

Philosophy of Medicine

Perspective

Trustworthiness, Non-Manipulation, and Public Health Guidance for Individuals

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Abstract

Public health guidance for individuals addresses private members of the public but is delivered through mass communications. We argue that “improving” public health guidance for individuals involves ensuring that it is trustworthy. This points to the need to clarify whose goals or interests such guidance should serve, because to be trustworthy is for a trustee to act in the interests of their truster. Public health guidance for individuals should serve the interests of the members of its target audience, aligning it with clinical medicine. We consider how guidance developers can be responsive to the interests of a heterogeneous public, maintaining trustworthiness by upholding a principle of non-manipulation.

1. Introduction: Wildfire Smoke and Public Health Guidance for Individuals

In 2025, smoke from the Los Angeles wildfires caused a significant increase in fine particulate matter (PM_{2.5}) in the air, later linked to an uptick in outpatient healthcare use (Casey et al. 2025). Even more extreme wildfires in Canada in 2023 degraded air quality across the globe, and scientists attributed between 37,800 and 90,900 deaths in North America and Europe to the resulting PM_{2.5} exposure (Zhang et al. 2025). In light of the threat of wildfire smoke, many are focused on improving the relevant public health guidance, including what we will call *public health guidance for individuals* (Coker et al. 2024). How to “improve” such guidance is a normative question with many dimensions, just one of which is how to ensure it is worthy of trust.

Public health guidance for individuals addresses private members of the public but is generally delivered through mass communications, not clinical (or other direct) encounters. It is not designed with the expectation that a clinician will help recipients interpret or apply it. As we define it, this guidance includes materials like the American Thoracic Society’s



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“tips for staying healthy during wildfires,” which instruct people to “stay indoors as much as possible with windows and doors closed” (American Thoracic Society 2026). It also includes online fact sheets distributed by public health agencies, such as “How to Prepare for Wildfire Season,” written in plain language and containing directions like “purchase a portable air cleaner that uses HEPA filtration to remove smoke from the indoor air” (British Columbia Centre for Disease Control 2024). Fact sheets like these target the general public, unlike other guidance documents that target public health agencies and partners (Coker et al. 2024, 3).¹ We understand them as clinical recommendations given from a population perspective (Alonso-Coello et al. 2016), which straddle the domains of clinical medicine and population-level health promotion. Because of this straddling, it is unclear whose goals or interests the guidance should serve: the individual’s or the population’s.²

In this article, we argue that an important part of “improving” public health guidance for individuals is ensuring that it is *trustworthy*.³ Whose goals or interests such guidance should serve is a contentious question, yet settling it is crucial, because, as we show, to be trustworthy is for a trustee to act in the interests of their truster. We consider how guidance developers can be responsive to the interests of a heterogeneous public, maintaining trustworthiness by upholding a principle of *non-manipulation*.

2. Trust and Trustworthiness in Public Health Guidance for Individuals

If part of improving public health guidance means ensuring it is trustworthy, we need a clear picture of what trust and trustworthiness involve. Among philosophers who study trust and trustworthiness, there is agreement on some basic points (McLeod 2023). Trust is an attitude within a three-place relationship: a truster trusts a trustee with a task. Trustworthiness is the normative property that permits the trustee to invite trust. What it takes to be trustworthy may depend on which truster and trustee we are talking about, and which task is at issue.

When it comes to public health guidance for individuals, we take the truster to be the general public—a heterogeneous mix of people. We take the trustee to be the developers of the guidance—also heterogeneous, but unified in at least one important respect by their roles within a health profession or institution, such as a public health agency or medical association.⁴ Characterizing the task is trickier, but two options echo core philosophical debates about well-being. One possibility is that the guidance developer’s task is to direct individuals toward what will in fact be best for them, according to some substantive theory

¹ How to “improve” guidance documents for public health agencies and partners is itself an important question, but we set it aside in this short article. For a comparison of public health guidance for individuals versus public health agencies and partners, see Coker et al. (2024).

² Some may hold that public health guidance for individuals can and should aim at a compromise or middle ground between advancing individual interests and population-level goals, or between supporting people’s own conceptions of well-being and directing people toward what is in fact best for them. That is a difficult argument to make, and we do not pursue it here.

