomplishments occurring in the 1980s included establishing pre-matriculation immunization requirements as a standard for entrance to college, and the creation of the AIDS Task Force inclusive of an HIV-related cooperative agreement with the CDC for subsequent intensive study and research, providing the nation's statistics on HIV seroprevalence in college students, and published in the New England Journal of Medicine.[97] Following this, other cooperative agreements with health promoting entities ensued along with spearheading other important studies, such as to address high risk behaviors, HPV prevalence, tobacco use, and meningococcal disease; the data collection from which was the driving force for producing guidelines, toolkits and white papers for use by college health professionals.[98] To have achieved this degree of intricacy and to have realized such impact through its influence, the ACHA has indeed lived up to its vision "to be the recognized voice of expertise in college health."[99]

Research and Advocacy. Throughout my own tenure as a college health professional, the Journal of American College Health (JACH) has consistently been a resource with regard to relevant research studies and emerging issues affecting college health practice. As a scholarly journal, it is entirely dedicated to health issues that affect higher education, replete with a review system, a research forum, a venue for putting forth current practice trends, as well as to offer opinions and viewpoints relevant to the field by various authors.[100] JACH is unique in that it is fundamentally interdisciplinary, while integrating diverse perspectives in a cohesive, organized, and effective method which appeals to the broad range of administrators, professional clinicians, students and scholars immersed in and affected by our field. As previously noted, outstanding

research has been done under the mantle of the ACHA, described and presented through the JACH, and continues to provide ongoing relevant research with themes related to higher education and to the practice of college health.[101]

Of significant impact has been the development and maintenance of pre-matriculation / pre-admission immunization requirements, with full attestation of its organizational position on the ACHA website Advocacy page, on which is stated positive commentary about immunizations offering safe and effective protection from vaccine-preventable diseases in light their recent re-emergence, and the vital role that vaccines contribute toward herd immunity.[102] From this position, the resource document "ACHA Guidelines - Immunization Recommendations for College Students" provides facilitation for comprehensive institutional immunization policy development according to best practices in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations published by the U.S. Centers for Disease Control and Prevention (CDC), while cautioning users to be aware of individual state law and exemption policies.[103]

ACHA actively conducts surveys on a multitude of significant issues, collecting accurate and pertinent data regarding the health of college students, especially the ACHA-NCHA (National College Health Assessment) research survey, a nationally recognized tool that provides information and data about the distinct population of college students in terms of health habits, behaviors, and perceptions.[104] Additionally, the association also conducts an annual survey about sexual and reproductive health services on college campuses, taking into account management strategies, assessing educational efforts, and compiling comparative data of participant health services.[105] Similar to the ACHA-NCHA survey, a more recent offering of the ACHA is the National Faculty and Staff Health Assessment, a survey tool for use with faculty,

staff, and graduate student employees of colleges and universities toward promotion of health and wellness and development of related programs for campuses, especially those with overlapping or shared student/employee health and wellness programs.[106] Campus health services, through ACHA membership, are able to both participate in these important surveys and garner from the resultant data various approaches to improve their own practices.

In addition to its many contributions toward advancing the practice of college health, ACHA also provides substantial advocacy for both college health professionals and the students served by them. As listed on the website (www.acha.org), ACHA offers an extensive list of "Programs and Services."[107] Among the many, several stand to be highlighted. Members and affiliates are encouraged to attend the Annual Meeting each May, the most distinguished annual college health event, providing an opportunity for networking, professional development, the exchange of ideas, and section meetings for specific interest groups. Another important service is that continuing education is also offered through online platforms and at various on location opportunities, in addition to ACHA's new Leadership Institute, a concentrated series of courses from which a certification is attained as a College Health and Wellness Professional. Further, AHCA has established a multi-year project entitled the Connected College Health Network, to advance educational achievement and health equity among students in institutions of higher education toward health care utilization and outcomes-based information, as well as other data related to administration, policies, health risks, student demographics and academic outcomes, and institution profiles.

Student advocacy is a prominent and influential role that AHCA assumes, boldly evident in the establishing of guideline document Addressing Sexual and Relationship Violence on College and University Campuses, and through effect on federal legislation by providing active

input into the Campus Safety and Accountability Act along with comments for combatting sexual violence.[108] Further advocacy for students is manifest in the statement that "ACHA fully embraces social justice, human dignity, and respect for all, such that denial of social justice can contribute to diminished health outcomes and quality of life."[109] This is ordained through various organizational position statements such as those on Anti-Bias/Anti-Violence, Non-Discrimination, Sexual and Relationship Violence, in addition to other statements on topics of national public policy, all intended to support student rights and the ultimate aim to protect and advance the health of students.

2.A.iv. Where We Fit In

Purpose and Value. Truly, the adage "if you've seen one, you've seen them all" does not apply to college health services. Quite literally, given the heterogeneity and uniqueness of each individual program, the truer rendition should be "if you've seen one college health service, you've seen *only one* college health service," an observation and quote accredited to Dr. Clifford Reifler, a respected and long-time physician-director of Rochester University Health Services.[110] Notwithstanding those differences, clinical health services, in terms of organizational reporting structures most typically report to student affairs or their equivalent, followed by various other areas including academic, business, central administration, or academic medical centers/medical schools.[111] Regardless of reporting structure, institutional size or campus health service capacity, effective programs are well-connected to the institution and to the student body and weave through the matrix of the campus environment, assuring awareness of services throughout the institution and demonstrating appreciation for its contributions to the health of the campus constituency.[112] In that regard, institutions of higher education (IHEs) possess all aspects of a community in terms of numerous measures, and build upon interrelationships and

interdependencies among its members and throughout all systems to influence health; a principle based on a socioecological approach to addressing health along several dimensions.[113] A healthy campus community reaches beyond the traditional model of health care in terms of treatment of illness to include the effects of environment and community on individual health and community wellness through integration into all aspects of student life, requiring senior student affairs administrators to intentionally and deliberately support strategies to achieve this goal.[114]

In the post-war era, a report of the President's Commission on Higher Education called for massive expansion of higher education, recommending the promotion of physical and mental health as central to the mission of higher ed., a concept that is continually reinforced through present-day, with some contending that health services not only help the individual student, but can improve an institution's bottom line by enhancing student retention.[115] How complex or comprehensive clinical health services are depends on many variables, but the value of health care services on campus has broad institutional implications when health issues negatively impact academic performance or are detrimental to learning outcomes, and the ability of campus health services to not only support students but to also form collaborative relationships with all aspects of the campus community is a quality that few other campus offices can claim.[116] Campus health services typify the purpose for being "responsible stewards" in terms of assuring the health and wellbeing of all college students, as defined by NASPA (the National Association of Student Personnel Administrators) in their document "Principles of Good Practice for Student Affairs." Reflecting on our very beginnings, this goal has been a constant throughout the development of the profession.

Transforming Culture. The effect of campus health services on populations of college students toward retention and degree completion may not be easily determined or generalized,

but as this discussion has put forth, clinical health services evolved from a brilliant historic legacy, and have undoubtedly affected innumerable individuals in positive and beneficial ways that could never be quantified. Institutions of higher education uphold missions and core values, guiding principles, and other structures that cumulatively create the campus culture. The infusion of health and wellbeing practices across an institution, however, can only occur if all constituents embrace student-centeredness, the belief in human potential, shared recognition of the value of learning, effective collaboration, clear communication, honesty and trust.[117] Engagement of the student voice toward health promotion and a holistic view of health and wellness in terms of physical, mental and social wellbeing while recognizing the connection between individuals and their environments places the responsibility on all.[118]

Whether known to few or many, there exists a groundbreaking resource that proceeded from the 2015 International Conference on Health Promoting Universities and Colleges, namely the Okanagan Charter, which professed a Call to Action appealing to institutions of higher education to create healthier campuses and communities.[119] This document lays the foundation for transformation, such that the first principle boldly states to "embed health into all aspects of campus culture, across the administration, operations, and academic mandates."[120] The Okanagan Charter provides a platform for those willing to courageously lead change through which all institutional policies, planning, and decision making takes into account physical health and mental wellbeing so as to support the flourishing of the entire campus. It puts forth a process that seeks supportive efforts among all academic, social, economic, and organizational strata and fosters connectedness, resilience, and empowerment through an ethos of care, compassion, and community action. Further principles contained in the charter hearken to the well-established college health tenet of health promotion, recognizing that the integration of

health and wellbeing must permeate across disciplines and throughout curricula in a cross-cutting approach that will nurture development of the person as a citizen, and indeed as a custodian of their own health and wellness. It prepares those willing to accept the call that significant effort will be required to engage institutional stakeholders, and successful mobilization will include not only setting ambitious goals, but strategic planning and the development of collaborations and partnerships both within and without the campus community, reaching across sectors not only locally, but potentially globally. Ultimately, this organized resource centers around the noble and decidedly human "right to health" taken from the Universal Declaration of Human Rights, recognizing the ideology of social justice, equity, dignity, and respect for diversity.[121]

As college health professionals and determined stewards of student health, in addition to answering the previously discussed appeal, complete and effective transformative influence must also occur in the context of performance excellence, by means of the pragmatic and tangible pursuit of quality improvement in the execution of college health practice. Yet a second Call to Action also exists that specifically addresses this challenge, citing three targets: better care, better health, and increased value.[122] College Health professionals from NYU (New York University) and other influential professionals and organizations gathered together (also in 2015) at a symposium on Quality Improvement from which emanated this call. Clear and definitive processes are identified throughout, and it is fundamentally congruent with the Okanagan Charter, establishing as the primary goal to enhance student health and wellbeing throughout the entire institution, acknowledging that this ideal is not merely the responsibility of campus health professionals, but must also be shared with institutional leaders across disciplines and roles.[123] By implementing effective quality improvement, standards of care improve, accountability increases, employee professionalism, satisfaction and pride intensifies; all of which directly

affect student wellbeing and subsequently their learning and success – a collective goal of all IHEs.[124]

Conclusion. College Health professionals may not fully appreciate the origins of their profession, each of whom having entered the profession through various channels, but after encountering students, ultimately realize that this field is both unique and extraordinary. Literary accounts of college health professionals both living and deceased have illustriously contributed to the recording the history of the profession, and in reading them, one realizes a sense of connection to our storied past and early origins. We consider early infirmaries and trailblazing caregivers who encountered students from equally diverse backgrounds, also living communally while learning intensively, presumably with similar challenges to that of present-day students. They grew to become the leaders of their collective futures and history makers of our professional past, and serve as an inspiration to those of us doing the same on the campus of today, hopefully to become the heroes of tomorrow's college health professionals who, in turn, will elevate what we do for student health and wellbeing.

The history of the practice of college health is indeed a story worth telling, and is a story with an infinite number of chapters yet to be written at a pace that is often challenging to maintain. At every turn of another page, at every pause to absorb both the spectacular and the mundane - our story unfolds in the embrace of a growing nation, the fight for freedom, and in this millennium through the explosion of life-altering technological changes as well as major medical discoveries and innovations that often outpace our own abilities to comprehend them. All the while, we maintain focus on a very unique but intrinsically diverse population of college students and learners who are both traditionally aged and profoundly non-traditional; both able-bodied and physically disabled; some thriving and healthy while many having chronic physical

and mental illness and behavioral challenges – each of whom we proudly serve as members of the exceptional community that is higher education.

All that contributes to making this facet of medicine so vastly unique is also justification for viewing it as a definitive subspecialty, despite the aggregate medical community not quite as convinced. Regardless of practice size, type or scope of institution, number of employees, or complexity of services, we are united and joined together as a formidable body under the respected mantle of the American College Health Association, formed nearly 100 years ago by astutely forward-thinking college health professionals, continuing to steer the profession toward excellence and distinction. To provide excellent care driven by quality improvement toward transforming campus culture while influencing the health, wellness, and wellbeing of each student and member of our community is to carry the torch lit and passed on through time by our predecessors. To that end, may Mr. Kipling's words hold true, and may we meet the challenges of the future while respectfully honoring our past.

2.B. College Health Services as a Healthcare System.

College Health Services (CHS) function to assure and improve the health of the student population of the institutions that they serve, protect against overt health threats, provide equitable access, and engage those whom they serve in decisions affecting their health in order to meet their needs and expectations in a holistic, balanced means. Taken from the World Health Organization's (WHO) key components of a well-functioning health system, these important concepts and related affirmations serve to illustrate that CHS in themselves also broadly constitute a healthcare system, albeit along a vast continuum of practice size, type, and scope.[125] The American College Health Association (ACHA) likewise references the WHO in their guideline document, *Standards of Practice for Health Promotion in Higher Education*, within

which is mentioned both the definition of health and the importance of creating health supportive environments.[126] In the U.S., the Department of Health and Human Services has established the Agency for Healthcare Research and Quality (AHRQ), which partners with various other resources to work toward excellence and standardize quality of healthcare in America.[127] According to the AHRQ, a "health system" is comprised of multiple elements among wide-reaching organizations that contain hospitals, physician practices, and other horizontally and vertically integrated components, but more importantly it recognizes that healthcare is delivered by means of a dynamic exchange with the surrounding environment, affecting safety, patient centeredness, efficiency, and equity.[128] It is precisely these characteristics that allows those of us in college health practice to acknowledge that our services also definitively form healthcare systems by virtue of their being student-centered, intrinsically correlated to the surrounding campus environment, innately concerned with student safety, should indeed be efficiently managed, and by all means must assure equity of care delivery. As universally applicable tenets and toward establishing a just culture in our field, from small one-nurse health offices in community or rural colleges to those health services with highly specialized, diverse health teams numbering in the hundreds can all embrace these characteristics and apply them to daily practice.

In the 1990s, the ACHA anticipated the impact of healthcare reform on college health services and recognized the concern for un-or-underinsured students in advance of national discussions in the public square, publishing the document "College Health: A Model for Our Nation's Health" which discussed the strengths and features of the college health primary healthcare model as being cost-effective, accessible, and inclusive of mental health services and health education; citing these characteristics as considerations for healthcare reform.[129] The

importance of recognizing determinants of health, prevention and surveillance of communicable diseases, the need for student (patient) participation in planning, assuring accessibility of services, and collaborating with campus and community resources are salient points emphasized throughout the document.[130] If thus having been referred to as a model for national reform, college health can categorically then be considered as possessing definitive characteristics of a healthcare system. Healthcare systems are affected by a multitude of factors both internal and external, and have various degrees of complexity in terms of patients served, oversight, services provided, funding, and interconnectedness to resources which culminate in the delivery of health services to a population.[131] Each of these themes pertain either completely or partially to most college health services in consideration of where they fit among an immensely pluralistic and diverse range of programs. Distinctions among institutions may vary with: size and population, institutional control (public or private), location or setting (urban, suburban, or rural), Carnegie Classification, affiliation (faith-based, Historically Black College or University, or having a minority-serving designation), connectedness to an academic medical center, or identity as community college, among other variances.[132] The workforce within each individual student health-related center also differs according to reporting line, leadership and business-related staff, amount, levels and focal specialties of medical and clinical services providers, health promotion staff, counseling and mental health professionals, as well as other ancillary positions and extended medical and EMS services.[133]

Notwithstanding these differences, as a healthcare system, the impact of college health services on campus health and safety, on relationships across the campus community, having utmost regard for health promotion, active prevention, and health education is without exception

vital to the development of institutional wellbeing and to the preparation of consumers and custodians of healthcare after graduation, as citizens of our nation and beyond.

2.B.i. Student-Centeredness

Value, Attributes, and Innovation. The physical and mental health and wellbeing of college students directly affects learning outcomes, as determined by research from neuroscience, cognitive psychology, and teaching studies.[134] Such results are congruent with what educators innately know - that health creates capacity, and those students with positive health status are better able to learn and engage meaningfully - yet the demands on health centers have progressively increased due to students with mental and behavioral health disorders, chronic conditions, and registered as having disabilities.[135] The value of on-campus clinical health services toward a student-centered support structure is both measurable and relevant. A longitudinal study done several years ago by the College Health Surveillance Network (CHSN) with 23 participating universities determined that of the 4.17 million patient encounters included in the study, sixty percent were for primary care with the five most common reasons being preventative visits, respiratory conditions, dermatologic concerns, generalized infection, and mental health issues.[136] Of further significance was that the study determined that health care facilities were regarded as accessible, and according to various added demographics, rates of utilization for primary care were close to that of the general population.[137] Students self-report their own health as predominantly good, very-good, or excellent; yet more than half also report having been diagnosed or treated by a college health professional for numerous common conditions, and said that many of those illnesses (effects of stress, upper respiratory symptoms, sleep disturbances, concerns for others, relationship issues, depression and anxiety, and substance use) did affect academic performance.[138]

The value of campus based clinical services is also demonstrated in a study done in 2012 by the State University of New York (Farmingdale), asserting that if students did not receive treatment at their campus health center, 10.5% "might not" have completed the semester, and 16% "would not" have completed the semester, further demonstrating the correlation between health, student engagement and retention, as well as highlighting the central and vital role of health services.[139] The prevailing interest in and value of campus healthcare services to student affairs leaders and administrators is that student's unique needs are met through effective practice models, assuring that students are kept on campus and in the classroom.[140] Health related issues should be a priority of student affairs agendas, in that among campuses where the primacy of health is upheld, both individual and environmental influences are examined through an ecological perspective of aspects of college life for improving health and wellness.[141]

College healthcare systems provide a basic need to the students of the campus community and should have organizational structure and leadership that supports and complements the learning environment including an articulated vision, defined scope of services, formed policies & procedures, personnel performance expectations, quality improvement measures, and adherence to practice standards.[142] These and other professional attributes identified by the Council for the Advancement of Standards in Higher Education provide pillars for and guidance to campus clinical services and set expectations for their functionality and effectiveness. The CAS Standards and Guidelines for Clinical Health Services state that campus health services must be intentionally designed, theoretically guided, integrated into institutional life, in complete regard for the population served, delivered through a multiplicity of formats and contexts, and assuring universal access - again reflecting those elements of healthcare systems previously noted.[143] Institutions of higher education are central to the development of not only

individuals, but also to society through the ongoing formation of students, and are called to support and promote health initiatives in partnership with campus health services.[144] Health related issues permeate all dimensions of campus life, and many problems that require the attention of student affairs administrators often stem from issues directly related to unhealthy behaviors and activities.[145] Although institutional demographics will determine what features are supported and offered through campus health services, whether a nurse-only service or an extensively comprehensive primary care practice inclusive of various specialties and amenities, the impact of those services on the unique needs and complexities of college students of any age is critical to retention, progression, and eventual graduation, as noted in the ACHA's "Framework for a Comprehensive College Health Program."[146]

Innovations in medicine are proliferating rapidly, to the extent that those noted in this discussion may soon be considered passé. For example, the rampantly expanding field of telemedicine has already intersected with college health medicine, appealing to millennial and Gen Z students who will likely welcome the expansion of convenient, accessible, and tech-friendly healthcare by means of self-service kiosks and other access platforms for telemed services. Whether complementary to, as an extension of, or in place of on campus resources such as with rural settings, telemedicine is being offered by insurance companies and has gained favor through improved regulations and policies which have reduced barriers for the field.[147] Healthcare innovations are predicted to provide "more for less" in the sense of value, improved outcomes, convenience, access, and simplicity – in less time for both the patient and the provider and with less complexity, according to the Deloitte Center for Health Solutions recent survey of leaders in healthcare.[148] From a financial perspective, the Deloitte Center portends that these innovations have the potential to upend traditional fee-for-service healthcare models, paving the

way for business models through value-based care, consumerism, and the proliferation of new data sources – all of which has equal potential to affect the college healthcare system.[149] In addition to also mentioning telemedicine, the other impactful innovations listed are: next-generation genetic sequencing, 3-D printed devices, immunotherapy, artificial intelligence, point-of-care diagnostics (from any location), virtual reality, leveraging social media to improve patient experiences, biosensors and tracking devices or monitors, and quick-stop retail health clinics.[150] Already mainstream, digital resources, social media, and interactive technologies support students' becoming more active partners in their own health and may even change health behaviors, while augmenting person-to-person healthcare provided in campus health centers.[151]

Resourcing. Over time, college health centers have had various funding models implemented by their institutions to finance operations. One traditional model is to assess students a "flat fee," which provides unlimited care for students with virtually no out-of-pocket expenses (with exceptions for purchased goods or procedures such as laboratory testing, radiology, etc.), earmarking resources necessary for overall operations, while general university fund allocations may then finance labor budgets and/or other larger-scale needs.[152] Variations on this model may include prorating the fee for part-time students or others eligible for services who do not meet eligibility criteria.[153] Health fees are a proven successful funding source that assures accessibility of services to all students on campus, can cover as much as 75% of an operating budget, and are supported by concrete metrics with which to calculate the fee.[154] The assessing of fees in addition to tuition or being imbedded within, as well as implementing "fees-for-services," are common strategies that have been and continue to be utilized since the evolution of campus health services because of fluctuating institutional support and in deference to students with varied economic backgrounds.[155] According to the ACHA "Framework for a

Comprehensive College Health Program," other funding models include intentional collaboration with for-profit health centers as well as private financial support or sponsorship, and grant-based funding.[156]

The passing of the Affordable Care Act in 2010 had direct impact and lasting effects on campus health services due to mandated coverage of preventive healthcare services (many of which are integral to public health issues on college campuses) while remaining in designated networks, as well as the "under 26 initiative" whereby students up to age 26 are eligible to remain on their parent's health insurance plans, and un- or underinsured students potentially being covered under Medicaid or state/federal exchange plans – some of which unfortunately contributed to declining use of such services.[157] By 2014, an overwhelming percentage of public and private institutions offered student insurance plans to students, viewed as affordable, comprehensive, and convenient for some; while others eligible for Medicaid were affected by portability issues.[158] These changes caused many colleges and universities to consider options such as eliminating or outsourcing health centers, raising the health fee to thereby cover services viewed as the "bread and butter", or implement insurance billing for services provided.[159] Third party billing has been in place for over two decades in some institutions, but realized an increase since the ACA was instituted, and is viewed as an opportunity for campus health centers to increase their financial independence, self-sufficiency, and to better serve students by credentialing services for wider network participation.[160] A move toward insurance billing is not a guaranteed revenue stream, given the present-day reality of health insurance, but if employing more of a private-practice billing model in terms of charging companies for all services plus collecting un-reimbursed balances (especially given the popularity of high-deductible health plans), additional revenue may be incurred.[161] Other possible pitfalls include the need for hiring

additional professional billing staff to accommodate the billing program (unless opting to outsource such services, thereby incurring additional costs), realizing less revenue when physician extenders provide the bulk of the care (due to reimbursement at a lesser percentage), and the need to determine with certitude any state-governed restrictions or policies for collecting co-pays and co-insurances.[162] By means of transitioning to 3rd party billing or direct billing to the university-sponsored health plan – many college health services have also realized the potential to equally provide medical care to faculty, staff, and their families; with secondary positive benefits such as increased credibility, increased utilization (due to faculty and staff as users of the services being more apt to refer students for care needs), and overall increased revenue potential through providing more comprehensive services.[163]

The cost of health center staffing salaries accounts for an immense percentage of resource consumption, despite many being notoriously inadequately staffed.[164] Campus healthcare systems must also have institutional support for adequate staffing resources by qualified professional and ancillary personnel to accomplish goals, objectives, and mission; and must have the administrative and governance backing and support to assure recruitment, adequately and competitively fund positions, provide access to professional development, nurture leadership capacity, and foster employee retention by means of consideration for work/life balance needs.[165] Providing healthcare in the unique environment of a campus setting presents administrative challenges and an ever-present need to meet not only clinical but also regulatory and legal challenges of higher education, with attention to staff maintaining appropriate scope of practice, ethical conduct, and strict adherence to confidentiality.[166] Competent and consumer-oriented staff result in content and satisfied customers, and well-managed staff are inspired through team-building, quality improvement that uphold standards for excellence, clear and consistent

communication, and transformational leadership through group decision making.[167] We can agree, intuitively, that health conditions affect academic performance and tie directly to student's lives beyond by means of their acquiring health-related patterns and behaviors that will be retained throughout their lives, and since obtaining a college degree is one of the major determinants of future health and economic status - the impact of well-functioning, effective, quality driven health care system as a priority for student success must not be overlooked or undervalued.[168]

2.B.ii. Impact and Quality

Campus Health & Safety. Distinctively, campus health, safety, and emergency preparedness are shared infrastructure concerns managed across multiple departments and offices throughout the institutional setting whether related to public and fire safety, environmental and occupational safety, hazardous waste, laboratory and materials safety, radiation safety, and information security, among other safety matters.[169] Institutions execute violence prevention and threat assessment by means of strategic models and processes to determine transient or substantive threats to the safety of the campus community.[170] Within that scaffold, campus health systems further recognize and mitigate health related safety risks by providing screenings, intervention strategies, treatment, education and outreach, and surveillance in terms of vaccine preventable diseases, other infectious and communicable diseases, mental health, sexual assault and relationship violence, drug and alcohol use, along with countless other matters.[171]

Of all safety threats, suicide risk is the most attention-grabbing, especially given recent high-profile celebrity suicides, and the CDC reports that over the past twenty years suicides in the U.S. have increased by 25% , remaining as the 2nd leading cause of death for college students.[172] Suicide prevention and risk reduction requires awareness, training, and resources –

primarily efforts directed by counseling centers, wellness programs, and student health centers through accountability to student affairs leadership and other student-facing sectors of the campus community.[173] The conversation about mental health issues as risk-contributory is mainstream, and some viewpoints have been critical. An article from 2015 in the "Grade Point" section of the *Washington Post* made the charge that university health care systems are understaffed, resulting in campus mental health clinics often being forced to prioritize services and limit treatment sessions, adding the suggestion that periodic or even annual mental health screenings should be done preemptively along with ardent wellness promotion as a shift of emphasis from crisis response to prevention.[174] Moreover, comprehensive plans for addressing students who reveal self-injurious thoughts or exhibit related behaviors and potentially pose a threat to themselves or others range from requiring immediate leave, abrupt eviction from housing, and imposed disciplinary sanctions, largely out of a concern for liability but potentially increasing the risk of harm.[175] The Americans with Disabilities Act (ADA) prohibits discrimination of students with mental health problems and universities must provide reasonable accommodations, modifications, and support even in the context of a leave of absence toward degree completion as integral to an all-inclusive campus-wide plan.[176] Campuses, for the most part, are integrated communities and offer organizational resources that can cumulatively affect positive change, especially that of mental health and student wellbeing.[177] The cultivation of resilience and other hope-sustaining attributes through skills training, the promotion of social connectedness and inclusiveness especially for minority and higher-risk population groups to reduce isolation, along with other campus initiatives to foster peer norms, reduce stigma, and encourage support-seeking are decisive steps that campuses can take to reduce this safety issue.[178]

The ACHA "Guidelines Addressing Sexual and Relationship Violence on College and University Campuses" clearly states that students are unable to learn in an atmosphere wherein they do not feel safe, and that students who have experienced assault are at risk for ongoing health problems, mental health issues, alienation, and other barriers to academic success.[179] Further, the guidelines refer to college health professionals as being uniquely positioned to take a leading role in addressing sexual and relationship violence and supporting students by means of trauma-informed prevention and response strategies. A routine search of the literature shows that abundant articles exist with regard to the safety risk of sexual assault and relationship violence on college campuses, bystander awareness, and alcohol consumption as correlated safety issues. As a prevailing concern of the federal government, the Department of Justice's Office on Violence Against Women offers a Campus Program that supports institutions of higher education to develop comprehensive responses to assault and violence which strengthen culturally relevant, survivor-centered approaches and advocacy.[180] Although the scope of this discussion is to broadly consider campus health and safety concerns, sexual assault is a major issue in that college women are four times more likely to experience sexual assault than any other group, and assault victims are at increased risk for re-victimization as well as long-term psychological consequences and multiple other risk-inducing health behaviors.[181] In close parallel to this is that two of the strongest predictors for sexual assault are having been previously assaulted, and substance use - with at least 50% of reported sexual assault cases among college students known to involve alcohol consumption by the victim, the perpetrator, or both.[182] There are far reaching considerations regarding not only the correlation of alcohol use and subsequent ongoing need for prevention and outreach, but for institutions to recognize multiple interrelated factors. Effective, sustainable changes to campus culture equates to strong

and cohesive collaboration with all institutional stakeholders to support consent education, bystander training, improved policy construction across various domains, and the recognition of cultural barriers, associated disparities and destructive attitudes.[183]

As noted, there are many other campus safety concerns including institutional pre-admission immunization requirements and surveillance, infectious and communicable disease prevention and preparedness, as well as related education and outreach which will be elsewhere conferred within this discussion as regards campus health systems.

Fostering Improvement. Sounding somewhat like a public relations mantra, the definition of quality healthcare as "doing the right thing, at the right time, in the right way, for the right person – and having the best possible results" epitomizes why college health services, as a forthright health system, must embed quality improvement practices as an imperative.[184] Quality improvement takes into consideration all work processes and associated variables that cause process breakdown, removes blame from individuals, identifies systemic issues, and cultivates full focus on improvement opportunities toward attaining best-practices, which ultimately results in enhanced perception by students, parents, and the institution.[185] Ultimately and idealistically, the motivation for quality improvement and practice excellence is student success as a result of total wellbeing.

Various QI theories have been utilized for more than twenty years outside of college health systems in all sectors of healthcare, including tools such as the "plan-do-study-act" method, the "define-measure-analyze-improve-control" model, and the "lean" methodology driven by the identified needs of the customer, aiming to improve processes by removing non-value-added activities, or waste.[186] Dr. H. Spencer Turner and Janet L. Hurley, in their book *The History and Practice of College Health* incorporated an entire chapter on QI and accreditation

issues, the authors for which outlined theories, key concepts, benefits, and methodologies for practice improvement through improved efficiency, cost containment, increased employee satisfaction, and improved patient outcomes.[187] Although compiled in the late 1990's, there are nine dimensions of performance identified under two categories – "doing the right thing," and "doing the right thing well," which continue to be relevant to today's practice, relative to appropriate care given to accomplish a desired outcome, most relevant to the patient's condition, coordinated across disciplines, with direct patient involvement in decision making – ideals that are timeless and germane to the present.[188]

Three specific aims foster QI capability, namely better care, better health, and greater value in college health practice.[189] This triple-aim approach is the outcome of symposium on Quality Improvement (QI) in College Health hosted by New York University with support from the AHRQ, held in 2015, with 88 colleges and 34 states represented through multiple disciplines and various sectors of clinical and mental health professionals, supportive organizations, and leaders in the field of QI.[190] As a definitive and tangible ideal to advance our profession forward, creating a just culture through use of the concepts identified during this landmark meeting of highly qualified professionals, and from the corresponding "call to action" article in the Journal of American College Health detailing the principles, it is scalable to any size or scope of college health practice willing to reach their performance pinnacle. Attention to improvement practices in college health practices is tremendously important to our realm because of several characteristics: college students are a large, distinct, and key population; QI supports student success; QI fosters greater expectations and increases accountability; and it supports professionalism, satisfaction, and empowerment of campus health staff.[191] The challenge that the NYU team laid forth extends beyond campus clinical services to the institution as a whole,

and to the national community of higher education, as well as to vendors, accrediting associations, third party payers, and all others involved in the spectrum of higher education – calling for a commitment to change and to undertake all actions necessary to use the "triple aim" of QI embedded throughout all facets to support student health and wellbeing.[192] Definitive practices were developed within this action-plan for institutional leadership and in terms of national support, structured toward increased improvement capability and capacity by means of knowledge and competence about QI, functional workforce and human relations criteria, data and infrastructure management, leadership building capacity, among various other associated resources for sustainable results.[193]

This being a profoundly radical change, to institutionalize quality also means to set forth a clear vision for prioritizing student health and wellbeing as empowering to students' learning and success. Challenging the institution to upend a culture that is satisfied with the status-quo, permeating the construct of continuous quality improvement in entirety throughout the institution, making health and wellbeing everyone's 'business,' fostering student involvement, and adopting such dramatic change from sound methodologies definitively laid forth by the NYU team, it is nonetheless achievable.[194] Tangential to this, the development of a national infrastructure supportive of a common vision and standardized processes toward an overall college health system re-designed around health and wellbeing will unequivocally result in better care, better health, and increased value.[195]

2.B.iii. Prevention, Promotion, and Education

Public Health Parallels and Strategies. The American Public Health Association defines Public Health as promoting and protecting the health of people and the communities where they live, learn, work and play.[196] Institutions of higher education are also a type of community

where a defined group of people live, learn, work and socialize. A recent posting within the ACHA Student Health and Wellness member email group around the topic of *Healthy Campus* discussed a quote by American author Wendell Berry, who coined a descriptive of community that relates to the campus environment, simply stating: "Community is a locally understood interdependence of local people, local culture, local economy, and local nature."[197] Community based strategies of health promotion and disease prevention within a defined group or population is the essence of public health, and the fundamental parallel of a campus community as a defined population in terms of age, social characteristics, common living spaces, location, and exposure clearly applies.[198]

The CDC lists ten top public health priorities in their Prevention Status Reports, the majority of which are also primary concerns for college health, including alcohol-related harms, food safety, HIV, nutrition & physical activity, pregnancy, and tobacco use.[199] As referenced in the ACHA-NCHA II (American College Health Association, National College Health Assessment) survey, it is evident that the prevalence of both these and other analogous concerns are reported by students as having negative effects on academic performance. [200] Assessing the population for indices of risk status provides the basis for epidemiological surveillance, a systematic interpretation of data for planning, implementing, and evaluating public health initiatives, which for the college health population drives the development of alcohol and drug use awareness campaigns, sexual assault programming, sexually transmitted and infectious disease screening, in addition to other targeted outreach. [201] As a resource to college health professionals, the ACHA offers a plethora of policy guidelines, recommendations, and position statements to advance the practice by developing and sustaining high quality programming in college health systems that specifically provide references for such public-health topics as All-

Hazards Emergency Planning, Immunization Recommendations, Opioid Prescribing, Tobacco, Health Promotion, and Tuberculosis Screening, including WHO sources. [202]

As a first-line function of public health surveillance, most institutions of higher education have implemented pre-matriculation immunization requirements for documentation of protection against vaccine-preventable diseases (VPD) because of residential living arrangements and overall increased opportunity for close contact and risk of transmission in campus communities.[203] With an increase in global travel and un- or under-immunized people, there has been a resurgence of VPDs, for example the mumps outbreak of 2005-06 centered in Iowa, largely affecting college students; and elsewhere again in 2013; as well as clusters of measles outbreaks from 2014 through present – the majority of whom were unvaccinated.[204] Immunization requirements are vital to community or "herd" immunity, such that national public health recommendations from the Advisory Committee on Immunization Practices (ACIP) of the CDC should be followed accordingly, and allowances for exemptions that are non-medical should be strictly considered and unimmunized students excluded from academics, activities, and residency during outbreaks.[205] Screening for tuberculosis infection for those students considered to be at increased risk is vital for controlling and preventing TB infection in university communities. The ACHA also provides Screening and Targeted Testing guidelines for program development, suggesting that all incoming domestic students be screened for risk factors by means of a questionnaire, whereas new international students arriving from countries where TB incidence is increased should be tested, as supported by epidemiologic identification.[206] The implementation of these recommended and substantiated institutional policies are integral to effective college health - as public health - practice.

The unmistakable parallels between college health and public health is rife with comparisons, applications, strategies, and approaches that would require volumes to exhaust. As cultural shifts continue to occur, socio-political issues ebb and flow, and the economic and employment landscape changes, public health issues remain constant. Approaching college health from a public health perspective through campus-wide embedding of health and wellbeing, will undoubtedly impact student success. The importance of forming relationships between local, regional, and state public health systems and institutions of higher education (whether vast or minute, public or private, urban or rural) is of great significance for illness prevention or containment, collaborative planning for prevention and promotion of common public health concerns, and for developing awareness campaigns that impact college students in any setting.[207]

Promoting Health & Literacy, Preparing Informed Consumers. Health promotion in higher education is a distinguished niche of college health that evolved in pace with growing public health issues on college campuses, fusing together an understanding of behavioral determinants for learning, distinguishing itself through purposeful design, and facilitating actions toward maximizing capacity for health.[208] On many campuses, health promotion offices are positioned in student affairs within central student services, have varying reporting structures, and may be funded separately from or in combination with clinical health services, or through other institutional allocations for outreach programming.[209] Because of the uniqueness of both the college student population and the setting of an institution of higher education, in the mid-1990's a highly qualified task force of individuals from member institutions of ACHA conducted extensive research toward establishing universal principles for health promotion in higher education, leading to the formation of the Standards of Practice for Health Promotion in Higher

Education.[210] These seven standards can effectively stimulate development of health promotion by assessment for competencies and application of promotion efforts that can fit the size and scope of any campus. Each health promotion standard fosters a comprehensive, collaborative effort across the entire institution, titled as follows in the most recent version from 2012: I. Alignment with the Missions of Higher Education, II. Socio-ecological-Based Practice, III. Collaborative Practice, IV. Cultural Competency, V. Theory-Based Practice, VI. Evidence-Informed Practice, and VII. Continuing Professional Development and Service.[211] With a central focus on public health and a clear vision toward the future, the early organizers recognized the central role that health promotion professionals play in creating innovative strategies to address behavioral determinants of health, to improve both individual and community health by addressing chronic disease, healthcare costs, demographic shifts, and risky health behaviors for ultimate achievement of overall student success.[212]

College health centers are integral to promoting health to the campus community, and are also influential in developing health literacy, or the ability to obtain, process, and understand basic health information to make informed decisions – a skill that requires development, about which assumptions should not be made but rather should be assessed for.[213] Health literacy extends beyond reading information to also include comprehension, numeracy, and both media and computer literacy according to concepts previously identified by the U.S. Department of Health and Human Services, and the World Health Organization.[214] Within this paradigm, comprehension is the ability to understand health-related texts in terms of reading ability; health numeracy is the capacity to understand numerical concepts used in comparisons; while media literacy means the ability to analyze new information for credibility and quality; with digital literacy as the ability to appropriately use digital tools to access and synthesize digitally obtained

information.[215] An effective mechanism toward cultivating health literacy is through participation in Healthy Campus 2020, a prodigious ACHA initiative (guided by the Healthy People.gov framework) for improving the overall health status on college campuses nationwide. It includes Student Objectives about critical public health concerns including a section regarding Health Communication, Health IT, and Education/Community-Based Programs which focus on health information gained from care providers with direct correlation to health literacy skills.[216] Individually and altogether, health literacy skills are necessary for individual decision-making about health care diagnoses and treatment, disease prevention, and health screenings; and the option to utilize a properly scaled assessment tool in order to help identify deficiencies in (or strengths of) our patient population would be greatly beneficial to targeted health promotion and education efforts.

With changes to the health insurance landscape in epic proportions over the past decade, the need for health insurance literacy is also integral to the ability of students to make informed and appropriate health care decisions. Health insurance literacy is the degree to which individuals can determine and evaluate information about health palms, select a plan for use, or utilize those under which they are covered.[217] Because of ongoing uncertainty of health policy, the increase in consumer-driven health plans, and the wide range of health insurance options – students are an overlooked demographic by policy makers, public health researchers, and health care providers in terms of health insurance literacy. The deficiencies in comprehension of college students of any demographic regarding plan terminology, cost structures, and other insurance verbiage is a concern on multiple levels.

Reaching students through technology as the status-quo will continue to reshape health promotion and contribute to health literacy by meeting students where they are.[218] Social media,

on the other hand, although offering opportunities for both producing and consuming health related content, does not provide an unproblematic environment for engagement and supportive networking, according to a study done on young adults with diabetes and mental health issues.[219] College students learn about health problems, healthcare access, costs and quality, as well as how to care for themselves through the services received within their institutions; and what is learned at this juncture has great potential to influence their future health status through the health behaviors, expectations, and preparedness embraced while in college, to better manage their health after graduation as future healthcare consumers.[220] Students who access care in campus health facilities, participate in health promotion programming, and take hold of health education opportunities among many other student-facing services stand to have the advantage of becoming better informed healthcare consumers if those of us in the profession do our utmost to provide high quality health care to best practices standards delivered with integrity, compassion, and sincerity.

2.B.iv. Integrated Forces

Prioritizing Holistic Wellbeing. *Great Jobs Great Lives* is a study of over 30,000 U.S. college graduates done in 2014 which noted that college graduates experience double the odds of thriving in all areas of well-being when they feel that their colleges prepared them well for life outside, affirming that institutions of higher education are responsible to their students to equip them not just for the pursuit of better jobs, but to successfully pursue better lives.[221] Wellbeing is the collective and interdependent combination of how people think about and experience their lives, which for a higher education institution transcends any one program or department, in that each has a shared responsibility to support campus-wide health and wellbeing as a sustainable, upstream approach to thriving.[222] Wellbeing has taken center-stage in higher education, with

varying terminology used to put forth the concept, such as wholeness, thriving, identity, or even Aristotle's eudaemonia.[223] The CDC offers further associations, primarily toward the integration of mental health and physical health resulting in more holistic approaches to disease prevention and health promotion, which when achieved is associated with numerous health benefits, decreased risk of disease, illness and injury, and increased productivity and longevity.[224]

Enhancing wellbeing throughout a college campus must expand beyond traditional models of health systems delivery by clinical, mental, and health promotion services toward a collaborative approach that integrates diverse disciplines, roles, academic centers, student services, administration, and the entire campus community by breaking down silos.[225] Achieving a culture change requires engagement of key community partners including student leaders; faculty and staff; conventional health related departments and services; parents, family, and friends; and partners from the surrounding community, which will look vastly different based on institutional characteristics, stakeholder buy-in, fiscal resources, and student engagement.[226] Of the many examples of how campuses have designed and implemented strategic plans for imbedding wellbeing throughout their campuses, New York University has a student-centered framework *LiveWellNYU* that is an evidenced-based, public-health model acknowledging that health issues which most impede academic achievement are largely preventable or treatable.[227] Intentional efforts for engaging partners, addressing the full spectrum of health and wellness, targeting specific population segments, using branding and other engagement strategies, harnessing the power of technology, and emphasizing evidenced-based practices resulted in a viable, realistic, well-functioning, maintainable program.[228]

Similarly, *Healthy Universities* is a model within the U.K. that applies the healthy settings approach within higher education based on the WHO definition of wellbeing, aspiring to

create learning environments that enhance the health, wellbeing, and sustainability of the university community enabling people to achieve their full potential.[229] Referencing the WHO Ottawa Charter for Health Promotion, the *Healthy Universities* framework language is substantially similar to concepts in the Okanagan Charter, an outcome of the 2015 International Conference on Health Promoting Universities and Colleges held in British Columbia, Canada, which builds further upon the Ottawa Charter.[230] The Okanagan Charter emphasizes that health is a fluid concept associated with wellbeing, is dependent upon surrounding environments, and that all sectors must be engaged toward achievement of health.[231] It cites three distinct purposes relevant to Health Promoting Universities and Colleges, and voices two clear calls to action: (1) embed health into all aspects of campus culture, across all operations, and (2) lead health promotion action locally and globally.[232] The document specifically pins down the role of higher education as central to all aspects of developing individuals, communities, societies, and cultures; with the responsibility to incorporate health promotion values and principles into mission, vision, and strategic planning.[233] Opportunities to advance human wellbeing as a determinant of learning, while compelling institutions to embed health throughout policies so as to transform culture and inspire all constituents to embrace the movement, is emphasized. The two calls to action are brought forth in an actionable framework that lists principles to be concretely implemented, and provides guidelines for systemic mobilization.[234] Because of the diversity of higher education settings and the variety of perspectives and contexts within which they function throughout this country (and across the world), the document also takes into its consideration the reality of transitioning populations, political oppression, environmental changes, and the resultant need to tailor the precepts accordingly, in deference to the intent to advance the charter internationally.[235]

The interrelatedness of environment and wellbeing and the re-imagining of healthy universities as having wellbeing infused throughout is essential to the holistic development of all college students who may therefore subsequently perpetuate wellbeing as the foundation for a healthier America, if not to hope for a healthier world.[236]

Rooted in Mission. Independent of the institutional mission, clinical health services should have their own statement of mission to provide context for the practice, a foundation for its strategic plan, and to convey guiding philosophies and values.[237] Health care systems are complex organizational structures in society, and most campus health operate as a microcosm of such systems, accountable to the population they serve for patient-centered quality care, sensitivity to the unique needs of college students, fostering personal growth and development, seeking continuous evaluation and improvement, abiding by ethical decision-making, and eliminating all barriers to access.[238] When not utilized to their potential, mission statements often fall to the fate of becoming ignored wall art or a wallet-card memento, instead of rising to a purposeful and useful commodity that all employees take ownership of.[239] The process for developing (or re-developing) a mission statement, to be effective, will speak to organizational values only if they are also people-values and are formed by direct involvement of all staff, resulting in a shared commitment to uphold the mission as a living, fluid document .[240] Through an intentional partnership, administrative staff can work with all employees to clarify purpose, determine guiding principles to steer discussions, establish themes, develop key verbiage, envision ideals by reflecting on both past achievements and failures, and acknowledging the need for revisiting, reaffirming, or revising its mission as needed, periodically.[241]

Mission statements reveal the heart and soul of an organization, whether functionally, strategically, or values focused, or may also express a vocational commitment to service –

regardless, it should attempt to answer what the organization seeks to achieve.[242] In an article about mission statements of academic medical centers, physicians from the University of Washington referenced a centuries old mission of King's College in Scotland as declaring the "pursuit of health in the service of society."[243] The authors challenge that within their field of academic medicine, a return to this original mission is critical for uniting and integrating the strengths found in academic excellence, productive research, and quality medical practice, after deviation over time from foundational precepts.[244] Within the context of our specialty, a review of mission statements from a broad variety of campus health centers divulges a range of mission statements, each somewhat distinctive, yet most having recurrent themes of improving student health, promotion and prevention, or enhancing academic success, while less offer altruistic or philosophical themes.[245] Of those reviewed, the statements that did reach beyond pragmatic concepts articulated a push toward wellbeing through use of language such as "transformational journey" and "resiliency."[246]

Clear directives are provided by the CAS Standards and Guidelines for Clinical Health Services, featuring discussion of Mission as the opening topic.[247] The CAS standards dictate that college health services missions must be to teach, provide, promote, and support clinical health care, preventative services, treatment of illness and injury, patient education, and general public health responsibilities.[248] Moreover, the standards address the importance of campus health services as enhancing the learning environment, advocating for the health of the entire campus community, with full consideration of the health status of the population served and of safety and emergency preparedness. Such tenets are universally applicable, and all campus health centers are urged through the CAS Standards to develop, disseminate, implement, and periodically review their own missions to assure alignment with institutional mission and best practices

standards – each of which unconditionally must instill the value of student learning and development.[249]

Formed mission statements and shared vision translate to strategic action. They provide a pathway to assessing health status and needs, enhancing access to services, establishing campus-wide initiatives and collaborative partnerships which reinforce and augment widespread endorsement of health policies, resource needs, evaluation processes, and future objectives.[250] Above all, the locus of every mission or vision is the students served, inclusive of all dynamic forces that characterize them, especially given the issues of rigorous academics, work and community service, mental and behavioral health, socio-economic stresses, minority and gender equity, social media intrusion, and socialization concerns – for which we must remain rooted in mission.

Conclusion. Throughout institutions of higher education, it is understood that there is an expansive range of clinical and mental health services which are as distinctive as the campus communities that they serve. The overarching realization that college health services provide an extremely valuable service cannot be overemphasized in as much as they provide services to a unique population in an equally unique environment, while striving to improve population health, protect campus communities against serious health threats, assure equitable access, and engage students and campus constituents through education and health promotion. With these ideals as the minimum standard for who we are and what we do, college health services are a microcosm of a healthcare system. Whether expansive state funded campuses with freestanding clinical services inclusive of a full complement of medical, diagnostic, therapeutic, and ancillary services; or the one-room, one-nurse offices of remote or rural limited scope institutions – the very essence of college health practice as being student-centered, interactive with the campus

community, overtly concerned with student safety, and cognizant of fair and equitable access to services designates our own system of health.

Since its inception, the formation of a national college health organization bestowed credibility and formality to the field through established guidelines, recommendations, academic journal and research publications, and an annual gathering. With deference to the pluralistic nature of college health practice, the presence of a unifying body to disseminate current and evidence-based resources specific to managing the health needs of the public that comprises campus communities, individual health services can aspire to high quality care delivery. Affecting national policy, the ACHA has advocated for college health on a federal level and continues to be a strong and influential voice.

Healthcare reform and mounting costs for higher education have influenced college health practice across generations, and changes in funding models over time has altered the trajectory of college health services toward seeking alternative funding models, participating with 3rd party payers, resulting in expanding awareness of practice standards, quality improvement, and accreditation expectations. These attributes lend further perspective of the profession as a healthcare system, with constructs and innovations that also directly parallel public health priorities. Professional staff have confronted these and other challenges by dedicating themselves to practice improvement, research and analysis, thus providing transformative leadership.

Prioritizing wellbeing for campus-wide health promotion, wholeness, and thriving is vital to generating students equipped with skills and practices that will lead them to living fulfilled lives. Inspiring campuses to re-imagine themselves as healthy universities with wellbeing infused throughout every aspect of campus life will require health services to have a profound presence

in strategic planning and policy redevelopment, influencing all sectors through health promotion values, acknowledging the interdependence of students with their surrounding environments, and safeguarding wellness as the common element.

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Chapter 3. Ethical Principles for College Health Services.

This chapter introduces the ethical approach of principlism in the first section, and continues with presenting general ethical concepts for application to college health services.

3.A. The Ethical Approach of Principlism for College Health Services.

Healthcare ethical principles apply to all disciplines and practices in the healthcare industry. Principlism provides the context through which the discussion of ethics in this dissertation will establish an original approach to Professional Ethics for CHS. Clinical health services within institutions of higher education, referred to by various titles, is a broadly encompassing medical discipline within a greatly varied demographic. Campus health services differ vastly in terms of the size and scope of medical care offered to students and the campus community among the wide-ranging spectrum of institutions of higher education.[1] A multitude of variables including biological, behavioral, emotional, and developmental affect and influence the health status of college students. Healthcare facilities on college campuses are uniquely positioned to impact retention, progression, and graduation through the services provided, thus the practical application of ethics to this niche of clinical medicine is both necessary and essential. Current trends that often mirror that of general public health also affect college students in terms of physical and psychological health and wellbeing. Parallel issues are also confronted daily by medical professionals in college health.[2] The following analysis will offer a brief introductory and limited evaluation of each of the four basic principles of healthcare ethics: autonomy, beneficence, non-maleficence, and justice; as they correlate to the exclusive specialty of college health medical services.

3.A.i. Autonomy.

Developmental Considerations of Wellness. The passage from late adolescence into young-adulthood is associated with major life transitions and developmental changes, not the least of which may include moving out of the family home and onto a college campus. Campus health centers are most frequently utilized by undergraduate students aged 17-24.[3] Among the multitude of developmental psychology theories, Erikson's stages of psychosocial development across the lifespan figure prominently when considering college students.[4] As emerging adults who may have potentially unresolved prior psychological stages while simultaneously attempting to master new tasks and stages, overall wellbeing is affected.[5] During this period, students in the phase of late adolescence and early adulthood establish behavioral patterns and lifestyle practices that will determine current and future health outcomes.[6] Cumulatively, these tasks and age-related achievements are equally impactful in the consideration of the physical health and complete wellbeing of college students. The principle of autonomy addresses individual freedom and the moral right to self-determined decision making, the hallmark of this point on the developmental continuum.[7]

Concurrent with these complexities, the college health practitioner must also regard vulnerability as relevant when providing health care to their patients. College students are often assuming primary responsibility of time management, academic workload, and complete self-care without the presence of parental or guardian support for the first time. Achieving health care independence, or autonomy, involves an especially awkward transition from a pediatric to an adult health care model, which innately contributes to vulnerability.[8] According to Beauchamp and Childress in their classic work *The Principles of Biomedical Ethics*, in the biomedical context, a vulnerable person may be characterized as being incapable of protecting their own

interests because of sickness or immaturity.[9] College students seeking care in campus health services accurately fit this definition. The presence of such services on campuses as safe, secure and confidential destinations for health and wellness care necessitates the formation of ethical practice recommendations within this unique healthcare setting. An article in the *Journal of American College Health* which details a study on health service utilization by college students reveals that usage differed by age, with those 19 years of age and younger being seen at much higher rates in their campus clinics. Further, the study provides evidence that younger student visits to campus health centers increase by 35% with age being an important epidemiologic factor for certain visit types.[10] Familiarity with the developmental needs of the demographic can steer college health professionals toward promoting and nurturing autonomy.

Academic success and achievement is a primary mission of institutions of higher education and learning. Over one hundred fifty-five years ago in 1860, Edward Hitchcock Jr., a medical doctor and professor of hygiene at Amherst College, was charged by the president of the institution to develop methods to advance the health of students. By the early 20th Century, campus infirmaries were erected to isolate students during outbreaks of infectious diseases. This expanded post WWII-era as communicable disease epidemiology evolved.[11] By the 1970s, medical societies began to focus on the need for the transition of adolescents into adult healthcare structures. Swift and significant medical advances made it possible for children with chronic illnesses such as heart disease, cystic fibrosis, and chronic renal disease to live longer.[12] Of the many variables that affect student success, heath is of utmost significance. In the *Handbook of Student Affairs Administration*, Ernest Boyer, an influential national leader of student affairs professionals in higher education, is quoted as having stated: “wellness must be a

prerequisite to all else. Students cannot be intellectually proficient if they are physically and psychologically unwell."[13]

The transition that a young adult encounters after receiving healthcare from a pediatric paradigm of primary preventative care to an adult medical paradigm of self-advocacy is challenging and overwhelming, but can also be rewarding if properly introduced. Often, this truth is first realized upon their debut in the campus health center. Students may present to health services with either chronic physical and behavioral health conditions or transient acute illnesses. Of the millions of students in U.S. colleges and universities, many report some form of disability or pre-existing medical or psychological condition. ADHD (Attention Deficit Hyperactivity Disorder), LD (Learning Disability), psychiatric disorders, and chronic illnesses characterize a significant portion of students with these conditions.[14] Regardless of reason, condition or co-morbidity, the newly autonomous college student accessing services becomes the independent consumer of healthcare, and college health service clinicians must bear in mind the substantial impact of developmental influences while providing care.

Decision-Making and Influencing Factors. The ethical principle of respect for autonomy relates profoundly to this life experience and transition. Respect for autonomy, by definition, involves recognizing the right of a person to make one's own decisions and can be affected by their disabilities, mental status, maturity, or incapacity to do so.[15] Virtually all theories of autonomy view two conditions as essential: liberty, or independence from controlling influences; and agency, the capacity for intentional action, according to Beauchamp and Childress.[16] In their newfound freedom and independence, college students are experiencing (most for the first time) true independence from controlling influences (parents and other significant adults) and the potential to realize their own capability for intentional action. As it

applies to further theory, an autonomous person possesses the capacity of self-governance: understanding, reasoning, deliberating, managing, and independent choosing.[17] While some students may exhibit said capacity, inherently, as young adults transitioning from adolescence, various challenges thwart this potential. Complete independence from controlling influences is not readily or systematically achieved, rather, it evolves. The National Institutes of Mental Health (NIMH), (a part of the National Institutes of Health [NIH], a national health authority which researches mental illnesses), refers to a significant limitation in late adolescence and young adulthood that prevents meaningful decisions and choices as being correlated to insufficient prefrontal cortex development, the area of the brain responsible for executive decision-making and complex planning.[18] NIMH researcher Jay Giedd MD is prolific in the research of this topic. His work was also the subject of a PBS (Public Broadcasting System) documentary on the "Frontline" series, entitled "Inside the Teenage Brain," which initially aired in January of 2002, indicative of a widespread interest in this topic. Another Giedd study from 2004 with MRI (Magnetic Resonance Imaging) of the adolescent brain affirmed that the prefrontal cortex emerged late in evolution and is among the last to mature.[19] Consequently, health practitioners in this subspecialty of medicine must be mindful of the impact of actual brain development on the capacity for the college student-patient to effectively embrace autonomy.

Reasons for which students may consider accessing healthcare in college health settings are multifold. This bears significance such that the Centers for Disease Control and Prevention (CDC) addressed this topic on a previous website in pages devoted to College Health and Safety. As a reputable United States governmental agency and trusted public health authority, the CDC is one of the major operating components of the Department of Health and Human Services, and has an established mission to identify and define preventable health problems and conducts

active surveillance of disease.[20] Specific to college students, the CDC has a revised page for young adults, which provides general health and safety tips that both inform and caution young adults about health risks related to nutrition and exercise, stress, substance use and preventing sexually transmitted infections.[21] Academic and social stress, sleep hygiene, and numerous other behavioral/mental health concerns often emerge for the first time while attending college.[22] Nutritional neglect and food insecurities are major determinants of health and wellbeing that frequently occur with college students, with the phrase "freshman 15" being most notable in terms of unhealthy eating, lack of exercise, and tendency toward weigh gain.[23]

The constellation of college student health risks dovetails into the three-condition ethical theory of intentionality, understanding, and non-control.[24] Students *intentionally* push previously guarded boundaries of substance use, sexual encounters, and nutrition - yet may not fully *understand* the consequences or outcomes of those decisions. The third condition, *non-control*, may be affected by internal or external influences such as peer pressure and peer influence, all of which impact autonomy. The effect of peer influence on alcohol, tobacco, and even prescription medications misuse along with other risk-taking behaviors is multifactorial.[25] The health services staff must be committed to a clearly stated, well-defined, achievable mission inclusive of the commitment to address students in consideration of their emerging autonomy. It is incumbent upon the institution to assure that newly admitted and matriculated as well as transfer students are made fully aware of campus health, counseling, and wellbeing resources. Access to health care is a fundamental, normative 'metaethical' concept viewed as a moral norm, and is completely relevant and impactful in the healthcare of students in institutions of higher education.[26] Further, students must be provided with tangible, welcoming statements of rights and responsibilities.[27] In so doing, the student becomes engaged in the self–health management

process regarding the availability of and process for accessing clinical health services. This expectation spans the provision of accurate information on operational hours, scope of services potential costs and fees, identification of the care providers in terms of position (medical doctor, mid-level practitioner, registered nurse, medical assistant, etc.), all of which contributes toward nurturing autonomy and relates to the sub-principle of *respect for autonomy* as a *positive obligation*.[28] In practice, clinical staff are deliberately poised to assess a student's level of understanding and capacity for autonomous choices about their own healthcare. Formalized transition plans may be necessary for certain students with complex medical and/or behavioral health histories as they assume independent living and adult responsibilities. Respect for confidentiality, adequate and complete patient-education, and guidance with decision-making are crucial applications of ethical clinical practice that contribute to patient autonomy. Also applicable to this transition is the concept of informed consent. In health care relationships, informed consent requires an attempt to instill relevant understanding, to avoid deception, coercion and manipulation, and to respect a person's rights.[29] In light of maturity, vulnerability, and cognitive ability, it is imperative that college health practitioners provide a thorough explanation of treatment and obtain procedural consent only when fully assured of the student's comprehension. Overall, it is incumbent upon the health service staff to respect the autonomy of the college student in the context of multiple social, developmental, behavioral, and physical health complexities.

3.A.ii. Beneficence.

Influence Potential of Clinical Health Services. Given what has been heretofore discussed as regards autonomy, it is clear that college students inherently encounter multiple challenges to their health and wellbeing. Student affairs personnel have also accurately analyzed

variants to student success, and report among multiple factors, that health is high atop the list.[30] Health related practices and behaviors should be the concern of campus governance and leadership across both academic disciplines and student affairs administration.[31] Given this shared insight, it is evident that college health services are capable of affecting and positively influencing those students who make use of and seek medical care from their campus health centers. Integral to the practice of college health medicine is for care to be provided in an ethical framework inclusive of the moral intention to do good. The American College Health Association (ACHA) *General Statement of Ethical Principles and Guidelines* asserts a commitment to enhancing the health and affirming the value, worth, and dignity of each individual.[32] This commitment is in accordance with core values expressed by ACHA, which are: social justice, human dignity, and respect for all; provision of student-centered services; professional excellence, responsiveness, and ethical practice; multidisciplinary and collaborative approaches to health; commitment and participation of those who advance health, and active involvement of students.[33] In like manner, the Council for the Advancement of Standards (CAS) "Professional Standards for Higher Education" provides clear guidelines by which clinical health services are to apply ethical standards in theory and in practice.[34] Having previously discussed the principle of autonomy as it relates to college students, the concept of beneficence is fundamentally intertwined in ethical practice of college health medicine. Beneficence, or the obligation to do good for the patient, can be viewed in the context of consequentialism as it pertains to clinical health services, such that through attention to this ethical principle, student wellbeing and achievement are inextricably correlated.[35]

The complexity and comprehensiveness of clinical services on campus vary extensively by student demographics, institutional type and mission, and the availability of health and

wellness resources in the surrounding community. Most institutions of higher education assure that provisions by clinical health services include incoming student immunization tracking, mental health services and crisis management, emergency response services and preparedness, and medical and/or nursing services to address communicable disease and public health needs.[36] At each of these junctures and opportunities of interaction with students, health care professionals and support staff should provide services so as to do the most good for the student in every situation toward that student's overall health and wellbeing. The ethical principle of beneficence refers to a statement of moral obligation to act for the benefit of others.[37] College health services are select health care settings that are innately relevant to this ethical principle because of the characteristics of the population that they serve. Beauchamp and Childress open their chapter on beneficence declaring that morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contribute to their welfare. Further, they determine that agents (in this analysis, the medical provider) must take positive steps to help others, not merely refrain from harmful acts.[38] Primarily because of students' vulnerability due to challenges previously noted, college health professionals must acknowledge and respect the student's adjustment to autonomy, while carefully developing a trustworthy relationship as care-giver and acting in such a way that indeed contributes to their welfare, which in essence is the application of beneficence.[39]

College health services are responsible to the student as the consumer to act with beneficence that is grounded in practicality and purposefulness. Referencing the ACHA "Framework for a Comprehensive College Health Program," college health services can enhance the health of students to the extent that such efforts in turn enhance the learning environment, and that these services address health risks and problems contextually appropriate to a student's

capacity to learn.[40] Current sociological trends, high-risk identification, evolving public health issues, healthcare reform, and new approaches to preventative medicine all have institutional implications. Policy refinement, procedural modification, and educational outreach are all functional elements that contribute to improving the welfare of this population. To that end, health care ethics is tangibly addressed with student life professionals through the both the CAS "Professional Standards" and by the American College Health Association not only in their standing committee on ethics, but also by means of their published guidelines.[41] In respect of this progress, however, ethical practice in the subspecialty of college health medicine continues to warrant further standardization, policy refinement, and establishment of proper guidelines for universal application.

Stressors, Challenges, and the Positive Impact of Clinical Health Services. Students in college encounter stressors that pose a threat to their academic success, whether due to physical, psychosocial, behavioral, or environmental causes. College students often seek care in campus health centers for sexually related and transmitted diseases (STD's) or infections (STI's). According to CDC statistics, nearly half of the 20 million new sexually transmitted diseases diagnosed each year occur among young people aged 15-24.[42] Women can have long-term effects of these diseases, which can adversely affect their future reproductive health. About 1 in 4 (26 percent) of all new HIV infections is among youth ages 13 to 24 years. About 4 in 5 of these infections occur in males.[43] Health care workers who provide medical care to students with these diagnoses are best able to functionally apply *specific beneficence.*[44] This is accomplished through the administration of effective treatment as per established clinical guidelines and standard of care, and by employing the moral obligation of teaching the patient about disease communicability, prevention and overt need for partner notification in the

framework of respect for autonomy and confidentiality. Also at the time of the encounter, it is consummately important to use the opportunity to assess whether the patient has experienced or been victim of abuse, trauma, harm, or intimate partner violence.[45] Further, the over-reaching public health concern of sexually transmitted diseases is then effectively regarded with each patient contact. Undoubtedly, this supports the principle of positive beneficence and the rules of obligation noted by Beauchamp and Childress to (1) protect and defend the rights of others (*the right to health care as a college student*), (2) prevent harm from occurring to others (*effective STD screening and education*), (3) remove conditions that will cause harm to others (*increase campus community outreach and effective prevention/education programs*), (4) help affected persons with disabilities (*college health services often integrate or collaborate with campus disabilities services for the provision of specialized services for persons with disabilities*), and (5) rescue persons in danger (*the potential to identify and intervene when a student admits to sexual coercion, abuse, or relationship violence*).[46] Beneficent conduct in this illustration extends beyond obligation to excellence in practice. Every clinical encounter should be viewed as an opportunity to recognize concerns or issues that might impact the wellbeing and quality of life of the student and the community.[47]

College students who engage in behaviors that may risk their health such as insufficient physical activity, poor dietary management, substance use, and high-risk sexual behavior often encounter poor health outcomes.[48] Certainly, students who undergo assessment, treatment, and counseling for any variety of presenting problems and who are determined to have conditions that relate directly to alcohol and drug use or abuse, or even to unhealthy eating, require of the caregiver 'the duty of rescue' as obligatory beneficence.[49] The conditions discussed by Beauchamp and Childress regarding this theory apply precisely to such circumstances. Using

this theoretical application for purposes of student health, the college health service care-provider has a *prima facie* obligation of beneficence in the form of duty of rescue toward the college student who may be using or abusing drugs and/or alcohol, or who has succumbed to unhealthy eating practices or who may even be eating disordered, with respect to the conditions noted as risk of significant loss of or damage to life, health, or some other basic interest, namely their academic success.[50] With either example, the college health services would act in collaboration with counseling and other relevant campus services to prevent negative consequences. No significant risks, costs, or burdens would occur to the student if maintaining confidentiality and providing services in accordance with and understanding of the student's insurance and financial needs. The end result of this analysis is that the benefit should outweigh any harms, costs, or burdens to the extent that the student's overall wellbeing and academic achievement will be improved.[51]

The College Health Surveillance Network study on utilization of health care identified other salient reasons for students seeking clinical services, including sleep deprivation, life-work balance, and academic stress as common presenting reasons.[52] Similarly, the American College Health Association conducts a periodic survey referred to as the *National College Health Assessment* to assist college health service providers, health educators, counselors, and administrators in collecting data about their students' habits, behaviors, and perceptions on the most prevalent health topics through voluntary participation of a broad cross-section of member colleges and universities.[53] The survey maps a wide-range of health issues including alcohol, tobacco, and other drug use, sexual health, weight, nutrition and exercise, behavioral health, personal safety and violence; and can be further tailored to collect data about students' smoking habits, contraception use, mental health issues, relationship difficulties, sexual behaviors,

exercise habits, preventive health practices, and perceptions of drug and alcohol use. Published results of the ACHA-NCHA study coincides with those of the previously referred to utilization study in terms of common challenges as they impact academic performance and wellbeing, with stress, sleep difficulties, anxiety and depression having the highest percentages.[54] College healthcare professionals caring for students who are coping with these stressors should recognize the opportunity at hand to establish therapeutic and trusting patient-caregiver relationships through repeated patient visits to both the health and counseling center offices. Outreach programming sponsored by college health and counseling services geared toward providing students with education and tools for improving overall health and wellbeing (such as sleep-hygiene topics, roommate and friendship management strategies, study and homework balance workshops, and the importance of recreation and fitness) are reflective of positive beneficence. For the past several decades, the ACHA provided the Healthy Campus (2000 and 2020) program which mirrored the federal public health program "Healthy People," recently reimagined as The Healthy Campus Framework.[55] The overarching goal of these initiatives is to provide direction to leadership through an aspirational framework that promotes and sustains health and wellbeing on campus as a place to grow and thrive.[56] The CAS Professional Standards urges a formalized internal outreach to students, groups, and organizations within the institution to adequately create awareness of wellness resources.[57] Implementing this or other similar initiatives universally in college health services is implicit in the ethos of beneficence. Ultimately, those who provide health and wellbeing services to college students with clearly identified needs and concerns are key contributors to academic achievement. By providing beneficial and impactful services that not only meet the physical needs of students but also nurture health-seeking behavior through

benevolent care practices, we will create positive relationships grounded in the ethical principle of beneficence.

3.A.iii. Nonmaleficence.

Teaching Through Treating. The ethical principle of nonmaleficence obligates us to abstain from causing harm to others.[58] Ostensibly, one may not regard college health services as providing quite the level of clinical medicine where potential harm would occur, such as with the seriously or terminally ill. However, regardless of the size or scope of the college health practice or that of the institution, campus healthcare professionals can routinely encounter circumstances in day-to-day practice that involve the avoidance of inflicting harm. A primary example is noted in a typical reason-for-visit to a campus health clinic, namely, the common cold.[59] Students presenting to their campus health clinic with cough, congestion, sore throat, fever, and other related symptoms often seek a 'quick fix' and often assert a need for antibiotic therapy.[60] Viral upper respiratory infections, or the common cold, is the third most frequent diagnosis in doctor office visits, with most adults experiencing 2-4 'colds' annually, caused by at least 200 different viruses.[61] College students, noted previously to have significant stress from academics and other causes such as communal living conditions, are especially susceptible to such common viral illnesses. When students are seen by their campus healthcare professional and actively seek and request antibiotic treatment for viral illness, the care-provider, following thorough assessment, is obligated to deny the request while providing ample education about viral causation and duration, symptomatic treatment, and self-care recommendations to their patient. Shared decision-making with regard to this pervasive reason for students to visit their campus health center in terms of when antimicrobials are needed or not, are challenged by patient perceptions and expectations.[62] The challenge to not prescribe antibiotics when requested effectively applies

the principle of nonmaleficence by avoiding potentially harmful consequences of increased antibiotic resistance and subsequent destruction of useful bacteria while leaving resistant strains left to grow and multiply, resulting in increased opportunities for other illnesses and disease states.[63] Ordinary yet impactful circumstances such as these convey the need for health services staff to discern between due care and inadequate care. Outreach promotional wellness programs and thorough patient education will also effectively reduce health risk.[64]

Upholding Standard of Care & Practice. Another applicable theory of nonmaleficence in the ethical practice of college health medicine is the potential for negligence and the standard of due care. As stated by Beauchamp and Childress, obligations of nonmaleficence include not only to avoid inflicting harm, but also to not impose risks of harm.[65] Unfortunately, the temptation of a campus clinic healthcare provider to conduct a cursory examination of a presumably healthy young adult patient for a routine complaint is conceivable. Frequency of visits for common, acute complaints and ailments as illustrated in the previous section, may often dominate the reason-for-visit list in college health centers.[66] Caution must be taken to not overlook subtle symptoms, minor complaints, or exam room statements not in line with the presenting complaint or issue at the time of initial patient triage. Professional malpractice is an instance of negligence that involves failure to follow professional standards of care.[67] Consider the following case-study as reported by a colleague in college health. A 23-year-old male resident college student with a known history of mental health concerns but no significant medical history documented in his health record, had frequent visits to his campus health service during his freshman and sophomore years, for minor routine complaints. After several years of having not been seen there, he once again came to the office as a fifth-year student with vague, nonspecific complaints, also informing the nurse that triaged his initial visit that he was

experiencing anxiety and stress due to a student-teaching placement in an inner-city high-school because of a non-supportive, challenging and highly critical field-instructor. The triage nurse directed her questioning along the lines of addressing the patient's stress and anxiety, which at initial presentation was the primary complaint. Following a prolonged triage encounter with the Registered Nurse, the student declined an appointment at that time with a health service clinician indicating to the nurse that "just talking about it made me feel better." Proper recommendations and referral to counseling services were made relative to the stress and anxiety, and a follow-up status-check phone call by the triage nurse was placed the following day to the student, who stated that he was 'doing better' and was 'working things out.' Later that second day, the student again came to his health center office, but was unable to be seen due to the late hour and no available appointments with the remaining clinician on duty, and was advised by the receptionist to return early the next day to secure an appointment. The following day, a Friday, the student did return to the office late in the day, and was evaluated by the nurse practitioner, who addressed his presenting complaints of vague upper respiratory symptoms and non-specific abdominal pain, along with complaints of 'having the shakes' and 'feeling feverish,' despite vital signs assessment completely within normal limits. His reason for visit at time of check-in did not refer to the 'stress and anxiety' from two days prior, instead emphasizing the respiratory and abdominal complaints. The clinician did, however, review with him the visit with the triage nurse two days prior, and queried the student about the stressful situation that was causing his anxiety, documenting accordingly and noting a review of the patient's past visit history and recorded medical history. According to the visit documentation in the patient health record, the practitioner did assess each identified physical complaint and performed her examination thoroughly, including relevant point-of-care testing which did not reveal any further cause for

treatment. Resultant standard conservative treatment recommendations were given, along with over-the-counter products for the respiratory symptoms, advising the importance of hydrating and rest, as well as instruction to continue to self-monitor the abdominal pain, for which the student was directed to proceed to the emergency room for worsening or changing pain or symptoms, as was further stipulated in the discharge instructions given to the patient.

Two days later, on Sunday, the student was found dead in his dorm room. Roommates and close associates stated that he had been coughing 'violently,' and 'spent the entire weekend in bed.' A preliminary autopsy revealed no underlying medical conditions, infections, structural anomalies or defects that would have contributed to sudden death. However, a much later, delayed report revealed that the cause of death was from a serious, sudden onset condition specifically associated with a particular endocrine disorder. In review of the medical health history, former visits to the campus health service, the recent encounter with the triage nurse, and subsequent visit with the nurse practitioner, with examination and assessment having been done to a thorough and appropriate degree; the student's presentation and outcome were incongruent. One could postulate, in hindsight, that the student could have been persuaded to proceed to the emergency room directly from the student health service for further evaluation and testing unable to be conducted in the student health office, which may have revealed the undetermined, underlying condition. Furthermore, one may wonder if this was negligence such that the student was not sufficiently guided. However, after close scrutiny of the documentation of the course of events and visits to his campus health center, and in regard of the coroner's final cause of death, negligence is unlikely in this circumstance. More likely, the student may rather have been experiencing specific, related symptoms which he chose either to ignore or to not disclose during any of his visits to the health office, all of which rapidly progressed and evolved after his last

visit to the clinic. Regardless, as a staggering example, all health care providers in college health medicine must always bear in mind the credo, 'above all, do no harm' in each and every interaction with the college students whom they serve, and to provide the utmost standard of care.

3.A. iv. Justice.

Academic Potential & Wellbeing. The final moral principle of Justice clearly applies to college student health services, particularly with regard to recent theories of justice outlined in *Principles of Biomedical Ethics*.[68] The wellbeing theory, specifically, as developed by Madison Powers and Ruth Faden explicitly for bioethics, public health, and health policy; can and should serve as a foundational, guiding theoretical principle for student health services in institutions of higher education.[69] Their basic premise stating that social justice is concerned with human-wellbeing relates to six core dimensions of well-being: health, personal security, reasoning, respect, attachment, and self-determination.[70] Student life professionals strive to improve campus community health and wellbeing by acknowledging the connection between health and learning. According to a publication by the National Association of Student Personnel Administrators, an affirming statement concludes that multiple variants influence college students' academic achievement.[71] The universal variant that affects all students is health. Students regularly report illness as negatively affecting their academic performance.[72] A recurrent theme throughout each previous section of this analysis has been that both academic and student affairs, and most significantly health professionals in higher education institutions concur that there is a correlation between students' health, academic achievement, and successful degree completion.[73] Given these facts, institutional efforts to ensure a healthy campus environment will have a crucial impact on student academic success as well as influencing

retention, a foremost concern of university administrators.[74] That stated, wellbeing is a central issue within the university community which deems that being healthy, being secure, and being respected are desirable states of being and that justice is concerned with the achievement of well-being, not merely the capability to pursue it.[75]

Germane to the correlation of student wellbeing and academic performance is the concept of capabilities theory. The basic premise of this theory is that the opportunity of an individual to reach states of proper functioning and wellbeing are achieved through core capabilities.[76] Within institutions of higher education, programs are subject to accrediting bodies that require assessment of services as part of accreditation renewal, and core dimensions and capabilities steer learning outcomes in assessment rubrics.[77] Campus health service assessment is pivotal to assuring that justice is adhered to in clinical practice.[78] Common tools may be either using survey of patients seen in the health center, or focus groups of students who frequent the services.[79] Care must be taken to not burden students, and especially to assure participant confidentiality in that students clearly understand what the survey data will achieve. Confidentiality, as informational privacy, is an essential concept that can be applied to assessment.[80] Assessment data should focus on relevant topics for student wellbeing, practice improvement, or other applications. Reference to or participation in national benchmarking through established tools such as the ACHA National College Health Assessment are effective alternative methods of data collection.[81]

Attention to evolving social and cultural trends on college campuses deem that campus health service providers engage with students through fair, equitable, just, and unbiased methods. The national focus on sexual assault on college campuses has been a driving force of policy, procedure, and programming.[82] In January of 2014, a White House Task Force to Protect

Students from Sexual Assault was established. In April of that year, its initial report, *Not Alone*, began to address identification of the problem, prevention of sexual assault, effective response for when a student is assaulted, as well as increasing transparency and improving enforcement through various measures.[83] ACHA has implemented guidelines for addressing this justice-driven issue on college campuses. The role of clinicians and staff in campus health centers must be to heed the responsibility to implement trauma-informed practices in their health centers, so as to provide sensitive responses to students who have been assaulted, thus lowering the risk of re-victimization.[84] The sensitivity and care surrounding this highly charged topic truly call for practitioners to embody the five focal virtues of compassion, discernment, trustworthiness, integrity, and conscientiousness in their role as caregivers.[85] Only then will students be served by means of the definitive virtue of justice.

Access to Services. Colleges and universities are microcosms of the larger public health sector and as such, toward the mission of the wellbeing of its 'public,' access to medical, nursing, psychological, and allied services as well as management of public health needs are important aspects of maintaining a productive living, learning and working environment.[88] This mission is at the heart of wellbeing and reflects back to the six core dimensions previously mentioned, as theorized by Powers and Faden.[86] College students, in order to thrive must also be enabled to achieve wellbeing through tangible conditions that are constructive to health. The campus health service environment should foster these conditions as regards facility and equipment, technology, personnel, resources, and accessibility.[87] Throughout their contextual statement about clinical health services in institutions of higher education, the CAS *Professional Standards* assert that challenges faced by today's health care providers were not even thought of at the inception of on-campus clinical health services over 150 years ago.[88] Today, the delivery

of healthcare on college campuses is further affected by other public policies such as the formation of the Patient Protection and Affordable Care Act in 2010, which addresses universal access to insurance. Through this act, children are entitled to health insurance coverage under their parents or guardians through age 26.[89] College admission requirements often include proof of medical insurance coverage, and campus health services are challenged with the decision of whether or not to implement medical insurance billing.[90] In light of public policy advancements surrounding universal access to insurance, institutions of higher learning are held accountable to their student population for providing more than basic-level medical services on campuses. College health services are called upon by their institutions to provide comprehensive primary ambulatory health care to its constituents and to provide rights and responsibilities to the students so that informed decisions can be made.[91] Additionally, they must provide, promote, support, and integrate with other campus resources to provide a comprehensive, ecological approach to the students they serve so that opportunities for wellbeing are enriched. Integrated wellness services including health, counseling, and recreation are an emerging trend.[92] The CAS publication draws attention to justice concepts that focus on access to a spectrum of services, addressing policy issues regarding health risks, the use of professional standards and accreditation of services of campus health centers, student involvement in evaluation of goals of services, and collaboration and partnerships with other campus services.[93] Several declarations in the contextual statement address social justice as inextricably interconnected to health, as well as emphasizing the regard for diversity, equity, and access. This focus on justice is expanded to pronounce that campus health services must advocate for the needs of diverse constituents when establishing and implementing culturally relevant and inclusive programs, services, policies, procedures, and practices.[94]

Through increased awareness, campus health staff must also be aware of personal biases and microaggressions, whether cultural, racial, or gender or sexual-orientation based. All must become increasingly invested in creating environments that promote safety and success with an awareness of campus climate.[95] Eliminating health disparities and achieving health equity is a primary priority of public health applicable also to college health services, as discussed in the Guidelines Addressing Sexual and Relationship Violence on College Campus publication of the American College Health Association.[96] Of the students on college campuses that describe their sexual orientation as lesbian, gay, bisexual, transgender, or other sexual minorities, these students report more harassment and discrimination and have more negative perceptions of campus climates compared with heterosexual men and women.[97] College health professionals are accountable to minority and underserved populations through ongoing education and by accessing resources such as guidelines for caring for LGBTQ students, published by the Gay and Lesbian Medical association.[98] In recognition of such disparities, practitioners must be cognizant of virtue ethics, or the ethics of care in terms of sensitivity and impartiality.[99]

With regard to a further special population, college health services must also collaborate with campus veteran's service departments in the care of students who are military service veterans. These students demonstrate high levels of suicidal ideation due to PTSD (Post Traumatic Stress Disorder), and are more likely to participate in other high-risk behaviors.[100] With the advent of the Post-9/11 Veteran's Educational Assistance Act of 2008, campuses have experienced increased enrollment of military veterans, inclusive of those who experienced multiple deployments. The higher education community responded with various standards, guidelines and toolkits to aid and assist this population.[101] Campus health offices must recognize

the plethora of medical and psychological difficulties as they serve the men and women who served our nation through their time in the military.

Access to services is a primary concern that is further supported through the theory by Norman Daniels put forth in *The Principles of Biomedical Ethics* in the section on egalitarian theories, which clearly applies to college health medicine. Daniels theorizes that health care is needed to achieve, maintain, or restore adequate or species-typical levels of functioning so that individuals can realize basic goals.[102] A health care system designed to meet these needs should attempt to prevent disease, illness, or injury from reducing the range of opportunity open to individuals. On college campuses, student health and wellbeing services are indeed functional health care systems. This analysis has provided evidence that college students must function in a state of wellbeing adequate to meet their academic goals, and college health services are the system by which prevention of disease through provision of ongoing education and access to services will afford that opportunity to all.

Conclusion. In conclusion, the four moral principles of autonomy, beneficence, nonmaleficence, and justice are theoretically and practically pivotal to the ethical practice and effective functioning of clinical health services on campuses of institutions of higher education. Despite the varied continuum of what constitutes clinical health services, at the epicenter are young people who have entrusted themselves to an select group of care providers. The students that are cared for, supported by, educated by, and nurtured through integrated health and wellness services are the future consumers of health care in the public community and marketplace. Thus, we as college health clinicians, hopefully will have prepared them adequately through nurturing their autonomy, providing benevolent care, having avoided inflicting harm, and in respect of due justice, having inspired a culture of wellbeing practices. If

true, we are sending them forward into the world beyond campus borders to ultimately influence and affect the health and wellbeing of future generations.

3.B. General Ethical Principles and Concepts for College Health Services.

Moving the needle of the gauge of clinician's respect for and understanding of ethical principles toward the positive of application to daily practice requires that we reach through the many layers of the four basic moral principles of respect for autonomy, nonmaleficence, beneficence, and justice.[103] In doing so, concepts encountered lend substance to the abstract by providing concrete application and reason to the daily clinical practice in caring for college students in the field of college health medicine. Realizing that the uniqueness of this sector of higher education has impact and significance that reach far beyond merely offering clinical services on campus, is cause for purer analysis of how healthcare ethics apply to the practice.

3.B.i. Common Morality and Moral Virtue.

Relating Morality and Virtue to Campus Clinical Health Services. Given the influence that medical professionals in college health have on the students that they provide care to, and through this study of how healthcare ethics applies to our field, an understanding of common morality and virtue are vital.[104] Beauchamp and Childress begin the first section of Principles of Biomedical Ethics probing this very topic, Moral Foundations. Defining ethics as a way of examining and understanding the moral life with approaches that are either *normative* or general, in that they are foundational to developing norms for specific contexts; and *non-normative*, including descriptive ethics which use techniques and facts to develop professional codes, mission statements, and policies; versus metaethics, concerned with theory, meanings of terms, and moral analysis.[105] Descriptive ethics are demonstrated in institutional missions, student

codes of conduct, and in professional practice codes, while metaethics analyzes language, concepts, and methods of reasoning.[106] University mission statements as well as physician and nurse practice standards are symbolic of descriptive ethics. Common morality, to further the discussion, encompasses the set of universal norms shared by all persons committed to morality and relates universally through commonly understood credos that traverse cultures and belief systems such as to not kill, to not steal, to tell the truth, and to obey laws, as a small example.[107] These are known as standards of action, or, rules of obligation.[108] Fundamental to these rules are corresponding moral character traits, or virtues, which directly pertain to ethical clinical practice and excellence. Health care providers in the collegiate setting establish authentic relationships with their constituents, and must practice within the context of such virtues, especially trustworthiness, kindness, honesty, integrity, and with nonmalevolence.[109] Although there is disparity of both opinion and practice between public and faith-based institutions, these universal qualities provide a common thread to the applicability of common morality. Antithetical to these esteemed traits of character are the opposing vices of such virtues.[110] Professionals in college health settings will encounter students who have been affected by consequences from actions of others with moral deficits such as victims of sexual assault and partner violence.

Particular moralities, on the other hand, are not universal – but contain concrete and content-rich specific norms pertinent to specific populations.[111] The diversity of institutional types including public or private, or with traditions such as religiously affiliated or specialized mission, drive the moralities of those IHEs, impacting the delivery of health care and outreach. Students seeking specific treatments or care at institutions with specific affiliations, such as Roman Catholic or other faith-based colleges and universities, may encounter conflict with the particular morality and ideals of the prevailing belief system if their personal convictions differ,

such as when seeking prescribing for contraception or freely available condoms. Likewise, non-universally practiced beliefs and biases of individual medical professionals may also potentially affect care delivery to students with differing moralities. However, Beauchamp and Childress provide a distinction between professional and public moralities, of which the specific general moral norms within the practice of medicine, with its special roles and relationships, require rules that other professions may not.[112] Regardless of rules, codes, moral principles, or policies - cases and scenarios that pose moral dilemmas for healthcare professionals are unavoidable.

The four primary ethical principles, respect for autonomy, nonmaleficence, beneficence, and justice, provide the essential foundation to our discussion of ethics and college health services.[113] Explicit rules and theories are expanded from these four elemental norms which are extracted from the common morality. Specification allows us to drill-down to relevant norms that relate more specifically to the practice of college health. The respect for autonomy, for example, is of utmost significance when considering younger undergraduate students, and becomes a practical instrument for moral reasoning. Within the context of the college or university community as a contained community, prevailing concerns for public health clearly affect moral decision-making, which can be supported by various rules, including substantive (such as with confidentiality & informed consent), authority (such as with administration overseeing resources allocation for health services), and procedural (such as internal policies and procedures that drive services provided).[114] Nuances present when health and counseling services are integrated or merged. Campus health services, unless outsourced and managed by an outside entity, are inimitable entities that are the ubiquitous 'square peg' unable to fit into the 'round hole' of other student affairs offices which are generally focused on student involvement, residence life, and other non-service driven elements of the campus community. Clinicians

caring for college students commonly employ, whether naturally or through concerted effort, the process of weighing and balancing between rules and obligations while acting as moral agents, often as regards respect for autonomy. Irrespective of any of these elements, the four principles detailed in this seminal work by Beauchamp and Childress artfully weave together through a multiplicity of factors that will structure and guide ethical practice in college health services.

Moral Excellence and Ideals. Health care workers, regardless of background, education, experience or specialty – possess intrinsic characteristics that likely led them to choose their profession, and propel their continuation in the field. Apart from altruism, moral character founded in the fundamental virtues of compassion, discernment, trustworthiness, integrity, and conscientiousness is at the core of caregiving and patient/provider relationships.[115] Focal health concerns of college students (common communicable illnesses, stress & anxiety, nutrition, sleep, sexual health, alcohol and recreational drug use) necessitate active virtues such as patient advocacy and concerns for justice. The "ethics of care," according to Beauchamp and Childress, are underscored by sympathy, compassion, fidelity, and love.[116] Caring for the college student population demands sensitivity to their problems, needs, and vulnerabilities, while simultaneously assuring their right to quality health care. Provider/patient relationships exist in the context of emotions and sensitivities that determine appropriate moral responses, varying from situation to situation. The vulnerabilities of student-patients and the circumstances that make their needs unique also mandate that care providers be cognizant not only of professional rules, codes, and role responsibilities but open to how integral the virtue of pure caring must be. Compassion shown toward the student who enters the clinic under the guise of a physical ailment but reveals to the clinician behind a closed exam room door that they've been struggling with managing stressors that are not only academic but are also social and familial, epitomizes an act

of mercy through sympathy and compassion, as well as competence to take necessary assistive action. The use of discernment in such scenarios guides the health care worker to employ the proper level of consolation without overt intrusion. Key to this is the realization that students receiving care in campus health centers are entering into an agreement of trust through their confident belief and reliance on the not only the caregivers skill, but also their trustworthiness. Campus health services must establish and maintain a culture of trust and a climate of confidence. Trust will take root when the staff members of the clinical health services value and possess the virtue of integrity, exhibited by congruence between achieved skills, ongoing commitment to excellence, and a determined consciousness of moral values.[117] Challenges to the balance between moral and professional integrity may arise when personal religious convictions clash with professional obligations, such as when a student presents to the clinic with an unintended pregnancy, and is adamant about their decision to abort.[118] In such cases, collateral virtues of patience, humility, and tolerance along with preemptive guidelines and recommendations may avert a staff member compromising their own moral integrity or that of the institution's if relevant. Further consideration of yet another preeminent character trait as pivotal to this analysis is the virtue of conscientiousness. Defined, a person acts conscientiously when they are motivated to *do right* because it *is right* through their own determining efforts to decide so.[119] Conscientious objections by medical professionals can enter into the day-to-day operations of campus health centers. Again using the example of transgender care, a nurse may refuse to administer hormone injections to a 'transgendering' student because of personal moral objection, but the patient's rights and interests must also be considered.[120] The institution's duty to inform and provide appropriate alternative options must also be weighed in terms of institutional makeup, policies and protocols.

Outside of the five focal virtues reviewed previously, extraordinary moral ideals reach beyond the required, obligatory level of the common morality.[121] In previous analysis, organizational ethics have been discussed in terms of relevance to on campus student health centers. When the institutions themselves aspire to lofty ideals by means of their historic relevance, founding identity, or institutional mission, the likelihood of student services, inclusive of campus health services, being held to that same standard rises precipitously. Service to the campus community involves a rudimentary understanding of the four categories of moral action: actions that are right and obligatory, those that are wrong and prohibited, others that are optional or neutral, and ultimately those that are optional but nonetheless laudable.[122] When a college health staff member accompanies a student in an ambulance to a nearby emergency care facility, continues to stay through an emergency surgical procedure, and waits for family to arrive from out of state – this is considered to be a supererogatory act. By definition, the act is neither required nor forbidden, it exceeds what the obligations of the role as staff member demands, and it is intentionally carried out in the interest of another.[123] Further, staff that are committed to the institution and to what they do in their role as campus healthcare providers often exhibit other forms of supererogation by volunteering at campus events or working beyond designated hours on special interest projects or community outreach, yet may often do so without subsequent reward.

For those professionals who touch students' lives on a daily basis outside of the classroom, within the environment of an on-site clinic, practicing the craft of college health medicine necessitates actions, motivations, personal conduct, and a mindset with a capacity for moral excellence.[124] For the four or more years that students receive care from their campus health centers, the care providers will influence students' ability to become stewards of their own

health and wellbeing, as well as consumers of healthcare upon entering the workforce. This contribution to a vital co-education as health care consumers directly correlates to campus health center staff moral excellence. Beauchamp and Childress reference Aristotle's teaching that virtue is acquired similarly to other skills such as carpentry, cooking, or musical instrument proficiency in that they require training and practice.[125] I would add that an effective student health center will also develop accordingly with regard to standards of care and excellence framed by profound moral distinction. Staff members achieving worthy continuing education, campus leaders becoming aware of health center initiatives and supporting student awareness of available services, outreach to the campus community by clinicians to promote health, educate the public, and to conquer stigmas associated with seeking medical or psychological support are all achieved when the goal of moral excellence is the polestar. As hospital systems or small community hospitals contribute to their communities, and governmental public health departments conduct surveillance and outreach to the public they serve, so too must campus health centers assume the distinction as leaders of health and wellness initiatives for the campus community as a microcosm of an actual municipality. Enhancing all efforts to do so are four criteria of moral excellence: faithfulness to the ideal, motivational structures that uphold virtuosity, exceptional moral character, and moral integrity.[126] Campus health professionals that meet these conditions through the care that they provide, the influence that they exert, and the priority that they give to the benefit of others will succeed in influencing those in our custody through lasting impressions. When students graduate, enter the workforce and live independently, our work will have been worth the effort if they can recall and reapply the medical care and effective patient education that was provided to them in the context of trust and compassion.

3B.ii. Vulnerability and Discrimination.