³ Strictly speaking, we take trustworthiness to be a property of agents (or possibly agent-like institutions), not of objects like guidance documents. Where we ask what makes public health guidance for individuals “trustworthy,” we are using a shorthand for the more careful but laborious question “what makes guidance developers trustworthy in their role as producers of that guidance, in a way that warrants extending the label to the guidance itself?”

⁴ Many public health agencies give guidance about wildfire smoke (Coker et al. 2024); an example of a medical association that does so is the American Thoracic Society (2026).

of well-being. Another possibility is that the guidance developer's task is to help individuals make autonomous decisions that align with their own values and serve their own conception of their well-being.⁵

Before we characterize the guidance developer's task as trustee, we reinforce that we have conceptualized the truster as the public, a heterogeneous mix of people. To call public health guidance "trustworthy" is to say that it is worthy of trust from the *public's* perspective, not merely that it is epistemically reliable or produced with good intentions. This way of tying trustworthiness to the standpoint of particular trusters aligns with Alison Hills's (2023) account of trustworthiness as responsibility to the truster, requiring the "right" values and judgment relative to them. Our analysis is informed by Hills's (2023) responsibility-focused view and Carolyn McLeod and Emma Ryman's (2019) account of fiduciary trust, both of which emphasize complex role-responsibilities and the duty to be responsive to the truster's values. While there is no single consensus account of trustworthiness—and no analysis likely captures every kind of trust relation—these accounts are well suited to analyzing trustworthiness in the relationship between public health scientists and the public. This is because this relationship is marked by an asymmetry of knowledge and by the trustee's exercise of discretion in interpreting and presenting information.

If the truster is a heterogeneous public and trustworthiness requires responsiveness to the truster's values, this constrains how one understands the guidance developer's task. On our framing, that task cannot be to direct everyone toward what is "in fact best" for them, regardless of their values. This shows that we have a view about whose purposes public health guidance for individuals should serve.

The dominant view in clinical medicine is that guidance should serve the patient (Charles et al. 1997; Elwyn et al. 2012), whereas population-level health promotion is typically understood as serving the health of the population (Public Health Agency of Canada 2001; Robinson 2022), according to a preferred conception of health set by institutional decision-makers (Kukla 2014). By conceiving the truster of public health guidance for individuals as the heterogeneous public, and not institutional decision-makers, we are effectively aligning that guidance with clinical medicine rather than population-level health promotion. In short, we take public health guidance for individuals to be accountable to the members of its target audience, not a paternalistic overseer.

3. Trustworthiness and Respect for the Truster's Autonomy

On our view, the guidance developer's task as trustee is to help individuals make autonomous decisions that align with their own values. We understand autonomy as a form of self-governance—the capacity to reflect on and endorse one's own reasons and values, and to direct one's life in light of them (Dworkin 1988; Christman 1991)—that is relational, exercised within social and institutional relationships that can either support or undermine it, and does not require total self-sufficiency or control over one's options (McLeod and Ryman 2019). This conception of autonomy, alongside a commitment to respecting it,

⁵ A third option, of course, is that the guidance developer's task is simply to describe facts about the world, not to direct people or inform their decision-making. However, we think it is obvious that the public demands more than this from health guidance and, moreover, that guidance developers aim to provide more, so we do not entertain this characterization of the task in this paper.

shapes our analysis of public health guidance developers' ethical duties to those whose trust they invite.

The relationship between trust and autonomy is contested. Some take deference to other agents (for example, legal or medical experts or fiduciaries) to be inherently autonomy-eroding, while others argue that autonomy can be supported by (and often requires) trusting relationships with agents who exercise discretion. We follow McLeod and Ryman (2019) in rejecting the assumption that trust and autonomy are always at odds. When a trustee's discretion is guided by the truster's values and objectives, partial deference can be autonomy-enhancing rather than autonomy-eroding, whereas *complete* deference to experts necessarily implies a loss of autonomy. McLeod and Ryman define complete deference as "letting others do what they think is best without them knowing what we want in our circumstances," and partial deference as allowing them to choose for us with our autonomous goals in mind (2019, 81). Although an autonomous agent may choose to defer completely to the expert, that decision is, by definition, the last autonomous decision they will make in that trust relationship.