College Students as a Vulnerable Population. Beauchamp and Childress discuss that concern for moral status in healthcare ethics is driven by concern for vulnerable populations.[127] College students, especially undergraduate learners, are often incapable of protecting their own interests due to sickness, mental health issues, and immaturity.[128] In previous sections, it has been stated that the developmental and psycho-emotional maturity which affects capacity to obtain, process, and understand basic health information as well as to make appropriate health decisions is greatly affected by evolving capabilities. In their examination of the theories of moral status, the authors point out that from ancient cultures through to our own in the present, different motives and theories are at work when certain groups of people have been refused social standing due to lacking properties that would secure full moral status, such as women and minorities. They continue to state that the worry today is that vulnerable groups are still held in discriminatory social situations, in that they fail to satisfy criteria of moral status because of dominant situations that deny them this achievement.[129] Although this dialogue is correlated to specific population descriptions, the theoretical value does also apply to college students precisely because of their developmental vulnerability, inclusive of identified minority sub-populations. Students of color, international and English as a Second Language students, those of sexual- and gender-identity minorities, and even those who are of political and religious minorities are at risk for equal status denial in terms of how they view themselves as integrated campus community members, and in their personal pursuit of physical, mental, and spiritual health and wellness. The moral status of these and all individuals assures that they deserve protections afforded by moral norms including principles, rules, obligations, and rights – especially as regards their own wellbeing.[130] Further, the added element of persistent social concerns including students with economic disadvantages

and those who have experienced violence or trauma in the past or concurrently, contribute to disparities and inequities that increase vulnerability.[131] It is therefore important that we emphasize two essential traits in the care of college students as a vulnerable group: sympathy and impartiality. Beauchamp and Childress state that the capacity for sympathy enables us to enter into the thoughts and feelings of another (human) being, forming a concern for the other's welfare.[132] They further reference David Hume as arguing that this capacity is limited, since bias and impartiality enter into many relationships and judgments in that our sympathy for others is typically "fainter than our concern for ourselves."[133] This is of particular concern as we consider disparities and stigmatized subgroups. The risk of students who are characterized as minorities or underrepresented as experiencing poorer health and psychological alienation is potentially greater than that of the mainstream student population. A multitude of factors contribute to this potential, including demographics of students accessing campus health services, knowledge of disease or illness prevention, variabilities in health determinants and health literacy in all various subgroups. Intentional outreach from campus health centers to such student sectors is of crucial importance and is inherent to values-based and ethically formed mission statements. Clinicians and health services personnel must strive to address any personal issues of limited sympathy for others different from them through a deliberate exercise of impartiality through calm and unbiased judgments and by intentional development of moral excellence.[134] Beauchamp and Childress assert that "sympathy is an ideal of conduct, which, when consistently achieved across a lifetime is a morally beautiful adornment of character," which – for me – is as perfect a credo for all college health professionals as any. On a daily basis, across the diverse continuum of college health services among the vast array of institutions of higher education in our nation, students who enter into our centers are indeed vulnerable with

regard to adapting or mal-adapting to college life and its stressors; having revealed or not revealed past medical, psychological, or social histories; have been exposed either directly or indirectly to violence or trauma; have co-morbid mental, emotional, and developmental conditions; and those who fall into minority subcategories previously mentioned – must all be cumulatively considered and honored. The recognition of all students who intentionally or unintentionally, knowingly or unknowingly fall into the descriptive of vulnerable, must pivot to the level of importance and significance that is due to them so that the wellbeing of all campus community members is prioritized for.

Avoiding Intentional or Unintentional Discrimination. At the core of how healthcare ethics applies to college health services is the general principle of justice. As personally coming from the perspective of a Catholic institution, social justice concerns prevail in any discussion of Catholic moral and intellectual tradition, and most poignantly with regard to health care delivery. One can consider that all institutions of higher education are in and of themselves true communities with comparable elements to a township or municipality; and in terms of this comparison campuses are comprised of a definitive population: an economy, residential living, task-specific buildings, and an assortment of human services. Of those services, campus health care of students is of utmost significance. It has been previously discussed that health and wellbeing directly affect retention and degree completion. To that end, inequalities in access to, distribution of, and disparities in health care delivery (for our purposes, on college campuses) directly pertains to the principle of justice and clearly correlates to discrimination.[135]

We have established that the provision of campus health services is extremely varied among the gamut of institutions of higher education, as is often referred to in this discourse. Issues of funding, staffing, resources, location, scope of services, and attribution of significance or

importance (in comparison to other student services) radically fluctuates from institution to institution. Despite these differences, it is pivotal to the establishment of ethical principles and guidelines in this area of clinical medicine to assure that justice and principles of justice are assimilated into practice. Justice is defined in Beauchamp and Childress as what is fair, equitable, and appropriate treatment in light of what is owed to individuals.[136] Equally relevant is the impact of distributive justice, or the fair and equitable distribution of benefits and burdens.[137] Most institutions of higher education incorporate funding for available student services on campus through either disclosed or imbedded fees and tuition. The rewards of scholarships, grants, or financial aid cover varying degrees of the components of a student's education. Clinical health services on campuses are often funded through tuition, fees, or by means of 3rd party insurance billing among other means and provisions too numerous to define. One may then logically conclude that all who are eligible for services would thusly receive them. Unfortunately, resources are often limited and affected by a multiplicity of institutional dynamics, which is in and of itself discriminatory. Problems of distributive justice can be viewed through both traditional theories of justice and more recent theories.[138] One that is concretely used by and clearly pertains to campus community health services is that of *well-being theory*.[139] This theory emphasizes essential or core dimensions of health and wellness, a commonly used schema in college clinical and mental health services. Madison Powers and Ruth Fadden pioneered this theory in pertinence to public health, bioethics, and health policy.[140] Dovetailing into what is familiar to all healthcare providers with any regard for social justice, is their basic premise that "social justice is concerned with human wellbeing."[141] The dimensions that are referred to in their theory (health, personal security, reasoning, respect, attachment, self-determination) are commonly replicated and extrapolated upon as any web-search of campus

health services will disclose.[142] What is of prime significance, however, is that the major concern of how these capabilities through their dimensional aspects relate to not simply health care, but most provocatively toward the acquisition of health. However, as with society in general, such theories and how well they are implemented are directly affected by institutional policy and support of tangible public health-driven programs (for example women's health services, health education, awareness, and prevention initiatives, and other population-specific services) so that a fair distribution is actualized and achievement of wellbeing is realized by campus constituents.[143] Powers and Fadden viewed the goal of reduction of inequality of wellbeing and resources as primary, while the absence of the conditions for wellness dimensions as being "seriously destructive to health."[144] Institutional administrative withholding of adequate funds for the development of essential clinical services is not only discriminatory as framed by justice concepts, but is self-defeating in terms of the advancement of the ultimate goal of successful degree completion. Egalitarian theories by Rawls and Daniels, according to Beauchamp and Childress, affirm that healthcare is needed to achieve specific levels of functioning so that individuals can realize basic goals, and that a healthcare system (i.e. campus clinical services for our purposes) should attempt to prevent a lack of health and wellness from reducing opportunity.[145]

A further relevant theory that seamlessly supports and vindicates the assertion of college health professionals' belief in their purposefulness and relevance is the innovative concept of *capabilities theory*. Defined, this theory emanates from the notion that in order to reach states of proper functioning and wellbeing, it is possible only through the achievement of "capabilities" that are essential to basic moral significance.[146] Quality of life is thusly contingent upon what an individual is able to achieve, and how well an individual can sustain and implement a group of

"core capabilities" which uphold a basic level of social justice, and include: life; bodily health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment.[147] The absence of these core capabilities in part or in total is proportional to the wellbeing of college students, and is of central significance for campus health care providers to not only realize, but to guard and defend.

The concept of disparities in health care is addressed by Beauchamp and Childress in their chapter on Justice.[148] They contend that healthcare disparities across racial, ethnic, and gender, and social constructs are problems of fair opportunity.[149] Despite this analysis as pertaining globally in terms of impact on our country and others, it is quite germane to the provision of campus clinical services. Utilization of health care services and various screenings and interventions must be assessed and monitored to determine whether potentially discriminatory variances exist. Do health promotion programs and other initiatives sponsored by campus clinical services intentionally reach all populations on campus, traversing cultural, racial, ethnic, social, and other population sectors? Is utilization of services affected by other disparities including fees for services, insurance status, accessibility for disabled or differently-abled students, location, or even other considerations such as current hot topics such as microaggressions and other insensitivities? Are campus healthcare providers adequately assessing for or conducting care within the structure of trauma-informed care, or with an awareness of other vulnerabilities including homelessness and food insecurity? The risk of discrimination of students with these and other disadvantages is a sad reality. One must be cautioned, however, that the tendency to overprotect, stereotype, or incapacitate those who are vulnerable is relevant to any discourse of healthcare ethics.[150] Sensitivity to students' healthcare

needs and just implementation of campus healthcare initiatives must rise to the level of strategic importance.

These students for whom campus clinical services care for are those who, in turn, will become the public policy writers, health care providers, and social system strategists of the future, as well as consumers of public health care. The experiences that they encounter while a student in an institution of higher learning have the potential to have positive impact.

3.B.iii. Professional-Patient Relationship.

Imparting Information and Maintaining Faithfulness. Although students obtaining healthcare from campus health and wellness centers do so for a finite period during their tenure as students, there must be a tacit understanding of professional-patient relationships. In previous sections of this study, the evolution of the clinical health services as well as that of the increased complexity of students seen, have both been considered. It is known that most mental health disorders peak during young adulthood, and that among college students, anxiety and depressive illnesses are prevalent, as well as diagnoses of ADHD and eating disorders.[151] According to the Journal of American College Health, students with chronic illnesses also exhibited increased anxiety as well as illness uncertainty and intrusiveness.[152] Because of this ever-evolving context, it is incumbent upon college health clinicians to fuse the principles of healthcare ethics with the day-to-day application of the tenets of veracity, privacy & confidentiality, as well as fidelity in clinical practice.[153]

College students, especially undergraduates, have a multitude of age-related developmental and maturational nuances that set the stage for how clinicians should convey information, primarily due to the student's developing autonomy. As patients in our clinics, the extent to which these young adults understand themselves, their own and others' expectations, and their

emerging belief systems; will affect how they exercise their autonomy toward their ability to care for themselves.[154] The task of self-care and attaining a healthy lifestyle is not readily achieved given social, academic, and personal acclimation. During times of illness, especially, the healthcare professional is obligated to provide care and impart information to the student that is accurate, comprehensive, and clearly delivered – all of which upholds the virtue of veracity, which Beauchamp and Childress assert is closely connected to autonomy.[155] For example, given the pervasive concern for high-risk sexual behavior, incidences of sexual assault and intimate partner violence along with the prevalence of sexually transmitted diseases (STDs) among young adults, the need for clear, direct, comprehensive imparting of information about the diagnosis, treatment, risks to self as well as the public health risk to others, must be through a foundation of veracity and trust between the patient and healthcare professional.[156] With half of all newly acquired STDs occurring in young people aged 15-24, as well as the increased risk due to a multitude of reasons, campus clinics are key in prevention and management.[157] The obligation, in this example, to engage sympathetically in recognition of the patient's emotional response while factoring in not only developmental matters but also the growing prevalence of mental health co-morbidities, along with balancing their informational interest, especially as regards negative outcomes which are a result of sexual violence or assault, must be upheld.[158] The virtues of compassion, gentleness, and sensitivity in deference to the ethical principles of beneficence and nonmaleficence apply directly to such situations.[159] Student concerns for privacy and confidentiality are tantamount to their understanding of their rights to privacy under the law, further discussion of which is to follow.[160] The significance of the professional-patient relationship and the absolute obligation of college health professionals to provide medically accurate information through robust education campaigns and outreach to the campus

community, is fundamental to the concomitant value of public beneficence and the inextricable link between our duty to and the rights of students to be informed.[161]

Public health concerns on a college campus equate to that of the general public in terms of epidemiological matters such as disease incidence and prevalence, and effective action of protecting the community while upholding effective public health policies.[162] Of primary focus in this regard are campus immunization protocols which are influenced by state law, recommendations of the C.D.C. (Centers for Disease Control and Prevention), with whom the A.C.H.A. (American College Health Association) has collaborated to establish guidelines and information for colleges and universities.[163] Immunizations are one of the 20th century's most significant public health achievements, yet, the risk for communicable and vaccine-preventable disease outbreaks on college campuses due to communal living arrangements and close person-to-person interactions necessitates immunization surveillance and compliance monitoring. As international student populations rise, there is increased risk of disease importation from endemic countries, in addition to the potential for exposure when students opt to study abroad, also a growing trend. As Beauchamp and Childress explain, public health surveillance is based on beneficence and justice in the prevention of harm to others, and overrides the concern for any risk to privacy because of the ideal of disease prevention.[164] Screening for tuberculosis, reporting of positive testing results to local or regional public health authorities not only for surveillance but for treatment programs, demonstrates the balance between rules of privacy and public health.[165] The same is true for STD's, as previously noted. State registries for immunization records are an innovative technology for monitoring, access, and information; nevertheless potentially controversial in terms of the risk of mission-creep in public health and divergent socio-political opinions on such registries.[166]

Because of the interest that we hold in the general health and wellbeing of the university community, it is worthy to also examine the important moral norm of fidelity, or professional loyalty.[167] Holding firmly to prioritizing for the best interest of the patient involves two considerations: that the professional disregards their own self-interest in circumstances that conflict with that of the patient; and that the professional holds the interest of the patient over that of any third party.[168] As an example, within the vast continuum of the size and scope of campus health services, many institutions contract for various services provided, such as physician or psychiatry services, physical therapy or sports medicine services, and so on. Despite the presumed cost-savings administratively, those who manage campus clinics must also be alert to infringement of the value of fidelity if those contracted individuals are creating opportunities, as an example, for further referral of patients out to their own or other community services and practices for continuation of care or treatment, especially when those individuals have a financial investment in the referral source, which exemplifies divided loyalty.[169] Other conflicts of interest occur when the campus health clinic and those who are treated there become a source and subjects for research. Staff members of campus health and wellbeing services often conduct evaluative research toward the improvement of quality care, as well as for the development of health education programs specific to the needs of the campus community. However, when grant proposals or the resultant publications from such research involve recruitment fees or gifts associated with outside stakeholders, further scrutiny is essential to further avoid either financial or non-financial conflicts, such as with the intention for professional advancement of the researcher.[170]

Campuses with policies that govern student requirements for medical insurance coverage and sponsorship of a mandated university plan for those who don't ("hard waiver") also affect

caregiver fidelity to the patient. Although insurance laws vary from state to state, and student health service financial and funding structures also vary to an extreme extent, campus health care providers nonetheless may have to contend with how the interplay of insurances, networks, fees, and reimbursement influence treatment decisions.[171] Concerns have arisen with regard to college sponsored health insurance plans as being overpriced and lacking in essential benefits. The ACHA has established standards to guide campuses to establish effective, appropriate, and credible student insurance programs.[172] Whether private plans endorsed by the college or university place students at risk due to inadequate coverage and exclusions for those needs which most affect college-aged students such as primary care, pharmaceutical coverage, and psychological counseling, begs the moral question of who is realizing the greatest financial gain, the insurance company, the institution, or the patient?

Confidentiality. In institutions of higher education, student records are regarded as sacrosanct, and are protected by federal laws which reflect back to the principle of respect for autonomy as well as the right to confidentiality.[173] There is a distinction, however, between a right to privacy and a right to confidentiality in terms of the failure of an institution to protect information or disclosing it without first party consent.[174] It is incumbent upon campus clinical (mental health and clinical health) services to provide notice regarding confidentiality of health and treatment records. In Beauchamp and Childress, the concept of privacy is deconstructed by Anita Allen into four forms: informational privacy (emphasized in healthcare ethics), physical privacy (relative to persons and their personal space), decisional privacy (as regards personal choices), and proprietary privacy (such as with matters of image).[175] The authors expand this theory to include relational or associational privacy, which – I believe – particularly attaches to our discussion of the right to privacy in the college health setting, in that it includes the

perspective of family and intimate relations' impact upon individual's decision-making.[176] Informational privacy asserts that confidentiality prevents re-disclosure of information originally disclosed between parties.[177] Idealistically, when others gain access to protected health information without authorization, the right to both confidentiality and privacy is infringed. However, within the context of standards of care and ethical practices, legitimate exceptions are realized. Beauchamp and Childress define two types of arguments regarding protection of confidentiality: consequence-based arguments and arguments from autonomy and privacy rights.[178] In 1976, the Tarasoff case resulted in the creation of laws and policies surrounding the duty to warn based on public endangerment.[179] The unfortunate truth of cases reaching national attention about college students with mental health burdens that resulted in tragic situations propels us toward a clear understanding of applicable laws and health and safety restrictions when students may be viewed as a harm to self and others.

Concerns relative to informational privacy are elemental to technological advances in medical care, ranging from that of the use of electronic health records, patient portals, data exchange, to virtual or tele-health/tele-medicine services.[180] This is likewise true with electronically filed insurance claims for 3rd party reimbursement of services, inclusive of random audits and record review. One can thus ponder how well these new challenges intrude upon the purity of the definition of privacy that describes a state or condition of limited access, which involves the right to also control access.[181] It would then suffice to say that metaphors used to express privacy of personhood include a variety of zones and spheres that ultimately should protect autonomy.[182] Although the students serviced by campus clinical health services have grown together with evolving technology, as professional health care providers, our clear

understanding of the very basics of privacy and confidentiality amidst the changing nature and advancements in medicine is without question a moral and ethical obligation.

3.B. iv. Consent and Surrogacy.

Autonomy and Informed Decision Making. The transition from dependence upon parents, guardians, and mentors to that of achieving relative independence for students attending institutions of higher education, is affected by physical, cognitive, emotional, and experiential influences. Campus clinical health services engage with students for medical and psychological care, as well as overall wellness and health promotion that contribute to student success, retention, and achievement. When students seek care from our facilities, a condition of ethical practice is to understand the importance of informed consent, both in terms of the obligation to disclose information and as to the quality of the patient's understanding and consent.[183] Under this condition, there is a clear correlation to respect for autonomy, which encompasses a student's ability to govern themselves and their decision making without interference by others or by conditions that may affect their choices, especially that of a lack of understanding in a given situation.[184] From the simplest of explanations when treating a student with a common viral respiratory illness, who regardless has the right to a thorough assessment and competent explanation of diagnosis, treatment, and prognosis; to the student in need of an invasive therapeutic procedure – each must be granted ample information to achieve relevant understanding without coercion, deception, or manipulation.[185] The student seeking prescribed treatment for a common cold, insisting to his caregiver that he "knows that it's a sinus infection," requires patient yet ample explanation of the distinction between viral and bacterial upper and/or lower respiratory illnesses and the standard of care for both evaluation and treatment, imparted to

the patient clearly and with their full understanding. Previously, the professional-patient relationship was examined in light of the concepts of veracity and trust. Through that relationship, however, the distinction between mutual or shared decision-making and informed consent is significant.

Within the setting of campus clinical health services, all who provide care to the students will do so in the context of two different senses of informed consent: first, the authorization of the individual for the medical treatment, meaning that the individual has authorized something through both informed and voluntary consent; and second, by appreciating that as a professional, he or she is conforming to the social rules of consent, which require legally and institutionally valid permission before proceeding with diagnostic or therapeutic procedures.[186] On a daily basis college health professionals encounter situations that require informed consent, from ordinary tasks such as venipuncture to those done in the course of a physical assessment, such as rectal or pelvic examinations. Students' ability to fully comprehend the extent of any procedure whether mundane or complicated, are inconsistent and are affected by past healthcare encounters and experiences, co-morbid physical and/or mental health issues, and developmental maturity – all of which require sensitivity and diligence in providing ample information. Throughout the study of healthcare ethics, theories have evolved with regard to the elements of informed consent, best delineated by Beauchamp and Childress in their seven-element definition which categorizes the components of consent into three classifications – the elements of threshold or preconditions: competence and voluntariness; information elements including disclosure, recommendation, and understanding of both; and two parts of consent: decision and authorization.[187] In the milieu of college health practice, these rudiments apply directly, regardless of complexity of diagnosis and treatment, such as with the simple example of an ear

irrigation. A young undergraduate student-patient presents to the clinic for a primary complaint of ear fullness and diminished hearing, stating that he is concerned that he has an ear infection. The clinician, through best practices, will undertake a complete assessment, determine that a cerumen impaction is the likely culprit, and will then consider treatment options, and potentially order an irrigation of the affected ear, for more thorough examination of the ear structures. Applying each of the above components of informed consent to this common scenario, the clinician (1) would determine the competence of the student to understand the diagnosis of cerumen impaction and need for removal of the impaction so that the examination of the ear can be completed, considering their self-assessment of "infection;" (2) would ascertain that the student voluntarily agrees and does not feel unduly persuaded or coerced into having proposed irrigation; (3) has fully disclosed all alternative options to the patient (manual removal or topical preparations); (4) provides a substantive recommendation of the best option; (5) should perceive that the patient understands the explanation provided through the disclosure and recommendation – particularly if the student has not previously undergone this procedure; (6) receive from the patient the decision to proceed with the option as presented, and (7) accept their authorization to proceed. A patient's competence presupposes cognitive abilities and the capacity for independent judgement, as well as the capacity to comprehend and process the information provided to them by their clinician.[188] The clinician's duty is to also provide full disclosure of possible consequences, or disadvantages and potential complications for each of the treatment options, such as potential TM (tympanic membrane or "ear drum") perforation, increased pain, potential infection with an irrigation; as well as tissue trauma and pain with manual removal; and the possibility of an allergic reaction, vertigo, infection, and hearing loss with topical preparations, especially if the TM is not intact. [189]

Disclosure, even in the above illustrative example, is central to patient decision-making through informed consent.[190] Medical professionals providing information to their patients are held to the standard of supplying facts and descriptions of the treatment or intervention as well as additional information that the clinician deems to be material, including a hierarchy of recommendations in the presence of more than one option, discussing why there is a need for consent, and explaining the nature and limit of the authorization.[191] Simultaneously, the care-provider should consider that patient's decision-making is also affected by their subjective beliefs, fears, and hopes, such that the medical professional is able to separate from their own views and objectives about treatment preferences and risks.[192] This relates to the *professional practice* standard of disclosure, grounded in professional standards of medicine, in addition to the *subjective* standard which considers the individual needs of the person; both of which dovetail into the uniqueness of college health given the diversity of the population and the uniqueness of college health medicine.[193] It is essential that all such disclosures are provided to the extent that the student-patient is able to make a voluntarily informed decision for or against a treatment or action, again with emphasis on autonomy, based on the depiction of the diagnosis, prognosis, alternatives, risks and benefits.[194]

At times, clinicians in our setting may employ therapeutic use of a placebo, which is antithetical to full disclosure, in that it may contain elements of intentional deception or incomplete disclosure.[195] Beauchamp and Childress present this concept in a manner that directly relates to a familiar situation likely encountered in every college health center, regardless of size or scope – that of the use of impure placebos for conditions in which they are not medically indicated, citing the example of prescribing antibiotics for the common cold.[196] Apart from the stringent concern for antibiotic resistance, the need for care providers to delay antibiotic

use balanced against the desire for patient satisfaction and the potential for the perception that the patient interprets that they've received inadequate care if they leave the office with "nothing," further illustrates the need for education about proper use of antibiotics as a key element of providing information. With this example, many clinicians would admit that they've prescribed antibiotics unnecessarily, irrespective of the viral lifespan, simply to quell further conflict.

Merging with this concept in terms of the element of understanding, many conditions exist in the college health setting that limit patient understanding, which can include but are not limited to immaturity (when considering underclassmen) or irrationality (such as with culturally challenging situations when providing information to international students who may exhibit fears or inaccurate beliefs about western medicine), even in the presence of cautiously presented information.[197] Pivotal to this is the discussion of information processing. In a previous section, the impact of incomplete pre-frontal cortex development involving executive decision-making, is a known challenge in late adolescence and young adulthood. Information overload, the use of highly technical medical terminology, and how treatment choices are framed, directly impact autonomous choice.[198] The use of decision aids such as anatomical models and other informational materials promote increased understanding and enhance decision making. Student-patients seeking care in campus clinical services for sexual and reproductive health concerns, as a familiar example, may have insufficient understanding of the plethora of risks associated with potential STI (sexually transmitted infection) exposure, the benefits of necessary screenings and treatment, and/or to discuss options for pregnancy prevention often do so with limited understanding, which deems our responsibility to reduce decisional conflict through adequate information.

Surrogate Decision Making. One may ask how surrogate decision making, or those who are authorized to make decisions on behalf of another individual (that is doubtfully autonomous or non-autonomous) relates to clinical health services on college campuses, in that the topic typically conjures images of incompetent, severely impaired, or terminal patients.[199] However, in recent years, the growing popularity of a health-care proxy for college students, in addition to other legally binding agreements such as durable power of attorney, are making their way into campus clinical services. Although variance exists from state to state, and in terms of individual institutional policy – the concept of surrogacy can and will enter into the framework of college health medicine. It is incumbent upon care providers to be aware of the three general standards proposed for surrogate decision makers, which are substituted judgment (used for patients who were once competent but for whom decisions are made according to what the patient would have decided for themselves, through close familiarity with their desires); pure autonomy (the acting-upon of prior autonomous judgment whether or not a formal advance directive exists); and the standard of best interest (or choosing the best option in the patient's best interest when necessary).[200] College students fall into the unfortunate statistic of risk for accidents as the leading cause of death for young adults, for which it would stand to reason that the best interest held by parents/guardians for their children would encompass the legal right to act as a medical decision maker, or surrogate. Issues can arise with regard to qualifications of surrogate decision makers, in terms of ability to make reasonable judgments, having adequate knowledge and information, possessing emotional stability, and a commitment to the patient's best interest – all of which may be impeded upon by the emotional duress associated with a catastrophe.[201] Documents that provide health care surrogacy to parents, or healthcare power of attorney, legally also provide access to medical records, and can include preferences about end-of-life care

through a living will. Options for when such documents are in effect can be stipulated to include a specific event, such as if the patient becomes incompetent following accident or injury, for which a medical determinant must be made, or in the event of a decision that must be made on behalf of the student-patient when they are unable, as with a life-saving surgical procedure.[202]

Conclusion. Moral standards, principles, and values should drive the choices made by and the conduct of college health clinicians in their care of their students. A sensitivity to the issues and vulnerabilities that contribute to the turbulence in the life of a college student will benefit our care of them by cultivating a climate of professionalism, trustworthiness, and advocacy. Our practice must be informed by the four universal guiding principles, with specifications that are unique to our context and setting, as well as through the influence of moral ideals and virtues. By constructing a framework within which moral principles structure our commitment to clinical excellence and health promotion, the students served will both benefit and prosper.

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Chapter 4. Professional Ethics: Quality & Virtue.

Chapter four focuses on professional ethics in the first section through a analysis of professional practice and quality, followed by a discussion of character and virtue in the second section.

Chapter 4.A. Professional Practice and Quality.

Elsewhere in this dissertation, it has been established that within organizational ethics, reasoning based on various moral theories can be applied to the workings of a health care organization, and indeed to that of a college health service, along with occupational standards and codes within the context of the existing organizational identity and culture. These concepts pertain directly to campus clinical health services across the vast continuum of institutional type and scope, and through a diverse interpretation of what college health services may look like at any particular school, as well as the extensiveness of or limitations to the care that they provide, conditional upon the characteristics of the institution. Professional organizations impute elements of different moral models when establishing formal codification of ethics as a guiding force for professional behavior and practice, such as for physicians, nurses, and allied health professionals. The attributes and tenets of authentic leadership have also been considered and discussed as applicable to the college health profession, given the varied models of management across the spectrum of campus clinical services, along with the tangible need for an ethics infrastructure to support and uphold the practice. Furthermore, the importance of abiding by professional standards as set forth by certification and licensure requirements as well as by accrediting bodies amidst disciplines has been considered relative to organizational ethics. Using the lens of professional ethics, this essay will peer more deeply into other aspects that are applicable to our distinctive profession, whether the campus health service is that of a one-room, one-nurse office

on a small, private campus; or a large, multi-story, free-standing clinic with an extensive assortment of providers, specialists, and professional clinical services.

Clearly, as has been discussed, within college health services there exists a rich history and remarkable progression and evolution of the field and development of various approaches to the delivery of clinical services to students and/or staff at institutions of higher education, especially under the mantle of the American College Health Association. Because of the inherent diversity of the composition of health services, suffice it to say there is a vast array of professionals and support personnel who altogether embody the depth and breadth of the practice of college health traversing the many institutions of higher education across the country. Acknowledging that professionals are distinguished by a specialized knowledge base and the training required to obtain it, in addition to their commitment to providing services to patients, clients, and students as consumers – they do so within the confines of standards of practice and conduct that specify and enforce obligations for members of that profession such that those to whom care is provided will find the professionals competent and trustworthy.[1] Such obligations encompass the ethics of a professional role, while professionals themselves must also possess the moral aptitude to uphold critically important virtues in addition to professional merit.[2] It follows that there is inherent moral significance to the provision of campus health services especially as regards the ongoing contributions to the wellbeing of others and through placing special responsibilities on each of the professions that constitute the college health services team, not only because of specific principles found in various professional codes of ethics, but also with respect to the individual care-provider's moral capacity as a college health professional.

Throughout the ensuing discussion, professional ethics will be further considered in view of the morality of the caring professions by looking at concepts that are either universal or

particular, examining sources of moral authority as well as the notions of trust and fidelity in professional practice; the functional necessity of inter-professional collaboration; and more reflection on quality of services. Such considerations are vital to acquiring and maintaining a standard of excellence and are essential for both front-line college health and wellness care-giving professionals, as well as those in middle-management and in senior executive roles.

College health services must be recognized and valued by their institutions as playing a crucial role in student wellbeing, success, and retention through minimizing the impact of illness, emotional distress and injury on academic studies, work, and life.[3] The broad range of professionals who serve students by providing general medical, specialty, urgent and episodic acute care; counseling and psychological services; laboratory, radiology, physical therapy and pharmacy needs; other ancillary amenities along with health promotion and education services; emergency medicine treatment; as well as increasingly popular complimentary and holistic amenities - undoubtedly (if not empirically) impact student retention and achievement.[4]

Chapter 4.A.i. Professional Morality and the Caring Professions.

Both Universal and Particular. Health programs within the environment of higher education are called to provide a qualified work force to meet the clinical, regulatory, and administrative challenges of delivering health care to campus constituents, as noted in the American College Health Association (ACHA) Framework for a Comprehensive College Health Program universal principles.[5] Stated minimum requirements are that providers maintain professional licensure within the state in which they are practicing, along with appropriate certifications, ongoing training, and by demonstrate competency of performance.[6] The Framework also references the expectations of college health professionals to be culturally competent and to undertake advocacy by addressing issues of social justice, human dignity,

respect for all, and health inequities as vanguards of a college health program.[7] These concepts are further supported by the Council for the Advancement of Standards in Higher Education contextual statement on Clinical Health Services, affirming that professional personnel are to be relevantly trained and credentialed, are expected to participate in ongoing education and professional development, and that their performance is consistent with institutional mission, goals, policies, and objectives.[8] Contingent to these legalistic and idealistic qualifications that delineate professional requirements, we must also contemplate aspects of morality toward being an ethically competent college health professional. In that we practice our craft within a very unique construct, having a rudimentary understanding of the moral foundation that underpins the four principles of healthcare ethics (autonomy, beneficence, non-maleficence, and justice) will serve to further advance our field.

To generally consider morality, included would be standards of conduct and moral principles, rules, ideals, rights, virtues, and norms such as those learned from childhood.[9] From our early years, we learn and develop through both intuition and experience while assimilating the many rules of a moral life, for instance to not lie, to not steal possessions from another, to not kill or do harm, and to be respectful of others – which are commonly accepted, universal norms shared by most people and are referred to as the common morality.[10] This common morality, as a consequence of human experience and history, has authority across communities, and is shared without imposing moral relativism or pluralism based on particular views or cultural practices.[11] Volumes have been written on moral theories, norms and virtues, far beyond the capacity of this discussion to thoroughly analyze, but to once again rely upon the *Principles of Biomedical Ethics*, Beauchamp and Childress make it clear that their four ethical principles (respect for autonomy, nonmaleficence, beneficence, and justice) do not themselves constitute common

morality, but are "drawn from the territory" of common morality in application to healthcare ethics.[12] Extended from the aforementioned, professional codes derive foundational precepts from norms that are universal, including to not cause pain or suffering, to prevent harm, to rescue someone in danger, to be truthful, to nurture the young and dependent.[13] Each of these examples clearly resonate with and correspond to elemental practices in college health: treatment of illness, health promotion and education, sexual health screenings, screening for intimate partner violence, truthfulness as with antibiotic stewardship, and essential patient education for newly autonomous young adults. By this paradigm college health providers are called to be responsible stewards for the health of diverse students in the unique social context of a learning environment, with ever-changing sociological trends, and confront day-to-day care within campus health centers that often functionally parallel primary and ambulatory care settings in the community.[14] Having the moral character traits of honesty, integrity, conscientiousness, trustworthiness, fidelity, gratitude, truthfulness, lovingness, and kindness as virtues that drive our professional lives in service to those whom we encounter in our campus health centers will inform decision making when ethical challenges arise.[15] An example of a relevant and significant sociological trend that necessitates such virtues is the increasing prevalence of mental health conditions in the population that we serve. National surveys reveal that 30-50% of college students have a psychiatric disorder, and mental health conditions rank among the top five reasons for accessing care in college health services.[16] The prevalence of students with mental health needs must be compassionately addressed in all facets of campus life and destigmatized through cross-institutional collaboration between all motivated, virtuous caring professionals throughout all service programs so that decisions are made ethically with regard to campus resources, clinical care, patient safety, and safety of the campus community.[17]

In contrast to universal moralities, particular moralities provide concrete, non-universal and content-rich norms that include professional practice standards, institutional guidelines, and religious traditions; as well as sentiments, attitudes, and sensitivities among diverse cultural traditions.[18] The caring professions in and of themselves are formed around practices, objectives, and values under a 'social mandate' to care for others through a committed application of professed knowledge and skills, a particular range of tasks, and based on expectations of certain consequences such as health, wellbeing, and (health) education.[19] In prior discussion of organizational ethics, it was mentioned that professional codes, such as those in medicine and nursing, set forth standards of practice as one form of particular morality especially because of roles, relationships, and rules that other professions may not require.[20] Common threads across health professional codes of ethics identify that practitioners are to put patient interests first and promote their health, safety, and rights; to protect their autonomy and dignity; to maintain confidentiality; to practice with honesty and integrity; to maintain competence; to respect other professionals and colleagues; and to practice without discrimination.[21] College health practice embodies these elements and typifies a particular morality given potential ethical and moral matters that can result from the overall healthcare reform climate, fluctuating institutional resources, increasing complexity and diversity of the population served, ever-changing sociological trends, and the particular influence that college health professionals have in delivering health care to a specific population and through health promotion for long term wellbeing.[22] If professionals are distinguished by specialized knowledge and training as well as a commitment to providing important services, then those of us in the profession of college health most certainly are expected to uphold specific competence and trustworthiness in our obligations to those served by us.[23] As professionals, altruism and positive attitudes toward

patients, a true interest in their wellbeing, and recognizing all persons as having inherent worth motivates virtue-driven caregivers beyond financial compensation, career advancement motives or even the most basic commitment to one's profession.[24]

Sources of Moral Authority. As individuals and as college health professionals, our own unique moral and personal values formation results from various life experiences and influences.[25] Over time, various moral development theories emerged with regard to social learning and behavior, as well as specific developments in moral philosophy in correlation to moral principles, centering on how people grow in their own sense of morality.[26] Among those, there exists a theoretical framework of four components that fuse together essential elements and concepts of moral development, each of which interacts with the others in terms of moral reasoning, comprised of: moral *sensitivity*, moral *judgement*, moral *character*, and moral *motivation*.[27] In our professional practice within the realm of college health, we often intuitively apply moral reasoning to daily decision making from the vantage point of our own personal moral foundation, doing so within the context of our work with both colleagues and patients, each with their own reference of moral development. This component, moral motivation, has most to do with how an individual weighs personal values against other considerations, and how those personal values may conflict with other moral criteria in shaping their critical ethical decisions.[28] When ethical decisions are to be made, having self-awareness and an understanding of one's own moral thinking is essential; as is the ability to recognize when a particular situation conflicts with personal or professional values, or when a given moral action may potentially endanger professional relationships.[29] Blasi identified that moral functioning is linked closely to moral motivation and character through one's moral self (including factors of faith/spirituality, past experiences, and intuition); and through one's responsibility for their moral action (referring

to the process of moral engagement); and finally to integrity (the consistency by which one approaches ethical issues in everyday life).[30] Consequently, this is clearly true for college health professionals given the all-encompassing nature of what constitutes college-health practice in terms of the diverse and complex characteristics of the students we serve, the extensively varied types of institutions in which we are situated, the continually evolving social and cultural trends of any given time, and our own individual moral-makeup as college health professionals.

Members of a profession are bound together by a body of knowledge determined by training, practice, and experience through common understanding and insight within their particular knowledge community, as well as shared notions of validity and reasoning.[31] We practice professionally from both the perspective of our own subjective moral foundations as well as the through the expectations of our occupational group as set forth by ethical codes and oaths that shape a profession's identity, principles, and beliefs.[32] College health practice exemplifies an inter-professional knowledge community, with superior understanding and insight of issues that affect both the traditionally-aged and non-traditional college student-patient. However, training and expertise alone does not provide ample credence for value judgments on moral issues, rather considerations of personal conscience do, as well.[33] Applying ethical and moral value judgments to clinical decisions or policy formation may involve tensions between value choices. This paradox is addressed by Veatch in an editorial in Lancet, an international general medicine journal, in which he discusses that although various professional bodies have codified their understanding of moral norms, each is inherently different and do not provide consistent moral guidance.[34] He adds that professionals are often members of other groups and organizations, such as religious or faith traditions from which they derive ultimate moral authority and professional moral behavior, or similarly those who profess no religious affiliation,

but stand by some other moral tradition that determines their allegiance, such as utilitarians, feminists, Kantians, Marxists, secularists, or by adherence to some other political philosophy. Regardless of affiliation, he cautions that such traditions can clash with professionally generated codes or norms, such as with the incompatibility of a professional who is committed to a faith tradition and the norms derived from those beliefs and teachings, which would in turn bear the highest status for the individual. The professional's source of their moral authority can affect the professional-patient relationship, in that patients also have moral views, possibly not accounted for in professionally generated codes. Veatch further suggests that amidst this tension, both professionals and lay-persons are called to think about the sources of norms that inspire their own loyalty.

In our work, we may seek to resolve these tensions by discussing with colleagues, consulting professional sources, as well as abiding within institutional mission, rules, and laws governing professional practice. Personal and societal influences in addition to the values systems of the patients we serve affect judgments and decisions.[35] The American College Health Association (ACHA) provides a communication platform for various special-interest group formation on their website as well as allowing a meeting forum during the annual ACHA Meeting for participating members, stipulating clearly that they do not recognize any as official communication channels for the association, nor do they endorse expressed content.[36] Of those, for example, there exists a Faith-Based Institutions Listserv meant to address ethical and programming issues related to health services at faith-based institutions. Within ACHA, such groups provide an outlet for caring professionals with specific moral and religious convictions that may not be congruent with all organizational positions or advocacy statements of the association, inviting critical dialogue.[37] Professionals may experience moral strain when their

own values are not in alignment with an organization or a group with which they are affiliated.[38] The question of which influence justifies one's ethical position is that of metaethics, or understanding the meaning and justification of our moral judgments.[39] The meanings of terms such as right, obligation, virtue, justification, morality, and responsibility are addressed by metaethics.[40] Integrating personal and professional beliefs occurs through both compatibilities and conflicts with 'value types' and corresponding goals, expressed as follows with value type/goal: power/leadership; achievement/personal success; hedonism/pleasure; stimulation/challenge; self-direction/independent thought; universalism/tolerance, understanding; benevolence/enhancing others' welfare; traditions/customs, culture; professionalism/adherence to standards; and security/safety, stability. [41] As professionals, it is imperative that we are self-aware and introspective relative to our moral authority, our value-type and corresponding goals, and our formation of ethical decision making.

Chapter 4.A.ii. Patient Trust and Professional Practice.

Information Technology, Social Media, and the Patient-Provider Relationship. In a previous section of this dissertation, the provider-patient relationship was discussed as regards the imparting of information and confidentiality – two essential features of the association between a care-giver and a care-seeker. Given that the population we serve are predominantly digital-natives, the ever-increasing, normative use of social media, and how information technology has infused all aspects of clinical practice - enhancing the patient/provider relationship through such opportunities - is most relevant to the college health setting. The Council for the Advancement of Standards in Higher Education Contextual Statement on Clinical Health Services acknowledges the provider-patient relationship by affirming that students who receive care in college health services are not "mere passive recipients of care, but

are actively engaged as partners in management of health," and that "college health services must engage students in a partnership in maintaining good health and in restoring health when a student becomes ill or injured."[42] Without doubt, the key element mentioned in this statement is student engagement. By means of the use of technology, we then honor the credo to 'meet students where they are,' providing interactive communication through websites, portals, secure messaging or e-mail, and in online communities.[43] The use of social media platforms provide an opportunity for more frequent communication with patients, changing how people interact with their providers and how they seek health information or make choices about care-providers or facilities based on options for social media interaction and through information technology.[44]

However, the complexity of timing and context in terms of sharing, re-posting, and further dissemination requires vigilant guidelines and effective policies as a starting point from which further strategies and best practices can be developed as technology advances.[45] Several years ago, in 2013, the American College of Physicians and the Federation of State Medical Boards (FSMB) produced a series of practical guidelines for medical professionalism online, with the caveat that they are to be adapted to emerging best practices in the tech sector.[46] The guidelines state that trust in the patient/physician relationship is achieved through applying ethical principles for preserving confidentiality, privacy, and respect; that the physician must be cognizant of potentially blurred boundaries between professional and social spheres and to comport themselves professionally in both; that electronic communication should only be used in an established patient/ physician relationship and only with patient consent, such that documentation about patient care communication is also entered into the patient's medical record; that physicians should self-audit online information regarding their practice and professional profiles for accuracy of information in online sources; and finally to warn providers

that online communications are permanent, and that all levels of medical professionals must have awareness that online postings may have future implications.[47] The American Nurses Association adopted comparable principles two years prior when the National Council of State Boards of Nursing released the White Paper "A Nurse's Guide to the Use of Social Media; and in like manner both the professions of pharmacy and physical therapy developed their guidelines for social media used during a similar time-frame.[48] Adherence to HIPAA prevents providers from sharing patient-specific information extending to all forms of communication including verbal, email, list-serves, online discussion boards, and social media – none of which can be assumed to provide ample security for patient-related, content-specific discussion.[49]

Aside from direct patient/provider communication, the effective use of social media for information sharing between providers and their patient population is advantageous in that followers can receive health news on current and relevant issues, changes to practice schedules or office hours, and even communication during a crisis or public health threat such as influenza or other highly communicable diseases with population health implications.[50] Media engagement to promote health, influence practices and behaviors, and inform students as a targeted audience is essential to the function of college health medicine. The Journal of American College Health featured an article in January, 2018 that looked at the feasibility of a mobile health-media literacy education program to improve sexual health outcomes in community college students, resulting in interventional effects on reducing self-reported risky sexual behaviors, positively affecting beliefs, knowledge, and attitudes, and increasing general media skepticism.[51] As a critical college health focus and major public health issue, 15-24 year olds account for nearly half of all newly sexually transmitted infections and self-reported high-risk sexual behaviors including unprotected sex, intoxicated sex, sex with multiple partners – all

occurring due to disproportionally inadequate sexual health knowledge or understanding; so the implications of this study are pertinent to all realms of college health practice, regardless of size or scope of services.[52] All of this definitively corresponds to the concept of the obligation of veracity in professional-patient relationships, such that - according to Beauchamp and Childress - veracity in health care refers to accurate, timely, objective, and comprehensive transmission of information as well as the way the professional fosters the patient's understanding.[53] This understanding of veracity, in particular, is intertwined with the principle of respect for autonomy, a consideration of vast importance with regard to traditionally aged, older adolescent and young adult college students as they exercise their autonomy through self-understanding and sociocultural expectations.[54] College students of this age-range seek to satisfy the need to be the causal agent of one's own life, to act in harmony with one's integrated self, and to engage in activities through their own volition and not because of social pressures, norms, or obligations, often played out in the virtual community, as a means of satisfying their need for autonomy through social networking sites – effectively endorsing the use of social media and communication in the context of the patient-provider relationship.

Perceptions and Perspectives. According to Beauchamp and Childress, trustworthiness and loyalty are morally central virtues in healthcare ethics.[55] Young adults often have perceptions of campus healthcare providers such as staff characteristics, concerns for confidentiality, fear of judgement, sensitivities to hostility or discrimination, or perceived unprofessionalism in terms of presumed lack of expertise among other help-seeking barriers; all of which are critical for college health service professionals to recognize and confront.[56] College students exist amidst an unusual convergence of social, behavioral, developmental, and financial responsibilities and experiences unlike most other population subsets, affecting various aspects

of wellbeing such as accrued risks of disease as well as vulnerability with certain aspects of health and need of intervention.[57] According to the Fall 2017 ACHA-NCHA survey, 55.3% of college students reported being diagnosed or treated by a professional for common health conditions, further indicating that academic performance was affected most by anxiety, depression, and stress.[58] College health professionals will realize that students seeking professional services should reasonably expect that they will receive comprehensive, competent care because of the fiduciary relationship between healthcare providers and patients to serve their needs with accuracy, reliability, and specificity.[59] Conversely, student's lack of understanding with regard to health center staffing and the professional's titles and skill level may result in confusion when unfamiliar with abbreviations of credentials next to provider's names.[60] Most students understand that doctors are able to diagnose, order testing, and prescribe, but their understanding of the difference between Physician Assistants, Nurse Practitioners, and subsequently their abilities to perform the same functions was significantly less, indicating suboptimal understanding of primary care providers commonly staffing student health centers.[61] Avoidance of this potential lack of understanding by clearly conveying name, title, and status as a most basic professional expectation is of prime importance toward respect for the patient and their intrinsic value and dignity.

Because of the inherent knowledge gap between patient and provider, clear communication and education so that the patient's interests and needs are addressed is essential, especially in the context of college health, since many students are yet adapting to decisional autonomy.[62] Students also take into consideration trusted advice of peers, broader campus staff, interactive websites, and other sources as a means of decision-making prior to accessing campus-based services. A study done in 2010 in Wisconsin of five institutions representing different

sectors and locations analyzed students' perceptions of provider characteristics, health care resources, the role of peers, and subsequently suggestions for strengthening health care services.[63] Of the areas studied, interviewed students' descriptions of what they look for in health care providers were organized into six themes: "providers need to know their stuff," "I want someone warm and welcoming," "being my resource to other resources," "gender matters, for the most part," "when intimidated, I turn to my peers," and "how to meet my needs."[64] Of interest, the student's interviewed revealed complex perspectives regarding provider characteristics in that some preferred having providers that were professional, appropriately credentialed, and qualified to address concerns; while many wanted health care providers to be casual, approachable, and who "talk with you, not down to you."[65] These thematic questions correspond to several key elements of professional practice virtues such as trust and veracity, and raise awareness of ethical principles such as beneficence, paternalism, and justice.

A further illustration of perceptions and perspectives is seen in the critical role that college health providers have in addressing substance misuse and abuse with patients in a trusting atmosphere. Clearly, students and providers have divergent perspectives of each of their roles in discussing substance misuse in the context of a regular office visit, with health professionals acknowledging it as a crucial issue while student resistance to discussions about alcohol and drugs is a communication barrier.[66] Students also express concern with providers' perceived attitudes and communication style, stressing that even the professional status of providers is a possible barrier to good communication regardless of empathy, citing intimidation, judgement and concerns for confidentiality and disclosure – all of which impact the effectiveness of potential screening and intervention.[67] In this example, the healthcare professional must be attuned to any risk of undue influence of implicit bias or unconscious attitudes that can have a

negative impact on the patient-provider relationship. Alternatively, the nursing staff are valuable as a resource to assess and intervene by means of close student contact, triaging for appointments, and outreach opportunities across campus. Nursing staff members can be utilized in prevention and awareness initiatives, can be trained for specific screening protocols, and can contribute to meeting the challenges of substance misuse by networking with on and off-campus resources.[68] As supportive to comprehensive efforts of substance misuse prevention and education efforts across departments and disciplines, nurse should recognize their own personal attitudes, biases, and beliefs by means of mindful self-reflection so that assessments are accurate, objective, and unbiased.[69]

Chapter 4.A.iii. Interdisciplinary Collaboration.

Benefits and Barriers. To many, the concept and practice of interdisciplinary collaboration may be second-nature, yet for others an unrealistic dream, relative to institutional size, scope of services, and administrative or fiscal support. Also, for similar reasons, there is an extensive range of staff composition among college health services in institutions of higher education as evidenced by the most recent ACHA staffing and salary survey.[70] Given the expansive range of institutional classification, size, setting, and enrollment, it would be improbable to formulate guidelines for staffing or to standardize staffing proportions and ratios. However, because of inherent diversity in the higher education community; a learning network is being developed by ACHA to connect institutions from across the nation and aggregate campus health and counseling center administrative data, along with population-related data, academic achievement information, and overall program characteristics that when compiled will provide data analytics and have implications for both care provision and policy formation.[71] College health practices positively align with standard features of primary care as per the definition found

on the American Academy of Family Physicians (AAFP) website, describing primary care as "comprehensive first contact and continuing care for patients with any undiagnosed sign, symptom, or health concern undifferentiated by problem origin, organ system, or prior diagnosis."[72] Even further, the AAFP states that primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses in a variety of settings.[73] College health services that associate medical and behavioral services whether through loosely coordinated services, co-located services, or by full integration serve as one example of interprofessional collaboration, with behavioral health and primary care providers working together to meet the population needs.[74]

Within college health, in addition to psychologists and other behavioral health clinicians, alternative models of practice can be comprised of staffing with a variety of disciplines and qualified health professionals or paraprofessionals, depending upon institutional attributes.[75] Successful elements of teamwork through inter-collaboration include common goals, role clarity, open communication, and improved patient care with stable team structure.[76] Nurses are proportionally the highest staffed profession in college health centers.[77] As a profession, they are commonly understood to effectively collaborate with other healthcare providers and engage as moral agents who contribute to ethical competency in primary practice through their role obligations of knowing how to act and practice collaboratively as fundamental to their education and training.[78] Interprofessional collaborative care requires a relational dimension that is essential to effective patient-centered care and to enhancing total wellbeing, and nursing practice is upheld by relational ethics that construct relationships between the nurse, the patient, and fellow professionals through engagement, mutual respect, and as "being-for-the-other."[79]

Professionals working with colleagues from other medical disciplines are asked to understand each other's perspectives, responsibilities, and competencies in deference to professional autonomy, while collaborating inter-professionally necessitates the mutual obligation of beneficence for the recipients of our services.[80]

In industry, there are models for use with cross-discipline training that have been adopted to primary care, as well as facility or institution-based interprofessional team training that focuses on team building, systems issues, performance improvement, reflection, and enhancing patient care – many of which can be applied to college health interdisciplinary teams, as primary care providers.[81] One targeted area of team training is conflict resolution as well as practical means of identifying barriers to interprofessional collaboration in primary care, for example assuring availability of electronic platforms that accommodate team diversity and improve communication, as well as to optimize collaborative practices based on practice context, training competencies, and finding balance between team dynamics, continuous quality improvement, and patient care goals that are holistic and in the best interest of the patient.[82] Conflict resolution between professionals is avoided through collaborative leadership and practice competencies among many other key provisions, but also in valuing social-relational practices such as open, authentic, and reflexive dialogue; reflective and considered judgments; and by cultivating an ethical-moral culture that maximizes moral agency and diminishes moral distress.[83]

Mental Health – Combining Forces. The staggering reality of students with mental health needs, as referenced throughout this dissertation, is one that continues to increase and spiral upward, as a growing focus on early identification and treatment of mental illness in precollege youth has allowed more students with mental health needs to matriculate to colleges and

universities.[84] A carryover from primary care practices in the community to that of college health is the continuation of pharmacotherapy for students with anxiety, depression, bipolar disorder, ADHD and other conditions - which has necessitated the integration of counseling services with health services through multidisciplinary collaboration, and has allowed many students to remain in or return to school through degree completion.[85] Enhanced clinical integration in settings that have cross-disciplinary collaboration for the care of students' mental health exposes staff from various disciplines involved to one another's language and ways of practice, increases bidirectional referrals, and results in ease of discussing multifaceted clinical presentations both between professionals and with patients.[86] In the general population, primary medical care settings account for the care of nearly half of patients with mental health disorders, and patients seen in integrated practices are known to schedule and keep their mental health appointments, seemingly also true for the collegiate population; and those students concomitantly engaged in psychotherapy or counseling experience less associated somatic complaints and tend to seek less general medical care.[87] One example of this is that student-patients with interdisciplinary treatment of mental health conditions may also be more aware of the relationship of physical to psychological symptoms, such as the student with anxiety who may better differentiate symptoms of shortness of breath, fatigue and dizziness as expressions of increasing anxiety as opposed to a medical condition with similar physical indicators.[88]

Over time, varying models of mental health care have been implemented on college campuses, subject to changing sociocultural conditions and institutional forces, along with improved treatment protocols, advances in research, and implementing best practices.[89] A review done in Current Psychiatry Reports submits that various evidenced-based programs including the National College Depression Partnership, Gatekeeper Training of non-medical or

psychological staff such as "QPR" (Question, Persuade, and Refer) for suicide prevention, along with increasing awareness and engagement of professionals across campus sectors will result in improved outcomes in addressing the mental healthcare needs of today's college student.[90] Similarly, Behavioral Intervention Teams have evolved over the past fifteen years as multidisciplinary groups of varying composition who meet regularly to discuss at-risk students, follow formalized protocols and strategies along with risk rubrics, and repeatedly undergo training for preparation to address threats or intervene when necessary.[91]

In addition to realizing the benefits of collaborative practices to address mental health needs on college campuses, it is equally vital to realize that legal and ethical standards differ between behavioral health and medical care providers.[92] Ethical concerns for patient confidentiality and their right to informed consent may pose challenges to interprofessional collaboration in light of practice code differences, recognizing that maintaining confidentiality is the bedrock of mental and behavioral health care.[93] As with the above example of multidisciplinary collaboration on behavioral intervention teams, licensed mental health professionals and medical care providers both practice under licensure requirements that hold them to more stringent standards of confidentiality than others on the BIT, yet the role of the counselor is crucial since nearly 75% of cases addressed by BITS involve psychological concerns.[94] In that regard, several possible stances may be taken by caregiving professionals who participate in BITs, ranging from participating as a consultant, or under specifically informed consent to be able to share pertinent information, or to implicitly divulge content – each of which may present tension between valuing and maintaining confidential information, risking censure, assuring the best interest of the patient, and ultimately protecting the campus community.[95] Beauchamp and Childress scrutinize the nature of medical confidentiality, but

also note justifiable exceptions or limits to privacy especially in assessing when risks to third parties outweigh prima facie rules or rights of confidentiality.[96] In collaborative practice, mental and behavioral professionals honor informed consent as an ongoing process that is revisited throughout the treatment plan and not just with initial introduction.[97] On the other hand, medical professionals acknowledge informed consent as the process that occurs when communication with a patient results in their authorization for or agreement to a specific medical intervention, providing diagnosis if known, the nature and purpose of recommended interventions, and the associated benefits, risks or burdens of all possible treatment options.[98] Such nuances, along with release of information procedures, warm hand-off protocols, documentation and electronic record keeping as well as billing are integral to integrated primary care in the community, and are equally daunting concerns for campus health services.[99]

Chapter 4.A.iv. More on Quality Improvement.

From Concept to Reality. The essence of continuous quality improvement (QI) is that it requires a commitment to constantly improving operations, processes, and activities to consistently and efficiently meet patient care needs within an organization, emphasizing that health care is a process and improvement goals are systemic.[100] College health professionals work within a unique setting that is the center of life, learning, work, and recreation for over 25 million people nationally, including students, faculty and staff.[101] The extraordinary impact that college health providers have on influencing health and wellbeing by promoting a campus culture of health as a shared institutional value can significantly impact the trajectory of population health through a transformative, institutional commitment to wellbeing.[102] Within this dissertation it has been mentioned previously that the "triple aim" of quality improvement in college health is the pursuit of better care, better health, and increased value – goals that promote

health, learning, and success of college students not only as individuals, but as a distinct population group.[103] As college health professionals from a range of disciplines, the challenge is to take quality improvement from concept to reality.

Throughout the arena of healthcare, fundamentals of quality care include key precepts that care should be safe, effective, patient centered, timely, efficient, and equitable – each correlating to the principles of respect for autonomy, beneficence, and justice.[104] Campus health care centers will seek improvement by introspection and self-analysis about their current system, openness to learning from others, correct and applicable use of technology, creative thinking, and implementing concepts for positive change.[105] In the context of professional ethics, quality improvement supports the professionalism and satisfaction of campus health professionals. Staff engagement in quality improvement and empowerment by continuous learning increases trust, shared accountability, transparency and improved communication; which in turn increases workplace satisfaction.[106] Benchmarking with other programs and services on ones' own campus or at other institutions allows campus health centers to compare their own processes to best practices as part of the analysis. The Network for Improvement and Innovation in College Health (https://collegehealthqi.nyu.edu/) offers tools and mapping for implementing analytical processes by asking: what is trying to be accomplished, how will a 'change' become an 'improvement,' and what changes will lead to the improvements.[107] According to the ACHA Framework for a Comprehensive College Health Program, the process of evaluating programs and services is compulsory for the provision of high quality and diverse college health programs.[108] As professionals, clinicians and caregivers, our duty to ensure that quality care is achieved in all patient encounters corresponds to a reciprocity-based justification of the obligation of beneficence.[109] An applicable instance of reciprocity is cited by Beauchamp and

Childress: knowledge gained from quality improvement processes becomes imbedded in the core of the practice of delivering quality care, in as much as patients on the receiving end profit from the accumulated information gathered and resultant improved practices by means of a continuous loop of feedback received from other patients, and so on.[110] Considering the uniqueness and distinction of our niche of medicine, college health, such reciprocity can have long-lasting benefits, especially if shared and disseminated to others within the field.

Is it QI or Research? Throughout the literature there are definitions and guidelines to help differentiate between quality improvement projects versus research, in order to help steer ethical decision making - yet it is also true that these differences are not always evident. While the general definition of quality improvement has been previously discussed, research is defined as "systematic investigation including development, testing, and evaluations designed to contribute to generalizable knowledge," and is formally governed by ethics established by "the common rule" as with the Belmont Report and the Helsinki Declaration which address the conditions necessary to protect research participants.[111] Other contrasts include that quality improvement projects usually include small samples for data collection, ongoing protocol and interventional changes to effectively address the needs of a local situation; whereas research deviates from established good practice, may be substantially funded, can have non-therapeutic intentions, and uses patients as subject as well as providing results are more generalizable.[112] According to the CAS Standards for college clinical health services, quality improvement and management programs must be developed through an ongoing cycle of assessment that establishes programmatic goals, learning outcomes, employs multiple measures, has developed processes for gathering and evaluating data, and which informs planning and decision-making.[113] These professional standards for health services in a collegiate setting dovetail into the "triple aim" of

QI in college health as noted in the "Call to Action" report of the QI Symposium noted above. As has been frequently mentioned, college health services exist on an expansive continuum dependent upon institutional characteristics, resourcing, and scope of services. To that end, quality improvement will look and feel different to each individual location, yet as both medical and higher education professionals, is it incumbent upon us to strive to improve our quality regardless of our place along that continuum.

Although both QI and research use systematic reasoning to address clinical issues, there are guides and analytical approaches that are more commonly implemented and apply to any scale improvement project. The Plan-Do-Study-Act (PDSA) is used to formulate a plan from which to change a process related to care delivery, carrying-out or 'doing' the plan as a test, observing and learning from or 'studying' the outcomes, and adjusting or modifying each step whether to repeat or complete (act).[114] Software options such as Six Sigma provide statistical computing and analysis of QI data for the study sample being analyzed.[115] Quality improvement studies within a very specific patient population are primarily interested in improving processes, practices, cost-effectiveness, and productivity of internal practices of an organization; yet best practices may already be known but not translatable to particular conditions or applicable to other settings, such as with varying degrees of sophistication of college health services.[116] An article from the American Journal of College Health provides an example of successful implementation of a problem-solving QI method known as FOCUS-PDCA (Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act) at a large university health center (over 67,000 annual visits) to address initial intake of allergy/immunization patients, along with triage and appointment distribution of general medical clinic patients.[117] The QI effort was described as simple and focused, and required minimal additional expenditure of staff time and resources.

It involved implementing changes in administrative, personnel, and procedural practices with benefits to both patients and staff in terms of patient wait times and reduced appointment noncompliance. Whether or not adaptable in theory or practice to other campus health centers, most definitely many will be able to relate to the usefulness of this QI project toward improving patient care, fulfilling assessment mandates, and enhancing professional capacity.

Conclusion. As caregivers on campus, professional ethics enter into the very fiber of *what* we do, *who* we are, and *how* we provide the services that are of indispensable value to our respective institutions in terms of student wellbeing, success, and whether directly or indirectly - retention. As professionals from an endless assortment of backgrounds serving patients within the higher education environment, we are guided by specific standards and professional codes of conduct that stipulate particular obligations and provide the ethical basis for practice. Both universal and particular morality, as well as the sources for individual moral authority impact our conduct professionally. By means of interprofessional, multidisciplinary, and broadly focused collaboration and integrated health care models found in many campus health and wellness centers, as well as those with student health services that are moderately staffed and narrowly focused, we ultimately strive toward the common "triple-aim" of better care, better health, and increased value.

Chapter 4.B. Professional Character & Virtue.

Chapter 4.B.i. What are Virtue Ethics and Why Bother.

"And if anyone loves righteousness, her labors are virtues; for she teaches self-control and prudence, justice and courage; nothing in life is more profitable for mortals than these."[118] This verse, from the Book of Wisdom, raises the enduring ideal of virtue as governing those characteristics that sustain a righteous life. Virtue ethics emphasizes one's moral character

whereas other approaches in normative ethics give emphasis to duties and rules or the consequences of one's actions.[119] As moral agents, virtue ethics consider what sort of person we will be and what sort of life we will lead apart from principles, norms and policies, rather in terms of character and how we express who we are through what we do.[120] As an example, when having to tell the truth in circumstances when it is difficult to do, a virtuous person does not truth-tell because of following a general principle that anyone in any situation must tell the truth, rather they do so from a desire to do the difficult and virtuous thing because of intrinsic motivation to be honest for the sake of truth itself, and in so doing further develop their own virtuosity.[121] Beauchamp and Childress' *Principles of Biomedical Ethics* is permeated throughout with virtue ethics, virtue theory, and concepts of moral virtue in assertion that the goals and structure of medicine, healthcare, public health, and research call for a deep appreciation of moral virtues.[122]

Within professional ethics, the role of virtue is abundantly clear in standards of professional practice, institutional expectations, and within the traditional practices of medicine, nursing, and all health-related professions – however, people differ individually in terms of character traits, mutually possessing and lacking both virtues and vices.[123] Fundamentally, there are elemental virtues that are crucial to the health and caring professions that correlate to role responsibilities, and by contrast vices that are unacceptable in professional life.[124] No conversation about college health medicine can escape the undeniable significance of maintaining a keen awareness of our own motivation as caregivers and the virtues that steer our practice and our impact on the lives of those whom we serve. The notion of virtue as regards prior discussion of professional ethics as well as organizational ethics has been considered, to some extent, in other sections of this dissertation. What follows is an introduction of and somewhat of a deeper dive into the origins of

virtue ethics, a closer look at what various sources identify as the virtues, as well as some criticisms of virtue ethics, and other considerations about character and conscience in our roles as caregivers.

As relates specifically to the higher education setting, the National Association of Student Personnel Administrators (NASPA) in their second edition Handbook of Student Affairs Administration devotes an entire chapter to maintaining high ethical standards.[125] Since many college health services are administratively positioned in reporting lines to student affairs or student services, it is relevant that the handbook addresses virtue ethics in the 'helping' professions. [126] The ethical standards are listed as principles that are ostensibly re-stated from and echo those of Beauchamp and Childress, while the commentary on virtue ethics puts forth an emphasis on virtues as personal quality traits that are meritorious in terms of context, citing four virtues that psychologists consider essential for ethical behavior in the helping professions: prudence, integrity, respectfulness, and benevolence.[127] The analogous use of these virtues to the student affairs profession (and by extension to those departments within such divisions of institutions of higher education) correlate to daily practice by posing the questions: "what principles are involved in making decisions about certain problems," and "what would a virtuous practitioner do under such circumstances?"[128] For health professionals, virtue ethics provide the beacon for understanding moral decision making and prudent actions. Virtuous character as an antecedent to the high-calling of caregiver is beautifully expressed in the 13th century prayer of Maimonides, a venerated and renowned Jewish philosopher of the 13th century, who correlated medical issues to Jewish Law: *May neither avarice nor miserliness nor thirst for glory nor for great reputation engage my mind, or the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to my patients. May I never see in a patient anything but a fellow creature of pain*."[129]

Philosophical Foundations and Historic Roots. At the very least, a rudimentary understanding of the philosophical foundations and historic roots of virtue ethics is valuable to the broader discussion of healthcare ethics for college health. It can be said that a virtuous person is one who is and does what is right and what is good. This is an established, realized or even idealized standard across and throughout cultures and traditions, celebrated in myths, literature, and ritual in both Western and non-Western civilizations.[130] According to a clear and delineated explanation of virtue ethics in the Stanford Encyclopedia of Philosophy, its Western origins are associated with Plato and Aristotle, reach back to the writings of Confucius in the east, and continued to provide the basis of Western moral philosophy through the time of history known as the Enlightenment, having thereafter experienced decline until a revival in the twentieth century.[131] Aristotle, the archetypical virtue philosopher, pursues the inquiry into virtue toward more than merely *knowing* what excellence is in order to *become* good as a "state of character" that makes a person good, equating *virtue* with *character*.[132] This emphasis on character traits and the dispositions, Aristotle emphasized, is more than a feeling about what is good or the capacity to make good choices, but that virtue is the habitual decision to act well, or a habit under the guidance of reason.[133]

Whether a dedicated or occasional student of ethics, readers will note throughout ethics texts frequent reference to Aristotle's central work, Nicomachean Ethics, in which he says that the good or goal of our aim in any situation should question what it is good for, is the goal worthwhile, and if the end-point of any such questioning is to attain "the Good."[134] Further, he explains that this Good is found within "eudaimonia," a Greek word with the roots *eu* (good) and *daimon* (spirit) – typically translated as happiness or flourishing, which Aristotle defines as the ultimate, universal human goal.[135] However, his theory is "naturalistic" in that it doesn't depend upon either

theological knowledge of God nor on metaphysical concepts, rather his conclusion allows for different people having different views about what eudaimonia is to them - for some it may terminate with worldly pleasure and enjoyment while to others this happiness is found in eternal salvation.[136] Aristotle suggests that human beings have a goal or a function of existence as rational creatures able to engage in virtuous activities which make them happy, understanding this through teleological thinking – an explanation of a concept through the function of its end purpose, or goal – also rooted in two Greek words, "telos" (goal) and "logos" (knowledge).[137] Aristotle's central virtue is practical wisdom, or *phronesis*, which enables one to consider what is appropriate to a given situation, in that "virtue determines the end, practical wisdom makes us do what is conducive to the end," appointing the good person as the phronimos, the person of virtuous action through practical wisdom.[138] Even further, Aristotle describes the human soul in terms of four "parts" that make up a complete human being, each with a distinct tendency: the vegetative, the appetitive, the deliberative and the contemplative.[139] In brief, his understanding is through premodern terminology, yet still regards aspects of a whole that identify different types of functioning that make up the entire living, thinking, doing human person.[140]

Thomas Aquinas, a Dominican scholastic philosopher of the Roman Catholic Church, is credited with the rediscovery of Aristotle's philosophy with its insistence on natural laws, from which he developed virtue-based ethics with elements from Aristotle and practical wisdom as the central virtue, but drawing from Christian theology he adds the theological virtues of faith, hope and charity as disposing humans to attain union with God.[141] Over time, classical and medieval philosophies of virtue were challenged by realism and other competing concepts by various philosophers in post-Medieval and post-enlightenment periods, in brief, such as rights (Locke), duty (Kant), moral sentiment (Hume), and consequences and utility (Bentham and Mill), this being

merely a concise summary.[142] Strong opponents to the concept of virtue have existed historically, disparaging it as a basis for morality, including those critical of virtue as unrealistic and fueled by self-interest such as Machiavelli who maintained that the virtuous person was doomed by having to exist among so many other non-virtuous persons; and Nietzsche who thought Christian virtues were the mark of weakness unbecoming his 'superman;' and even through the more contemporary Ayn Rand who condemned virtue as contrary to success.[143]

A multiplicity of other perspectives exist and are beyond the scope of this limited foray into virtue ethics, including the views and teachings of various world religions. Of personal interest, however, is the understanding that Christian ethical traditions emanating from the life and teachings of Jesus Christ have been analyzed, deliberated, investigated, discerned, and otherwise deliberated by countless theologians, thinkers, and writers from a wide variety of faith traditions. Christians as believers are factually and dynamically in different stages of belief, understanding, commitment, and spiritual growth – which results in varying behavior depending upon time and condition, yet they accept certain rules of behavior as normative and binding.[144] Accordingly, Christian ethics in this sense is not a morality system based on principles, but arises out of the "ethos" of a community of people who believe in a covenant relationship with God, and consider themselves obliged to follow the teachings of Christ because of their belief and faith – ultimately a view of Christian ethics as the response of human love to God's divine love.[145] But, as this is neither an essay on philosophy nor a treatise on faith or reason, may it nonetheless entice further interest about the subject, giving consideration to both the ancient philosophers and the many religious and philosophical traditions throughout history, and to both the supporters and detractors of virtue ethics. All the more, most will agree that to live the good life is a decidedly universal pursuit. As those of us in college health are confronted with scenarios and dilemmas that beg the

two predominant questions of virtue ethics, 'what should I do,' or 'how should I act,' reflecting on the philosophical origins and historic foundations is why we *should bother* to at least familiarize ourselves with an understanding of its philosophical origins and historic foundations.

Exemplarist Virtue Theory. Beauchamp and Childress address moral excellence through four reasons that motivated their treatment of the subject, one of which affirms that morally exemplary persons and actions provide ideals that help guide and inspire others to higher goals and to lead morally better lives.[146] They go on to explain that extraordinary persons function as models of excellence, providing examples for others to follow, true moral exemplars otherwise known as the moral hero or moral saint.[147] Through the experience of admiration, we acknowledge and identify exemplars and engage in moral learning by imitation, whether by present or past references of persons in history, science, entertainment, and so on.[148] A contemporary virtue theory known as exemplarism upholds the model of moral excellence grounded in exemplars of moral goodness in terms of concepts of right action, virtue, and good life identified directly through the emotion of admiration.[149] Zagzebski constructs this theory through comparison and analysis of differences between existing moral theories through three concepts: *the good*, *a virtue*, and *a right act* in contrast to utilitarianism, Aristotle's eudaimonia, Kant's notion of a good will, and Plato's Form of the Good.[150]

Considering herself as having outlined a 'radical' virtue theory dubbing it exemplarism, Zagzebski meticulously puts forth her argument and process for developing the theory, pinpointing four attributes that determine the worthiness of a moral theory.[151] Essentially, the theory: should provide an understanding of moral practices and simplify them; should be applicable to our practical lives without being a 'manual;' should justify our moral beliefs and practices as a foundational structure; and must connect to the domain in which the moral beliefs are practiced.[152]

She espouses that as humans we have imbedded within us the practice of picking out 'good persons,' learning through narratives of both fictional and nonfictional admirable and imitation-worthy people, which she refers to as moral learning, done principally by imitation, as previously noted.[153] The advantages of exemplarism are many, according to Zagzebski, including its simplicity, correlating traits of admirable persons to virtue, and support from the psychology of admiration as the link between the desire to be moral and a thorough network of moral concepts.[154] She does not, on the other hand, imply or assume that we are to always trust our emotion of admiration, realizing that it can be shaped by other's emotional responses, but only after we reflect upon and fully trust our own feeling to take the object of our admiration to truly be admirable, or worthy of our imitation.[155] She offers an example of preexisting exemplarist structure in an ethical analysis of the Analects, the writings of Confucius, in that Confucius regards the Duke of Zhou as an exemplar, while his students treat him as one – pointing out that the ideas of a good human trait and the proper way to behave are determined by reference to the exemplar.[156] In a parallel way, scholars of virtue ethics have also pursued how the Bible presents persons as moral exemplars, viewing them as paradigmatic by illustrating specific virtues as part of humanity's relationship with God.[157] Christian ethicists and biblical scholars view Christ as the most important instance of a moral exemplar through the language of the New Testament, and other figures such as Paul who "imitates Christ," and encourages his audience to "imitate him."[158]

Day-to-day examples of real-life moral exemplars, heroes, and saints will surface in the reader's mind, of people that meet the criteria of moral excellence. Beauchamp and Childress list the criteria for exemplars as being faithful to a worthy moral ideal; that they forgo self-advantage in service to a moral ideal; that they are given to actions of high order and quality; and that they are persons of both moral and personal integrity.[159] Exemplars that we judge to be virtuous and

moral and from whom we first learn virtue by *mimesis* or imitation offer to us evidence that virtues are both the means to and constituents of human flourishing.[160] In as much as the virtuous life is developmental, each person has a way unique to them of being human, and will uniquely find their own original way of being virtuous, shaped by imitating past models, but articulated individually.[161]

Interestingly, a study done in 2017 investigated how moral exemplars affect inspiration, or what aspects make it more likely that people feel admiration toward a moral exemplar?[162] The researchers focused on finding the antecedents of admiration, measuring both the feeling component (admiration) and the more motivational action tendencies (inspiration), from the position that although the emotion of admiration has recently realized increased attention in psychological literature, the antecedents had not been studied.[163] Operating from the understanding that not all moral virtues trigger admiration, but moral excellence does, they predicted that two aspects of a moral action would make it be viewed as excellent: the need for it to be perceived as important, and the need for it to be out of the ordinary, or 'surprising.' Further, the researchers believed that finding the antecedents for moral exemplars would help in designing interventions that could inspire people to become better persons, with the main idea that perceived importance of and perceived surprise about the actions of a moral exemplar correlate to stronger feelings of admiration, which then lead to more inspiration for the admirer to become a better person.[164] They concluded that their study empirically found that perceived importance is a powerful antecedent of admiration, and that role models inspire others most when their actions are viewed as more important, whereas the element of surprise was more speculative, although a sense of amazement is definitely part of what admiration is.[165] Within our field, the occasion to be moral

exemplars for peers and colleagues, as advocates for the students we serve, and as quality-care providing professionals - exemplar virtue theory clearly pertains to the practice of college health.

Chapter 4.B. ii. Virtue Practiced.

Classic Virtues for Healthcare and Beyond. Having had a glimpse at the philosophical and historical basis of virtue ethics, giving thought to what those virtues are and how they define the "good" physician, nurse, and all healthcare professionals is essential to the topic. As professionals in healthcare, certain virtues are pivotal to our roles and practices apart from the technical performance skills necessary to perform, and provide our moral compass of character.[166] To comprise and discuss a comprehensive 'list' all virtues is beyond the scope of this dissertation, but examining virtues that are most essential to the healing purposes of the clinical encounter, as well as virtues derived from several other perspectives and how they all converge, will hopefully serve to broaden our understanding.

Beauchamp and Childress detail five focal virtues for healthcare professionals: compassion, discernment, trustworthiness, integrity, and conscientiousness, which have been presented in other sections of this dissertation.[167] To briefly review: compassion enables us to focus on another's pain, suffering, disability and misery; discernment allows for sensitive insight and astute judgement; trustworthiness is a confident belief in and reliance on the character and competence of another; integrity is reliability, soundness, and whole integration of moral character; and conscientiousness is the motivation to do right because it *is* right along with the due diligence to determine *what* is right.[168] Of these, the last two, when viewed as 'moral' integrity and 'moral' discernment, reach beyond feelings and emotions as the substance of a morally good state of mind apart from merely conceiving what is right or worthy.[169]

In a similar manner, Pellegrino lists seven virtues that he views are entailed by the nature of the provider-patient encounter, which themselves can be supplemented by other virtues, which he argues are merely variants of the original seven. His list of virtues are: fidelity to trust and promise; benevolence; effacement of self-interest; compassion and caring' intellectual honesty; justice; and prudence.[170] Directly comparable to Beauchamp and Childress' trustworthiness, fidelity to trust and promise necessitates formation of trust between provider and patient as vital to healing and stresses that the patient has no choice but to trust their caregiver; benevolence intends every act as for the good of the patient, and effacement of self-interest protects the patient from exploitation for provider self-advancement.[171] Pellegrino discusses compassion and caring as being imbued with many contingent meanings, but as necessary for the patient to fully 'heal,' in so much as the healthcare professional allows themselves to feel the particularities of the patient's life story, the relevance of their illness to this time in their life, and to grasp the predicament of their illness.[172] This viewpoint resonates deeply with our profession, in that college students of all ages certainly do have particularities that impact their health and wellbeing, (and as has been noted, their academic success as a result), and for college health professionals to exemplify the virtue of compassion and caring is primary. The virtue that Pellegrino dubs as intellectual honesty posits that healthcare providers can also become agents of great harm as well as great good, acknowledging the trust that patients afford them as well as the power derived from both knowledge and skill can tempt the professional to lack humility or the ability to admit when they don't know something.[173] This cautionary reminder that humility is also a virtue is significant for our milieu, especially with regard to the professional-patient relationship in the college health setting, when much of the population are newly autonomous with regard to health-care decision making. Justice, Pellegrino offers, is the virtue of the covenant of trust, or the promise to help –

contending that when viewed through the lens of a principle, justice is strictly applied, but as a virtue in and of itself, addresses the specific needs of the patient regardless of what is 'owed' through commutative justice dictates.[174] Finally, his view of prudence as practical wisdom applied to clinical decisions in balance of alternatives reflects both Aristotle's phronesis and from Catholic moral teaching, Acquinas' prudence.

In light of the above two viewpoints on what essential virtues are for healthcare providers, it is fascinating to realize that when identifying virtues as culturally valued strengths of character there are universalities over time and among thinkers across the ages.[175] Throughout world cultures, faith traditions, and during the course of history - theological, philosophical, and educational literature about virtue share common themes that clearly emerge when compared. In a study done to search comparative literature by reviewing prior attempts at listing the virtues crucial to human thriving along with determining how these listings converge; six core virtues emanated: courage, justice, humanity, temperance, wisdom and transcendence.[176] Descriptions for each virtue classify the ideals of each: courage as the exercise of will to accomplish goals in the face of opposition; justice as strengths that underlie health community life; humanity as interpersonal strengths that involve tending and befriending; temperance as strengths that protect against excess; wisdom as cognitive strengths that entail the acquisition and use of knowledge; and transcendence, or strengths that forge connections to the larger universe.[177] Various influential religious and philosophical traditions were surveyed, including Christianity, Judaism, Athenian Philosophy, Buddhism, Confucianism, Hinduism, Islam, and Taoism. The authors caution that their intent was to discern broad resemblances across traditions, putting aside distinctions between virtues and values, and did not attempt to determine specific semantic or cultural equivalencies.

A Few Criticisms. In order to conscientiously live a moral life, we are in an ongoing quest of acquiring skills, making judgments, and when confronted with ethical dilemmas and decisions, are constantly learning the skills necessary to discern what guidelines to follow, what principles apply, and identifying contingent moral virtues and ideals.[178] That said, ethical theories that are based either in principle or on the virtues have both been disparaged in that critics claim that they fail to adequately provide specific directives or instructions.[179] The Stanford Encyclopedia of Philosophy lists specific objections against virtue ethics, including how they are to be applied; whether they are adequate; if they have relativity; may competing virtues be in conflict; are they self-effacing; can they be justified; is egoism an element; and of situationist problems.[180] Commonly heard objections generalize that virtue ethics are concerned with 'being' more so than 'doing,' satisfying the question of "what sort of person should I be," but not fulfilling the question of "what should I do," as an agent-centered not act-centered philosophy.[181] Pellegrino also puts forth that virtue ethics, along with other moral and ethical theories, are all necessary and illuminate one another based on the circumstances, context, and features that make each moral event unique, the details on either side of which intersect with both the application of principles and virtues.[182] He asserts that virtue based ethics pertain in his theory of healing, yet is not a stand-alone normative theory, but must related to other ethical theories and moral philosophies for the health professions.[183]

Another charge is that the focus on character and motivation that typifies virtue ethics over and above the outcomes of actions may ignore other moral consequences.[184] Using a public health scenario as applicable to college health, for example, because of the broad range of professionals and clinical services provided in our field, listing virtues to each specific role would be challenging. The virtue of honesty, as an illustration of the criticism, with regard to publicizing

health risks specific to certain populations may serve to stigmatize some, in the sense that honesty as a virtue should also be tempered with justice relative to ways of using and dispensing health risk information to certain communities.[185] This situation is evident in the stigma of HIV testing, identified as one of the strongest barriers to HIV prevention and treatment-seeking, and although HIV prevalence in U.S. college students is estimated to be quite low, it is also thought to be significantly underreported, possibly correlated to stigma.[186] In this population, perceived social stigma associated with HIV testing was found to be an impediment to testing and provokes fear of social discrimination, so determining 'channels of least resistance' to promote HIV testing is necessary for increased acceptance and as being socially desirable.[187] A recent study published in the Journal of American College Health concluded that HIV testing stigma is influenced by knowledge, that individuals who have proper pre-testing counseling will have stronger knowledge gains, and that college health promotion personnel can use information obtained in the study to develop communication campaigns for specific demographics, illustrating the virtue of honesty tempered by the principle of justice.[188]

Because virtue ethics is focused on self and self-cultivation, it has come under criticism by some who have suggested that virtue theory can be stretched to include compromise by turning away from the agent's self-cultivation toward a process through which constructive compromise results.[189] Such theorists offer that within each of us humans is a gravitational-pull upon our own perceptions and emotions, while at the same time we are also concerned with how we come across to others, through recognizing an intimate desire for connection.[190] They add that regardless of how an individual regards their own capacity for virtue, it was learned, developed, and expressed through interaction with others, and that only by decentering from one's self and being mutually open to the other might a new dimension of virtue be properly understood.[191] Even further, one

particular position about this view of expanding virtue ethical theory through compromise is that it pushes not toward *abandonment* of one's conscience, but rather toward *reconstructing* it, although, a sense of self-betrayal may ultimately result if unjustifiable moral concessions are undertaken.[192] Concerning this position, however, I offer that in any given situation compromise may truly be what one should *not* do because it involves the sacrifice of deep moral commitments, as stated by Beauchamp and Childress with regard to conflicts between one's personal sense of integrity and their professional integrity.[193]

Confronting the task of comprehensively listing and acknowledging challenges and criticisms of virtue ethics is beyond the scope of an essay of this size - there are so many angles from which to explore both that this brief glance may seem reductionist, but my intention is to provide an introduction. Of the many philosophers, ethicists and theologians that have pondered the virtues and have written extensively on the topic, if further interest prods the reader to delve more deeply into this fascinating matter, they will most certainly encounter vast and significant comparative theories, analyses, and conceptions. While considering the various criticisms and oppositions to virtue ethics, realize that the capacity to balance many competing moral considerations is the essence of moral character as healthcare professionals, along with practical astuteness, discriminating intelligence, and sympathetic responsiveness - capacities integral to wise moral agents.[194]

Chapter 4.B. iii. It Begins with Character.

Character and the Empathetic Encounter. Character is at the core of the individual, and describes how a person tends to be and act, what they feel and value, but is also not unchangeable and is not expressed in every circumstance.[195] Ideally, persons of virtue are not only properly motivated but also experience appropriate emotion such as sympathy or regret, even if the

emotions don't result in any particular action, nor do they merely act upon inclination or find impetus from the potential for personal gain.[196] It would follow that character in action, properly motivated and appropriately framed by emotion is the foundation of an effective caregiver-patient relationship, regardless of setting. In an article about empathy, a medical oncologist offers eloquent insight into character, stating that love for the patient is no substitute for expertise and technical craft, but it may be true that love…or empathy, the ability to feel for the other and to imagine oneself in the other's place…is a necessary pre-condition for good medical practice and the maintenance of respectful relationships.[197] There is empiric evidence that patients are more likely to understand and follow clinical instructions when the clinician employs an empathetic style of communicating and is able to convey empathy.[198] From the standpoint of neuroscience, empathy is seen as a cognitive-affective process that enables people to know and feel the experience of another."[199] However, Beauchamp and Childress caution that empathy alone is insufficient for humanizing healthcare, and that although generalizations can be made about how caring clinicians should respond to patients, each situation requires a unique set of responses and actions appropriate to the context.[200]

The risk of a patient feeling as though they are 'just a number' in many healthcare environments sadly devoid of concern for personhood is not only demoralizing but leads to alienation, misunderstanding, and poor treatment outcomes.[201] In college health practice, given patient turnover by nature of the transience of student enrollment and utilization of services for a finite length of time, health services professionals should conscientiously avoid treating patient encounters mechanically and without hospitality. The empathetic encounter in the clinical context sets forth good intentions of the practice, is indispensable for information gathering needed for diagnosis and treatment through our communication and dialogue with the patient during history

taking, symptom review, and relevant therapeutic decisions.[202] Even in the understanding that empathy is primarily a cognitive skill that helps the caregiver to understand the needs of the patient, when coupled with compassion elicits 'tuning-in' to patient needs without being overt emotionality.[203] Taken from the language of Martin Buber, a Jewish philosopher-theologian of the 20th century, this mutuality is a form of grace for which one must always be prepared, but on which one can never count, and during which we - as caregiver - must not reduce the other to what was presupposed before actually encountering them - as patient.[204] Buber's concept of mutual growth through authentic creative dialogue confirms the basis of empathy in provider-patient relationships, as giving oneself over to the needs of the other.[205]

Within the empathetic encounter, other simpler elements are also at play during the interaction, which may or may not be intuitive, for example, tact, self-awareness, good humor, reverence, and simplicity.[206] The risk of neglecting these lesser elements in the college health setting may be affected by care providers repetitively encountering similar visit types and common conditions.[207] Tact, for example, is not a skill that is taught formally, yet is essential within the context of a clinical encounter in the sense of the provider's being able to say enough and let enough go unsaid, thereby creating an opportunity for the patient to disclose – momentary silence may imply acceptance and alleviate fear or concern.[208] This further relates to the care provider or staff member also being self-aware. The character trait of being self-aware is complex, and is critical for how we understand ourselves, relate to others and the world, and allows us to evaluate ourselves in relation to the other by examining our motivation, behavior, and emotional state within a given situation when decisions were made, in accordance with our will, habits, and reasoning – all of which enters into clinical decision-making.[209] Whether by formal self-reflection through journaling or when heeding to observation from peers who may

critique disposition or technique, the clinician who can 'see themselves for who they are' by realizing their strengths, accepting their weaknesses, and knowing when to consult with another - will become better versions of themselves for their patients.[210] Realization of one's self then allows for mutual respect and the fullness of the trait of reverence for the other through humility, self-effacement, respect and awe for the life and person for whom care for is entrusted to the clinician.[211] Countless additional 'lesser' virtues elemental to effective and authentic, virtue-based patient encounters can be further listed and explored, but most importantly, when applied to each face-to-face opportunity to serve those entrusted to our care, these traits will enhance the occasion. Objectively, however, caution with regard to blind reason and impartial reflection because of constant exposure to the suffering and problems of others can lead to emotional burnout, so the ability to employ 'detached concern' or 'compassionate detachment' appropriately is the counter-balance, a valued characteristic of an effective and good clinician.[212]

Defects of Character. For as much as the discussion of virtue regards morally valuable traits and ideals, the term vice is less commonly used in the realm of ethical theory, yet while persons who are honest, fair, caring, and otherwise virtuous are admired, we condemn those who display dishonesty, malevolence, uncaring, unfairness, or dishonor among other vices.[213] Human beings by nature are fallible creatures, and regardless of character or training, we all can and do make judgement errors, act offensively, or otherwise depart from good.[214] When attempting to be empathetic, for example, too deep emotional involvement will get in the way of objective understanding and may mislead the care provider into being strongly paternalistic, for example.[215] In that regard, our understanding of basic psychological processes and our own attitudes, emotions, biases and experiences are necessary for conditions that may occur within the dynamic of patient-care, such as transference or counter-transference, projection, repression,

and so on so.[216] Such circumstances occur in conflict of interest scenarios when professional judgement of clinicians is unduly influenced by personal attitudes or competing interests, creating temptations, biases, and other hindrances that result in breach of role responsibilities and actions befitting the expectation of the professional positon.[217] In terms of college health settings in general, referencing an article in the Journal of American College Health, staff displaying negative attitudes drain the organization because of the toxicity, can adversely affect morale, and in the end hurts students.[218] Difficult employees lacking in character may have far-reaching reasons for their inadequacies that manifest in the workplace whether due to past trauma or their own lived neglectful circumstances, resulting in bullying and threatening peer relationships, attendance or competency issues, and deleterious treatment of patients through rude treatment of or destructive comments about students or even more subtle microagressive actions.[219]

Moral integrity is complete and sound integration of moral character when our aspects of self – our emotions, aspirations, knowledge, and virtues are complementary and integrated, resulting in faithfulness to our moral values and standing up in their defense when necessary.[220] Those lacking moral integrity through the vices of hypocrisy, insincerity, bad faith and self-deception fall to breaks in connections to their own moral convictions, most commonly in the deficiency of lacking sincerity about moral convictions or the failure to act upon one's convictions.[221] Violations of professional conduct occur when the professional deviates from established standards and codes, or when competing commitments cause abandonment of the capacity to pursue moral objectives.[222] The American Nurses Association Code of Ethics for Nurses with Interpretive Statements addresses this in Provision 5, which states that the nurse owes duty to self as well as others in terms of promoting health and safety, preserving wholeness of character and integrity, maintaining competence, and furthering personal and professional

growth.[223] As healthcare professionals who advocate for our students to practice wellbeing, so too is it our responsibility to see that we maintain effective professional life/work balance to mitigate any deviation from professional conduct expectations. Critical self-reflection, noted above, should recognize and sense internal sanctions that rise from recognizing one's own acts of violation of professional standards appearing in the conscience as feelings of remorse, guilt, shame, disunity, or disharmony.[224] Because college health services range broadly in terms of institutional size, practice scope, staffing, and so on – ongoing vigilance with regard to staff and employee performance, professional development, and continuous quality improvement processes will isolate and identify any staff 'at risk' for character defects that are situational, temporary, or in need of direct intervention.

Chapter 4.B. iv. Accounting for Conscience.

What is Conscience? The character trait of conscience is immortalized in the 1940 Disney movie version of the classic children's tale Pinocchio, when Jiminy Cricket admonishes "always let your conscience be your guide." Although the word is used effortlessly in common speech, the meaning is owed further scrutiny. As a moral guide, conscience has both positive and negative aspects in that it tells us what is right and what should be done, but equally informs us of what is wrong and what is to be avoided.[225] The depth and essence of conscience is the subject of limitless philosophical and theological works. How conscience (as a moral characteristic) and conscientiousness (as the state of employing one's conscience) weave into the fiber of college health practice will vary depending upon person, professional role, circumstance, and individual moral conscience – so, what follows will hopefully inspire contemplation and consideration of the role of both in our professional practice. Two emphatic statements about conscience gleaned from early patristic writings include one that urges "do not dishonor your

conscience, who always provides good advice, for it is your angelic and godly advisor," and another that counsels "after God, let us have our conscience as a rule and goal in everything."[226] Other early Christian philosophers defined conscience as a dual-nature concept of a reflex or gut-feeling that interrelates with reflective insight into the impact of our actions.[227] In a similar manner, Beauchamp and Childress propose that what conscience is *not* is some special moral faculty or self-justifying moral authority, but *is* a means of self-reflection about actions that are good or bad, obligatory or prohibitive, right or wrong, and virtuous or vicious.[228] In contrast, some contend that conscience can be perceived as irrationality and bears 'quasi' religious status, questioning the veracity of decisions made according to conscience, with seeming potential for abuse by professionals, leading to discrediting of their position.[229] Those who challenge that moral discernment is not limited to Abrahamic religions and who themselves come from secular traditions that believe conscience alerts a moral agent to his or her desires will nonetheless agree that moral reflection and discrimination should still take place regardless of from what source core values are drawn.[230] Amidst our pluralistic society, the understanding of conscience to many will likely be through the dualist understanding, with both the 'gut-feeling' and 'insight' pieces working together with reason through a dynamic tension that overlays all.[231]

Among professionals and across disciplines, morally sensible and conscientious persons will understandably disagree over moral priorities in light of conflicting moral norms as there is no single, perfectly reliable method of resolving moral disagreement.[232] Moral diversity and moral disagreement in any clinical setting is a foregone conclusion, and can arise from varying facts about given scenarios, stemming from which norms may or may not apply, which take priority, how they are specified and balanced, if there is need to protect someone as a result, conceptual disagreements, and other factors.[233] Conscientious judgments are based on evidence

as perceived, and each of us may defend our own decision differently than others, hopefully without rebuke or reproach from one to another.[234] The uniquely human experience of our *head* telling us one thing while our *heart* tells us another is the duality of conscience ensuing from an immediate judgment and a retrospective review – the dynamic process of reflex and reflection.[235] Listening to one's inner voice, our internal compass as a contributor to moral decision-making for healthcare professionals is vital and should not be suppressed, but should also not imply that judgements of conscience are impervious to challenge and explanation.[236] Healthcare personnel when challenged to act against one's conscience or core moral convictions is an assault on one's moral integrity, and if breached result in a loss of self-respect and other deleterious feelings, which in turn affect peer and patient relationships.[237] Professionals of good-will may hold radically divergent moral beliefs, obvious fodder for much moral, philosophical and political controversy; but forced capitulation of a medical professional to a morally objectionable circumstance cannot become obligatory.[238]

Objections of Conscience. With regard to divergent moral beliefs among health professionals and challenges of moral conscience, the need for balance in consideration to the interests of the patient, the professional, the institution in which the professional practices, and as regards public policy is complex. Conscientious refusals by myriad health care professionals abound in all sectors of medical practice, and accordingly no single model of appropriate response can cover all cases, yet it is incumbent upon the professional to inform employers, patients, and peers when conscientious objection interfere with provision of services, recognizing essentially that the objection lies with the procedure or process, not with the patient.[239] Alternatively, others believe that protecting the exercise of conscience to enable healthcare professionals to maintain their moral integrity through legal conscience clauses does not

adequately protect either patients or third parties from harm, burden, and other consequences; and that such policy provisions weaken healthcare organizations and regulatory boards.[240] However, matters of conscience and moral integrity are the subjective priority of values within oneself, which in turn defines a person's moral agency and are, at their core, deeply and powerfully existential.[241] Great scrutiny should be applied to situations that involve the rights of both patients and conscientiously dissenting professionals, with ample and prospective disclosure of their grounds for refusal and avoidance of merely idiosyncratic appeal to conscience without true moral merit.[242] College health is not devoid of morally challenging situations by any means. When encountering patients face to face, acting together, a moral drama unfolds, since both provider and patient have their own history of moral development.[243]

Conclusion. The above probe of virtue ethics for consideration in college health practice will serve as an introduction to a content-laden, historically opulent, multifaceted journey into a venerable facet of healthcare ethics. Having a glimpse through history of ancient philosophical roots, through the path that virtue ethics and virtue theory has taken through present-day is but a taste for curiosity seekers to further explore the contours of virtue ethics, and find applicability to their own experiences in our distinguished field of college health medicine.