On this picture, the question of what makes guidance developers trustworthy is inseparable from the question of how they use their discretion to support, rather than replace, individuals' autonomous decision-making. McLeod and Ryman's (2019) analysis is helpful here, as it shows how the fiduciary–beneficiary relationship is similar to the relationship between guidance developers and guidance users. In particular, they stress that fiduciaries exercise discretion when deciding what information to give their beneficiaries, how to present it, and whether to recommend a specific course of action—the same forms of influence that guidance developers have over guidance users. Both relationships thus involve asymmetries in knowledge and influence. One important difference is that fiduciaries frequently have the power to take action on behalf of their truster—for example, entering a plea on their behalf—whereas guidance developers never do.⁶ This might tempt one to think that guidance developers take on less responsibility, since individuals remain free to ignore their advice. But guidance developers occupy their position of influence willingly, and they are compensated for it, materially and socially. In exchange, they must assume at least some ethical responsibility for how their guidance shapes trusters' deliberation and decisions (Douglas 2009). This is consistent with recent arguments that public health officials should be held accountable for Covid-related advice that was not adequately supported by science (Rasmussen et al. 2023). However, this means we must articulate, as precisely as we can, what guidance developers are responsible for, in virtue of their role. Following Hills's account of trustworthiness as a form of responsibility, specifying these responsibilities is to give an account of what it is for guidance developers to be trustworthy in this context (Hills 2023).

4. Responsibilities of Trustworthy Guidance Developers

We have argued that a trustworthy guidance developer supports individuals' autonomous decision-making. Their first responsibility is to provide the available information that is relevant to the decision at hand. Contemporary decision frameworks already give us a

⁶ Of course, government decision-makers sometimes exercise coercive or directive powers on behalf of the public (for example, issuing mandates or closing venues), often under the influence of the same people who develop health guidance, but government decision-makers are not themselves guidance developers.

reasonably clear picture of what this includes. Approaches such as the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Evidence-to-Decision framework (Alonso-Coello et al. 2016) and the Ottawa Decision Support Framework (Stacey et al. 2020) converge on a set of core informational domains that are clearly relevant to individual decision-making. We can take these as a starting point and extend them to other questions relevant to autonomous deliberation, drawing on philosophical work on scientific evidence and decision-making (Winsberg and Harvard 2024; Winsberg 2024).

First and foremost, guidance developers are responsible for describing the nature of the decision and the available options, as well as the expected benefits and burdens (that is, possible side-effects, harms, inconveniences, or costs) of those options, described not only qualitatively but quantitatively (that is, in terms of effect sizes), wherever possible. Equally relevant to rational decision-making is the uncertainty about these benefits and burdens, which means guidance developers should give not only point estimates but also the plausible range of effect sizes within which benefits and burdens are likely to fall. Once they do this, however, they cannot responsibly stop at a bare confidence interval. This is because a range from a weak or highly indirect body of evidence does not necessarily inform rational choice in the same way as a range from a robust body of direct evidence. Thus, to avoid misleading users, guidance developers must indicate the overall quality of the existing evidence and also acknowledge where relevant evidence does not yet exist at all. Furthermore, because experts routinely dispute how much weight to assign to different sources of evidence, guidance developers should characterize the state of expert agreement or disagreement about how to interpret the evidence they have described. This tips over yet another responsibility domino: Guidance developers owe users an account of who put the guidance together, what qualifies them to do so, and how their capabilities and judgment compare to others who might have done the job instead. Finally, guidance developers should be clear that there is more than one reasonable way to weight benefits and burdens, and cue individuals to consider how they perceive the relative desirability of their options. Providing this higher-level information is equally crucial, since on a relational autonomy view, supporting individuals' autonomous decision-making means fostering their process of reflective deliberation.

5. Trustworthiness and the Case of Wildfire Smoke Guidance

Expecting public health guidance developers to provide the above decision-relevant information applies familiar ideas from fiduciary theory and shared decision-making in clinical care: Agents who exercise discretion over information owe those who depend on them the kinds of information they need to govern themselves according to their own reasons and values (McLeod and Ryman 2019; Ludewigs et al. 2025). Specifying the guidance developer's responsibilities in these terms is valuable, because it shows where existing public health guidance for individuals could do more to meet this standard. For example, the American Thoracic Society gives instructions during wildfire smoke events—"stay indoors as much as possible with windows and doors closed" (American Thoracic Society 2026)—yet fails to include any discussion of expected outcomes, uncertainty, or evidence quality, nor any reflective prompts or questions that engage with what matters to

people.⁷ We have two concerns about these omissions. While the first will likely be shared only by preference-satisfaction theorists or others who accept a pluralist conception of well-being, the second should give pause even to those who think guidance should pursue a singular goal, such as protecting lung health.