From our earliest formation as moral individuals, each of us can recall those exemplars of virtuosity that formed our own moral convictions, whether popular, historic, or in the lives of religious personages; as well as the cultural, traditional, and spiritual pathways that have unfolded within our lives as both professionals, but yet as patients ourselves. We live in times unparalleled as regards quantum developments and discoveries in medicine that will hopefully not lead us away from moral integrity, but should instead demand a more secure and definitive self-awareness of our own moral compasses. Having the framework of classic virtues that have

withstood the test of time and the human potential to open and create pathways of excellence in professional practice will be abundantly necessary in our futures, as much as they have upheld our professions through today.

Excellence of character in the caring professions is an indelible component that is integral to ordinary life, to our responsibilities within society, and to our progression as humans. Virtuous traits that sustain our commitment to the good, to uphold the binding standards of action and rules of obligation as found in the common morality by means of high moral character traits despite the continually emerging problems of public policy in a pluralistic society, will nonetheless steer us through challenges and adversities because of our commitment to caring for the other.[244]

Virtuous character is shaped, defined, and experienced from a multitude of perspectives and ethical systems. A tangible example of this is through several uncommonly similar versions of the Golden Rule that weave a common thread throughout humanity – for Christians, "Whatever you wish that men would do to you, do so to them, for this is the law and the prophets;" for Jews, "What is hateful to you do not do to your fellowman. This is the entire law, all the rest is commentary;" for Muslims: "No one of you is a believer until he desires for his brother that which he desires for himself;" for Buddhists, "Hurt not others in ways that you yourself would find hurtful;" and for Hindus "This is the sum of duty; do naught unto others what you would not have them do unto you."[245] Whatever tenet is most inspiring among these and of those not mentioned, may we each embrace it and practice the virtue that it preaches.

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[2] Beauchamp and Childress, *Principles of Biomedical Ethics*, 32-33.
[3] "Framework for a Comprehensive College Health Program," American College Health Association, 2016, 1, https://www.acha.org/ACHA/Resources/Publications/ACHA/Resources/Publication.aspx?hkey=7c6f174f-ea50-4102-947e-38c2de3b7d53
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[10] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3.
[11] Beauchamp and Childress, *Principles of Biomedical Ethics*, 4.
[12] Beauchamp and Childress, *Principles of Biomedical Ethics*, 410, 421.
[13] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3.
[14] Paula L. Swinford, "Advancing the Health of students: A Rationale for College Health Programs," *Journal of American College Health* 50, no. 6 (May, 2002): 309-311.
[15] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3.
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Chapter 5. Professional Ethics: Care & Wellbeing.

Within this chapter, professional ethics for college health is explored further in the first section through an analysis of professionalism and care, and in section two as regards wellbeing.

Chapter 5.A. Professionalism & Care.

Previously within this dissertation, it has been discussed that moral norms within the context of principles, rules, rights, and obligations govern right action; while moral virtue as a trait of character is of critical importance to those practicing in professional medical roles.[1] The ensuing analysis of an ethic of care is consistent with the use of principlism throughout this dissertation which presents a novel approach to professional ethics for CHS. Moral virtues, moral character, and moral excellence (as discussed in the ethics of care discourse) are complimentary to principlism. The proponents of ethics of care provide different perspectives, as noted by Beauchamp & Childress, which are discussed in the chapter.

Common nomenclature such as "health *care*," "medical *care*," and "nursing *care*" immediately connotes the specific virtue of care, or even further an ethic of care, as a potential subcategory of virtue ethics – commonly emphasizing traits of interpersonal relationships such as sympathy, compassion, fidelity, and love.[2] Similarly, within the context of college health, the dynamic that is formed between students seeking care and those of us providing that care, engenders trustworthiness, quality of care, and sensitivity toward the unique needs and vulnerabilities within this specific population.[3] It cannot be overstated that college health services traverse a broad and diverse continuum, varying in size, scope, staffing, and types of services provided; and the multitude of professionals who deliver care and services at college health centers do so through myriad professional capacities and supportive roles.[4] Given this

exceptionality, at various touch-points between college health professional and support staff with students, we encounter equally broad variability from the newly autonomous undergraduate, to the non-traditionally aged student, and everyone in-between; therefore, doing so with an understanding of the 'ethics of care' may undergird how our actions are performed, the motives and feelings that inspire us, and whether such actions promote or impede the relationships that we may potentially establish.[5]

To that end, I propose that there is an interrelatedness between the one providing care, and the one being cared-for through a reciprocal commitment that directly influences wellbeing. In the sections that follow, I aim to provide an overview of the ethics of care by peering into its origins and early theorists, as well as to explore the essential theme of its core notion of being caring-for and taking-care-of others; while overlaying this discussion with a parallel glimpse into the ethics of wellbeing – both of which have fundamental correlation to the essence of our craft – the provision of care to and promotion of wellbeing in college students. Care ethics seeks to maintain relationships by normatively contextualizing and promoting the wellbeing of both care-giver and care-receiver through a network of social relations, building on the motivation to care for those who are dependent and vulnerable, drawing upon virtue from personal experiences and professional abilities.[6] Elsewhere in this dissertation, vulnerabilities particular to college students have been heretofore mentioned and considered. Public and social media, periodicals, and countless other information sources abound with "hot topics" that fuel the context within which an ethic of care toward promoting wellbeing is both necessary and relevant regardless of institutional setting or scope of services. From personal experience, those hot-button issues are experienced daily through encounters with students that present to clinical health services with comorbid chronic illnesses; a history of or newly surfacing behavioral and mental health issues;

those who have experienced violence, abuse, assault or other traumas; an increasing number of students who are classified as having disabilities or in need of accommodations; students characterized as minorities; international students; student veterans; students with financial burdens and who may also be facing housing or food insecurities; those coping with chemical dependencies or substance misuse; and the list goes on. As we begin to further probe the ethic of care, it may be useful to keep in mind how one source concisely depicts care ethics: *show up; shut up – be fully present; seek their story; suspend judgment; and stick with them*.[7]

Chapter 5.A. i. Care Ethics: Roots & Origins.

Theorists: Gilligan & Tronto. As with other health care ethical theories and concepts that have relevance to or may pertain to the practice of college health, a look into the roots and origins of care ethics will aid in understanding and applying it to our field. According to Beauchamp and Childress, as an off-shoot of virtue ethics, the ethics of care gives prominence to characteristics involved in close personal interactions, including sympathy, compassion, fidelity, and love.[8] Early writers on the ethics of care emphasized that women differ from men in that men primarily view care through the lens of rights, obligations, and justice; while women stress an empathic association and strong sense of responsibility.[9] In contemporary society, this may seem biased or implausible, yet, the origins of such thinking is found in feminist writings, with Carol Gilligan being a prominent theorist, offering that "women speak in a different voice," through research calling this voice the "voice of care."[10] In another section of this dissertation, I referenced Kohlberg's theory of moral development - Gilligan was an associate of Kohlberg's, and because of discovering gender bias in his research due to his use of only male subjects, she pushed past his findings to pursue her own approach.[11] It is precisely this research that resulted in her discovery that women frame morality "in a different voice" (which became part of the title

of her widely-read work), asserting that this 'voice' determines how what has to be done in a given situation will best preserve and nurture the human relationships involved.[12]

She did not, on the other hand, entirely reject Kohlberg's framework or stages of development, but did purport that any discussion of morality can only involve the morality of justice and fairness, which Gilligan contrasts with her "ethic of care and relationship."[13] Essentially, there are three characteristics that distinguish Gilligan's ethic of care from solely a morality of justice. First, it revolves around responsibility and relationships rather than rights and rules; second, ethics of care are associated with real-life application, not formal and abstract concepts; and third, as opposed to being expressed as a set of principles, Gilligan frames her morality as an activity – the activity of care.[14] Her philosophy is considered by many to be the first to move moral theorizing framed according to the concept of selves as being independent, to that of interconnectedness and interdependence, with caring being on a continuum of varying levels of emotional involvement of those in caring relationships.[15]

Another early writer on the topic is Joan Tronto, who argued against a "women's morality" and emphasized a care ethic inclusive of values traditionally associated with women, but charging that morality is to be taken more seriously, while advancing the perspective that through the cooperation and mutual interdependence of care, care ethics are to be understood in a political context.[16] Similarly to Gilligan, she also differentiated between obligation-based ethics and responsibility-based ethics, upholding that relationships with others is the starting point of an ethic of care and thus establishes a "habit" of care.[17] Tronto's approach diverts toward theorizing further about care as a political ideal and strategy, as is developed in her book, *Moral Boundaries – A Political Argument for an Ethic of Care.* Throughout, she examines moral

boundaries and develops her methodology to an ethic of care by defining elements of care, outlining four phases of caring, and concludes with theorizing about care and political theory.[18]

Tronto examines caring as a word common in everyday language that carries with it two aspects, first – it implies a "reaching-out" to something other than self, and second – it implies action.[19] She provides a definition of caring as "a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible," (specifying that 'world' includes our bodies, selves, and environment as an interwoven, life-sustaining web).[20] This definition provides the framework for her theory, asserting four distinct features. First, it is not restricted to human-to-human interaction; second, it does not limit relationships to being either dyadic or individualistic; third, the activity of caring will vary among cultures; and fourth, caring is an ongoing as both a process and disposition of living.[21] Also according to Tronto, there exist four elements of care within an ethic of care, namely caring about, taking care-of, caregiving, and care-receiving.[22] These four elements of care extend from what she states are four ethical elements, namely: attentiveness, responsibility, competence, and responsiveness.[23] Within the health care practice, and applicably to the context of college health, we can connect these phases of care and correlated elements to our daily provision of health care to our specific population. In that my own frame of reference is that of a nurse, when equating each concept to patient care, the relevance becomes abundantly clear. Attentiveness necessitates clearly detecting or determining patient need, for example with a well-functioning triage system for the campus health clinic; responsibility as fundamental to patient-care parallels with providing that care within the confines of the defined scope and practice of campus clinical services; competence connotes the diligence of the clinical staff and providers toward professional development and ongoing quality improvement; and responsiveness as caring

college health professionals links all that we do to the need for comprehensive, holistic, well-being promoting services.[24]

Theorists: Noddings & Tong. Yet a third early care ethics philosopher is Nel Noddings, who specifies care ethics as a relational ethic, emphasizing the roles of both the care-provider and the one being cared for toward maintaining that relationship.[25] She distinguishes relational caring from the virtue of caring by emphasizing the reciprocity of the relationship between the one providing the care and the one receiving the care, while the virtue of caring is particular to the individual character of the care-giver.[26] Noddings extends Martin Buber's "I-thou and I-it" notion regarding relation as reciprocity to compare care ethics as mutual recognition and appreciation of response, such that the response either completes the relation or provides cues about the need to continue it.[27] She expresses similar themes to that of other care ethics theorists, such as the importance of attention as being of central importance, and that the care-r must first be attentive in a way that is also receptive, open, and allows for empathic understanding of the needs of the cared-for.[28] Noddings offers that the language of care ethics such as care, attention, empathy, response, reciprocity, and receptivity infer special meaning, as a moral way of life.[29]

Throughout her book *Caring*, Nel Noddings granularly analyzes caring in terms of its fundamental nature, as well as to finely evaluate specific characteristics of each of two roles – that of the care-provider and the care receiver, in addition to exploring caring as an ethic through constructing an ideal, extending caring beyond human interaction to animals, plants, and things; and fusing aspects of moral education through an ethic of care.[30] She counters that building an ethic on caring is not a form of act-utilitarianism or situation ethics, but finds morality in the consciousness of the one-caring – nonetheless distinguishing her own theory as not one of

agapism or a command to love, rejecting the notion of universal love, but concedes that much of care ethics is to be found in Christian ethics.[31] Noddings also regards the commitment to care and ability to define oneself in terms of capacity to care as a feminine alternative to Kohlberg's stage #6 morality, in which the moral thinker ascends to the highest principle, or that of love, loyalty, and relief of suffering – comparing women as care-givers that don't necessarily rank principles in priority, but do concern themselves with maintaining and enhancing caring.[32] Further, she posits that women prefer to consider moral problems in view of concrete situations, approaching them not through abstract reasoning but as problems to be lived and solved, the approach to which is founded in caring.[33] Further, women characteristically apply feelings, needs, situational conditions, and a sense of personal ideal rather than principles toward action and application of morality.[34] Frequently, she references the maternal/child relationship and upholds it as the single greatest source of strength for the maintenance of the ethical ideal.[35] Throughout *Caring*, Noddings' emphasis on attention and the question of "what are you going through" is foundational to the process of increasing an ethical ideal through strengthening the capacity to care.[36]

In a Journal of Medicine and Philosophy article from over twenty years ago, author Rosemary Tong provides a clear and informative analysis from the standpoint of acknowledging the works of both Gilligan and Noddings as fodder for philosophers to contrast the ethics of care with that of justice.[37] She puts forth a deep-dive into the justice/care debate by comparing it to two "older" debates which she refers to as the "principles versus virtues debate," and the 18th, 19th, and 20th centuries "male morality versus female morality" debate, by constructing her own concept fusion and calling it "feminist virtue ethics of care." Tong takes the model from narrative ethics of understanding an individual's story or a society's tradition to gain

understanding as with the moral virtue of empathy, and continues to bind care ethics to virtue ethics.[38] Meanwhile, she also partitions the feminist approach to ethics into four categories, through a comprehensive review of the familiar philosophies of Rousseau, Mill, Beecher, Nietzche, MacIntyre, and others who each identify differences between "so-called" male virtues/values and female virtues/values, doing so toward her overall effort to identify elements that make a virtue ethics of care feminist in the sense that it is precisely the kind of ethics that healthcare practitioners should espouse.[39] Summarily, this analysis challenges healthcare providers to embrace and uphold an ethic of care by developing caring feelings as well as conscientious desires and empathetic skills toward becoming caring persons.[40] Tong's insightful conclusion transcends socio-political implications through thoughtful exploration, concluding that her so-called "feminine virtue ethics of care" provides the "proper moral medicine for much of what ails contemporary healthcare."[41] Her statement may very well continue to resonate two decades later, if not generally, quite possibly for those in the practice of college health.

Chapter 5.A.ii. Care Ethics: Challenging Viewpoints.

Lack of Normative Content. Healthcare ethics (in this case, the ethics of care) can indeed be applied to the practice of college health, but - as this dissertation is intended to broadly expose the reader, especially college health professionals - it is imperative that viewpoints of both proponents and opponents to various theories and approaches be recognized. To that end, the ethics of care is most certainly not free of criticism. Within a decade of Carol Gilligan's *In a Different Voice*, publications in both medical and nursing journals put forth challenges to and pointed out inadequacies of care ethics, which I offer as merely a means to acknowledge existence of the debate, as well as to further the reader's interest and understanding. For example, once such critic - a professor of nursing at a college in England - contests that relative

to the nursing profession, adopting an approach to ethics based on care is "hopelessly vague," and lacks normative and descriptive content.[42] This critic espouses that said vagueness is due to a lack of analysis of the meaning of care, and subsequently lacks a credible source of moral meaning in the sense that care-related terms are used to imply that care is itself *a* good, or is *the* good, which – according to this educator – is invalid and false.[43] Essentially, if care-related terms are used to convey a moral judgement, this opponent to care ethics charges that the "what and how" of the underlying moral judgment are not objective.[44] From this perspective, the opposition to care ethics is that although most humans care about different things to different degrees, this does not make us 'caring' in the sense of being morally significant, because what we care about may in itself be morally neutral, or morally wrong.[45]

A second criticism also hails from a nursing perspective, which may resonate with the multitude of nursing professionals found in the practice of college health. It carefully peels back the familiar credo that nurses 'make a difference' in patient outcomes 'because they care,' stating that there is little supportive evidence to uphold such a claim; and that efforts suggesting that care, as the sole definitive characteristic of an ethical basis for nursing, has raised debate within the profession.[46] It is the opinion of this critic that a singular focus on care alone has impeded a clear understanding of the true nature of the relationship between caring and what must be a broader base of ethical knowledge that must underpin the profession by means of an individual's personal moral sensibility, transformed into disciplinary ethical knowledge through three essential elements: respect, trust, and mutuality.[47] The argument further asserts that ethical knowledge creates an opportunity for responsive nurse-patient relationships which effectively do influence patient outcomes, because of two assumptions: (1) personal and public (principles, laws) moral knowledge is the foundation of ethical knowledge within the discipline, and is

required to further the practice of nursing; and (2) nurse-patient relationships can then become responsive when undergirded by an ethical framework that allows for caring behaviors to occur.[48] Another query made in this example is whether care can constitute an ethic in and of itself, as is found abundantly in nursing "care paradigm" literature, though not addressing what compels nurses to care to a greater extent than other healthcare providers; further questioning if that "greater care" in and of itself may possibly border on the unethical - especially if it becomes paternalistic or authoritarian, maternalistic or patronizing.[49] In sum, through this perspective, the term caring is both imprecise and inefficient to fully comprehend all that nurses do and how they do it, and care must be situated within a broader framework that fuses moral and ethical knowledge with effective practice.[50]

Lack of Moral Guidance. Of interest to note, an entire issue of the Journal of Medicine and Philosophy addressed care ethics from multiple perspectives, likely due to both enthusiasm and uncertainties, carefully dissecting it relative to what some considered to be problems with vagueness and narrowness, or the lack of it providing adequate moral guidance to either clinical settings or any other area.[51] A key question that surfaced by ethicists as arbiters of the debate was to ask simply, what sort of theory or account an ethic of care is it meant to be, due to confusion about whether Gilligan's writings put forth a formal approach, or if they supplanted prior traditional theories.[52] How early writings on the ethic of care either shared or challenged traditional ethical concepts such as deontology, consequentialism or virtue theory as well as if care ethics was meant to provide guidance on action, motive, or method – are each fodder for consideration.[53] One writer proposed as series of questions about how care ethics are to be conceptualized.[54] First, might care be thought of as an alternative principle of right action, and if so, is it then to be considered a virtue or synonymous with virtue theory; second, what meanings

of care are to be considered in the debate of relating care with justice; third, can care theory stand up to principlism; and finally – does it provide an entirely new possibility within moral theory of assessing the normative appropriateness of relationships.[55]

Three of these targeted alternatives are put forth by the author to examine where care as an ethical theory might map onto more traditional ethical analysis, because of language used by care theorists, placing it on par with prior concepts. [56] The fourth notion, however, posits a completely different concept that instead may suggest a new path for the map. If care is integrally associated with relationships as a central theme, it then differs from both right-action and virtue theory, which are concerned with those acts independent of the actor's character, or with those praiseworthy traits of the actor independent of the nature of the action.[57] Moreover, if care theory is to be viewed as a branch of normative ethics, there are even further challenges to be met, according to the perspective of this author. For example, in as much as there is a list of principles of right-action and a list of virtues, so too should there be a list of relationships; yet - when considering those possibilities, if the list includes authoritarian, paternalistic, maternalistic, subservient, collegial, etc. – adding 'caring' to such a list would give pause to how it would be normatively valued or approved.[58] Further, is it interesting to consider how care holds up as a relational term, or to maintain the claim that care can describe the nature of an action; all the while realizing that it is more natural to perceive care as a disposition or character trait.[59] As a virtue, then, care would have to be a persistent disposition or character trait of a particular individual, not of a relationship between individuals.[60] Given that, the author concludes that if care is to be used to describe a relation, then an account of the characteristics of that relation must also be provided, along with a rationale for how those characteristics are normative,

including assessment criteria for both the character of those engaged in the relationship as well as to determine if the actions were morally right.[61]

A final challenge to care ethics worthy of mention is suggested by two faculty from a combined university nursing and bioethics center, charging that trust – as central to nurse/patient relationships – must be studied from the viewpoint of not only reliability and competence, but also regarding good-will within that relationship.[62] They suggest that the trust approach will supplant patient care approaches based on contract, paternalism, and care alone as inadequate for foundational nursing ethics.[63] Their viewpoint puts forth that contracts may fail to meet the moral demands necessary to recognize one party as vulnerable and incapable of voluntary agreements; and that paternalism can be criticized on many levels, but primarily as reducing both patient autonomy and dignity; while care-theory, although continuing to be applicable and enduringly popular, may fall under scrutiny as potentially exploitative or unfairly partial.[64] Baker's Theory of Trust is used to develop their analysis, as it is compatible in three areas: (1) it integrates the ethics of care with justice, (2) it acknowledges vulnerability and the potential for evil in relationships, and (3) it establishes a network of trust, or climate of trust.[65] In so doing, these two faculty suggest that linking a nursing care ethic with trust theory addresses situations and concerns that nurse's face in their profession relative to the context of their influence or power in healthcare systems.[66] The element of trust, without question and having been previously discussed, is vitally important to all nursing roles in patient care, and naturally quite so within the context of student health, given the many unique characteristics and qualities of this population subset, referred to throughout this dissertation.

Chapter 5.A.iii. Complimentary Findings: A Direction for Caring.

Caring & Wellbeing: Galvin and Todres. Despite having examined the roots, origins, and prominent theorists of care ethics along with several challenges to those theories, it is also important to discuss other complimentary and associated concepts that are presented toward practical application, often overlapping with both original ideas as well as contested views. One such complimentary approach derives from a framework offered as a care-approach for application in health care and policy formation, through three key perspectives for relational understanding in professional practice.[67] *Caring and Wellbeing, a Lifeworld Approach* is an account of this approach, written by two people - one a nurse and the other a psychologist - who introduce their method through a narrative describing a "lifeworld" approach toward "humanizing" care; then propose how care can be informed through an understanding that health and illness, wellbeing and suffering are connected to our lives daily; and conclude with a research-based illustration by means of a case-study, ultimately identifying themes that emerge from that illustration.[68] What is striking about this is the clear tie-in of care to wellbeing as provisional for the practice of healthcare, coming from what they acknowledge to be a deeper epistemological and ontological underpinning.[69] The dominant leitmotif of *relating* in care ethics when overlaid with a focus on *wellbeing* toward the care of college students is aligned with that which is already known, college health services are critical to student retention, academic achievement, and success.[70] Given the diversity of colleges and universities, each institution possesses a unique vision for student health and wellbeing that is appropriate to them, which should also be aspirational, idealistic, and future-oriented.[71] From *Caring and Wellbeing*, there are quite a few idealistic takeaways, especially considering that through their research, the

authors establish specific vocabulary for their framework, including the notion "caring *for* wellbeing."[72]

From the philosophical question that asked what makes people feel more human in situations in which they receive care, Galvin and Todres drew from phenomenological writings of several perspectives to develop their framework.[73] They constructed eight interrelated dimensions that occur on a spectrum which describe experiences that either enhance one's feelings or that obscure them, in their words "forms of humanization and dehumanization."[74] These eight 'pairs' of dimensions are distinguished as overlapping and inversely relative, and take place within the context of a clinical setting between the cared-for and the care-provider, as seen in the examples to follow. "Insiderness/objectification" is the first dimension that can be used to describe situations wherein the patient, as the sole authority or 'insider' on what they are experiencing relative to illness or circumstance, is met by the possibility of 'objectification' by the care-provider when their needs are dismissed as merely fitting into a diagnostic category or as relates to wrote clinical work-up of their complaint, without truly responding to their needs, concerns, fears, and so on.[75] It is beyond the scope of this essay to fully review and develop the remaining seven dimensions, but another bears mention as relates to our practice. Certain commonalities exist among college health services regardless of size or scope largely due to congregate living, learning, and socializing; for example, the recurrence of patient visits for common acute respiratory illnesses, often interpreted as redundant and burdensome, are known to constitute a substantial proportion of same-day visits to college health centers.[76] To that end, college health providers, when mindful of these dynamics, may apply the dimension of "uniqueness/homogenization" to recurrent, redundant visit scenarios in that each student-patient is to be valued for their own uniqueness within their own context, and not reduced to

generalizable attributes and characteristics when focusing excessively on deemphasizing this uniqueness through categorizing them, such as to state "here comes another [patient with] pharyngitis."[77] Other dimensions, which one can effectively contemplate as relative to our specialty, include: agency/passivity; togetherness/isolation; making-sense-of/loss of meaning; personal journey/loss of personal journey; sense of place/dislocation; embodiment/reductionist body.[78]

Galvin and Todres complex interpretation of their kinds of wellbeing is intended to provide various directions for caring, viewed existentially as a felt experience when individuals are facing health-related challenges, represented in a lattice-like, woven correlation describing concepts and conditions.[79] Within that lattice are categories of spatiality, temporality, inter-subjectivity, mood, identity, and embodiment layered across movement (mobility) and location (dwelling) – affecting person's experiences and states of wellbeing.[80] Not intended to be formulaic, but the structure allows for application to aspects of college life that in turn impact care, including a student's adjustment or "at-homeness," their mental health and "future orientation," their recovery from illness or "renewal," and so on.[81] Again, this peek into their narrative is worth further exploration by the reader, and can provide insight for research and applicability to college heath on many levels.

Human Caring: Jean Watson. Another care theory complimentary to the ethic of care is one that may be noticeably familiar to nurses, especially since nurses are predominant within the field of college health, assuming many different roles and responsibilities ranging from direct care to health promotion, management, research, and advocacy among others.[82] Considered to be a "middle range" nursing theory, Dr. Jean Watson's *Theory of Human Caring* is replete with references to the importance of care as an ethical construct, determined to be middle range

because of being focused, concrete, and able to be practically applied to practice.[83] From this theory, many contingent concepts have emanated from her original work, with various subsequent publications that in sum create the Caring Science model.[84] This model sets out to be a foundation for caring based on deep moral and ethical precepts in an effort to elicit nursing as an art, a science, and even a spiritual practice in its compassionate service to society and humanity.[85]

The caring science model was adopted by the American Nurses Credentialing Center as a magnet program that offered to health systems and nurse-led organizations a series of affirmations regarding caring.[86] The affirmations provide structure for application to practice standards, and in synopsis, include: human caring is not a commodity; caring does not equate with economics but can work with cost-effectiveness; caring is a professional ethical covenant that nurses share with the public such that they will sustain human caring even if circumstances threaten; caring is deeper than customer service; care-providers and patients enter into relationships that create healing environments; transformative healthcare must come from a consciousness stream that changes care from the inside, out; relationships, partnerships, and authentic connections allow healing environments to evolve; health must be spiritualized and extend beyond medical/technical and cure-oriented approaches to health and illness; creative solutions can be achieved when the caring model is employed which will transcend other, ineffective models. In reading each affirmation individually, college health nurses in a multitude of roles may discern how the statements translate to college health services or how they may provide a context from which to enhance existing practices.

Watson's care theory dovetails with care ethics through emphasis on the terms 'transpersonal' and a 'transpersonal caring relationship,' echoing what has previously been

reviewed relative to the early writers of care ethics and the focus on relating.[87] By imposing the term transpersonal, Watson thrusts the concept of caring into deeper connections between the self and the other, acknowledging that a true caring relationship moves beyond the surface to a connection that embraces the spirit of the other, acknowledging their illness, pain, suffering and absence of wellbeing through a truly authentic relation, in the moment.[88] This may feel somewhat esoteric to readers who are either not nurses, or are nurses who work under circumstances of duress because of underfunding, understaffing, multitasking, etc., as well as the reality of the often transient nature of the patient population in college health, depending upon size and scope of the facility; yet - despite these and other barriers, when considering that patients may present to the clinic with one complaint, there are potentially (or typically) other underlying issues, comorbidities, concerns, stresses, and circumstances that rightly do warrant an attempt at a true caring relationship.

Within Watson's ongoing reconstruction of her theory, which has maintained its original tenets yet has dynamically shifted with ongoing reevaluation and expansion, the concept of 'caritas' nursing is used to define the perspective of brining caring, love, and heart-centered relational practices into both our lives and our work, which Watson determines as a core precept for professional nursing.[89] There is concrete application of 'caritas' through what are called 'caring-in-action' indicators, and are most certainly thematically applicable to any clinical practice, with obvious relativity to college health.[90] Examples of those are as follows: making caring integral to organizational vision and culture; giving a name to the caring practice model in use; establishing caring rituals practiced universally; use of alternative caring/healing modalities such as sound, music, art within the environment; implementing relaxation and/or meditation rooms; cultivating practices of kindness and equanimity; achieving centeredness when with

patients for full engagement; practicing affirmations and statements used by all to convey caring; and development of "caring competencies" using the caritas theory for staff development.[91] Such practices sustain the transpersonal approach, allowing for the care-giver to engage in the provider/patient or caregiver/care-receiver relationship to enhance their sense of wellbeing and wholeness, regardless of complaint or disease process.[92]

Watson delves into a far deeper implication of relating as the crux of the care ethic, when she avows that the care-receiver co-creates along with the care-provider their own meaning for healing and wholeness, while the care giver's will and consciousness affirms full significance of the patient, thereby honoring the "I-Thou" relationship through what Watson calls genuine presencing and centeredness in the caring moment.[93] Again – although this may be outside of the comfortable-thinking range of some, the practical takeaways for application to what we do in college health on a day-to-day basis is more likely recognizable, such as the care-provider's ability to connect "trans-personally" with another through gestures, facial expressions, touch, verbal expressiveness and clear conveying of information – all of which truly becomes a care-giver art that contributes to intentional caring, which may potentiate relational harmony and will promote wellbeing.[94] Watson reflects that ongoing personal–professional development in the realm of care theory and the approach of caritas will promote caregivers to enter into a deeper level of professional healing practice, allowing them to awaken to the transpersonal condition of the world and to actualize more fully "ontological competencies" necessary for this level of advanced level of practice.[95] The following conclusion offered by Watson may ultimately convey the take-away from this review of her theory: "*We learn from one another how to be human by identifying ourselves with others, finding their dilemmas in ourselves. What we all learn from it is self-knowledge. The self we learn about…is every self. IT is universal—the*

human self. We learn to recognize ourselves in others…which keeps alive our common humanity and avoids reducing self or other to the reduced moral status of object."[96]

Chapter 5.A. iv. Alternative Approaches.

Personalist Approach: Janssens & Selling. Care ethics, as per the preceding discourse, was developed in the fields of moral psychology as well as political theory; has been scrutinized by healthcare ethicists regarding its place in clinical-ethical dilemmas; has had impact upon corresponding nursing theory; and is a concept that has been reasoned through various lenses.[97] One of those viewpoints is through the personalist approach. Having previously considered Noddings' theory, and her statement of honoring the *I-Thou* relationship, we have a clear segue into a brief introduction into personalist philosophy. A New York Times article from the summer of 2018 seemingly captures the essence of personalism, offering several leading anecdotes, such as that within journalism, important life lessons gained include that people are always more complicated than one thinks; most human beings are filled with ambivalences; and that 'our' culture does a good job of ignoring the uniqueness and depth of each person.[98] More importantly, the author professes that personalism honors the infinite dignity, uniqueness and depth of each person as human being, affirming that there is great distinction between humans and other animals through a depth, complexity, and superabundance to each human personality.[99] He challenges what is referred to as 'achievement culture' in that dignity does not depend upon what one does or on one's presumed successfulness, but that infinite worth is inherent in every human being, and that every human encounter is a meeting of equals.[100] The exhortation offered is that we should do what is possible to see each person in his or her full depth, yet he acknowledges that it is astonishingly hard to do, causing us to have "I-it" (*I*, the nurse and '*it*,' the pharyngitis) as opposed to "I-Thou" (*I*, the nurse, and "*Thou*," the human,

college-student patient) encounters as Watson also stated.[101] The article urges that we be open to the giving of ourselves to the other as a gift, through love, and to be open to both with intentionality, charging that today's social fragmentation did not spring from shallow roots, but from distorted world views that "amputated people from their own depths, having divided them into flattened, simplistic identities.[102]"

With those concepts on hand, the view that care ethics is based on an anthropology dominated by the bi-directional dynamic between care-giver and care-provider, and that given the compassion and empathy necessary, this perception of care ethics as both value laden and having normative content creates a clear connection between care and the relational view of the human through particular personalism schools of thought.[103] Louis Janssens' contributions to Louvian personalism focused on the principle that the human person is defined as a totality, having eight dimensions, each of which is interrelated and mutually interconnected; restated later by Joseph Selling, offering that the core of what it means to be human ultimately lies in relationality.[104] As relates to care ethics, specifically, one way of conceiving the personalist view is that we are woven into a network of relationships as humans, through which people are changed because of entering into care relationships with one another, and that they *become who they are* relative to others who have and who do take care of them.[105] From the personalist approach, the ethical standard to evaluate care practices stipulates that good care is aimed at the capacities and powers of individuals and their development, which cannot be sufficiently answered from a normative context, but is expressed as respect for and complete value of the dignity of the human person in all its dimensions.[106] Personalism provides an opportunity, then, for an ethical view from which to evaluate and optimize care practices.[107]

Reflecting back on a statement made at the beginning of this essay taken from Beauchamp and Childress, the ethics of care emphasizes characteristics of value to interpersonal relationships such as sympathy, compassion, fidelity, and love. Such characteristics, as we have seen, are carried through to varying degrees among the roots and foundations of care ethics, as well as within complimentary theories, and as just discussed, are echoed clearly within the personalist view. The groundwork of the meaning of care as a moral phenomenon and basis of an approach to ethics can no doubt fill volumes; emanating from varying philosophical, rational, secular, theological, or other perspectives. Those in healthcare may never think about how they would explain care as a concept, or if their workplace values instill care as a priority, or possibly look upon such considerations as rhetoric over reality.[108] Alternatively, others – those with boots to the ground, especially – may exclaim "*I* am the ethic of care," wholly embracing that they have made a commitment to care and service either professionally or innately and naturally, as an extension of their being, or personality.[109] Care-givers may reflect that the relationship formed with the one being cared-for (as familiar care-ethics language) is based on a promise, not an agreement, to care for the whole person – body, mind, and spirit.[110]

Christian Approach: Pellegrino & Englehardt. Although seemingly cross-cultural, such precepts are principally elements of a Christian perspective of care, in which compassionate care is an extension of the Biblical teaching to "love your neighbor as yourself."[111] References to caring as an act of faith might also involve the risk of opening oneself to caring for another who may not want to be cared for, encountered regardless of clinical setting.[112] The Christian inspired ethic of care centers on precepts which include but are not limited to valuing that human beings are created in the image of God; that each are called to live in loving relationships with God, self and others; as well as to recognize others as having intrinsic value, worth, and

significance.[113] The writings of Edmund Pellegrino (referenced elsewhere in this dissertation in discussion of virtue ethics), among the depths of his comprehensive vision and foray into professional virtue in the clinical context, also explore the healing relationship as well as conflicts that result within a pluralistic, secular culture when rooted in Christian morality.[114] He puts forth that adherence to a Christian and charity-based ethic shapes the mode of the provider-patient relationship (the essence of care ethics) consistent with the covenant, or promise to help as a binding submission to good, embracing a higher ideal and commitment to service, incorporated within the notion of vocation.[115] Pellegrino reminds us, however, that the Gospel gives no definite guidance or set rules for resolving ethical issues or moral dilemmas, but it teaches that charity is the transcendent ethos of the encounter with the sick, becoming an interior principle that encompasses philosophically derived internal morality, transforming it into an act of grace.[116] Engelhardt, in *The Foundations of Christian Bioethics*, similarly offers that the response to those in need is an expression of personal love, the focus being on the character of the charity that motivates the giver.[117] What he refers to as the radical Christian call of unqualified love taken from early patristic experiences and writings, is used analogously with what those in the health care professions are prevailed upon when giving care in that it is done with complete concern for health and wellbeing as central to their practice.[118]

Within the introduction of this essay, a snapshot of care ethics is depicted in the slogan: *show up; shut up – be fully present; seek their story; suspend judgment; and stick with them*, and offers much in translation to the practice of college health. *Showing up* requires us to give of our energy toward being fully present, noticing what is occurring around you, and tuning into the needs of both colleagues and patients; *shut up* entails aspects of care that fosters true listening and hearing, especially in the context of the complexities of the college environment, offering

this as an invitation to actively take part in the care relationship; *seek their story* is crucial for all who obtain care in our health centers, especially in consideration of the prevalence of mental health concerns that dominate our landscape; *suspend judgment* demands responsiveness, empathy, and compassion for all; and *stick with them* encompasses the holistic and complete commitment to the total wellbeing of those we care for.[119] One can submit then, that for those whom we encounter along their journey toward wellbeing, healing, and wholeness – care unfolds layer by layer, season by season and can be transformative for those *doing* the caring as well as those *being* cared for.[120]

Conclusion. Health *care*, medical *care* and nursing *care* each immediately points toward an action inclusive of something being done by another for another – coupled with the virtue of care. Care ethics, specifically, is grounded in the core notion of relational caring as occurring between persons. The ethics of care gained momentum toward the latter half of the 20th century, putting forth the belief that moral actions result from interpersonal relations, and that humans vary with regard to their dependence on others, most prominently from the perspective that there are differences between how men and women embrace this relational morality, such that women do so "in a different voice." Another theory emerged which identified four elements that together define the ethic of care, namely: caring about, taking care-of, caregiving, and care-receiving; having stemmed from the ideals of attentiveness, responsibility, competence, and responsiveness. Further development of ethics of care concepts contributed to the understanding that the maternal/child relationship serves as a model on which all relationships can reflect, and that the question of "what are you going through" is foundational to strengthening the capacity to care.

Over time, care ethics endured criticism expressed along many thought streams. Some opposed its precepts from the perspective that although most humans care about different things to varying degrees, this does not make us 'caring' in the sense of being morally significant, in the sense that what we care about may in itself be morally neutral, or morally wrong. From the nursing vantage point, another critique professes that the term caring is insufficient to fully comprehend all that nurses do and how they do it, and care must be situated within a broader framework that fuses moral and ethical knowledge with effective practice. Others suggest that trust, as central to nurse/patient relationships, is an undervalued element of some care ethics theories, when studied from the viewpoint of not only reliability and competence, but also regarding good-will within the relationships established.

Correlated care theories that are imbued with tenets of care ethics are replete throughout facets of clinical practice, largely by means of nursing care theory. These platforms provide a direction for caring that nods to an ethic of care, and elevates common practice to clear acknowledgement of the relationship between care-giver and care-receiver, toward mutual maximization of wellbeing. Yet, beyond the theoretical - alternative views regarding the foundations of what it means to care from ontological perspectives has also been offered, from which the reader is invited to contemplate, explore, or merely pass beyond. Nonetheless, having had this opportunity for exposure to care ethics, let us now move on toward further exploration of our care of others with deeper regard for concepts related to the frequently used term, wellbeing.

Chapter 5.B. Professionalism and Wellbeing.

Chapter 5.B.i. Overview: Wellbeing and Ethics.

In the previous chapter, it was proposed that care ethics and the ethics of wellbeing are interconnected. Care ethics dictates that we have special obligations to proximate others, focusing on interpersonal relationships through caring, which in its most explicit form fulfills one particular definition of wellbeing as *that which we care for when caring for others*.[121] Further, wellbeing is of central importance to healthcare ethics in that the wellbeing of humans is a foremost normative concern, although many approaches fail to capture important ethical aspects, insufficiently attending to the fact that wellbeing is a holistic and dynamic phenomenon.[122] Wellbeing can be understood as fundamentally intertwined through both subjectivity and relationality, such that relationships occur between people – resonating with the primary theme of care ethics - through which they become who and what they are by means of this relatedness to others.[123] In as much as wellbeing literature often focuses on individualism, as humans, social attributes such as cultural values and beliefs - in complement to personal values and goals - provide the broader normative framework toward *relational* understanding of what it means to live a meaningful life.[124]

Wellbeing has surfaced as a commonplace term in the vernacular of college health and higher education, and is frequently incorporated within this dissertation. In early 2019, the Chronicle of Higher Education published a report on emerging trends, along with an online summary review, with one section entitled "The New In Loco Parentis,"[125] According to the review, many universities are requiring freshmen courses focusing on improving wellbeing, intending to engage emerging adults in the value of health; while others are creating departments or offices of wellbeing, offering coaching in areas like stress management, goal setting, and

resiliency in an effort to serve the 'whole' student.[126] Students, as consumers, are also attuned to wellbeing. In the course of visits to our health center, I have encountered patients who have shared with me their use of wellbeing related smart-phone applications, including those with names such as "Calm," "Headspace," "Moodnotes," and "Happify." Nonetheless, to consider the meaning of wellbeing beyond the colloquial, we should submit that it is more than a feel-good factor, more than a marketing slogan, and equates to more than personal success or happiness.[127] Although wellbeing may seem to be a recent trend, the concept itself is anything but. Relative to linking health with wellbeing, the World Health Organization in 1946 put forth the following definition: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," conclusively linking health to wellbeing, and continuing in relevance to present day.[128]

As an increasingly more prominent concern in higher education, a call to action by a consortium of national college and higher education associations was put forth in 2018 as a commitment to innovating, supporting, and fostering a holistic, integrated, and strategic approach to wellbeing as a shared responsibility across campus.[129] This commitment acknowledges that there are large-scale benefits to proactive, upstream approaches that will increase student 'flourishing' by focusing on the whole *person*, whole *educational experience*, whole *institution*, and whole *community* – clearly a testimonial to the communal and relational aspect of wellbeing.[130] Preceding this action-call by several years, the Okanagan Charter was developed even more broadly as an international effort to provide a conceptual framework for universities and colleges to promote health and wellbeing in all aspects of campus culture.[131] Its vision statement aptly captures the importance of an institutional focus on wellbeing: "Health promoting universities and colleges transform the health and sustainability of our current and

future societies, strengthen communities and contribute to the well-being of people, places and the planet."[132]

Toward our common endeavor of caring for the wellbeing of those who attend these institutions, let us now delve further into the ethics of wellbeing through examining various theories, approaches, studies, and concepts from which the contours of wellbeing take shape.

Culture of Campus Wellbeing. Acknowledging that the wellbeing of college students is of supreme importance, let us also briefly consider the connotation of wellbeing over time, as well as several ethical principles that it aligns with. Certainly, as college healthcare providers - those for whom this dissertation is purposed – each of us has a personal understanding of wellbeing in terms of our own life-practices, and assumingly, of how total wellbeing impacts the students for whom we care. Having emanated as a focal concern across campus sectors, wellbeing is central to all aspects of care provision through clinical, mental health, and interrelated services. The precipitously increasing unease related to mental health concerns is empirically substantiated by evidence from the Health Minds Study, done annually since 2007, which examines mental health, service utilization, and related issues among undergraduate and graduate students.[133] The prevalence of students entering colleges and universities with acknowledged mental health diagnoses as well as the overwhelming proportion of those who seek out mental health services, psychotropic medications, and have positive depression and anxiety screenings, has continued to rise.[134] Many institutions have fully embraced that wellbeing and higher education are inextricably linked as a proven core dimension of the greater purposes of higher education, situated alongside engaged learning, civic purpose, and preparation for living meaningfully in the world.[135] Institutional changes that result from an attention to wellbeing are essential to fulfilling the promise of higher education.[136] Responsively, the

Association of American Colleges and Universities developed the Bringing Theory to Practice project which specifically advances wellbeing as a principal tenet, having published a compilation of essays in a publication entitled *Well-Being and Higher Education, A Strategy for Change and the Realization of Education's Greater Purposes*. With this clear correlation of wellbeing to all aspects of higher education, it is important for overall understanding to then take a closer look at the concept of wellbeing, and unwrap it a bit further.

Even the word itself, wellbeing (or *well-being*), has seemingly taken on an identity of its own, yet continues to be used interchangeably with the terms wellness and health. Wellbeing has been broadly studied by philosophers, sociologists, psychologists, and within healthcare.[137] The Ancient Greeks' asked the question "what constitutes the good life," and had competing beliefs about happiness, fulfillment, and the human experience; for example, the epicurean and hedonist conviction of maximizing pleasure and minimizing pain as the path to happiness, versus the stoics who devalued both pleasure and pain.[138] Aristotle, if able to comment today in light of the emphasis on wellbeing in our culture, would likely remind us of how significantly his own concept of wellbeing, or *eudaimonia* (previously noted in an earlier discussion on virtue ethics), continues to apply, challenging the gratuitous seeking of pleasure, wealth, and so on - instead emphasizing a life of meaning through cultivating high degrees of virtue.[139] Furthermore, Hippocrates' many principles of healthy living continue to resonate 2,500 years later - including some of his best-know statements such as: "*let your food be your medicine, and your medicine be your food;"* and "*natural forces within us are the true healers of disease,"* as well as *"it is more important to know what sort of person has a disease than to know what sort of disease a person has*."[140]

It is beyond the scope of this essay to recognize the many thinkers, philosophers, and theologians after the ancient traditions, from the emergence of Christianity through the Middle Ages and the Renaissance, and into the period known as the Enlightenment and beyond – each of whom formulated beliefs and paradigms of human fulfilment and what constitutes the good life, affected by the conditions and turbulence of their own points along the timeline of human history.[141] Interwoven throughout and across world cultures, many historically established systems of wellness continue to impact present-day practices, as with yoga from the Ayurveda of India, acupuncture from Ancient China, Arabic Unani medicine, and Native American use of botanical healing properties; amidst countless other examples among peoples and nations.[142] In America, during the 19th and early 20th centuries, natural therapies and a holistic approach to health were prominent, some of which had origins in Germany, while others were pioneered by the likes of the founders of Kellogg, Post, and Ralston-Purina – food purveyors who championed good health through diet.[143] In the spirit of those times, even Thomas Edison offered that "*the doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease*."[144] Enter the 1960's, Dr. H. Dunn, former Chief of the National Office of Vital Statistics, found his own inspiration from the WHO definition of health and asked: "*Why is it that we physicians always speak of levels of illness and we never speak of levels of health*."[145] His work with wellness proliferated, and he is credited with developing the High Level Wellness theory, from which a foundational definition emerged: "High-level wellness is an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning."[146] Dr. Dunn's writings also inspired another physician, John Travis MD, who worked with the National Public Health Service, the experience from which he developed several

key concepts and paradigms of wellness, and is recognized as a pioneer physician in complimentary medicine.[147]

Although not definitive, the preceding broad portrayal of the progression of wellbeing at least affords some perspective of its ever-present influence, having been conceptualized during the course of time and amongst many cultures, having endured trends, fads, and many re-creations, yet seemingly here to stay as a social norm. As recently as October of 2018, relative to our own specialty, the American College Health Association hosted a Leadership and Innovations Summit in order to concretely develop inventive solutions to improve student wellbeing so as to promote a more holistic experience for students, emphasizing building a culture of campus wellbeing as well as a foundation for wellbeing by addressing the most basic human needs of food and shelter.[148]

Ethical Structures of Wellbeing. From that perspective, promoting a culture of campus wellbeing and addressing the most basic of needs, we can now turn toward the ethical structures of wellbeing. Beauchamp and Childress put forth that egalitarian theories of justice from various philosophical influences have shaped theories that address wellbeing.[149] Capabilities theories emanate from the premise that there is moral significance to achieving wellbeing, in that the quality of life is contingent upon the achievement of and ability to sustain as well as exercise 'core capabilities.'[150] Within other capability theories, one finds further mechanisms of wellbeing, as with Powers and Faden's concrete list of six dimensions of wellbeing including justice, personal security, reasoning, respect, attachment, and self-determination (addressed elsewhere in this dissertation within the discussion of common morality and virtue).[151] These elements extend beyond beneficence and social utility to directly pertaining to policy formation that creates conditions for wellbeing, unquestionably a mutual concern for justice of both student

affairs and academic leaders within institutions of higher education. Policies driven by capabilities theories can shape how institutions as communities correlate their commitment to wellbeing through the relational features of higher education's full purposes through self-identity, civic engagement, and connections that nurture what it takes to live meaningfully in life beyond college.[152]

As an element of consequentialism, which rules that actions are right or wrong according to the balance of their good and bad consequences, utilitarian theory also applies ethical structure to wellbeing through the basic principle of utility.[153] The origins of such concepts as 'the greatest good for the greatest number' (which the reader may recall from prior content) are attributed to the writings of Jeremy Bentham and John Stuart Mill.[154] Seen as hedonistic utilitarians, they derive utility from terms of happiness and pleasure, and suggest that persons are motivated by factors that will assure happiness, regardless of encountering obstacles in the process of the pursuit. [155] While Bentham put forth within his theory of utility that benefit, advantage, good, happiness, pleasure, and the like "all come to the same thing;" even some contemporary social scientists seem to think that wellbeing, utility, happiness, life satisfaction, and welfare are interchangeable.[156] Other utilitarians challenge this view, arguing that many other essential elements contribute to wellbeing, including beauty, knowledge, understanding, and deep personal relationships, and that 'the greatest good' is to be assessed in terms of the total intrinsic value of an action.[157] Ironically, it is said that J.S. Mill eventually realized that he was deeply troubled by his own lack of sentiment and emotion, and turned to the poetry of Wordsworth that ministered to deeper longings in his soul, which he credits for having found within himself sentiment and emotion that were so lacking.[158]

Continuing the general theme of justice, another viewpoint proposes that conditions that optimize wellbeing are in effect justice promoting, which is conceived as "wellness as fairness."[159] This perspective is echoed in an editorial from the Journal of American College Health of nearly twenty years ago, still befitting to our times. In his analysis, the author points out that colleges have created entire systems of healthcare, counseling, and prevention that should make access to clinical care, preventive interventions, mental health services, and health information easy and relatively unobstructed.[160] It would follow that through such services, the higher education institution that offers comprehensive clinical amenities then directly contributes to a justice-promoting environment whereby aiding in students achieving their full potential, and toward attaining optimal wellbeing. Care-providing professionals are positioned to "nudge" or gently persuade students toward health-enhancing behaviors through environments that are conducive to promoting various aspects of wellbeing.[161] Wellness as fairness, then, is an approach to wellbeing that introduces the principle of justice as an umbrella under which multiple resources are organized to promote individual, interpersonal (i.e. relational), and community wellbeing by acknowledging that conditions must also be optimal.[162] One would thus surmise that colleges and universities that embrace the ideal of institutionalizing wellbeing would also enthusiastically invest sufficient resources in and demonstrate due respect for essential clinical and mental health services, thereby endorsing the concept of wellness as fairness.

Wellbeing is often framed by the term taken from Aristotle as the eudaimonic perspective, or by contrast to that which he opposed, the hedonic understanding; such that wellness and satisfaction over time equated to the eudaimonic approach, while happiness and short-term pleasures are emphasized by the hedonic.[163] Research done in support of the

eudaimonic approach argues that maximizing hedonic pleasure is associated with dead-end routes to wellness such as selfishness, materialism, and risks of ecological destructiveness; yielding further evidence that it produces more stable and enduring wellbeing.[164] The preponderance of research done on the 'science of happiness' has drawn from surveys and experimental approaches seemingly preoccupied with identifying variables that enhance or diminish self-reported wellbeing in a positivistic manner, stressing happiness as a cultural ideal, which may in effect lessen emphasis on other ways of understanding human wellbeing.[165] Literature cautions that care should be taken to not reduce wellbeing, a complex and dynamic idea, to a static or compartmentalized inventory that can be objectively measured.[166] In the context of higher education, wellbeing will reflect differently according to institutional variation, and (as previously noted) the priority given it as well as the administrative and fiscal support for promoting it. At any rate, having looked at how wellbeing concepts evolved through time as well as theories and principles that lend ethical structure to it, let us now further consider the critique of wellbeing as happiness.

Chapter 5.B. ii. Perspectives of Happiness.

Studies on Happiness. While there are many possible points of entry to begin the following discussion, a quote attributed to Viktor Frankl, renowned psychiatrist and Holocaust survivor, expresses it simply: "it is the very pursuit of happiness that thwarts happiness."[167] Unquestionably, happiness is understood in different ways to different people, which is apropos to one definition of happiness as 'subjective wellbeing,' or the experienced state that contains comprehensively positive affective elements.[168] The growing popularity of positive psychology in the 1990s, with increased emphasis on how to enrich one's life and flourish as opposed to focusing on illness, suffering, and misfortune gave noticeable rise to the study of happiness.[169]

While research and scholarship about happiness proliferated, it was seemingly disproportionately more than research done on what makes life meaningful – interrelated and overlapping concepts, yet with significantly different roots and implications. Positive psychology turned away from 19th century psychiatry models of mental illness pathologies to the concepts of thriving, fulfillment, and contentment of not only individuals, but also families and communities; extending happiness research to life-satisfaction surveys, self-assessment strategies, and self-improvement techniques, greatly impacted by online resources and social media.[170] Interpreted by some as a 'movement,' it was largely pioneered by the work of Martin Seligman who claimed through positive psychology, psychometric testing and digitization of happiness and subjective wellbeing would advance, and that it would revolutionize the study of psychology.[171] This work influenced both popular and political culture, for example, as evidenced by the UN General Assembly succeeding in having over sixty countries sign a motion encouraging them to in effect pursue happiness and wellbeing through public policies.[172] Over time, however, Seligman came to re-invent his original work in a later publication that somewhat self-criticized the accentuation of happiness as too open to hedonic interpretations, prone to subjective bias, and insufficient for empirical measurement; and moved toward preferring the term wellbeing, instead.[173]

The interest in studying happiness is not limited to recent decades. In 2015, a TED talk entitled "What Makes a Good Life? Lessons from the Longest Study on Happiness" became wildly popular - viewed over 13,000,000 times - detailing a Harvard University longitudinal study initiated in 1938, implemented to uncover clues to leading happy and healthy lives.[174] Scientists from Harvard began tracking the health of nearly 300 sophomore men during the Great Depression, one of the world's longest surveys, among the most famous recruits of which was President John F. Kennedy, with some still living from the original group.[175] Over time,

offspring of the originals were added to the study, which admitted only men since the College was still all male, collecting a vast assortment of data on physical and mental health, with adjustments to the control groups and the more recent inclusion of women over the decades.[176] Several revelations from the study suggested that developing and maintaining relationships are what provide people with meaningful lives, and that relational happiness has powerful influence over health, interpreted as a form of self-care.[177] This relational component hearkens back to the interconnectedness of care ethics and the ethics of wellbeing, as noted in the first piece of this essay. Such ties, the study concluded, protect people from life's ups and downs, delay physical and mental decline, and are better predictors of long and fulfilled lives than social class, IQ, or genes – consistent across all groups – confirming the correlation between contented lives and relationships with family, friends, and community; further solidifying the connection between wellbeing and relationality.[178]

Critical Viewpoints. Among prevailing ideologies of happiness also exist critical viewpoints, for example, the perspective that permeating rhetoric about attaining wellbeing and personal fulfilment may seem to some an ideal that is difficult to attain. Normal, non-pathological, and routine emotional occurrences of feeling disillusioned or dejected as well as facing common problems and dilemmas along one's lifetime instead become issues regarded as needing remediation.[179] As college health professionals, we are all too familiar with situations that are viewed as stressors in college, such as difficulties with social interaction, interpersonal habit changes, academic challenges, living arrangement maladaption, and sleep disturbances – each of which may correlate to depressive symptoms. Looking back to only a few decades past, nearly parallel issues were determined to be adjustment reactions, often handled by a single visit to counseling services, or by environmental modifications and other services.[180] However, given

the highly publicized prevalence of mental health issues within the college student population, the dubious question of 'why' is still not completely answered. Without question, however, it is palpably connected to statistics of the same within the adolescent population, as those students have become and will continue to become our students. Determining the reasons behind this trend is difficult, yet theories abound regarding shifting socio-cultural trends over the past decade, with increased use of electronic communication and digital media having had a larger effect on mood disorders in comparison to prior generations, indicating that those who spend more time on digital media are more likely to be depressed and unhappy.[181] Other reports have found that the use of devices such as smartphones for at least 5 hours per day have doubled over the past ten years, and those who spent the most time on phones were 70 percent more likely to have suicidal ideations or attempts.[182] Further information determined that the lack of sleep due to increased screen time at night is on the rise, as face-to-face time is declining – each of which is associated with increased depression, along with the fact that blue light interferes with falling asleep and affects melatonin production – a further risk for increased anxiety and depression.[183] Despite such cultural paradigm shifts, within the course of normal reactivity and subjectivity of human emotion, we will inevitably experience depression, grief, and sadness regardless of causation. Some have proposed, however, that constant exposure to the discourse of happiness may actually cause unhappiness due to unrealistic expectations, and that episodic experiences are sometimes prematurely judged by mental health professionals and social scientists as 'treatable disorders,' especially within the context of our increasingly medicalized society.[184] Similarly, it has also been suggested that the increased prevalence of depressive disorders may not purely and conclusively be due to a precipitous rise in mental disorders, but possibly also because of the

manner in which normal sadness has been 'pathologized' over recent decades in various ways, and as noted by increased prescribing of mental health medications.[185,186]

Still others contend that contemporary society is producing individuals who seem less ready to accept responsibility for their feelings, and more willing to unload their burdens onto professional therapists or physicians, some of whom are possibly too eager to accept the task, therefore contributing to the problem.[187] The issue of entitlement among college students also adds a layer of complexity to the theory in that the tendency to externalize responsibility instead of having self-regulation, which may lessen successful interpersonal and academic engagement, results in a diminished sense of happiness or well-being.[188] Research done on the effects of permissive parenting and resultant indulgence, avoidance of limit-setting and of negative appraisals so as to increase self-esteem and self-worth – and consequently happiness - has contributed to entitlement in college students who are accustomed to parents anticipating and averting obstacles and problems for them.[189] Further, the oft-referred to "helicopter parent" with over-involvement in their college student's lives can also contribute to problematic adjustment and higher levels of depression and anxiety as a result of decreased levels of self-efficacy, leading to social adjustment problems.[190] This over-involvement interferes with student self-determination, expressed by a theory that outlines three critical needs for optimal development and functioning; (1) the basic need for autonomy and ability to make individual choices; (2) the basic need for competence, or a sense of self-confidence; and (3) the basic need for relatedness, or feeling part of meaningful, caring relationships.[191] The unintended message delivered by potentially well-meaning motives may imply that children need control and parental involvement because their own abilities are insufficient, certainly counterintuitive to development of a sense of wellbeing.[192]

Within North American culture, it has been noted that particularly high value is placed on happiness and experiencing positive emotions as evidence of personal and social success, which has implicitly shaped how researchers understand human beings; and the prevailing culture, characterized by individualism and personal success, has engendered a 'cultural script' that further nurtures unrealistic expectations.[193] This extends to higher education, itself, as a product to be obtained, in which the atmosphere may be rife for entitled and consumerist beliefs focused on external incentives.[194] Universities vying for admission prospects often proudly assert through marketing tactics high levels of student satisfaction, either explicitly or implicitly promising that the student attending the institution will be happy and satisfied, even boasting of greater employability following graduation.[195] The marketplace is seemingly exerting pressures on colleges to respond to consumer demands, promoting aspects of campus life such as guaranteed happiness as commodities, affirming the consumerist relationship between the institution and the student and/or their family.[196] Such commentary may beg the question of whether the dominant materialist and consumerist way of life in our culture contributes to the construction of identity, and that while individuals strive to attain an inner sense of authenticity, what results instead is a constructed identity in the form of a saleable commodity by which people "sell" themselves into relationships, social standing, jobs, careers, and so on (college admissions, possibly?) toward the ongoing elusive pursuit of happiness.[197]

At Yale University, a course entitled "Psychology and the Good Life" became the most popular course in the university's 300-year history.[198] An initial slide in the class PowerPoint notes "WARNING!!! You are about to learn that everything you thought was important for being happy isn't," as the start of a course designed to teach how to be happy, as an intended life-changing course offering wellbeing boosting activities.[199] The demonstrated appeal of the class

and its promise that science can make anyone happier is accompanied by the risk that if taken to extremes, the idea that happiness is an acquired skill can actually be dangerous, in that it can become burdensome to unhappy people who might interpret that they are responsible for their own wellbeing.[200] Of parallel interest, a former professor at Yale wrote a critique of America's elite universities entitled "Excellent Sheep," referring to 'sheep' as the excessively high-achieving former students of his who were groomed from an early age to attain Ivy League admission, having a singular focus on achievement, resulting in "toxic levels of fear, anxiety, depression, emptiness, aimlessness, and isolation."[201] This same author posits that it is misguided to think that schools are offering classes to instill things that can't actually be instilled in a class. Of those who took the course, not all were unconditionally sold on the concept, resulting in several criticisms of it.[202]

Yet, throughout many colleges and universities, similar efforts have been undertaken. In an article from the Chronicle of Higher Education, the question is posed whether colleges, who teach students how to think, should also teach students how to thrive, citing polar ends of a divergent spectrum between the two conceptual extremes of 'responsibilities ending at the classroom door' versus 'responsibilities extending into every aspect of students' lives' – a continuum upon which colleges have traversed for centuries.[203] Departing from either extreme of the utilitarian view of 'come, earn your degree, and leave' with the credentials needed to earn a good living; or the early-historic model of imbedded, paternalistic and explicit control of both scholarship and conduct – institutions of higher education are instead pursuing strategies by which to help students thrive and flourish.[204] Clearly attributable to the rise of mental health diagnoses of incoming students and while in college, institutions are tackling the challenge through a variety of approaches that connects wellbeing with coursework, or by establishing

offices to specifically address wellbeing needs, among other creative tactics.[205] One professor views this as "the facilitator era," suggesting that colleges are encouraging students to make better and healthier choices, not as a guarantee of outcome – or to add, of happiness – rather to provide reasonable opportunities from which students can individually decide.[206]

Chapter 5. B. iii. Holistic Wellbeing – an Institutional Concern.

Institutionalizing Wellbeing. Student success and retention is an interest across nearly all institutional sectors. In consideration of the astute statement above as ours being the "facilitator era," institutionalizing wellbeing should be a corresponding concern that dovetails into both student academic success and retention.[207] Multidimensional models of wellbeing offer components that differ among their theoretical formations, but to view wellbeing holistically, the use of a model specific to college students that includes dimensions pertinent to college-life will clearly enhance physical and mental health care practices as well as all facets of student life throughout their educational experience.[208] Hettler's model of holistic wellness was developed to promote wellness in both university and community settings, and has been used to improve college student health-related behaviors as well as having been used to enhance efforts for the prevention of and management of diabetes.[209] In this model, six broad dimensions of health-related wellbeing provide categories from which all aspects of wellbeing can be infused into daily life, recognizing that it is a life-long endeavor, within institutions of higher education as ideal settings for facilitating wellbeing. Those dimensions and correlated practical examples are: *physical* wellbeing (e.g. diet, physical activity, substance use, hygiene, etc.); *emotional* wellbeing (e.g. self-identity, self-esteem); *intellectual* wellness (e.g. inspiration from and stimulation through mental/thinking activities – inclusive of classroom, experiential, and co-curricular learning); *social* wellbeing (e.g. sense of community and social support); *occupational* wellbeing

(e.g. job satisfaction, but as relates to college students, possibly academic and career-related learning); and *spiritual* wellbeing (which implies different connotations based on individual interpretation).[210]

Academic success is obviously impacted by cognitive factors such as intellectual aptitude, but equally so because of other variants including physical and mental health, along with secondary causes including substance use, physical inactivity, poor nutrition, ineffective stress management, and other modifiable influences.[211] Initiatives such as ACHA's Healthy Campus (discussed elsewhere in this dissertation) utilizes assessment data to develop frameworks for improving student health in institutions of higher education, noting impediments to academic performance such as stress, anxiety, sleep difficulties, and recurrent upper respiratory infections, along with work obligations – factors congruent with the six wellbeing dimensions.[212] Although studies of wellbeing in college students are extensive, the data is aging in terms of comprehensiveness toward measuring wellbeing carefully and in a holistic manner, with less found in the literature specifically focusing on holistic wellbeing assessment. Ultimately, since the college years (especially for traditionally aged, emerging adult students) are often considered foundational for forming health and wellbeing behaviors, which if continued into adulthood will greatly impact health promotion and disease prevention.[213] Assessing students across the domains of each wellbeing dimension can expose risk factors within the institutional environment, many of which only begin to appear in late adolescence and young adulthood, from which preventive programs and wellbeing initiatives can be developed and implemented.[214]

The wide variety of wellbeing assessments have frameworks that are derived from theories or models such as the Hettler Six Dimension model previously referred to, many of

which are integrative and transdisciplinary.[215] By nature, wellbeing is subjective and complex in addition to expanding through ever-evolving trends, creating challenges for consistency and comprehensive representation of students' state of wellbeing – possibly due to the inconsistency across institutions and lack of consensus on what wellbeing initiatives look like among campuses, and the earnestness with which institutions realistically commit to wellbeing.[216] Attention to theoretical bases for, methodological study and implementation of, feasibility of, and relevance to functional application of outcomes are critically relevant to assessing and investigating college student populations for legitimate development of evidence-based programs toward realistic institutional change.[217] Colleges and universities routinely collect health-related and behavioral data for purposes of federal mandate or programmatic planning, and may consider revising or adding elements to surveys or focus-group studies that directly address wellbeing holistically toward improving student's mental and physical health among all dimensions, and subsequently their academic success – an effort that requires collaboration between all institutional sectors.[218] Understanding and advancing wellbeing requires interdisciplinary collaborative efforts by all stakeholders that are interested in promoting it's theoretical understanding, carefully measuring it empirically, and putting forth combined efforts to cultivate wellbeing, touching all aspects of the university community from admission processes, student services, athletics, residential life, program coordinators, and auxiliary services, to faculty and administration, and beyond.[219] Ultimately, each individual, every group, all departments and each separate administrative unit should continually and deliberately persist to realize the role they play individually and cumulatively in defining, promoting, and advancing wellbeing for the campus community.[220]

Mobilization Strategy. The higher education environment provides unique conditions in which strategies can be implemented to combat unhealthy lifestyle choices and foster wellbeing, an urgent concern given that long-term health and wellness behaviors are established in college wherein students are learning also to balance academics, work, relationships, and self-care.[221] Because of institutional diversity, each campus will have its own unique vision for wellbeing that will be appropriate for its students, accepted by its staff and faculty, and attractive to its stakeholders from within and outside of the organization – the particulars of which must be both idealistic and realistic, aspirational and future-oriented.[222] While vision is important, it is not enough; concrete mechanisms to bring theory and data to life and translate them into action in terms of leadership, staffing, budget and resources necessary for campus-wide student health and wellbeing improvement equates to scrutiny of the resource diversion to programs and projects that are not aligned with the aim of institutionalizing wellbeing, with full realization that systems, not people, are at the root of sub-optimal outcomes.[223] In prior discussions within this dissertation, it was noted that specific features for improving campus culture include: student-centeredness, belief in human potential, recognizing the value of learning in the improvement of wellbeing, effective team work, communication, honesty and trust.[224] Ironically, throughout the history of higher education, the work of shaping and nourishing human beings was thought to be a core purpose of a college education, still echoed in many mission statements found today, yet in reality might remain a disconnected element.[225]

The growth and prosperity of higher education consequently divided the cultivation of student wellbeing from other primary activities through increasing institutional size and diminishing personal engagement; also due to increasing diversity, adding far-reaching complexity to the meaning and circumstances of wellbeing; along with the trend toward

decreasing residency which uncoupled students from the community context; as well as many institutions specializing wellbeing to the extent that it separated from academic work; and a greater focus on the 'business' of higher education as opposed to its mission and purpose.[226] Talented and experienced professionals within campus clinical and mental healthcare services, as well as those who specialize in and oversee campus ministry and recreation offices are well-positioned to influence and participate in reconnecting holistic wellbeing to the heart of higher education. One paradigm through which to set conditions for mobilizing campus communities offers six essential strategies necessary for intentional and systematic implementation. Not established as a specific sequence or temporal order, each step will work in conjunction with the others, but are to be followed in their entirety, namely to: (1) educate the community; (2) make wellbeing mission-central; (3) anchor wellbeing in academic programs; (4) build a curriculum and pedagogy of wellbeing; (5) recognize advisement as a key point of leverage; and (6) assess learning outcomes related to wellbeing.[227]

Beneath an overarching mobilization strategy such as that which was just outlined, each component will combine and interact to surpass temporary, ad-hoc type initiatives that fizzle and fade. Regardless of institutional size or composition, it is unwise and unsafe to assume that faculty and staff are sufficiently knowledgeable about wellbeing to effectively develop, carry-out, and nourish effective programs, and careless reliance upon medical professional staff, psychologists and counselors, spiritual mentors, public safety or judicial officers to help students regain balance as they experience personal distress, does not address wellbeing beyond short-term attention.[228] For education to be transformative, for it to build capacity toward not only academic achievement but also toward the potential for students to have lifetime achievement and satisfaction, colleagues throughout the institution are called to learn about and embrace a

foundational understanding of wellbeing from the perspective of all dimensions, by means of methodologies and functions that work together to nourish the individual.[229] Within mission statements, strategic planning agendas and curriculum development - core aspects of wellbeing should be integrated and reflected in daily life.[230] The most difficult challenge may be to penetrate the heart of the academic enterprise to truly integrate wellbeing to embody whole-person education because of how institutions have sequestered formal learning and intellectual endeavors from other living and learning aspects.[231] Further, fostering wellbeing in the advisement process might mean to also reframe advising to become personalized and relational, framed by protocols that inform wellbeing considerations of workload and system-related requirements.[232]

Reflective of prior discussion, how assessable wellbeing is given its qualitative and developmental nature, the use of tools to measure and capture indicators of student wellbeing must become periodic and ongoing with cumulative application of data for continuous outcome improvement.[233] All students, whether rising adults, adult learners, or other non-traditional learners are positioned along individual points of lifelong learning and as unique persons with their own significant histories and circumstances. Those students range from the over-parented, entitled undergrad, to the single-parent and full-time working student, to the first-generation student on scholarship hailing from a lifetime of social and personal trauma, or the newly decommissioned veteran, as well as those for whom English is not their native language, and especially those battling a plethora of physical, mental, and behavioral challenges. Our commission, then, is to recognize each student as having their own, individual needs for ongoing wellbeing development, and to facilitate their possibility to achieve it.

We are called to honor the humanity of our students, encountering each as a person with intellectual, personal, social, and spiritual potential; viewing them as the future of our nation and the global society.[234] An institutional commitment to wellbeing would suggest that students, faculty, and staff have a clear and working understanding of what it means to have lives well-lived and to respond well to a full range of emotions and challenges.[235] By infusing well-being into all aspects of the campus community, the foundation for lifelong wellness is laid forth – an environment that will lead students by facilitating their academic and occupational potential within and outside of the classroom, respective of physical, mental, emotional, and spiritual health needs and concerns. In that regard, as a concluding thought about holistic wellbeing, I have taken notice over my years in this profession that many colleagues within our field add the following quote to their email signatures, attributed to Herophilus of Chalcedon - Physician to Alexander the Great, translatable to the necessity of wellbeing within our institutions, especially if we also recall the WHO definition of 'health': "When health is absent, wisdom cannot reveal itself, art cannot become manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."

Chapter 5.B. iv. Health Capability and Health Related Quality of Life.

Individual Self-Care. Earlier, capabilities theory was discussed relative to the ethics of wellbeing. The relevance of capability to health functioning has four distinct underlying components: wellbeing freedom, wellbeing achievement, agency freedom, and agency achievement.[236] These concepts may not be in language that is seemingly practical or pertinent to every day practice, understanding the ethical underpinnings of health capability allows us to then also grasp important aspects of health-related quality of life, or HRQL. Health capability affords the conditions that affect health and one's ability to make good choices about their health

and wellbeing, and the consequences faced in making those decisions; effectively resulting in the need to find balance between paternalism and autonomy – which, I believe, is the crux of much of what our role is in college health.[237]

Wellbeing is achieved within an individual state, within one's freedom to do so; through achieving one's goals and objectives as agency achievement, while agency freedom is to pursue what one values and regards as important.[238] To have health capability is to have the individual ability to be healthy, but is also dependent upon how one's external environment enhances or detracts that potential, as well as the individual's health-seeking skills, beliefs and values about health, health goals, and ultimately their self-efficacy.[239] Although conceptually borrowed from public health, this bears direct relevance to the college environment, especially if imagined as truly a wellbeing institution, in that at the community level health capability would be an aggregate of external, contextual influences, social norms supportive of wellbeing, interdependent networks to enhance wellbeing, necessary capital to support it and to assure access to and utilization of resources, along with effective systems throughout to support the individual toward maximizing their health capability and HRQL.[240]

Ostensibly, self-care practices that maintain and promote physical and emotional wellbeing include healthy eating, adequate sleep, regular exercise, and suitable socialization; yet the paradox of college life is that many students are susceptible to psychological distress and physical illness because of experiencing increased stress, ineffective self-care, and less-practiced good-health behaviors.[241] This topic has been studied relative to three types of analyses: descriptive research regarding the difficulties that students have in establishing and maintaining health-promoting behaviors (physical activity, healthy eating, sleep hygiene); correlational studies identifying links between self-care practices and antecedent or consequent conditions (as

with health practices and perceived stress); and intervention studies that examine the impact of self-care practices on wellbeing.[242] From the notion that students are unlikely to do their best academically if they are not practicing adequate self-care and that unhealthy habits and lifestyles are prevalent among the college population, three components are at play – the student (who must attain awareness of their own self-care needs and determine strategies for meeting them); the services available to students to enable students to access resources and offer intermittent interventions (specifically clinical health services and counseling and/or coaching services); and the whole of the institution (as meaningful, purposeful cultivation of and commitment to wellbeing).[243] Nonetheless, it is critical to appreciate that students with preexisting health conditions, prediagnosed mental and behavioral health issues inclusive of history of various types of trauma, as well as those with difficult financial conditions (in addition to numerous other tangential concerns) undoubtedly experience definitive barriers to health capacity and self-care capabilities – and who may also subsequently utilize campus support services far more so than intermittently, for whom open-arms and benevolent understanding is explicitly demanded.

Both as a conspicuous construct of self-care and in correlation to HRQL, the impact of physical activity on overall wellbeing is universally understood. State-of-the-art campus recreation centers at institutions of varying sizes and affiliations can compete with deluxe private clubs across the country, and offer features such as climbing walls, sand volleyball, indoor tracks, golf simulators, as well as whirlpools and saunas in addition to being aesthetically attractive – all of which adds value to an education on many levels, from attracting admissions to claiming to help improve student health and wellbeing.[244] Regular physical activity, physical exertion, and social interaction associated with of the use of these facilities are known to minimize health risks, and can have significantly positive impact on student's lives and

HRQL.[245] Students who are less active or sedentary may perceive themselves negatively with regard to physical and psychosocial functions related to HRQL, which is a consideration for assessment tools geared toward identifying college students who may be at increased risk for social adaptation issues and mental health concerns.[246] The correlation to physical activity and wellbeing continues to be studied relative to various specificities, but it is generally found throughout the literature that physical activity positively affects most aspects of health and is associated with lower levels of physical and mental health problems.[247]

Spiritual Wellbeing. As our final foray into holistic wellbeing in this essay, considering the significance of the relationship between spiritual wellbeing and health related quality of life is immensely important. Spirituality as a component of total wellbeing has been described as the "directing" dimension, in that it provides a sense of direction for optimizing other aspects of wellness, while due to its abstract nature it cannot be defined by a singular, unified statement.[248] The tension between considering spirituality and religiosity as separate concepts has some perceiving that religion is the smaller concept under the larger domain of spirituality, while others viewing both as inherently intertwined, related phenomena."[249] Aspects of spirituality, however, have been measured and studied, with some reporting that in the college population, the relationship between life purpose and perceived wellbeing has been augmented by optimism and a sense of coherence, as well as indications of the link between prayer fulfillment and life satisfaction.[250] Further evidence from some studies indicates that spirituality can be a protective factor against risky health behavior as regards alcohol consumption and substance abuse, such that spirituality and religiosity offer a buffering effect upon decision making, results from which having found significant differences between religious and non-religious students abstaining from marijuana and other drugs.[251] Among other outcomes of known research, students with a

higher sense of spiritual wellbeing also self-reported less mental health related issues such as isolation, anxiety and lack of self-regulation, and increased altruistic attributes such as a greater connection to nature and others, and a deeper sense of peace and contentment.[252]

Within the academic realm, some schools have begun to include concepts of joy instead of happiness relative to courses and publications, noting that joy is not as often considered by modern theologians, simultaneously calling for a transformative movement driven by an articulation of joy that attends to human flourishing.[253] Transformation toward human flourishing recognizes the need for self-transcendence, or going beyond oneself toward both one's neighbor and toward a deeper experience of the self as an organic part of human existence; and the spiritual life lived in communion with one's neighbor offers a sense of fulfilment as part of the movement toward even higher transcendence.[254] These depth-laden viewpoints are congruent with not only individual health related quality of life but with the ideal of holistic wellbeing across the institution, and clearly pertain to the relational aspect of wellbeing. As regards those college students who are considered to be emerging adults, comprehending one's life, the world, and how one fits into the world becomes an important pursuit of identity formation, characterized by *presence of* meaning, or the understanding of one's existence as purposeful and significant; and by the *search for* meaning, or a person's efforts geared toward exploring and increasing the significance of their life.[255]

Such concepts mirror the correlation to some of what is also known to be true of suicidal students, that many of whom struggle to find life's meaning; and in consideration of the rising prevalence of young adults with suicidal thoughts, plans, attempts, and completion – determining that spirituality may increase this population's capacity to find meaning and purpose, is worth further focus.[256] Targeted research done on college students distinguishing *religious* wellbeing

as one's relationship with (and derived satisfaction, strength, and support from) God, as differentiated from *non-religious, existential* wellbeing (or perceptions of fulfillment and satisfaction with one's life through meaning and purpose) yielded solid results that students with higher levels of religious, existential, and total spiritual well-being reported lower levels of suicidal ideation.[257] Within this study, it was shown that although many college students did not demonstrate high involvement in organized religion, they did report high levels of spiritual and existential wellbeing, and low levels of suicidal ideation.[258] A national initiative launched in 2012 for suicide prevention strategies pointedly called for colleges and universities to increase evidence based programs to address suicide prevention, from which followed multiple endeavors toward awareness and prevention that continue to present-day.[259] The complexities and stressors of college life, of individual backgrounds, and in the context of facing ambiguity, uncertainty, and change tremendously impacts students. If finding meaning and purpose in life in some way mediates those challenges, the fact that there is capacity for students to not only achieve wellbeing, but to do so through personal transformation and transcendence, offers hope. I will share yet another of Frankl's insights to conclude this consideration of the spiritual dimension of wellbeing, namely that: individuals who feel helpless to control a situation they perceive as hopeless can rise above themselves, grow beyond themselves, and by so doing, change themselves. People can turn a personal tragedy into a triumph.[260]

Conclusion. The wellbeing of college students is undeniably a pivotal concern for not only those who provide direct patient care and counseling services to those in need, but that it becomes a driving force for the entire academic institution. The term wellbeing is woven into the common language of our times, yet complete cultivation of a campus culture of wellbeing wherein a true spirit of care is infused throughout all aspects of the student experience requires

authentic dedication to furthering the understanding of what a wellbeing university looks like to each individual institution.

The 21st century student is unlike any other before them, and the college campus is more heterogeneous than any other time, with student diversity dominating on many planes, in addition to greater expectations for services and amenities that has raised the stakes of attracting and retaining students. The critical presence of social media and burgeoning technologies has changed the contours of living and learning as a college student, with benefits and consequences of both continuously realized and still surfacing. Mental health diagnoses and utilization of support services in our institutions has also surpassed prior experiences, evidenced by a stark increase in both patient volume and acuity being experienced in counseling and clinical medical facilities.

Amidst these and other cultural shifts, dedicating our work and attention to holistic wellbeing in terms of each dimension of human wellness will hopefully fuel our own capacity to facilitate and encourage our students to rise above themselves, to turn toward the other, and aspire to even greater transcendence - ultimately realizing their own fullest potential of mind, body, and spirit.

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[260] Taliaferro, "Spiritual Well-Being and Suicidal Ideation," 89.

Chapter 6. Professional Ethics: Agency & Accountability.

In this chapter's continuation of professional ethics for college health services, section one probes organizational ethics in terms of practice standards of institutions, followed by a discussion of the ethical accountability of healthcare providers concerning high risk health-related practices of young adults in section two.

Chapter 6.A. Organizational Ethics: Practice Standards of Institutions.

Regardless of size, historic relevance, or academic focus all institutions of higher education clearly profess their mission, vision, and/or values throughout websites, in promotional literature, and prominently in buildings as any search of online resources or visit to a campus will convey.[1] Likewise, those institutions with on-campus clinical health services affirm either an extension of the institutional mission or dovetail into the statement through the development and promotion of their own, which in the long run should navigate operations.[2] Because of the evolution and importance of clinical health services due to an ever-changing student population (inclusive of non-traditionally aged learners - both minors and adults, international students, recent military veterans, and non-immunized students), as well as the tenuous landscape of healthcare reform, the importance of integrating health and wellbeing into said statements, as well as understanding the correlation to various principles of organizational ethics to the function of on-campus health services, is paramount.[3] Campus health services are effectively a structured healthcare organization within a larger system - the academic institution - functionally interdependent, to which organizational ethics clearly pertain.

For many consecutive years, nurses and other healthcare professionals have been rated highest among professionals in the annual Gallup Poll on Honesty and Ethics in Professions.[4]

The impact of professional ethics that undergirds established standards and principles of what makes a particular occupation a "profession" are translatable to the field of college health medicine. Despite not being recognized as a specialty in the broader healthcare system, the domain of college health medicine does indeed constitute a profession in terms of service quality and economy; sensitivity to patient uniqueness; enabling and enhancing student growth and development (toward eventual successful degree attainment); continuous evaluation and improvement; ethical decision making; and a diverse practice scope.[5]

Clinical health offerings on college campuses vastly differ and can include as limited or extensive a menu of services and specialties as varied as the campus communities that they serve. For this reason, it is vital that college health professionals maintain an understanding of professional ethics pertaining to occupational standards and codes, organizational identity, culture, and accountability; as further means to achieving excellence of practice, regardless of size or scope. Professionals who aspire to excellence are committed to delivering their best adhere to ethical principles with distinction and notable virtue, and embody steadfast professionalism.[6] In that we consider ourselves as members of an authentic practice specialty, we must align our personal and organizational conduct with ethical and professional standards inclusive of responsibility to our patients, the campus community, an orientation to service and a commitment to lifelong learning and improvement, in our acknowledgement of professional ethics.[7]

Chapter 6.A. i. Organizational Moral Agency.

The College Health Service as an Organized Healthcare System. All clinical health services, irrespective of size, scope of service, or reference as public or private, secular or faith-based, must commit to several fundamental priorities. Among these are a commitment to high

standards of ethical conduct, patient care, and community service which will influence daily behaviors and decision-making.[8] To unpack this further, any college health service functions as an organized health system due to its relationship with and service to the institution, the obligation to provide thorough patient care, and the duty to serve the campus community (any combination of resident and commuter students and/or faculty, staff, and employees, or by extension the surrounding pubic; depending upon the scope of services offered). In *The History and Practice of College Health* by H. Spencer Turner and Janet Hurley, a definitive reference book, the authors assert that college health services are expected to strengthen environmental determinants of health to protect the human potential of the academic community as regards learning, retention, and productivity.[9] That said, as an organization, campus health services are held accountable to core values and moral positions defined by mission statements which determine the culture by which both clinical care and health promotion are delivered.[10] In light of this, the organizational ethics concept of moral agency applies not only to those who practice in this unique niche of clinical medicine, but recognizes college health services as an organizational entity bearing its own moral agency. Defined, a moral agent is a person who can evaluate right from wrong; who has the power to take voluntary action; who has moral obligations, duties, and responsibilities to act; whose action can be evaluated; and who is accountable for his or her own actions.[11] Care providers and health promotional professionals, both elemental in college health services, assume the responsibility of acting independently as individuals, with singular motivation, choices, values, and character while contributing collectively to the functioning of the organization.[12] Further, an individual's conduct can represent an organization when enacting its policies, while the reputation of an organization can be fruitfully developed based on the moral agency of its individual employees, or negatively

affected when employees do not act in accord with structured policies.[13] All aspects of patient care including professional, educational, managerial, financial, and contractual are dependent upon this ethical approach as the lens through which clinical practice and campus community education outreach strategies should be developed. In *An Introduction to Healthcare Organizational Ethics*, Robert T. Hall emphasizes that if we expect institutions to act responsibly as moral agents and to adopt and implement institutional goals, we have to be prepared to accept the concept of institutional integrity, that is, the idea that ethical principles are essential to its mission. He continues, emphasizing that we cannot expect an organization to overlook its principles and commitments in order to accommodate all patient requests or community expectations.[14] This is easily applied to college health practices in consideration of both institutional mission and commitment to the provision of primary health care and health promotion.

Implication of Stakeholder Theory. Borrowing from business ethics, healthcare practices can aptly utilize stakeholder theory to address the interests and impact of people served and those who interact with it, or are affected by its decisions.[15] This is not to say that healthcare can be conflated with business or corporate structures as commodities, rather, as a reworking of the stakeholder model.[16] Adapting the stakeholder strategy to involve a "priority list" of stakeholder interests for healthcare ethics facilitates the delineation of five focus areas: (1) patient population, (2) professional excellence, (3) organizational viability, (4) community access, and (5) public health.[17] Extrapolated further for integration into college health practice, the "patient population" equates to the students served; "professional excellence" as an overarching expectation to uphold standards of practice and care as well as to achieve formal accreditation; "organizational viability" suggesting the value and impact (for our purposes, especially that of

student academic success and retention) of what services are provided; "community access" relating to accessibility of services in terms of physical location and including that of underserved or underrepresented populations; and finally "public health" clearly corresponding to campus outreach, prevention, and education. In a white paper produced by the Gallagher Higher Education Practice, a group specializing in providing benefits and risk management for higher education institutions world-wide, the report clearly addresses the impact of stakeholder theory as regards student health across campus.[18] This valid and influential think-tank study emphasizes that the wellbeing of college students is important to multiple departments and services on college campuses, and that student health and counseling centers have the primary responsibility to manage the general health of the student body. It discusses that stakeholder theory extends to on-campus clinical health services with significant influence on these generally-named offices and departments: Admissions and Enrollment Management or those areas involved in recruitment and retention, (*in that access to healthcare and physical wellbeing during student's time on campus contributes directly to both*); Athletics Department (*to the extent that campus health services care for or collaborates with student athlete physicals, NCAA requirements, etc.*); Residential Life (*given the communal living, the association with health services for widespread illness mitigation and management such as viral respiratory and intestinal infections, influenza, and routine illness; communicable disease outbreaks; pest infestations and outreach programming*); Disability Services (*for integrated management of students with various disabilities and resultant medical care needs for maintenance in a campus setting*); Public Safety / Campus Police (*for emergency consultation or response and appropriate follow-up of students after intervention by this department*); Dining Services (*for nutritional programming and/or food allergy compliance and awareness*); Facilities Management and/or

Environmental Services (*for chemical, waste, equipment, environmental hygiene, etc. concerns*); Faculty / Academics (*for students with faltering attendance or other perceived concerns and medical excuse policy considerations*); Judicial Affairs (*for code violations that involve physical wellbeing*); and Risk Management / Legal Counsel (*for student health insurance concerns, crisis-related student concerns, and campus emergency management*). As is evident by this all-encompassing reach across the institution, campus health services are of strategic importance to both mission and student success. As the primary healthcare provider within the larger campus community, stakeholder related strategies with guidance from mission, mindfulness of ethical principles, effective communication and public health initiatives, solidify relationships with departments throughout campus.[19]

Chapter 6.A. ii. Institutional Mission & Commitment.

Mission: Vision & Strategic Importance. To further the analysis, the moral concept of stewardship as the foundation of organizational ethics is of utmost significance to the fundamental practice of college health medicine. As taken from Contemporary Catholic Health Care Ethics, for example, in terms of the biblical understanding of stewardship as presented in Catholic theology in regards to Gods' creation, "we are called to respect God's gift, to enable it to flourish, and to conduct ourselves in a manner that is consistent with it."[20] Further, in the Catholic tradition, there is a rich understanding of the meaning of stewardship that can be adopted as a foundation for organizational ethics, pertaining as much to secular healthcare as it does to religious (i.e. for college health services of either secular/public, or faith-based institutions).[21] The two mission related ethical principles of stewardship and integrity function in an integrated manner to uphold the mission as a guiding principle to foster trust and confidence, that is, "to be who we say we are."[22]

Within an institution of higher education, as is also true in the 'outside' community, a sense of trust must be attributable to available clinical health services, regardless of limitations or expansiveness. Stewardship cannot be reduced to the allocation of limited resources, although this is often a prevailing concern for college health centers. Rather, a sense of stewardship and integrity in healthcare fosters virtuous organizations through reciprocating between ethical principles, decisions, and conduct.[23] Having a vision for maximizing student potential through their education and general development is a vital component of a successful mission and must be an explicit goal.[24] Trust in the institutional commitment to student health and wellbeing is challenged by an ever changing campus landscape, and demographic changes impact institutional resources that merits a strong commitment to stewardship. Considerations such as caring for students with long-term or chronic health conditions including those needing very specific medication management (such as injectable biologics for various conditions, medication therapies for a plethora of mental health and behavioral disorders, hormonal therapies, etc.), challenge the mission and vision.[25] Earning trust from students, parents, the university community, and beyond is crucial. This is accomplished through acting consistently, exhibiting integrity, and meaning what is said, or simply put - walking the talk.[26] Successful college health services exemplify certain characteristics that work together to ensure enhancement of stewardship, as well as embodiment of mission and vision, which establishes and secures trust. According to the History and Practice of College Health (although since published, campus climate has evolved dramatically), the essential relativity to current practice still does apply. In essence, those characteristics are: (1) stakeholder involvement; (2) a direct link to the institutional mission such that campus health services are perceived as making a vital contribution to the success of the university; (3) assurance that services fulfill need; (4) staff that

are committed to the service; (5) the service is efficient and productive; (6) appropriate use of technology is enabled; (7) funding keeps pace with need; (8) uninsured or underinsured students are kept to a minimum or none; (9) periodic internal review; and (10) adequate and efficient facilities.[27] All told, these principles clearly correlate to stewardship and are guideposts for earning the trust of the population served and those with collateral interest.