First, guidance such as “stay indoors as much as possible with windows and doors closed” misses an opportunity to support autonomous decision-making by individuals with different circumstances and values. For example, someone who experiences a serious decline in mental health from staying indoors may reasonably wonder whether the associated benefits to lung health outweigh the harms to their mental health. For them, helpful guidance would describe the marginal lung-health impact of staying indoors and show sensitivity to the dilemma posed by the tension between lung health and mental health. However small the risk may seem, guidance should guard against this worst-case possibility: steering individuals toward an action that is net harmful for their well-being, by obscuring the relevant trade-offs and inhibiting their own value-guided deliberation.

Second, even if we assume a conception of health that prioritizes lung function over mental health, guidance like this may fail to advance its own goal because of the details it omits. Notably, recent evidence suggests that indoor PM_{2.5} and other smoke-related pollutants can, under at least some conditions, approach or exceed outdoor levels, depending on building characteristics, ventilation, and indoor sources (NCCEH 2026). By bypassing real-world complexity and scientific uncertainty, a simplistic direction like “stay indoors as much as possible with windows and doors closed” could risk undermining its own goal, effectively encouraging at least some people to remain in indoor environments that are more dangerous to lung health than available alternatives. A related concern is that people with already poorer-quality housing and fewer options for mitigating exposure could be more likely to suffer harm from simplistic advice.

These two worries help to clarify why we have conceived the truster of public health guidance for individuals as the heterogeneous public, rather than as institutional decision-makers with a single, preferred conception of well-being, and why we argue in favor of aligning this guidance with clinical medicine rather than population-level health promotion. One reason for this stance is that, to justify directing people toward any action (even an ostensibly health-protective one), one must be reasonably confident that it will not do them more harm than good. On our view, being reasonably confident in this sense requires a sufficiently advanced and stable body of relevant scientific evidence. As we have previously argued, this sort of evidence takes time to develop and is more the exception than the rule (Harvard and Winsberg 2021). Thus, although we do not claim that it is never acceptable to attempt to direct people toward a specific health behavior, we maintain that the evidentiary bar for doing so is high. When it is met, it may be appropriate for health scientists working in population-level health promotion to support institutional decision-makers in adopting directive policies—in such cases, the truster is the institutional decision-maker, not a heterogeneous public. In the more common situation where the science is still developing, it is not appropriate for institutional decision-makers to be directive; here, the truster is the heterogeneous public, and the task is decision support. This is where we locate public health guidance for individuals.

⁷ We should note that the American Thoracic Society is not unique in this respect. Readers will easily find other public health agencies that give similar advice, but one example suffices for our present purposes.

6. Trustworthiness, Discretion, and “Representational Risk” in Guidance Development

We have argued that guidance developers are responsible for providing decision-relevant information across several well-established categories, but the devil is in the details. Instructing guidance developers to address core informational categories does not specify their responsibilities completely, because they must still use their discretionary judgment when handling what Hills (2023, 749) calls the “open-ended” details of their complex task. Indeed, Hills (2023) emphasizes that it is neither possible nor desirable to specify in advance exactly what a trustee must do in every circumstance. This means that responsibilities that can be articulated are only one part of what trustworthiness-as-responsibility involves.

Guidance developers must exercise their own discretion when deciding what to include within each core informational category and how to present it. These include fine-grained choices about how to frame alternative protective actions (for example, how exhaustively to describe different types of air filters or masks), which uncertainties to address (for example, those arising from imperfect evidence versus complete knowledge gaps), and how to explain the downgrading of evidence (for example, whether to explain distinct types of limitations or summarize them more generally). We cannot specify in advance how guidance developers should handle these fine-grained choices in every context. This is troublesome, because these choices pose “representational risk” (Harvard and Winsberg 2022, 11). Each one involves anticipating and weighting the potential harms of disclosure versus nondisclosure: judging, on the one hand, the risk of denying individuals information they need, and on the other, the risk of burdening them with details that will hinder rather than help their decision-making. And as much as we have stressed the need for trustees to understand and center their trusters’ values, there is, realistically, no way for guidance developers to ensure their every choice reflects the values of a heterogeneous public.