College and university institutional mission statements often include allusions to "lifelong learning" or "total person," only inferring the importance and significance of health and wellness.[28] Some, however, do directly mention physical wellbeing as a key component to overall statements and strategic goals.[29] Of prime importance is the correlation of the promotion and significance of articulating purpose and values. The mission statement of the university wherein I am both Health Service director and a student, for example, through inference of the statement "…serves God by serving students" can be interpreted that services provided to students, i.e. medical and psychological care, is part and parcel to the mission. Countless other examples can be referenced with regard to mission statements that clearly articulate a vision of student wellbeing.[30] However, the health service itself should establish a clear, concise statement of mission as a framework for the organization, a foundation for a strategic plan, and as a means to articulate to all stakeholders the philosophy and values or clinical practice and health promotion as the driving force.[31]

Of pivotal importance to an institutional mission is the value of a healthy student, which bears impact on higher education institutions in the formulation of their various strategic plans and goals.[32] Strategic planning is a process that addresses questions about an organization's mission (who it is) and vision (what it wants to be or do in the foreseeable future), and relies on that mission and vision to guide the creation of objectives, directions, assessment tools, and a

formal implementation plan.[33] The American College Health Association (ACHA) provides guidelines on various topics for college health professionals. In their Standards of Practice for Health Promotion in Higher Education, several key principles apply to the discussion of the strategic importance of health.[34] The very first statement regards health as the capacity of individuals and communities to reach their potential, and health as a "positive concept emphasizing social and personal resources as well as physical capacities" (with reference to the World Health Organization statement of 1986).[35] The standards developed from these principles refer to the need for strategic planning for health promotion as a core value for institutions of higher education, and the application of ethical principles to practice.[36] College health practice can be characterized as a convergence of multiple fiscal, legal, administrative, and clinical processes for a specific population, of which the responsibility and accountability affect both students and those interested in them.[37]

Commitment: Resources & Sustainability. Campus health centers are as varied as the institutions in which they are positioned, ranging from small nurse-only offices that provide minimal services, to extensive multi-campus clinics of large research institutions where services are comprehensive and may include pharmacy services, physical therapy, radiology and diagnostics, full service laboratories, vision care, and even campus EMT services or after-hours care, among other amenities.[38] Conversely, smaller institutions may not provide any on-campus services, such as community colleges, very small and specialized institutions, and for-profit colleges.[39] Despite institutional size or provisions, resources dedicated to purposes of preserving and promoting the health of students is a proven, consistent need over time. In *The History and Practice of College Health*, the authors' account of the development of campus health services reveal that the very problems which inspired the need for campus medical care

still exist, perhaps even more so than one hundred fifty years ago. The need to change "how we do business" is more important to the rest of the higher education community and to the outside medical community than ever before.[40] The evolution of services is chronicled in this important work, summarizing the earliest documented references to "infirmities" as reported by Thomas Jefferson as Rector of the University of Virginia in minutes of the Board of Directors from 1826, through the period of profound growth and development of college health over the first half of the twentieth century due to the pioneering efforts of Drs. Edward Hitchcock and Thomas Story, and of the decades through and to the new millennium.[41]

Methods for funding and fiscal resources throughout the evolution of clinical health services have included fees assessed in proportion to poverty level, through tuition and general fees in the early decades of the 20th century, which continued until after World War II, when in the late 1940s the first student health insurance program was inaugurated at the University of Denver.[42] By the 1990s and into the early 2000s, increasing costs of medical care due to advances in medicine and technology resulted in increased concerns for funding.[43] In 2008, the Government Accountability Office prepared a report that examined the insurance status of college students, student insurance plans and nationwide requirements. At that time, the results were sobering, revealing that upwards of two hundred fifty million dollars was incurred by un-or-underinsured college students for cases not involving accident or injury.[44] Passage of the Affordable Care Act several years later created provisions for college students to be covered under their parents' plans through age twenty-six. Prior to that, throughout the progression of college health practice, multiple financial approaches and structures for funding sources and supplemental or combined options evolved, as varied as the institutions in which they were contained.[45] Often, fees are established according to enrollment and projected expenditures,

and are attached to or pooled from tuition, loans, and scholarships.[46] Ethical considerations result in terms of justice, in that students who may never use clinical or mental health services pay toward those that others are benefitting. Further, allocation of collected fees may induce competition between offices and departments who are seeking financial support for programs and services. An article from the Fiscal Times, a digital news financial publication with multiple platforms, in an article from May 2014 revealed that multiple funding sources have caused "financial bloat" and "mission creep" in student health centers across institutions of higher education in the U.S.[47] The accusation put forth asserts that funding through campus health fees and payments from insurers enable university health centers to spend "extra cash" for "boutique services and progressive programs." Further scrutiny addresses the insurance mandate put into place by many institutions while simultaneously collecting health fees. Harvard University, as an example, at the time of the article charged a health fee of $958.00, while requiring the purchasing of health insurance at a cost of over $2,000.00 annually. Concern for what is being provided to students despite fees and costs effectively challenges the ethical concern of resource allocation. Within the article, yet another topic rooted in ethics and morality is raised by the statement that at many student health centers, fees go to promoting "progressive causes" including emerging socio-behavioral topics, diversity and inclusion, and an "anything goes" attitude toward sexuality, adding that "many services offered are only tangentially related to actual student health." The article continues to cite a plethora of programming offered to students by health and wellness centers, ranging from essential clinical operations such as allergy injections, to alternative therapy offerings like acupuncture, yet extending to extraneous and controversial services such as hormone therapy and gender reassignment. Although volumes can be written on the very issues raised in this particular article alone, I suppose that a return to the

four ethical principles which have stood the test of time should guide the scrutiny of such debate topics, providing checkpoints for both clinicians and ethicists: beneficence, or the obligation to do good for the patient (college student) and others; non-maleficence, or the obligation to not harm the patient (again, the college student) or others; autonomy, or the right of the patient (college student) to decide what is to be done; and justice, or fair treatment of the patient.[48]

The ultimate goal of equitable funding of student health services is sustainability, and simultaneously the definitive role of campus clinical services is to keep the student body healthy for class attendance, co-curricular activities, retention, and eventual degree fulfillment.[49] One must confront the correlation of campus health service sustainability in the U.S. to the very present political and social topic of healthcare reform. In the early 1990's, during the height of the Clinton Health Care reform debate, collegiate health programs were at a crossroads. Campus health center funding was cut significantly, with institutional federal support being cut from nearly 50% to approximately 16% in the late 80s' early 90's. At that time fees were significantly raised to compensate budgets for health centers.[50] Given recent pre-PPACA (Patient Protection and Affordable Care Act) healthcare cost considerations and the uncertainties of current post-election reform, the reality of managed care will factor into decision-making in our era. The needs of students and families for health care access calls for campus health services to be better stewards of their beneficiary's funds.[51] Turner and Hurley recognized the importance of the need to embrace adaptation in the provision of college health services, stating "the mission of the student health service is to keep the most students at the most books the most time" and adding that services can no longer be carried out in isolation. They advise that we need health care pioneers who can forge new alliances and new partnerships who can accept the challenge of performance excellence despite limited resources, or doing more with less and doing it

exceedingly well.[52] A proposed set of guidelines for higher education charges planners to consider options such as managed care network participation; outsourced services for accuracy and maximized return (surpluses from which will upscale hard assets and service expansion); circumventing conflict of interest and ethical challenges by offering school plans that are both beneficial and mission congruent; and reallocation of the student health fee toward co-payments and deductibles as per state insurance law.[53] In February of 2016, the ACA affected national policy making by issuing a comment to the Centers for Medicare and Medicaid Services (CMS) which in turn resulted in a final rule to permit insurance issuers to establish separate risk pools for student health coverage at individual institutions of higher education, and exempt student health insurance coverage from the general actuarial value requirements to a minimum of 60% for SHIPs (student health insurance plans).[54] If continued, this will assure sustainability and equity in SHIPs for federal funding of the Basic Health Program through 2018. The active voices of student and college health professionals has the potential to affect positive change.

Chapter 6.A. iii. Organizational Identity.

Organizational Culture. Although campus health services are encompassed by the institution's mission and/or identity, internally within its own structure it acquires its own distinctiveness as an organization within the institution, having its own sense of character and personality. In effect, this is organizational culture. One view of the definition of organizational culture is that it is a set of shared values, beliefs and assumptions shared by its members, which in turn influences their thoughts and feelings, and guides behaviors, yet is expressed through ceremonies, stories and legends, rituals, and the like.[55] Another analysis views that literature on organizational culture interprets it as either an 'attribute,' or something that an organization "has," (such that it can be altered and manipulated); or conversely as a 'metaphor' for defining

the character and experience of the organization, or what it "is," (more toward a phenomenological approach).[56] Yet a third perspective characterizes cultures through how they differ by values, and asks – are ethical values (such as dignity, loyalty, equality) emphasized, or are pragmatic values (such as productivity, efficiency, achievement) stressed.[57]

While essentially a construct of business ethics, the concept of organizational culture also can be applied to healthcare settings. If business and industry have organizational cultures that foster conditions which are service or product or driven, then health care organizational cultures should be patient-centric with positive patient care outcomes as a driver.[58] Within the academic setting that campus health care services exist, the very tangible business concern of budgeting and funding health and wellness-related services places administrators into viewing operations from a business ethos, while having to integrate the values and ethics of clinical practice, resulting in balancing how to provide necessary student health services with competing for funding and resources that support optimal care standards and ensure salaries for adequate staffing.[59] Being that healthcare organizations are, by nature, pluralistic because of the contributions of multiple disciplines toward patient care, subcultures also emerge, either in congruence with the dominant culture of the organization, or in relation to departments and subspecialties.[60]

When the culture of an organization is lacking morally or ethically, movement toward a change in values through educating members is necessary, along with acquiring leadership committed to moral excellence with the ability to directly confront those culturally deficient elements so that positive change can occur.[61] Imagine, for example, a scenario in which the campus health care center managed by an ineffective, stagnant director who has grown complacent, unduly reliant upon an outsourced physician who provides the center with clinical

services, viewed by staff as arrogant and demanding. Within this office, daily management has remained essentially unchanged for decades, staff entrenched in equally stagnant, comfortable roles, with no applied innovation or advancement in as many years. Due to an unanticipated, sudden resignation, a new staff nurse is hired, and within a relatively short period of employment, discerns the ineptitude and toxicity of the existing organizational culture. She attempts to stimulate change by proposing process and policy changes to the director among other beneficial suggestions by shared with work peers, given her knowledge base and valuable work experience in a family medicine clinic – yet is repressed, spurned, and unwelcomed in her attempts. Frequent student complaints are registered with the Dean of Students regarding rude conduct and ineffective treatment by clinical staff. From this example, at the minimum, it can be seen that the culture of this particular student health center was dysfunctional and fruitless, lacked integrity, the legitimacy of the administrator was in question, and reorganization was an abject necessity. Various methodologies of culture change exist, and can certainly be applied to this scenario, but three key sources of resistance are: lack of ownership, complexity, and external influence.[62] Within the previous scenario, when the new staff nurse proposed change met with resistance, the existing staff could have perceived a threat which may only have been averted if the entire staff would have conceded that the proposals were positive; and possibly the frequency with which the new nurse proposed change did not meet realistic time frames in terms of complexity; likewise the involvement of this health center with other departments in the institution as stakeholders, perhaps would have interpreted the need for change as a failure of the administrator.[63] Every organization, like every student health center, is unique – and facilitating culture change is a complex challenge, as evidenced in the previous example.

An Ethics Infrastructure. Large healthcare systems are confronted with constant challenges that require adapting generally established values due to economic shifts, socio-political climate fluctuations, technological advancements and many other realities that increase reliance upon effective organizational structures.[64] Such a statement clearly also pertains to the field of college health medicine. The essence of an ethics infrastructure is a focus on individual, professional and institutional ethical issues and decisions; a linked set of processes and operational structures; responsiveness to the institution and all stakeholders; realization of a long-term perspective; and the involvement of professionals, administrators, and the community served.[65] At the level of an average college health center, this could suggest that all staff preserve a strong ethical understanding; that policies, protocols, and operations are harmonious; that the entity exists as a solid partner within its division and beyond throughout the institution; and that those who are eligible for care are active participants in evaluation and feedback. The lived reality, however, is that achieving this ideal requires concentrated effort and stratagems. Building an ethics infrastructure can be executed with four guidelines: (1) conducting a formal process to develop core values which are linked to mission and vision; (2) correlating an understanding of ethics and stated values to daily clinical practice through open and clear communication; (3) building supportive structures that sustain the culture; and (4) devising ongoing assessment and monitoring processes for ethical performance with regular, educational feedback opportunities.[66] Campus health centers may determine a list of core values that reflect the institutional mission but pertain to the clinic setting; undertake communication methods to stimulate ongoing dialogue about the values; assure that administrators and leaders assure progress toward ethical awareness; while assuring periodic review of the core values in relation to ethical decision making in the clinical setting and with campus outreach. Regular staff

meetings are prime opportunities to further discuss core values and ethical practice as a recurrent agenda item, with opportunities for staff exploration on ethics related topics. Discussions of fictional or real case studies enable discussions to ensue from differing viewpoints by using formal reasoning processes, from any of the theoretical principles already discussed.[67] In theory and in practice, these four guidelines provide a useful starting point for a college health center to initiate or re-establish a solid ethics infrastructure.

The purpose of establishing an ethics infrastructure is to assure that each and every ideal or value developed is woven into all daily processes and decisions, inclusive of all organization members interrelating with a common purpose.[68] The management concept of systems thinking provides support to an ethical infrastructure by concentrating on communications, interrelationships, internal processes, and actions toward ongoing reevaluation and redesigning to result in performance excellence.[69] How we think and make decisions as individuals and in groups in terms of perceptions, norms, and so on is at the root of systems thinking.[70] Overall, striving towards forming an ethical infrastructure for whatever incarnation of a campus health service one may belong to, will facilitate the organization and its people to clearly profess, take ownership of, self-monitor, and sustain through a unified commitment to shared values and priorities.[71] Essential to the sustainability of an ethics infrastructure and an implication for practice is the need for ongoing professional growth and development opportunities toward ethical behavior (which should be ardently supported by administration).[72]

Chapter 6.A. iv. Organizational Accountability & Practice Standards.

Accountability: Health Literacy & Quality Performance. Having the capacity to acquire, understand, and apply basic health information, being able to seek and utilize healthcare services, then making decisions and choices about one's health are all traits of a health literate

individual.[73] The health literacy concept grew out of a groundbreaking study done in the early 1990s by Emory University and the UCLA Medical Center in Los Angeles, and utilized "The Test of Functional Health Literacy in Adults" (TOFHLA) to measure health literacy skills (in adult participants that spoke English or Spanish).[74] As further research evolved on this topic, several prominent definitions also resulted as an outcome, including those developed by the AMA (American Medical Association), the definition cited in Healthy People 2010, (a Department of Health and Human Services nationwide health promotion and prevention agenda), and that of the WHO (the World Health Organization), which extends its definition beyond the impact that health literacy has on the individual, and adds that benefits are social, as well.[75] Even more impactful is a policy statement of the British Government that addresses social determinants of health as well as disparities, and clearly links educational status to both.[76] The element of education is what must become central to the accountability that we have as organizations to contributing positively toward the development of the students that we serve to acquire not only academic knowledge in their chosen fields, but also toward their growth as truly health-literate individuals and educated healthcare consumers. With each and every patient encounter, college health professionals along every touch-point can impact health literacy. From answering a phone call or greeting a walk-in customer, a nurse triage assessment, during the clinical exam, working with a health educator, obtaining prescriptions from the pharmacy, discussing charges or billing, and anything in between through to the point of check-out – each staff member has an opportunity to clearly communicate, educate, reinforce, and reassure the student's understanding and contribute to a positive outcome.[77]

In 2010, a study that looked at Health Literacy in College Students was conducted at the University of Cincinnati and published in the Journal of American College Health.[78] It made use

of the previously referenced TOFHLA and resulted in several significant hypotheses: health literacy levels varied across gender, race, between junior and senior students, between declared majors, between students' 'actual' and 'expected' literacy levels, and had varying degrees of how important health literacy was to the participating students.[79] Moreover, gleaned from this study were the following conclusions that are quite significant for college health practitioners: college students still had difficulty understanding and utilizing some information; colleges and universities should not assume that all students are health literate upon graduation; all disciplines should realize the importance that health literacy skills can have on students' futures, without which can increase adverse health consequences, and that those responsible for health education communications should assure that materials are appropriate for intended audiences in consideration of a diverse population.[80] The prime takeaway from this study is that collaboration among campus health educators, college health service professionals, academics and higher education officials toward improving health literacy skills in all populations of college students, must be a priority.[81]

In order for our profession to advance health literacy in our institutions, there are specific attributes that should be implemented by all campus health centers, such that they create an environment that will enable patients to access and benefit from our services.[82] These ten attributes were developed and compiled by professional participants in the Institute of Medicine of the National Academies Roundtable on Health Literacy in 2012, from a plethora of references and resources, and is an incredibly worthy tool with concrete, practical applications for any health care organization to make use of.[83] The attributes are not rigidly ordered, nor are there specific task-driven methods suggested, but adapting them to clinical practice will result in improved literacy. A summary of the attributes are: (1) leadership makes health literacy integral

to mission and operations; (2) health literacy is integrated into planning, evaluation, safety, and quality improvement; (3) workforce is prepared in health literacy and monitored for progress; (4) population served is included in design, implementation, and evaluation of health information; (5) avoids stigmatization of populations by meeting needs within a wide range of literacy skills; (6) uses strategies in all communications and confirms at all points of contact; (7) provides easy access and navigation assistance; (8) designs materials that are easy to understand and act on; (9) addresses health literacy in high-risk situations, transitions of care, and regarding medications; (10) conveys what insurance plan covers and what must be paid for.[84] Absolutely each of these attributes are directly applicable to the realm of college health medicine, and if implemented will be transformational.

Of utmost importance is to realize that health literacy is an issue of the dignity of the patient, and of integrity in the interdependence between the patient and the professional.[85] Regardless of what type of institution campus clinical services are situated in, a lesson taken from the Ethical and Religious Directives for Catholic Healthcare Services bears impact on any clinical practice because of its all-inclusive perspective. In essence, persons needing healthcare and professionals who provide the care enter into a relationship of mutual respect, trust, honesty, and the professional must avoid manipulation, intimidation, or condescension such that the inherent dignity of the person is respected and protected, regardless of social status.[86] Whatever physical, mental, and spiritual capacity the patient has is to be regarded with our imparting of knowledge, so that they participate more fully in a holistic healing process.[87] Any lack of health literacy is an obstacle to this co-responsibility, for which our duty is to remove those obstacles through a commitment to improving the health literacy of our students.

Quality performance is an aspiration of a organization accountable to its parent

institution. A definition that closely resembles a statement of ethics is from the U.S. Agency for Healthcare Research and Quality, states that quality performance means "doing the right thing, at the right time, in the right way, for the right person, and having the best possible results." Key dimensions in quality patient care are that it should be safe, effective, patient-centered, timely, efficient, and equitable.[88] Assuming that persons seeking medical care trust that their care providers have adequate skill and are moral and ethical, it can then be said that ethics define properties of character while quality defines properties of technique.[89] The expectation that high-quality health care should increase the opportunity for good outcomes should also involve an assessment of both, from which effective quality improvement programs can be developed.[90]

For quality performance to take place, three fundamental strengths to consider are: (1) respect the needs of your customer; (2) process inefficiency results from process variation, (3) a team approach is the best approach.[91] Turner and Hurley relate this to the practice of college health medicine in that the "customer" is the student (although related or external customers may be parents, insurance companies, and other university departments); while process inefficiency engages problem-solving by data collection of all factors of any inefficient process; and the real understanding that not only are clinic care providers team members, but effectively all department personnel extending out to the division or program that the campus health services are positioned in.[92]

Accrediting bodies such as the AAAHC (Accreditation Association for Ambulatory Health Care) and the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) provide performance improvement techniques, tools, and training for ambulatory care practices such as college health clinics.[93] Six principles for quality improvement identified by Turner and Hurley connect to college-health specific scenarios. First, the focus on quality

should tie into the strategic plan of the division; also, quality improvement should be both patient and organization-focused; patient scenarios that are recurrent, high-risk, and problem-oriented should take precedence; patient satisfaction in addition to outcomes must be emphasized; work staff who perform health care are the best source for problem identification; and improvement processes should be from expert sources.[94] Given the variation of sizes and specificities of campus health services, any processes that improve quality care, increase patient and employee satisfaction, increases efficiency, enhances communication, and decreases costs will not only please administration, but will also increase the odds of good health outcomes.[95]

When healthcare organizations seek to improve quality, it is viewed as an intrinsic part of normal operations. By using the clinical setting to guide and improve practice through data collection, care providers gain insight about systems functioning, procedures, record keeping, and so on.[96] Continuous quality improvement is an approach that commits to improvement of process in and on every occasion, toward constant improvement of operations, leading to improved patient care and viewing healthcare quality performance as a process that focuses on the system, not on individuals.[97] A distinction should be made to clarify the difference between quality improvement versus research. In essence, when data is collected for purposes of improving process, typically small samples are used, protocols and policies are updated often, ineffective methods are done away with, and new ideas are sought – all of which relates to local operations; whereas research strives to improve global problems by providing generalizable results.[98] If quality improvement does involve a deviation from established practice, includes patients as subjects, makes use of blinding or randomization, or if participants are subject to risks beyond clinical interventions, such studies could then also be regarded as research.[99] As such, the ethical responsibility to cooperate with quality improvement opposes the ethic that research

is voluntary, to the extent that even HIPAA (the Health Insurance Portability and Accountability Act) imposes patient protections in quality improvement with the statement "…conducting quality assessment and improvement activities…that the obtaining of generalizable knowledge is not the primary purpose of any studies…"[100] At the very least, any movement toward improving quality performance involves a long-term commitment from management and staff, with the reassurance that continuous change is best achieved through a planning process that involves as many employees as possible which inspires ownership and, in turn, enthusiasm.[101]

Practice Standards: Leadership & Accreditation. Despite unique challenges due to patient diversity and distinct health care needs of those serviced, college health itself is not classified as a subspecialty given its relativity to various medical specialties including young adult, internal, gynecologic, and family medicine, although arguably it can be. Most undergraduate college students range in age from 18-21, and graduate students typically in their mid-twenties but ranging throughout the lifespan.[102] College health service clinicians, both physicians and midlevel practitioners, are often licensed and certified in either adult, adolescent, or women's health.[103] Clinical services personnel may also include a spectrum of support staff, including front-office and business personnel, as well as nursing staff inclusive of advanced practice registered nurses, wellness program and outreach coordinators, other specially certified registered nurses, licensed practical nurses, medical assistants, laboratory personnel, and many other trained ancillary staff, depending upon extent of services provided.[104] With such widespread variety, it is incumbent upon the facility leadership to have a clear understanding of scope of practice limitations, licensure and certification renewal processes and requirements, state law or practice code toward both ethical and safe practice, and effectively record related personnel specifics within the context of policy and procedure documents.[105]

Patient safety is compromised when staff practice beyond their ability. That said, with RNs compromising the bulk of college health service staff, clearly stated and carefully followed nursing practice protocols are essential to have in place, periodically reviewed, and respectfully followed.[106] Across the country, this emerged as a universal concern among nursing professionals in college health, to the extent that at the national ACHA conference in May 2012, one hundred nurses from throughout the nation connected, collaborated, and reached consensus in the development of eleven protocols, all specific to the practice of college health.[107] They defined protocols as being a "set of predetermined criteria that define appropriate nursing interventions that articulate or describe situations in which the nurse makes judgments relative to a course of action for effective management of common patient care problems, as a written document mutually agreed upon by nurse and provider by which the physician delegates to the RN the authority to perform certain medical acts, all of which comply with laws, rules, and regulations of state." The use of evidenced-based protocols assures standardized, consistent care; is based on current technology; enhances cost effectiveness; provides direction and guidance; and limits conflict and misunderstanding.[108]

Nurse-directors of campus health services with an understanding of nursing practice concepts effectively apply theory to practice. In The Essence of Nursing Practice: Philosophy and Perspective, author Suzie Hesook Kim references the notion that healthcare practice is the integration of best research evidence with clinical expertise and patient values.[109] She discusses five distinct dimensional qualities of nursing practice that are germane to the discussion of ethical leadership. Namely, scientific (knowledge translation and application), technical (performance), ethical (choice selection), aesthetic (expression in self-presentation), and

existential (comportment).[110] Those in positions of management, especially with backgrounds in nursing, can enhance their leadership skills with cognizance of these dimensions.

Of further importance as regards leadership is the understanding of competency. The Institute of Medicine (IOM) in 2004 identified six competencies that are essential for all health professionals: patient centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.[111] Effective and ethical leadership, regardless of setting, should consider these six competencies as elemental, and they apply seamlessly to the practice of college health medicine, offering supportive structure to practice standards and management. Further, with accountability to institutional administration, adherence to these competencies will invariably result in favorable outcomes with regard to patient care and satisfaction, staff commitment, and practice excellence.

Fortunately, the existence and evolution of the American College Health Association has consistently been the primary source for advancing standards of practice in the field. As far back as the early 1970s, the ACHA created tools for guidance of health programs both in junior and community colleges, and eventually for all nurse-directed health services, by the mid-1990s.[112] These initiatives called attention to the complexity of health care of college students, and contributed to the basis for standardizing services and leadership. Moreover, the *Guidelines for a College Health Program* were established and published by the ACHA with multiple periodic revisions, through 1999.[113] More recently, the creation of the *Framework for a Comprehensive College Health Program* replaced the former *Guidelines*, in consideration of the plethora of clinical changes and cultural paradigm shift over the past seventeen years. The *Framework* is intended to address the unique stressors and needs of today's college student, and can be adapted to most health service programs, and is referenced within this essay.[114] This document provides

guidance in terms of elements, concepts, and services according to the institution's resources, campus population, campus community health needs, and surrounding community resources.

While the provision of standards of practice and functional guidelines serve to promote both ethical leadership and contribute to overall patient safety, college health services can incorporate even higher-level criteria through accreditation.[115] The AAAHC (Accreditation Association for Ambulatory Health Care) is an accrediting organization that was founded in 1979 "to encourage and assist ambulatory health care organizations to provide the highest achievable level of care for *recipients in the most efficient and economically sound manner, accomplished by the operation of a peer-based assessment, consultation, education and accreditation program."*[116] *According to the History and Practice of College Health, in 1961 an ACHA committee was formed to develop standards for a college health program, and was done through liaison partnerships with other national organizations such as the American Medical Association.*[117] That very same year, the association then being 41 years old, had at their annual meeting the theme of "Ethical and Professional Relationships."[118] Accreditation imposes stringent adherence to standards for quality improvement and management, clinical records and health information, environmental care and patient safety, and health education and wellness.[119]

Safety concerns in a primary-care environment such as a campus health clinic are multifold, and are analogous to those most common to patient safety, overall: medication errors (both in terms of administration and in prescribing); infection prevention; device malfunction (for any non-pharmaceutical patient-care related instrument); and errors in diagnosis.[120] Establishing a culture of safety is a prevailing priority of all healthcare organizations, and must also be so of college health services. Universal elements that support a practice that assures

patient and environmental safety correlate directly to organizational leadership, and include the assurance of a blame-free work environment, transparency, and tools, techniques, and processes for evaluating occurrences and preventing errors.[121] Health Service staff must have the freedom to report potential safety concerns or self-report errors without fear of blame or repercussion. As adapted from a safety culture tool developed by the Agency for Healthcare Research and Quality, student health leadership must commit to open communication, ongoing organizational learning and professional development, regular policy review, attention to staffing ratios and operational needs, and cautious patient handoff between health and counseling services.[122] Recognizing the importance of emerging autonomy of many undergraduate students seeking medical care independently of parental or guardian advice, the central importance of assuring patient safety becomes a focal point.[123] Similarly, when considering non-traditionally aged students, international students, and veterans, applying patient safety considerations are of utmost significance.[124] Essentially, the concern for patient safety reflects back to the moral concept of stewardship, and is imperative to effective clinical practice when integrated with the institution's mission and vision.[125]

One area that is lacking is the standardized nursing staff credentials, and unfortunately there is no current academic program for the certification of Registered Nurses in college health services. Formerly, the ANCC (American Nurses Credentialing Center), a subsidiary of the American Nurses Association, offered certification in the specialty practice of college health medicine, initiated in 1991, but the on-line course was discontinued by 2005.[126] However, according to Devin Jopp, current President of the ACHA (American College Health Association), plans are in place for the creation of a Leadership Institute affiliated with ACHA, to further advance the field.[127] Once established, such an endeavor offers potential for increasing

practice standards, promoting excellence and thusly safety, and elevating the status of college health service practice based on the impact that services have on student wellbeing and ultimately on retention.

Conclusion. College health services merge effectively into concepts of organizational ethics. By virtue of the amenities that they provide within colleges and universities, as well as the multiplicity of interrelations throughout campus divisions, their capacity to enforce, uphold, and embody institutional mission is unrivaled. As representative microcosms of healthcare systems outside of the academic realm, practice standards for ethical leadership and medical care enable students utilizing these services to access comprehensive medical care, informative health promotion, dynamic education programs, and integrated elements of wellbeing. In all, despite the continuously evolving campus climate, college health services are an abundantly viable and functionally indispensable health system within the organizational structure of higher educational institutions.

Furthermore, the college health medicine as a profession has evolved into a very distinct, high impact subspecialty of medicine because of the unique needs and characteristics of the population served. A preeminent concern is that mental health issues have incrementally risen in college students, and the need for effective, integrated wellness services are a focus of many institutions.[128] Campuses are trending toward investing in student health and wellness by building dedicated structures and edifices that offer a multitude of wellbeing services that combine campus clinical and ancillary services, mental health services, recreation services, alternative and holistic practices, and spiritual centers as a one-stop convenience due to the changing needs and expectations of students.[129] These facts point to the realization that our profession is one of impact, value, and enduring relevance. Continuing the practice within a

framework of applied ethics which are specific to the health and wellbeing of college students is supported by a variety of moral and ethical perspectives, each of which serve to guide and inform our specialty.

Authentic leaders of college health services are called to fuse ethical practice with key organizational processes toward virtue based practice. From this, a noble organizational culture will proceed, and an infrastructure rooted in ethical principles will be sustainable. The task of increasing the health literacy of the campus constituency can be transformational, and will spur societal benefits due to health literate graduates becoming good stewards and consumers of healthcare as they integrate into their life and work communities. Our commitment to quality performance through safe, effective, patient-centered and equitable care with ongoing self-monitoring for continuous improvement will assure good and beneficial outcomes. Campus clinical health center teams are the bulwark for the success of our ventures, and their voice is at the core of positive organizational scholarship and an ethical professional organization.

Chapter 6. B. Ethical Accountability of Healthcare Providers: High Risk Health-Related Practices of Young Adults.

Chapter 6.B.i. Rationale: Public Health Challenges of Young Adults.

A critical and distinct period of human development occurs during the transition from adolescence and emergence into young adulthood, generally considered to be from age 18 through the mid-to-latter 20s, relative to increasing cognitive abilities and the maturation of other brain systems.[130] The enthusiasm and promise of these years likely form among the best and most nostalgic memories for many who have aged past, and this period of human development effectively sets the stage for later adult life. Whether due to enrollment in post-secondary education or by entering the workforce, young or emerging adults are moving from dependence

upon parents and others toward self-reliance for emotional, residential, and financial independence - adding to their evolving foundation of life-learning, life-skills, and self-sustaining abilities.[131] In that regard, the capacity for self-governance should further include other associated capabilities such as understanding, reasoning, deliberating, managing and independent choosing, yet - such characteristics may not be in balance relative to particular choices in this complex life stage.[132] While recognizing that persons each develop individually, this challenging period is also clearly associated with increased risk-taking behavior because of the impact of the gap created by a rapid increase in affective reactivity and sensitivity to reward, as contrasted with the slower-to-develop ability to self-regulate; resulting in behaviors that can be viewed as both risky and immature.[133]

Tasked with individuating from parents while also balancing family connectedness, they are developing identities that will carry into adulthood. This movement from adolescence to young adulthood is characterized by motivational and emotional brain system dynamics that often propel emerging adults into suboptimal decision making.[134] A strong orientation toward and sensitivity to peers as well as responsiveness to their immediate environments, combined with limited self-control and lack of concern for long-term consequences collectively contribute to diminished decision-making capacity, especially in emotionally-charged situations – clearly impactful conditions in any context - but palpably true for those young and emerging adults in institutions of higher education.[135] Caregivers and clinical providers who encounter young adults in any setting would do well to appreciate these nuances and better comprehend the resulting ethical accountability concerning high risk health-related practices of this age group, principally true for those involved in the primary care of students in higher-education settings.

Marked advances in technology have profoundly impacted the young adult of the 21st Century to an unprecedented extent, vis-à-vis immediate and ever-present access to personal electronic devices, resulting in a communications paradigm shift together with pervasive influence on popular culture.[136] It is said that the typical emerging adult is engaged with digital media to some degree for upwards of 12 hours per day, perceptibly much of their waking hours.[137] Mobile social networking sites and social media platforms are predominantly utilized by the young and emerging adult population, with research revealing that social networking behavior results in an exploration and presentation of self that is integral to the pivotal developmental task of identity formation, nevertheless studies have also indicated that social networking use may threaten these developmental milestones.[138] Evolving cultural conditions impact the systems by which this generation of emerging adults navigate psychosocial needs as driven by use of social networking which contributes to their sense of belonging, need for connection, and acceptance.[139] Admittedly, while many healthcare providers are digital immigrants, through our own use of social media and information technology we value that young adults entrusted to our care are digital natives who have challenged the conditions by which people communicate and interrelate, compelling us to contemplate many contingent healthcare ethical considerations.

This essay will examine public health challenges of young adults relative to high risk health concerns and other issues that today's emerging adults face, primarily those attending institutions of higher education, by means of an analysis of related causes, influences, and systems-related factors. It is written from the perspective of my own experience as a college health nurse administrator, with hope that healthcare providers who service this unique and often struggling population reflect upon this fundamental discussion as we strive to ethically and

holistically care for 'the other' in front of us, and sincerely promote the capability for human flourishing. As healthcare providers committed to advancing the health of the students we serve, we must also realistically confront the challenges, truthfully address the root causes, and strive to make an impact that will last beyond the time that they are under our care.

High Risk and Consequence. The U.S. Preventive Services Task Force (USPSTF) has determined that there is abundant evidence for screening young adults as relates to specific areas of high risk, ranking the top three to be substance use, sexually transmitted infections (STIs), and mental health.[140] While each risk category is distinct and specific, all three are interconnected and rise to utmost primacy for healthcare providers to identify when working with young adults. Within primary care, it is standard practice to weigh patients at every medical visit, with screening for obesity also noted by the USPSTF given that obesity is a burgeoning health concern in the U.S., and healthcare providers are tasked with intervening as far as to promote dietary changes and recommend increasing exercise.[141] Providers discuss weight concerns with patients both empirically through Body Mass Index values and also confront patients about potential comorbidities that can develop, such as diabetes and heart disease, while addressing weight in terms of current and long term effects.[142] It is incumbent upon those of us caring for young adults in college health practices whom we identify as being at potentially high risk for substance use, STIs, and mental health concerns to equally and consistently screen for and address the behaviors, and candidly discuss the related consequences of these three top tier concerns, as commonly as we do for obesity.

In the introduction to this essay, it was noted that substantive neuro-cognitive changes including overactive motivational and emotional areas of brain development contribute to suboptimal decision making in this age group. This is evidenced by a strong orientation toward

and sensitivity to peers, responsiveness to immediate environment, limitations in self-control, and a lack of inclination toward understanding long-term consequences; yet this developmental stage allows for other characteristics that are lacking in earlier adolescence.[143] Congruent with these features is the propensity for high-risk behavior to increase through adolescence, reach its peak in young adulthood, and eventually decline with aging.[144] When applied to the context of life in college, clinical visits related to health issues associated with high risk behaviors become opportunities for healthcare providers to engage with and inform emerging adults in deference to their simultaneously developing capacity for autonomy. Along with the overarching duty of informed consent within professional practice standards, both are held in delicate balance through support and guidance from caring professionals through authentic, non-overtly paternalistic, and respectful patient-provider relationships.[145]

Among the many concrete depictions of the proclivity for high risk behaviors, the phenomenon of dramatically rising sexually transmitted diseases or infections (STDs/STIs) figures prominently. Also a focus of attention across popular media, it garnered attention even from the Wall Street Journal which featured an article that raised alarm for this prevalent public health topic, emphasizing concerns for related high-risk behaviors especially among young adults in the U.S.[146] It is not within the scope of this essay to detail specific high risk sexual practices, techniques, or particular methods nor to categorize risk relative to sexual orientation, gender, or any other explicit attributes – rather, it will broadly address risk and consequence as a pervasive healthcare challenge of significant ethical impact that definitively affects young adults. In that regard, detailed and specific statistics from the Centers for Disease Control and Prevention (CDC) reveal that 15-24 year olds account for half of all new STIs, women aged 20-24 had the highest rate of reported chlamydia cases, and men aged 20-24 had the highest rate of

reported gonorrhea.[147] Of staggering significance, the annual costs of STDs to the U.S. healthcare system is estimated to be as much as $16 billion.[148] Those costs may be direct (involving examination, testing, treatment, etc.); or indirect and intangible such as long term sequelae of untreated or inadequately treated acute infections along with multiple other considerations (for example suppressive therapy needs for HSV-2 infections or outcomes of untreated infections such as infertility).[149] Due to the preponderance of undiagnosed and unreported STDs, data on chlamydia, gonorrhea, and syphilis represent merely a fraction of the true burden of STDs in the United States.[150] The federal government has prioritized health objectives to reduce the proportion of young adults with chlamydia infections, gonorrhea rates, transmission of syphilis, and genital herpes.[151] In that regard, attention to the growing concern for high-risk health behaviors of young adults in college has improved over time, with surveillance through systematic data collection having begun in 1995 with release of the National College Health Risk Behavior Survey.[152,153] Quite adeptly, in their book about the history of college health written over a decade ago, Turner and Hurley provide an insightful reflection of STD diagnosis and treatment as being inextricably linked with the practice of college health for at least 80 years prior, citing historical reference to the need for "teaching the essentials of disease control as a problem of conduct as well as of public health," underscoring the need for diligent education about high risk sexual practices.[154] The American College Health Association (AHCA) continues to improve upon this necessity and regularly implements an annual Sexual Health Services Survey, an important mechanism for assessing the burden of disease for STIs in college populations.[155]

Directly correlated to statistical evidence is the lack of knowledge and skills, or health literacy, of young adults given their developing cognitive abilities and information processing

capacity as well as their limited understanding of how to navigate the health system.[156] The potential for false beliefs or tainted understanding about high risk sexual behavior due to ignorance interferes with informed choice, to the extent that healthcare providers have an obligation to support the newfound autonomy of this population through the need to impose often unwelcome information relative to negative outcomes.[157] Consequences of low health literacy emanate as poor sexual health decisions along with delays in or difficulties with seeking care and understanding information, while improvement of health literacy would enhance competency to seek services and improve decision-making capacity.[158] Germane to having aptitude for health literacy is an individual's capacity for autonomy, which involves elements of self-governance that include understanding, reasoning, and choice toward becoming good managers of one's own health.[159]

Furthermore, when historically considered, socio-cultural shifts in the past several decades reflect an increasingly permissive peer-influenced social script that has been endorsed throughout entertainment, social media, and social networking - advancing what is referred to as 'hookup culture.'[160] Research on this topic has traversed disciplines from psychology and sociology to medicine and public health, given the high risk impact and potential for negative consequences that accompanies hookup behaviors.[161] Hookups encompass many and varied sexual behaviors between partners in a non-committal relationship, with the mutual understanding that the interaction does not imply commitment, and within the college population hookup behavior rates are said to range from 60-80%.[162] Sexual risk taking involving hookups are associated with a multiplicity of related negative consequences ranging from contracting sexually transmitted infections or unintended pregnancy because of comparatively low condom use, along with a high comorbidity of substance use, increasing the potential for sexual assault,

intimate partner violence, as well as unanticipated emotional and psychological fallout.[163] A review of the literature and statistical reporting on the scope of the problem clearly indicates that women experience higher rates of sexual victimization than do men, who are also more likely to perpetrate sexual aggression through sexual violence or assault in correlation to alcohol consumption and binge drinking.[164,165] Risk factors are both universal across most college campuses but also specific to individual institutions, for which data should be contextualized and collected toward the creation of prevention programs for local realities.[166]

In her book "Consent on Campus: a Manifesto," Donna Freitas thoroughly investigates and challenges the existing state of affairs regarding a plethora of issues surrounding high-risk behaviors relative to hookup culture, sexual violence, consent, privilege, and the impact of alcohol on sexual assault. She calls to task higher-ed administrations that satisfy Title IX requirements through "check-box" compliance about raising awareness and statistical collection, challenging instead that academics and student affairs professionals should link arms through deeper and more meaningful education efforts of building a culture of consent and transformation by stimulating students with what she terms 'big questions' that inspire deeper reflection and insight.[167] As healthcare professionals situated in campus clinical health services, our role is pivotal to any hope for cultural transformation and the charge to reduce sexually transmitted infections along with high-risk sex practices in this age group. Student-patients should trust not only in our professional abilities and technical competence, but more importantly in the authenticity of our commitment to their safety, confidentiality and privacy - in synthesis with true respect for their autonomy.[168] Trustworthiness, loyalty, and fidelity are morally central virtues in our relationships with patients, indeed to those emerging adults who most need

information to guide their decision making, potentially impacting their future health across their lifetime.

Beyond this limited examination of high risk sexual concerns in young adults, as was previously mentioned, two other prominent areas of high risk are substance use and mental health. Due to the pervasiveness of these issues, there are seemingly endless national and regional networks, associations, coalitions, councils, centers, and institutes devoted to assessment, strategies, prevention, publications, and information dissemination available to healthcare professionals who work with young adults with regard to alcohol and substance use and mental health.[169] Among them, the 2018 National Survey on Drug Use and Health reports that alcohol and illicit drug use in young adults is a ubiquitous concern with over 55% of young adults identified as current alcohol users, more than a third as admitted binge drinkers, 2 out of 5 being users of illicit drugs, and over one third as regular marijuana users.[170] In the same survey, correlated mental health statistics convey increasing percentages as compared to previous surveys done on depression and other mental health conditions, as well as for suicide risk. Each of these content areas of substance use and mental health are persistent, permeating, and tangibly overwhelming to care providers of young adults, as well as overlapping in their associative relevance to high risk sexual behaviors. One study of college students integrated the correlation of alcohol use to sexual hookups as being associated with distinct drinking motives related to behavior (such as coping with and regulating otherwise negative mood and emotional states along with the intention for enhancement), directly increasing risky sexual behavior.[171] It is clear that the need for institutional risk assessment, ongoing evaluation, and strong policy responses to mitigate risk and inform targeted areas of concern for the health and safety of those entrusted to us is a tangible reflection of the ethical principle of beneficence.[172] However, we

can take from Beauchamp and Childress that such precautionary processes must also be justified by rigorous interpretation of all ethical principles as pertains to transparency, involvement of the population, and in consideration of social, cultural and psychological perspectives essential to evaluating risk – directly relevant to high risk health concerns of young adults across these three areas, and to their consequences.[173]

In Consideration of Cultural Context. Autonomous decision-making requires the capacity for particular choices made through intentionality, understanding, and control or non-control, and such conditions exist on a continuum within the context of relevant external influences.[174] As relates to young adults, particularly those attending institutions of higher education, the context and influence of the college environment as the external influencer has profound relevance. In something known as the 'dual process model of culture,' culture often motivates action at an unconscious level of thought, while people equally use culture to justify their behavior.[175] To depict this through a concrete example by one of the top three high risk concerns of young adults identified earlier, we can examine individual variables related to heavy episodic alcohol use (or binging) in terms of the motivation for consumption as a central concept with incentives that include enhancement of affect and sociability, coping, and conformity.[176] Specific student attributes such as first-year status, freshmen with underlying mental health conditions, and Greek-life affiliation correlate to increased risk for problematic alcohol consumption and related consequences.[177] It is substantiated in the literature that the risk for negative consequences from excessive drinking occurs across the general young adult population, but most notably for college students where social drinking motives emerge as a significant mediator of relationships in an established context of normative college campus activity to facilitate social interactions, as well as an attempt to regulate negative emotions.

Taken together, this simultaneously increases the likelihood of alcohol-related harms, as previously noted relative to the intersectionality with sexual risk taking.[178]

Alcohol-related negative consequences are well documented, resulting annually in over 1,800 college student deaths, 600,000 injuries, nearly 700,000 physical assaults, and 97,000 sexual assaults.[179] Aside from these staggering numbers, alcohol misuse is palpably correlated to academic decline as well as attrition from college.[180] Knowing this, healthcare providers in collegiate healthcare centers meet face to face with young adults who are putting themselves at risk due to internalized beliefs about the centrality of alcohol use in college, conceding that doing so is a 'rite of passage,' or is 'just as important as the academic experience,' consistent with social norms theory and research, adding pressure for conformity to others' drinking behaviors.[181] The multifold risks and negative outcomes of heavy episodic drinking that parallel with beliefs that alcohol is 'part of the fabric of college life' is a hard-fought battle to attempt to deconstruct, especially in light of the heavily researched correlation to regrettable sexual experiences as consequential to drinking.[182]

A parallel context-related influence is evidenced by how the college environment itself promotes perceived norms that encourage risk behavior given that emerging adults are more likely to engage in risky decision making in the presence of peers, especially through means of peer communication which serves to reinforce acceptance of behaviors that carry significant risk of personal harm.[183] In that social networking sites are heavily utilized by young adults to communicate, alcohol-related images depicting alcohol in a positive social context are predominant, posted to social media sites by either the participant themselves by nearly 46%, or by others tagging the participant at about 54%, garnering peer approval through 'likes' or other positive comments through the vast majority.[184] The approval of alcohol consumption within

social media posts by others has been sufficiently researched, indicating that the perception of peers approving of the conduct (affirming a positive injunctive social norm) does in fact lead to increased drinking behaviors and to more excessive alcohol consumption because of favorable social media enhancement through posts that reflect a particular social setting displaying relatable groups of people.[185] Along with that, notably increasing rates of anxiety contribute to increased alcohol use as in light of the "FoMO" concept (fear of missing out), a subtype of social anxiety that results from increased use of social media - a rather novel behavioral phenomenon of adolescents and young adults.[186,187] FoMO relates to increased incidence of negative alcohol related consequences, and is an identified risk factor for alcohol-related harm in college students.[188]

Moreover, the use of mobile dating apps and online dating websites has increased in recent years, especially for young adults, and there is documented evidence of increased levels of sexual risk behavior in those who seek sexual partners by these means, along with higher rates of unprotected sex, STIs, and increased number of partners.[189] A specific study done on college women found that users of one popular dating app reported significantly higher rates of casual hookups and one-time sexual partners as opposed to non-users.[190] Newer research clearly points to mobile dating app use as contributing to increasing STI diagnoses in young adults given their prevalent use of this technology, including impulsivity as a consistently associated factor in that neurocognitive development is incomplete and young people are more apt to 'live in the moment' and less likely to delay gratification, not considering potential consequences.[191] Enhancing existing educational outreach efforts across campus sectors through incorporating awareness of the influence of alcohol posts on social media (especially during particularly salient social event times in college life), in addition to the responsibility of healthcare professionals to

regularly integrate dialogue about the influence of peer communication such as social media posts, sexting, and app use as engendering negative consequences cannot be overemphasized.[192,193]

Knowing that young adults engage in frequent communications relative to participating in hookups, binging, and substance use, it is of interest that they also may occasionally overestimate peer acceptance of these risk behaviors in that considerations for preserving friendships or avoiding embarrassment may result in softened disapproval.[194] Disclosure of risk behavior to friends when a supportive response is expected may result in equivocation or the use of vague and abstract language that can be interpreted in various ways.[195] Perceived norms of peer approval and participation encouraging risk behavior are seemingly inherent to college student culture, yet accurate feedback about peer beliefs and overestimating peer acceptance may result due to goal conflicts, such as wavering on supporting or discouraging a particular risky behavior which can affect friendship.[196] Communication studies offer that young adults are also often strategic as to posting potentially incriminating information, balancing risks and benefits of disclosure on social networking sites including stigma and relational risk, while weighing social validation, self-representation, and relational development.[197]

Despite care taken by individuals, privacy may be compromised by others who post unauthorized content, indicative of the lack of respect for peer privacy boundaries which can consequence identity, relationships, and health.[198] College students considered to be most at risk are those with strong 'alcohol identities' meaning that these were most likely to consume alcohol and post about it.[199] An additional peer communication practice viewed as normative is 'sexting' (the exchange of sexually explicit content via mobile phone and social media), employed as a mechanism to initiate sexual contact.[200] Sexting is directly associated with high

risk sexual practices including unprotected sex, multiple partners, and sending messages due to alcohol-related encounters because of disinhibition from drinking – effectively increasing the chances of sexual encounters.[201] Technological advances have changed the way people connect socially and sexually, which also impacts how college health professionals engage with young adults when assessing for high risk or when treating and intervening for negative health outcomes from high risk behaviors.

Yet a further contributing context-related occurrence to consider is the nature of sexual content contained in many music forms, as well as the habitual and heavy listening habits of young adults and how repeated exposure is directly correlated to expectations regarding sexual activity, attitudes toward sexual behavior, engagement in high-risk sexual behavior, and substance use prior to sexual encounters.[202] One analysis reports that college aged young adults listen to music between two and four hours in a given day and hear approximately 34 references to alcohol or marijuana in popular music through positive portrayal of 'partying,' with nearly 1 in 5 songs including explicit reference to alcohol and substance use.[203] Repetitive exposure to lyrics about substance use, degrading sex messages, negative sex content, as well as recurrent thematic references to casual sex popularizes risk behavior associated with impaired judgment and substance use.[204] How media influences the perception of reality because of repeated exposure has been further evaluated through cultivation theory which offers that the more a person is exposed, the more they believe what they are exposed to as being real and normal, with certain genres of music and musical lyrics creating false understandings.[205] There are staggering statistics suggesting that highly sexualized music videos fuel aggressive behaviors and permissive sexual attitudes, altering sexual scripts and roles while normalizing risky sexual behavior practices.[206] A study done on over 700 college students examined the relationship

between sexual behavior and sexual content in music, lyrics, and videos over a variety of music types from a cultivation theory framework, which supported prior research findings that exposure is indeed associated with engagement.[207] Music can, in this sense, be considered a 'super peer' and can impact perceived societal norms because of the commonplace nature of sexual content, influencing thought processes and behaviors through negative sexual cognitions that increase sexual risk.[208] In the cultural context of life in college, repeated exposure to music videos laden with sexual imagery is found to encourage sexual permissiveness and promote views of sex as recreational and inconsequential as well as repeated endorsement of unhealthy sexual attitudes through some music types.[209] Healthcare professionals and health educators in the college health setting will recognize from this that repeated exposure to such content obscures the line between reality and fiction for listeners, therefore conversations about media literacy that engage young adults relative to the negative messages and ideas around provocative sexual and substance use images in music that are glamorized and inaccurate is essential and necessary.[210]

From this discussion, cultural context is clearly acknowledged as having impact upon the ways in which healthcare providers advance the health of young adults in college health services. Providers and support staff have opportunities to reasonably and positively influence students through encounters that not only serve to heal, but also to inform and lead through beneficent, ethically justified education and guidance toward our common goal of risk reduction.[211]

Chapter 6.B. ii. Root Causes: The i-Words. (The prefix "I" connotes "internet" – such as in iGen).