While some gap between guidance developers’ discretionary judgments and individuals’ own preferences is inevitable, this does not mean that trustworthiness is unattainable. It does mean we need a clearer normative standard. We need a high-level principle that gives guidance developers a workable sense of what their role ethically demands, one that builds on Hills’s (2023) account but says more about how the discretionary part of their responsibility must be exercised if it is to be worthy of trust.

7. A Principle of Non-Manipulation for Public Health Guidance

The principle we have in mind is simple and unsurprising, given our other commitments: *non-manipulation*. Although trustworthy guidance developers must use their discretion when making fine-grained choices, they must refrain from covertly steering individuals to adopt specific behaviors. They must support individuals’ autonomous deliberations and conceive of success in terms of decisions that result freely from those deliberations and reflect individuals’ own reasons and values. Although philosophers widely recognize an ethically acceptable form of “rational persuasion” (Blumenthal-Barby 2012, 346), we argue that this form of influence is not attainable in the guidance developer–user context. This is because the relationship involves marked asymmetries in knowledge and influence, and the

communication medium is inherently indirect and one-sided. Indeed, public health guidance has the limitations of all “public communication” contexts, wherein speakers cannot identify individual-level features of their audience members and must therefore make assumptions about them (John 2015, 84). It lacks precisely what the clinical encounter provides; that is, the contextual factors and opportunities for dialogue with the patient that support communication in medicine (Chin-Yee 2023).

Manipulation is often framed as a form of influence that falls between two normative extremes: coercion, rejected as generally impermissible, and rational persuasion, regarded as the ethically acceptable ideal (Blumenthal-Barby 2012). Where exactly “good” rational persuasion ends and “bad” manipulation begins is what philosophers debate. We take manipulation to occur when guidance developers seek to persuade individuals to adopt a preferred behavior, either by overtly endorsing a particular action or by covertly shaping how individuals perceive their options or the supporting evidence in ways that bypass or constrain their capacity to deliberate in line with their own values—for example, by excluding, downplaying, or distorting decision-relevant information (Harvard et al. 2021; Winsberg and Harvard 2024). The only form of influence that we take to be ethically acceptable on the part of the guidance developer is what we call “nondirective” influence.⁸ For example, when a clinician presents her patient with the best available information about treatments A and B, makes it clear that the choice between them is preference-sensitive and that either one is reasonable, and explicitly invites the patient to judge for herself which treatment she prefers, we take it that the physician influences the patient, but without coercing or persuading her, overtly or covertly, to adopt a preferred course of action.

We can anticipate three follow-up questions. First, what do we have to say about guidance developers’ intentions? Can they still be charged with manipulation if they steer individuals in a particular direction only semiconsciously? Yes: on our view, explicit, fully formed intention is not required for manipulation. Rather, we recognize guidance developers as manipulating whenever they either overtly endorse a specific option or exercise their discretion over information and framing in ways that they know (or reasonably ought to know) will steer behavior by bypassing or constraining value-guided deliberation, even if they would resist describing themselves as “trying to manipulate” anyone. This means guidance developers must take reasonable care in presenting a balanced picture of the available options and the supporting evidence.

Second, should our context-specific account be read as saying that manipulation is always wrong? The short answer is no: We are not attempting to settle the general question of whether manipulation is ever permissible across all domains of life. Our claim is narrow: In the context of developing public health guidance for individuals, manipulation in our sense is never acceptable. Because we take guidance developers’ task as supporting, rather than replacing, autonomous decision-making, any attempt to steer behavior—whether by

⁸ We are adapting this term from the genetic counseling literature, where, on our reading, “nondirective” counseling means avoiding, altogether, the goal of persuading your audience to adopt some preferred course of action (see, for example, Clarke 1992). We are aware that just because one stops short of persuading in favor of a preferred course of action, that does not imply that one reaches the end of the spectrum that goes from coercion to rational persuasion. In the context of an expert giving guidance to a lay audience, the asymmetry of epistemic position makes it unavoidable that the expert will fail to meet that ideal. However, we think most readers have a good enough primitive understanding of manipulation—including when an expert’s good-faith effort to convey what they know while respecting their audience’s autonomy strays into it—that we think it is useful to introduce nondirective influence as a normative standard whose primary goal is to avoid manipulative guidance.

overtly endorsing a preferred action or by excluding, downplaying, or distorting decision-relevant information—undermines their trustworthiness.