Generational Shift. Most would agree that generational differences in behaviors, attitudes, and personality traits are distinguishable with each successive age group from that of their predecessors, inclusive of societal and cultural changes, trends, and influences. Still, those to whom we currently refer as young or emerging adults (extending into their late 20s) reflect a trajectory of change and a shift so stark that it may be heretofore unprecedented.[212] Taking from Pew Research Center statistics and information, the generation known as Millennials encompasses anyone born between 1981 and 1996, while those born after have had several names attributed to them, referred to as either Gen Z (Generation Z), iGen (i Generation), or Homelanders.[213] The researchers at Pew add that generational cut points are tools useful for analysis but are not determined by exact science, such that Millennials and Generation X who precede them both span 16 years, whereas the post WWII Baby Boomer generation spans 19 years.[214] Considering the implications of the label iGen, the prefix '*i*' is said to connote 'Internet' (which was commercialized in 1995), but equally as influential is 'i' for iPhone in that the dominance of smartphones and constant access to the Internet has been an ever present reality for these young people.[215] However, there are many other equally impactful 'i-words' that contribute to our understanding of those differences that we should take into account toward an improved relational empathy of what distinguishes i Gen. A prominent author on this topic, Jean Twenge, has written extensively about the traits and trends of this rising generation, adding for consideration further descriptive 'i' qualities such as: *i*ndividualism, *i*n-no-hurry, *i*n-person no-more, *i*nsecure, and *i*nsulated – among others, from which she expands her research.[216] Their sense of individualism is a carry-over from childhood and adolescence as self-focused stages in which they remain longer as a result of over-parenting, related to the 'in-no-hurry' trait, evidenced for example by one in four iGens not obtaining a driver's license by the time they

graduate high school, as well as declining employment in later adolescence; along with 'in-person no-more' reflecting ever-increasing screen-time and social media use as detrimental to cultivating interpersonal skills; which ties into snowballing mental health issues in the presence of related social pressures and expectations.[217] When considering possible root causes for health risk behaviors and consequences in young adults, healthcare providers in campus health services would do well to think through these characteristics.

Cognitive processes such as perception, memory, understanding, and thinking are model competencies for human adulthood, and it follows that self-determination is realized through self-consciousness or the capacity to engage in purposeful actions and appreciate reasons for doing so, as well as to use emotional and communicative properties that support rationality and higher order volition.[218] In young or emerging adulthood, bridging adolescence with adulthood over an extended time, there are several key features that dominate the pathway to self-determination, including: identity exploration, self-focus, instability, optimism, and feeling in-between.[219] In comparison to college-aged young adults in prior decades, and in consideration of the emergence of the neologism "adulting," studies done on iGen/Gen Z reveal maturity fears and a reluctance to accept standard adult responsibilities, as well as a tendency to embrace parental overprotection and assent to controlling parenting styles, thereby not quite meeting the aforementioned competencies.[220] Intrusive and controlling parenting during childhood and adolescence has been a phenomenon traversing both iGen/GenZ and of the generation before, Millennials, with characterizations impacting the later stage of emerging adulthood.[221] iGen, however, has known no other parenting style, having carried them from adolescence to young adults in college, where parents unabashedly step-in to register students for classes, maintain on-

demand communication through smartphones, provide daily wake-up calls, schedule appointments, and otherwise infiltrate what should be self-managed task fulfillment.[222]

Although many theories and explanations are offered on this topic, having worked in higher education for over fifteen years along with comparative perspective as a parent of two daughters who both managed to survive college, one a Millennial and the other from iGen/GenZ, a highly plausible and thought-provoking explanation calls into account the overprotection tendencies that have become a societal norm. Parenting of iGen young adults has been affected by both risk and fear of risk, following their own upbringing replete with milk-carton missing children ads, and well publicized and effective consumer safety warnings including use of seat belts, wearing of bicycle helmets, lead paint awareness, and second-hand smoke dangers – which, despite the positive successes of these pursuits – the resultant propensity to secure a childhood as safe as possible, generally and inevitably created unforeseen problems.[223] Emphasizing that while it is clearly understood that any effort to protect children from environmental hazards and accidents is a principled improvement, when overprotection spirals beyond reasonable measures that, in turn, prevent normal developmental experiences - their ability to become functional adults may be negatively affected. Psychologists have offered insight into parental overprotection, over supervision, and preoccupation with safety as affecting normal childhood development by stifling creativity and independence while also potentiating fragility.[224] Equally, according to a recent research study, overt parental psychological influence on young adults, especially of those in college, leads also to increased impulsivity with substance use, sexual, and other risk taking due to inhibited identity formation because autonomy is not fostered.[225] Alternatively, other research studies have demonstrated that parenting styles that combine warmth and structure actually promote prosocial relationships and peer selection and

may provide protection against risky sexual behavior and may have long-lasting positive impact upon their children's lives.[226] Nonetheless, as young adults emerge from adolescence toward increasing self-reliance and responsibility, there is inevitable relational uncertainty with parents as the dynamic changes and the transition to independence during this unsettled life stage evolves. Many young adults continue to seek out and rely on parents for financial assistance, advice, and emotional support, while simultaneously working on autonomy and identity formation amidst uncertainty and ambiguity with parental roles, leading to changes in how obligated young people feel to share or disclose risky behaviors or more personal issues.[227] Clearly, the balance between assistance and interference in young adults' communication with parents can either facilitate or complicate self-efficacy and achievement as outcomes of the phenomenon of over-parenting.

Unlike any other time in history, this generation of young adults is experiencing a momentous sociocultural shift catalyzed by the international growth of the most impactful 'i-word,' the Internet, and within it the mediated technologies of social media and social networking sites (SNS).[228] The current spectrum of young adults are referred to as digital natives – they did not have to 'learn' to use devices or the internet, it was a 'fact of life' for them. Since 2007 when the iPhone was introduced, they entered adolescence with smartphones in-hand, and during that same time Facebook was opened up to anyone over the age of 13 – so, those born since the mid-1990s have conceivably lived their entire adolescence on social networking sites.[229] Although the use of social networking sites has become culturally normative, research supports that the younger a person is when they engage in social networking use, their risk of cumulative negative effects on wellbeing increases due to the perpetuating cycle of use for social support that is effectively grounded in comparisons with others as a means of determining self-

worth, contingent upon approval or 'likes.'[230] Unprecedented transparency that exposes them to social comparison for determining self-worth and self-esteem as being contingent upon approval from others by driving a sense of belonging and the need for acceptance profoundly impacts identity consolidation.[231]

Thinking about it from a practical sense, prior to what the norm now is, if in previous generations persons were to go about holding in hand a photograph of themselves asking either friends or strangers if they like it, or for that matter if the same were true for nude or suggestive photos of oneself – imagine what reactions would have ensued! Use of SNS are fluctuant, as sites waffle in and out of popularity when new platforms come into being, nonetheless continuous updating of photos and streams of images and videos sent out and shared is maintained only by exorbitant amounts of time online and with electronic devices.[232] Social networks establish relational ties, links, and patterns that reflect ones' values, meaning, beliefs, and other attributes, as well as a receptivity to social forces that impact health related behaviors both positively and negatively.[233] College students having social networks with far reaching distal influence affects their beliefs and practices by increasing risk for hazardous alcohol and other substance use as well as social context factors contributing to mental health issues.[234] Given this and how much is not known about the effects of smartphone use, social networking and any related benefits or harms, social psychologists have offered that social networking sites benefit users when they are used to make meaningful social connections but harm them through deleterious pitfalls such as social comparison and isolation, with strong indications that mental health is directly and negatively impacted.[235]

Contributing Influences. The above noted characteristic differences of iGen/GenZ as typified by several relevant 'i-words' illustrate some of the attitudes, beliefs, and approaches that

they hold which also factor into root causes for public-health related high risk behaviors. Giving thought also to the previously identified priority screening needs pertinent to those behaviors - substance use, sexually transmitted infections, and rising mental health issues - we should glance back into the historical beginnings of college health and know that there are common threads woven throughout time. Concerted efforts to establish programs for "venereal disease control on college campuses" as early as 1920 were patterned after military programs designed to do the same.[236] Over time and traversing significant historic events, in the post WWII years, social hygiene (as a euphemism for sexual health) became a focus for developing health dispensaries and infirmaries on college campuses.[237] Campus medical services continued to evolve in sophistication as formally organized entities over the next several decades when growing attention to "comprehensively addressing the emotional needs of students" and "establishing environmental mental health and safety programs" became focal themes for national gatherings of college health professionals, along with escalating efforts toward disease prevention, health education, and increasing attention to drug and alcohol use.[238]

Comparatively, in the late 1990s, a comprehensive article about the health of college students appeared in the Journal of American College Health, discussing the very same three health risk behaviors altogether, advising college health professionals that education and promotion efforts should be designed to reinforce individual and collective behaviors during the 'critical period' before unhealthy lifestyles are developed.[239] The author (an MD and then Medical Director of a very large state university) identified that alcohol abuse and binge drinking was a predominant issue on campuses, responsible for unplanned and unsafe sexual activity and violence. Comparing alcohol use as rising on college campuses while drinking overall in the US at that time was declining, he acknowledged that colleges and universities were "unwittingly

perpetuating their own drinking cultures through selection, tradition, policy, and other strategies that reinforce the wrong types of behavior."[240] About mental health, he correlated student stress-related disorders and ineffective coping with transition to independent living as comprising the majority of visits with healthcare professionals. Moreover, regarding screening for and prevention of sexually related diseases, he asserted that despite efforts to educate college and university students about risky sexual practices, by all indications the knowledge gained was not resulting in positive behavioral changes given that the prevalence of many sexually transmitted infections was still on the increase. He admonished that more innovative behavioral intervention techniques would be needed to achieve one of the primary national health objectives of that time for the college-age population: a reduction in unintended pregnancy and transmission of STDs and HIV infection.[241]

Nearly three decades following the publication of that article, as previously noted, we still continue to struggle with what was described earlier as a 'current phenomenon' of dramatically rising sexually transmitted diseases and infections as a high risk health concern for young adults, especially for college health services, according to statistics from our national public health agency, the CDC. Contextual considerations of college life and culture have been reflected upon within the limited scope of this essay, but other contributing influences must also be realized by healthcare providers who work with affected students on a day to day basis. Health literacy was identified earlier relative to sexual risk taking such that when health literacy is lacking, poor sexual health decision-making along with delays in seeking care or in absorbing and understanding relevant information are all affected by capacity to do so. Concerted efforts to improve health literacy have been broadly and actively implemented across campuses for decades through widely differing staffing structures and strategies to implement health

promotion and education to the extent that 70% of health promotion programs are situated in student health centers, while over 90% of campus health centers offer some type of health promotion services.[242]

However, if STI statistics for young adults inclusive of college students continue to be on the rise, other fundamental questions have to be raised in order to probe into why this is true. The CDC clearly states that interventions for young adults that address underlying aspects of the social and cultural conditions affecting sexual risk-taking behaviors are needed, as are strategies designed to improve the underlying social conditions themselves.[243] An article from Inside Higher Ed recognizes that colleges struggle with unprecedented increases in STDs among young adults, offering to "explain the increases," stating that the college age group is a "tough population for everything," however not addressing the "why" but instead suggesting increased education and prevention – and so goes the same loop of known increases, more education and prevention, continuing increases.[244] Education and prevention efforts of health promotion communications disseminate messages intended to promote the health of individuals and the public through influential content that in and of themselves intersect with ethical precepts and moral concerns relative to social and cultural context.[245] Within campus health centers, clinical staff and health educators provide a plethora of written and digital information sources, one-on-one education by means of clinical visits, participate in health fairs, exhibit posters, and offer STI awareness and testing campaigns; although institutions vary with regard to sexual health services and what is offered for contraception, condom distribution, immunizations, referrals, community support, and partnerships.[246]

On the other hand, both private and public institutions serve to influence and reinforce cultural conditions of sexual permissiveness through events and programs that, however well-

intended, detract from sexual integrity. Campus wide promotional events such as "Sex Week" stretch far beyond merely distributing condoms as a means of safe-sex practice and delve into exhibitions of a wide variety of tools for sexual practices, offering instruction on 'negotiating successful threesomes,' BDSM (bondage and sadomasochism) and other sex fetishes, as well as hosting skits, plays and events such as "Sex on Saturday Night, "Safer Sex Jeopardy" and "Sexual Chocolate" at freshman orientation programs which are intended to discourage date-rape, but are suffused with sexually explicit, crass content that may equally serve to reinforce high-risk sexual behavior.[247, 248] Young adults are influenced by norms and mass media as well as sexual scripts relative to events and presentations such as those noted, which reinforce that casual sex is normative, associated similarly to the influence of pornography on sexual attitudes and risk behaviors.[249] Pornography portrays a view of sexuality that is often shallow, misogynistic, and fully separated from the context of healthy committed relationships and is associated with increased numbers of sexual partners.[250] Clearly, both are significant elements of social and cultural conditions that affecting risk-taking. Within clinical research literature, it is reported that the effect of pornography on users, although not routinely screened for, should be intentionally incorporated into sexual-health visits because of the permeating availability of streaming internet delivery of porn content, the risk of addiction, and high potential vulnerability of young adults.[251]

Negative social and personal consequences associated with sexual attitudes that increase sexual risk taking (sexual encounters with uncommitted partners, high-risk sex acts, and impulsive sexual behaviors) are the concern of researchers and scholars across many disciplines, supporting that specific risk categories directly correlate, such as age group (young adults), age of first sex (increases likelihood of risky behavior in young adulthood), number of sex partners,

and binging on alcohol, among others.[252] If science and research caution that young adults are at risk for behaviors and practices that can result in negative physical and emotional consequences, and if it is the mission of clinical health services on college campuses to not only provide health care but also to advocate for a healthy campus community by leading the discussion on health-promoting environments and prevention of high-risk alcohol use, STDs, and sexual assault while simultaneously contributing to preparing students for life beyond the university - it is counterintuitive to then justify campus promotional events under the guise of "safe sex," the substance of which directly conflicts with the CDC's statement to address underlying aspects of the social and cultural conditions affecting sexual risk-taking behaviors.[253,254,255] Equally, campuses that neglect ideological balance in terms of offering support to students who may have competing points of view about how best to navigate their own sexuality in opposition to predominant socio-cultural influences and seek guidance through services offered in campus health centers, health education and information must also be available in as much as those choosing mutual monogamy or even if committed to abstinence are also equitably served. Young adults, as patients, are each uniquely constituted by psychological, familial, social, spiritual, and physical forces that contribute to their 'becoming,' and campus healthcare providers who view their practice equally as an art and not merely a science, will strive to promote the good of the patient apart from surrounding social pressures.[256]

Chapter 6.B. iii. Systems Approach: Capacity, Understanding, Agency.

Neurobiological Complexities. Today's young adults are challenged by high risk behaviors that are influenced by generational differences, cultural context such as the college environment, as well as other impacting factors, including neurobiological complexities that are specific to their life stage. The ethical accountability of healthcare providers to this age group

must take into account those unique features that affect capacity, understanding, and agency. Over the past several decades, there has been ongoing progress in the understanding of the developing brain through adolescence into young adulthood, inclusive of proliferative neuroscientific research and neuroimaging studies relative to prefrontal cortex formation and executive function.[257] Understanding has traversed general categories of cognitive and affective neuroscience as well as development theory, while that of neuroeconomics and translational studies include consideration of reward-based learning along with cognitive control functions and emotion related behaviors – all of which suggests that there are multiple systems that are dynamically interactive during adolescence and into young adulthood.[258] These empirically described systems involve behavioral regulation and control, incentive-based behavior, as well as "avoidance versus approach" responses, and encompass the neurocircuitry involved in processing correlated actions.[259]

That said, the implications of such studies are impactful in and of themselves to those who work with young people, yet there exists additional evidence that the brain changes based on lived experiences, suggestive of the reality that many of today's young and emerging adults may be negatively affected by a true lack of responsibility rather than merely 'programmed' to make poor choices.[260] With phone tracking apps and other current and evolving digital technologies, emerging adults were recently adolescents accustomed to parents constantly knowing their whereabouts, congruent with the societal trend of 'growing up slowly' as well as other previously referred to features of iGen/GenZ who embrace overprotection or 'cocoon' mentality.[261] An article in the Chronicle of Higher Education addressed this phenomenon pointedly, observing that parents who have protected, awarded and celebrated the current generation of young people have also insulated them from challenge, defeat, uncertainty, insult,

and stress since infancy – rendering them emotionally incapable of coping with challenges.[262] On the other hand, the author probes that if this is true - is the proper role of a university to also protect and pamper, or rather to prepare students for the difficulties of the real world, in essence saving them from themselves, so as to enable them to become effective citizens.[263]

As this essay has acknowledged, heavy episodic alcohol use is of immense concern as a health risk to young adults, as is high risk sexual behavior - unquestionably interconnected to brain related development and neurobiological conditions in young, emerging adults. Studies done with MRI (magnetic resonance imaging) qualify that binge drinking is associated with detectable brain changes that include decreased volume and accelerated thinning in the frontal and prefrontal cortices, also associated with changes to brain white-matter.[264] Control over impulsive actions is a key aspect of executive brain functioning, and heavy alcohol use has been correlated to response inhibition as well as directly affecting emotional processing systems in adolescents and young adults.[265] It is also understood that heavy alcohol use in college students impacts something known as prospective memory, which is a form of memory that relates to carrying out an intention at a future point in time as relates to day-to-day tasks, due to the neuro-toxic effects of alcohol, with heavy drinking specifically related to impairment of time-based prospective memory.[266] Young adults' acquisition of personality traits and movement toward psychological maturity are empirically negatively linked to problematic alcohol use, directly affecting both personality and development due to changes in impulsivity and neuroticism.[267] The proclivity toward repeated patterns of heavy intoxication from binge drinking with intense use over short periods is due to the belief that alcohol facilitates 'liquid courage' associated with regretted sexual behavior, and over time has increasingly adverse effects on prefrontal neural systems and inhibition control.

Of equal interest, young adult chronic marijuana users also demonstrate cognitive deficits in attention, processing speed, and executive ability.[268] There has been a noted decline in the perceived risk of cannabis and an increase in recreational users over the past fifteen or so years, likely due to mass-market appeal of potential therapeutic value of its component cannabidiol (or CBD) as well as legalization for medicinal use which has affected patterns of consumption.[269] A survey conducted by the National Institute of Drug Abuse to determine drug use among traditionally-aged college students (as compared to their peers not attending college) revealed that daily marijuana use was then at the highest level since the 1980s for this age group.[270] Medical use is also associated with problematic dependence, and attention to persistent recreational or medicinal prolonged use causing lasting neurocognitive deficits in several areas of the brain is the subject of ongoing research.[271] Although neuropsychological functioning is said to return after about a month of abstinence, deficits can persist up to six weeks post last use, while further research has shown that even after fifty days of abstinence there may be residual effect on attention, psychomotor speed, and cortical areas with working memory and executive function.[272] The neurotoxic effect of cannabis is particularly concerning to emerging adults due to their ongoing brain development and neurodevelopmental changes that take place from older adolescence into young adulthood, especially as regards dysfunction of executive-level decision making, risky judgments, and irrational choices.[273]

Young adults in college with risk for unhealthy substance use that seek primary medical care at their campus health centers are met with an opportunity for early intervention commonly known as SBI (screening and brief interventions) that integrates screening for this public health risk as integral to their clinical encounter.[274] Alcohol SBI is a top-tiered recommendation of the NIAAA (National Institute on Alcohol Abuse and Alcoholism) College Drinking Task force as

well as of the U.S. Surgeon General, yet only about one third of four year college health centers perform routine screening.[275] In addition to SBI as an essential element in college health center patient visits, it is vital to engage in frank discussions toward harm reduction promoted through a trusting patient/provider relationship that equally acknowledges factual information about marijuana as an illegal substance and emphasizes the known deleterious effects on brain function. Barriers to achieving effective dialogue in either of these areas are multifold. Discrepancies between perceptions that students have versus that of health services providers as to the extent of substance abuse by students at the institution is one factor, as are differences of opinions about who should initiate the topic of substance abuse in a college health care setting, especially if the student views the discussion as unrelated to their encounter, along with challenges to provider–patient communication when students feel that they may be 'judged' or that screening is more the role of a psychologist or counselor.[276] In any case, brain development and cognitive processes are pertinent to planning effective institutional health promotion/prevention programs. In the young adult population, peer norms are a strong source of reward as are neurobiological factors that determine individual decision-making capacity.[277] Taken together, prevention and intervention efforts that have potential to bolster students' agency and awareness can be informed by both.

From Interaction to Empowerment. As healthcare professionals, we are distinctively positioned to affect the success of college students as individuals, to strengthen campus communities, and to influence wellbeing in alignment with missions of institutions of higher education toward student achievement, retention, and success.[278,279] The ethical concept of veracity, weighted by principles of autonomy and beneficence, clearly pertains to the role that healthcare providers within a college health setting have toward the students served, in terms of

empowering them with critical skills needed for self-management, self-reflection, and accurately transmitted information.[280] Particular vulnerabilities in light of relevant cultural and developmental influences discussed throughout this essay reinforce the obligations that we have as healthcare providers to address risk and improve health outcomes. In the Western secular context, sexual involvement varies substantially in terms of frequency, regularity, number of partners, contraception use, and engagement in high-risk sexual practices – but, approximately 85% of young adults are sexually initiated.[281] Consequently, with each interaction between patient and provider there is also opportunity for growth in and of their capacity for autonomy and empowering of their moral agency.

The meaning of informed consent in a clinical context is flavored by literature, policies, and practices. In one sense it refers to an individual's autonomous authorization of medical care while in another it denotes obtaining legally valid consent from patients prior to treatment.[282] In order to meet students where they are in terms of those risks from which to adequately inform, we must also realistically understand that within the patient/provider interaction, the two likely meet as moral strangers – each with potentially differing views regarding the moral significance of actions and causes of high-risk health behaviors, and are distanced by conscience, cultural, philosophical, and confessional differences.[283] Health and wellbeing is impacted by an individual's identity formation, the development of which persists into and through young adulthood, as well as that of features central to moral identity as predictive of positive health outcomes.[284] In conjunction with all other unique attributes intrinsic to emerging adults, identity synthesis can be either a risk or a protective factor for many health issues.[285] In that most colleges and universities presumably have broadly diverse populations made up of individuals who embrace many differing views of cardinal elements of life, each having divergent value

systems, moral foundations, and character development; moral diversity is equally as real and manifest.[286] Effective communication practices that enhance a sense of shared decision making within the therapeutic encounter between patient and provider counters the imbalance inherent to the patient/provider relationship in light of these differences and patient dependence upon provider expertise.[287] Apart from informing through iterating physical consequences such as infection, unintended pregnancy, future infertility and so on; from this dynamic encounter emerges an ethos that allows for divergent moral perspectives to work in partnership to attain the willingness to be treated and honoring the authority to treat.[288]

That said, respective of those differences, human dignity is a concept that transcends the tension inherent to this reality. If students are culturally conditioned to view sexual partners as a means to an end that in truth diminishes their own worth and dignity, then those involved are not - as they so report - 'fine' after binge-drinking related unwanted sexual encounters which ultimately may result in an STD, lingering anxiety, depression, or reconsideration of possible sexual assault.[289] Instead – cultural components impacting high risk sexual behaviors can alternatively be viewed and influenced through a term with which this generation largely identifies – that is, through the lens of justice.[290] Rather than perpetuating that casual sexual encounters and multiple partners replete with emotional ambivalence and lacking intimacy or attachment (as long as 'safe sex' is employed) is acceptable, alternatively, students might instead be encouraged to consider both dignity and justice as integral to romantic relationships.[291] Asking students to also contemplate the notion of how they perceive 'rights' in relation to sex, that is to say, what boundaries they may espouse regarding what they will or will not do or tolerate relative to the same for a romantic partner, is utterly relevant to human dignity and mutual respect.[292] In a sense, harm reduction of high risk consequences may be attainable

through a concept referred to as a 'dignity intervention,' intended to increase dignity while also promoting other beneficial educational or clinical aims.[293] To that end, therapeutic dialogue, patient education, health promotion and prevention efforts that challenge students to slow-down and unplug from the constant feed of information pushing them onward, forward, and upward in a culture where messaging, comments, and profile updates are constant, so that a true opportunity for self-advocacy through stillness and critical reflection can ensue, may also foster reconsideration of or retreat from high-risk behaviors.[294]

Chapter 6.B. iv. Systems Approach: Precision Medicine and Epigenetics.

Precision Medicine. The U.S. Precision Medicine Initiative was launched in 2015 because of rapid advances in biomedical sciences, information technologies, and data science, with relevance to precision public health through the gathering of increasingly more accurate population and individual information on prevention, health determinants, and disparities.[295] Propelling this field is the precept which informs that precision medicine is about providing the right treatment to the right patient at the right time, while precision public health is viewed as providing the right intervention to the right population at the right time.[296] Beyond the genomics of precision medicine are other forms of what is referred to as data-intensive elements of biomedicine such as electronic medical records research, longitudinal epidemiological studies, crowd-sourced health data tracking and environmental health research; all of which are interwoven with other data (phenotypic, genomic, transcriptomic, economic, and sociocultural) toward further understanding how someone responds to treatments for disease.[297] This accumulation of data reflective of a diverse population base is needed to identify genetic markers and other characteristics predictive of treatment response, in as much as different ancestry may result in varying genomic structures of diseases.[298]

Advancements in general and public health medicine has brought about an extended life expectancy, and consequently age-related chronic diseases including neoplasms, cardiovascular disease, diabetes, respiratory, and other disorders among them.[299] Although chronic medical conditions associated with longevity are being addressed by precision medicine, such technologies may also become relevant to college health practice. Survival rates for children with chronic illnesses is also increasing, meaning that more children with such conditions are surviving beyond adolescence into adulthood, and are pursuing higher education, as evidenced by nearly 20% of U.S. college students reporting allergic or asthmatic conditions, and over 5% reporting currently having cancer or type 1 diabetes.[300] Previously considered terminal or life-limiting, such conditions are now considered to be chronic, and bears implications for psychosocial functioning and adjustment into adulthood in that many of these students report higher levels of illness intrusiveness in addition to having comorbid mental health adjustment disorders such as depression and anxiety.[301] The transition from pediatric to adult care often takes place at the time of entry to college, and individuals with chronic medical conditions must adjust to tasks associated with their condition such as seeking out campus health care, managing prescriptions, and balancing the challenges and demands of college life.[302]

The field of pharmacogenomics as part of the field of precision medicine may hold further promising possibilities for people with chronic diseases by discovering how a person's genes affects their response to medications, which will lead to physicians selecting drugs and doses best suited to each individual.[303] The FDA currently includes pharmacogenomics information for nearly 200 medications, allowing physicians to tailor prescriptions for people with certain gene variants for dosing, side effects, and levels of effectiveness all the while drug companies continue to develop and market medicines for people that have specific genetic

profiles.[304] It is astonishing to think of the related advancements that will affect the future – which is actually the present – of both public and college health.

Epigenetics. The impact that our environment has in terms of population wide exposure toward long-term effects on DNA of future generations is the crux of epigenetics, defined as stable changes in gene function usually due to environmental factors that cannot be explained by differences in the DNA sequence alone.[305] There is evidence from both epidemiological analysis and animal models to support that epigenetics traverses generations, (intergenerational effect) evidenced in common public health concerns, for example maternal nutrition in a mother's childhood being linked to increased risk of her children incurring illness if as a child she was poorly nourished, as well as the effects of smoking in mid-childhood affecting next generation growth patterns.[306] Realizing that the human genome contains two copies of every gene (one inherited from the mother and one copy from the father), for a limited number of our genes only the copy from one parent is turned on, or vice-versa – known as imprinting, meaning that the epigenome discerns between two copies of the same imprinted gene to determine which is switched on.[307] Over a lifetime, the epigenome can change with environmental or lifestyle influences which prompt chemical responses in the DNA, which in turn cause changes to the epigenome, including smoking, diet, and exposure to infections.[308]

The future of genomic science and technologies is unfolding before us, and the impact that epigenetics/epigenomics will have in conjunction with each new discovery will upend traditional concepts of our understanding of many diseases as well as that of public health. A very recent article in the New England Journal of Medicine foretells that epigenetics will lead to a new age of understanding of how a patient's genome, environment, development in the womb, and disease risk all weave together, and that the sciences of genomics, epigenetics,

epidemiology, and others will adjoin for new and vastly improved prevention of disease as well as lessening their effects.[309] Within this article, replete with technical biologic and scientific details, a bold statement is made by the author that he and his colleagues assert that all cancers have similarities, and that a central feature of the disease is a disrupted, unstable epigenome impacted by not only mutations but by antecedent epigenetic changes to normal cells due to age and injury.[310] Considering this example as well as the opportunities for incorporating epidemiology and epigenetics into risk assessment and disease prevention, the possibilities for public health, primary care, college health, and virtually all facets of medicine are seemingly endless.

Conclusion. Young and emerging adults, especially those attending post-secondary institutions of higher education, face many public health challenges that are encumbered by high risk behaviors and other influential factors, whether developmental, generational, societal, or cultural. Specific and tangible areas of high risk that are among those for which scrupulous screening efforts are needed are also inevitably correlated. Substance use, sexually transmitted infections, and disturbances in mental health reign true for the young adult population in general, but have definitive impact upon health outcomes for college students. During this critical period of their lives, young people are building upon a foundation of life-learning, life-skills, and self-sustenance while also balancing independence from continued but marginalized reliance upon parents and mentors. Although that descriptive may be applicable across generations throughout time, there has been an unprecedented cultural paradigm shift of the present-day young adult from their forbearers, inclusive of controlling influences that have caused a plethora of related consequences. Growing up as digital natives immersed in the "internet-generation" with devices in hand and perpetual connectedness with social networking has impacted systems within which

they navigate psychosocial needs that drive their sense of entitlement and desire for belonging, connection, and acceptance.

An increasingly permissive peer-influenced social script which is culturally endorsed by popular entertainment, social media, and multiple other influences has adversely affected sexual health choices complicated by low health literacy and other limitations including neurobiological and developmental complexities that bear upon decision-making capacity. Heavy episodic alcohol and other substance use continues to be a pervasive concern on most college campuses, resulting in negative consequences including death, injury, physical and sexual assault – yet, the social norm of alcohol use being viewed as a rite of passage remains to be a precarious challenge. Institutions of higher education are called upon to address underlying aspects of social and cultural conditions that affect risk-related behaviors, for which campus health centers effectively assume public health management of associated consequences. In that regard, clinicians and healthcare professionals are uniquely positioned to positively contribute to institutional goals of student achievement, retention, and success.

Throughout this discourse, it has been established that fundamental parallels relate public health to college health. In both spheres, health care providers seek to promote health through efforts of prevention by means of education, while developing policies and methodologies to protect each of their respective populations, be it geographic or that of a campus, through recognizing determinants of health that affect the whole. Over time, largely through the efforts of the American College Health Association in standardizing health practices and promotion in higher education, health care services at many U.S. institutions of higher education have evolved to meet the needs of the changing student. Central to the practice of college health is the recognition of how the principles of healthcare ethics apply to our craft, which echo established

principles for the ethical practice of public health, drawing upon key values, beliefs, and shared moral ideals.

Emerging medical technologies are impacting the practice of both of these fields, especially as regards research in genomics and genetic medicine as a flourishing scientific endeavor with daily pronouncements of thrilling new developments. By considering each of the principles of healthcare ethics – autonomy, beneficence and maleficence, and justice; this final subsection has provided a mere glimpse into applications of genomic medicine that touch public health, reach toward college health, and offer a future for both as if taken from the imagination of writers of science fiction.

Infectious disease, immunizations, sexually transmitted diseases, the prevalence of mental health co-morbidities, and substance use and abuse are but a few of the hot-topics that persist as utterly relevant to college health. Non-traditionally aged students, post-combat veterans, international students, and students with limitations due to chronic illnesses and disabilities all contribute to a vastly diverse landscape that beckons us to open ourselves to possibilities for improved amenities, expanded offerings, and the provision of services that are in pace with the general medical community. The concept of campus-wide wellbeing is at the forefront of academic discourse, and health services are crucial to a successful environment of wellness. A future with genomic medicine as integral to those expectations is quite possibly not too distant.

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Chapter 7: Conclusion.

This concluding chapter presents a brief summary of the analysis to consider the contribution of the work to College Health Services.

Summary of Analysis. Chapters 2 and 3 present the context of CHS as a basis for the analysis in the dissertation. In chapter 2 the discussion of CHS as an evolving field provides a historical perspective and an explanation of CHS as being a healthcare system. The historical perspective involves a brief look back at the emergence of the field, a consideration of evolving trends and development, the contribution of the formation of a new organization for the field, and how CHS fits in today. The discussion of College Health Services as a Healthcare System explains how College health services function as a healthcare system regarding student-centeredness, its impact on the university community by means of quality of services, health prevention, promotion, education, and other student services.

Chapter 3 continues to present the context of CHS as a basis for the analysis in the dissertation. This chapter discusses the relevance of prominent principles in healthcare ethics as a foundation for the development of an approach to professional ethics. The ethical approach of Principlism is explained for College Health Services via a brief introductory analysis of each of the four basic principles of healthcare ethics: autonomy, beneficence, non-maleficence, and justice. Further ethical concepts for College Health Services are discussed, including common morality and virtue, vulnerability and discrimination, the professional-patient relationship, and consent and surrogacy.

The subsequent chapters present an approach to professional ethics by engaging pivotal themes that shape CHS. Chapter 4 explains the importance of quality and virtue in professional ethics for CHS. Regarding professional practice and quality, professional ethics is considered in

view of professional morality and the caring professions, patient trust and professional practice, the necessity of inter-professional collaboration, and quality services. Professional character and virtue are considered in relation to discourse on virtue ethics as being important for CHS, including how virtue relates to practice, the foundation of character, and matters of conscience.

Chapter 5 continues the discussion of professional ethics in consideration of care and wellbeing in CHS. The importance of professionalism and care for CHS is explained in relation to Care Ethics by considering its roots and origins, challenging viewpoints, and complimentary findings including a direction for caring and alternative approaches to care. The significance of wellbeing and ethics for CHS is explained in relation to considerations of happiness, the concept of holistic wellbeing as an institutional concern, health capability and health related quality of life.

Chapter 6 addresses the role of agency and accountability in professional ethics for CHS. Two related areas are considered. First, there is a discussion of practice standards of institutions with regard to organizational ethics. Here, the significance of organizational ethics for CHS is discussed in relation to organizational moral agency, institutional mission and commitment, organizational identity, and accountability and practice standards. Second, there is a discussion of the ethical accountability of healthcare providers regarding high risk health-related practices of young adults. Here, the analysis focuses on the public health challenges of young adults, considering root causes and systems approaches that include capacity, understanding, and agency, as well as precision medicine and epigenetics.

Contribution of the Work. College health services are as varied as the institutions in which they are situated, and encompass an equally diverse range of healthcare and non-healthcare professionals along with support staff who provide essential clinical and related

services to students and others. Over time, a multitude of historic, political, and cultural influences affected the evolution and development of health services on college campuses. The field of college health was further advanced through establishment of a national organization (currently the American College Health Association) which fostered a professional network, facilitated further refinement, and provided a forum for advocacy. Given this progression and in consideration of continued growth within this unique realm of medical care, an introduction to healthcare ethics for all college health professionals is exceedingly relevant. This work is a resource that provides historic perspective, discusses college health as a healthcare system, introduces ethical principles of autonomy, beneficence, non-maleficence and justice as well as general ethical concepts for practical application, and frames this exclusive niche of medicine further through professional ethics that are relevant to all institutions of higher education. This is the essence of why this analysis is necessary.

CHS function to assure and improve the health of the student population of the institutions that they serve, protect against overt health threats, provide equitable access, and engage those who are cared for in decisions affecting their health in order to meet both needs and expectations holistically – defined components of a well-functioning health system. This illustrates that college health services, themselves, constitute a healthcare system, albeit along a vast continuum of practice size, type, and scope. Universally applicable tenets toward establishing a just culture in the practice of college health are relevant across-the-board, from small, one-nurse health offices in community or rural colleges, to complex health centers with highly specialized, varied medical providers and services numbering in the hundreds. Elements of healthcare systems that are horizontally and vertically integrated toward student-patient

centeredness, safety, efficacy, and efficiency are characteristics that can apply to all CHS practices and correlate to the campus environment.

A multitude of variables - biological, behavioral, emotional, and developmental - affect and influence the health status of college students. Healthcare facilities on college campuses are uniquely positioned to impact retention, progression, and graduation through the services provided, thus the practical application of ethics to the practice of college health is both necessary and essential. Regardless of reason, condition or co-morbidity, the newly autonomous college student accessing services becomes the independent consumer of healthcare, and college health service clinicians must bear in mind the substantial impact of developmental influences while providing care. Overall, it is incumbent upon college health services staff to respect the autonomy of the college student in the context of multiple social, developmental, behavioral, and physical health complexities.

College students inherently encounter numerous challenges to their health and wellbeing. Analysis of variables to student success correlates to multiple factors, with health-related concerns situated high atop the list. Health related practices and behaviors should be a focal concern of campus governance and leadership across both academic disciplines and student affairs administration. Moreover, college health professionals must acknowledge and respect the student's adjustment to autonomy while carefully developing a trustworthy relationship as care-giver and acting in such a way that indeed contributes to their welfare through clinical encounters viewed as opportunities to impact the wellbeing and quality of life of the student and the campus community. By providing beneficial and impactful services that not only meet the physical needs of students but also nurture health-seeking behavior through benevolent care practices, positive relationships grounded in the ethical principle of beneficence are fostered.

Ordinary yet impactful day-to-day circumstances are cause for health services staff to discern due care in consideration of the principle of nonmaleficence, as well as by means of thorough patient education, outreach and promotional programs toward effectively reducing health risks. CHS professionals must always bear in mind the credo, 'above all, do no harm' in each and every interaction with the college students whom they serve.

Wellbeing as a central issue within the university community deems that being healthy, being secure, and being respected are desirable states of being, and the principle of justice is realized in attaining a state of well-being, not merely by the capability to pursue it. College students, in order to thrive, must also be enabled to achieve wellbeing through tangible conditions that are constructive to health. CHS must advocate for the needs of diverse constituents when establishing and implementing culturally relevant and inclusive programs, services, policies, procedures, and practices. Broad and intentional collaboration with other campus services will assure a comprehensive and ecological approach for students toward eliminating health disparities and achieving health equity while augmenting opportunities for wellbeing, which echoes basic precepts of public health.

The four moral principles of autonomy, beneficence, nonmaleficence, and justice are theoretically and practically relevant to the ethical practice and effective functioning of clinical health services on campuses of institutions of higher education. Notwithstanding the varied continuum of what constitutes campus clinical health services, at the epicenter are an equally diverse patient population. Those who are cared for, educated by, and nurtured through integrated health and wellness services are the future consumers of health care in the public square and marketplace. College health professionals will hopefully prepare students adequately in deference to the four principles of healthcare ethics by nurturing autonomy, providing

benevolent care, reducing potential harms, and in respect of due justice, by inspiring a true culture of wellbeing.

College health professionals are poised to influence the health and wellbeing of those trusted to their care, and as such must also have an innate understanding of other ethical concepts such as morality and virtue, in addition to a basic perception of ethical principles. When institutions themselves emphasize reputations based on historic relevance, founding identity, or significance of institutional mission - the subsequent expectation for campus health services as being held to that same standard rises precipitously. Professionals who work in the college health setting by introduction to professional ethics will realize that moral standards, principles, and values should drive the professional conduct of the all involved in this service as they care for students and others. A sensitivity to the issues and vulnerabilities that contribute to the turbulence of the life of a college student will benefit our care of them through cultivation of a climate of professionalism, trustworthiness, and advocacy. CHS informed by the four universal guiding principles and influenced by moral excellence and fundamental virtues will sustain a culture of excellence. By constructing an ethics infrastructure within which moral principles undergird a commitment to clinical excellence and health promotion, the students served will not only benefit, but will prosper and thrive.

CHS must be recognized and valued by their institutions as playing a crucial role in student wellbeing, success, and retention through minimizing the impact of illness, emotional distress, and injury on academic studies, work, and life by providing quality health care. Healthcare providers in college settings are responsible stewards of the health and wellbeing of diverse students in the nuanced context of a learning environment amidst ever-changing trends and influences. College health professionals who uphold moral character traits such as honesty,

integrity, conscientiousness, trustworthiness, fidelity, gratitude, truthfulness, and kindness as virtues that govern their professional conduct will be equipped to confront ethical challenges when they arise. Various models of practice can include staffing clinical services with a variety of disciplines including behavioral health clinicians, depending upon institutional attributes and organizational commitment. Successful elements of teamwork through inter-collaboration include common goals, role clarity, open communication, and improved patient care with stable team structure. Nurses are proportionally the highest staffed profession in college health centers. As a profession, they are commonly understood to effectively collaborate with other healthcare providers and engage as moral agents who contribute to ethical competency in primary practice through their role obligations of knowing how to act and practice collaboratively as fundamental to their education and training. Interprofessional collaborative care requires a relational dimension that is essential to effective patient-centered care and to enhancing total wellbeing, and nursing practice is upheld by relational ethics that construct relationships between the nurse, the patient, and fellow professionals through engagement, mutual respect, and as "being-for-the-other." Professionals working with colleagues from other medical disciplines are asked to understand each other's perspectives, responsibilities, and competencies in deference to professional autonomy, while collaborating inter-professionally necessitates the mutual obligation of beneficence for the recipients of our services. Integrating primary care with behavioral health exposes staff from various disciplines to one another's language and ways of practice, increases bidirectional referrals, and results in ease of discussing multifaceted clinical presentations both between professionals and with patients. Quality improvement and collaborative practice management programs should be developed through an ongoing cycle of assessment that establishes programmatic goals, learning outcomes, employs multiple measures,

and develops processes for gathering and evaluating data, all of which will inform planning and decision-making.

Within professional ethics, the role of virtue is abundantly clear in standards of professional practice, institutional expectations, and within the traditional practices of medicine, nursing, and all health-related professions – however, people differ in terms of individual character traits. Fundamentally, there are elemental virtues that are crucial to the health and caring professions that correlate to role responsibilities, and by contrast vices that are unacceptable in professional life. For healthcare professionals, virtue ethics provides a beacon for understanding moral decision making and prudent actions. In college health practice, given patient turnover by nature of the transience of student enrollment and utilization of clinical services for a finite length of time, health services professionals should conscientiously avoid treating patient encounters mechanically and without a sense of hospitality. The empathetic encounter in the clinical context sets forth good intentions of the practice. It is indispensable for information gathering needed to diagnose and treat through communication and dialogue during all touch-points with the patient. Such concepts of virtue ethics are integral to an introduction to healthcare ethics for college health professionals, with the understanding that virtuous character is shaped, defined, and experienced from a multitude of perspectives and ethical systems. Virtuous traits that sustain a commitment to the good will nonetheless steer college health professionals through challenges and adversities because of a commitment to caring for the other.

Care ethics are relevant to CHS as a further professional ethical approach in consideration of the interrelatedness between the one providing care, and the one being cared-for through a reciprocal commitment that directly influences wellbeing. Through an introduction to

the roots and origins of care ethics as well as various approaches to the ethic of care, CHS professionals will follow that it elevates common practice through acknowledgement of the relationship between care-giver and care-receiver, toward mutual maximization of wellbeing. Wellbeing is of central importance to healthcare ethics in that the wellbeing of humans is foremost a normative concern, although many approaches fail to capture important ethical aspects, insufficiently attending to the fact that wellbeing is a holistic and dynamic phenomenon. Wellbeing can be understood as fundamentally intertwined through both subjectivity and relationality, such that relationships occur between people – resonating with the primary theme of care ethics - through which they become who and what they are by means of this relatedness to others. Throughout this dissertation, wellbeing is a central theme that correlates ethical principles and professional ethics by means of an introduction to healthcare ethics concepts and theories for CHS. Because of institutional diversity, each campus will have its own unique vision for wellbeing that will be appropriate for its students, accepted by its staff and faculty, and attractive to its stakeholders from within and outside of the organization – the particulars of which must be both idealistic and realistic, aspirational and future-oriented. Overall, infusion of wellbeing as a cross-sector priority is congruent with not only individual health related quality of life but promotes an ideal of holistic wellbeing across the institution, only sustainable with CHS at the core.

Because of the evolution and importance of clinical health services due to an ever-changing student population, regardless of size or scope, campus health services are effectively a structured healthcare organization within a larger system - the academic institution - functionally interdependent, to which organizational ethics clearly pertain. That said, as an organization, campus health services are held accountable to core values and moral positions defined by

mission statements which determine the culture by which both clinical care and health promotion are delivered. In light of this, the organizational ethics concept of moral agency applies not only to those who practice in this unique niche of clinical medicine, but recognizes college health services as an organizational entity bearing its own moral agency. CHS supported by a framework of applied ethics specific to the health and wellbeing of college students through a working knowledge of moral and ethical perspectives will continue to guide and inform the specialty. Authentic leaders of college health services are positioned to fuse ethical practice with key organizational processes toward virtue-based practice. From this, a noble organizational culture will proceed, and an infrastructure rooted in ethical principles and a commitment to quality performance through safe, effective, patient-centered and equitable care with ongoing self-monitoring for continuous improvement will assure good and beneficial outcomes.

Ultimately, at the core of CHS are young and emerging adults who face many public health challenges that are encumbered by high risk behaviors and other influential factors, whether developmental, generational, societal, or cultural. During this critical period of their lives, young people are building upon a foundation of life-learning, life-skills, and self-sustenance while also balancing independence in consideration of an unprecedented cultural paradigm shift of the present-day young adult from their forbearers, inclusive of growing up as digital natives immersed in the "internet-generation." Emerging medical technologies will continue to impact the practice of college health, such as through ongoing development of genomics and genetic medicine, which beckon us to open ourselves to possibilities for improved amenities, expanded offerings, and provision of services in pace with the general medical community, secured and reinforced by an ethical framework.

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