Third, what do we have to say about the various forms of nonrational influence that many consider too benign to count as manipulation? Popular examples include things like nudges and warnings meant to communicate risk (Noggle 2018). Our answer is again straightforward: In the context of public health guidance for individuals, any technique that steers individuals toward a preferred behavior, either overtly or covertly, is *pro tanto* wrong. What matters for us is not whether information provokes emotion but whether it is being used to steer. For example, if guidance presents the comprehensive range of alternative actions in the face of unstoppable wildfire smoke, all of which have baked-in burdens and fail to fully protect against risks, it may inevitably elicit unease among its readers. However, if it remains neutral about which action a person should take and acknowledges that wildfire smoke presents a real dilemma whose management requires reflection, it does not manipulate. In contrast, guidance is manipulative when it makes just one course of action appear uniquely acceptable, thereby stifling other reasonable responses.

Having clarified what we mean by manipulation, we can now say why it is incompatible with trustworthiness. Manipulation is not autonomy-promoting: While partial deference can be autonomy-enhancing (McLeod and Ryman 2019), we must recognize that the truster's deference and the trustee's influence exist in interaction, and along a continuum. Thus, we cannot simply say that complete deference is problematic while partial deference is benign; instead, we must draw a finer line that explicitly refers to the trustee's influence. On our view, that line falls where that influence becomes manipulative, no longer promoting the trustee's autonomous deliberation and decision-making.

8. Toward Non-Manipulative Public Health Guidance for Individuals

We have argued in favor of a normative shift in the development of public health guidance for individuals, toward an explicit understanding of its purpose as supporting individuals' autonomous decision-making, rather than persuading them to do anything in particular. What proportion of current public health guidance for individuals is overtly or covertly persuasive in this way is a value-laden empirical question that we have not addressed in this paper. However, there are prominent examples of wildfire smoke guidance with a *prima facie* intent to persuade individuals to adopt specific behaviors,⁹ including guidance that endorses health-protective actions supported by only low-quality evidence, such as air filters and masks (NCCEH 2025a; 2025b). Shifting guidance developers away from the goal of persuading to adopt a preferred course of action is, we have argued, a justified first step.

If the goal of public health guidance for individuals should come to be seen as supporting decision-making, further work will be needed to help guidance developers recognize and avoid manipulation. Even the use of frameworks like GRADE and the Ottawa Decision Support Framework—which embody a degree of respect for autonomous decision-making—does not prevent guidance developers from stacking the deck in favor of a given action. For example, nothing in GRADE constrains scientists from formulating research questions so narrowly that they avoid having to downgrade for indirectness: A rapid review of masks

⁹ Guidance from the British Columbia Centre for Disease Control is just one such example: <https://www.bccdc.ca/health-info/prevention-public-health/wildfire-smoke#Protect> (accessed July 20, 2026).

during combustion-derived air pollution episodes, for instance, can legitimately focus on chamber studies of filtration performance while leaving the real-world effectiveness of masking essentially unaddressed (NCCEH 2025b). This may steer attention toward proxy outcomes, downplay the lack of evidence from the very conditions in which individual decisions must be made, and subtly inflate the expected benefits of an intervention, unless reviewers either undertake parallel assessments of direct evidence or clearly explain that laboratory findings do not straightforwardly generalize to real-world conditions.

We anticipate objections to our proposal. Some may hear us as saying that public health officials must identify a literally comprehensive set of alternative actions and exhaustively map stakeholder values, when they obviously cannot; others may see our argument as purporting to care about individuals while ignoring their desire for simple, actionable messages. While we cannot respond to these concerns in a detailed way here, we acknowledge the need to get clear on what constitutes a reasonable balance of comprehensiveness and comprehensibility and we favor working with the public to do so (Harvard et al. 2025).

Finally, we expect that many guidance developers will be reluctant to adopt a decision-support model, out of concern that this means failing in their professional duty to encourage people to protect their health. Our view is that this concern should not override fears of undermining autonomy or giving harmful advice, and we should retain some faith that people can make good decisions for themselves. At the same time, as we have argued, there is room for population-level health promotion to work with institutional decision-makers when the relevant scientific evidence is sufficiently advanced and stable. We know from experience that guidance developers grapple with hard questions about what to “recommend” to individual members of the public. The view we have outlined here suggests making recommendations only when it is possible to be non-manipulative. In a way, we think this makes the guidance developer’s job morally easier—at least, enough to balance the added responsibilities we have articulated for them.

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