Ethics Large and Small: Moral Considerations in Response to Childhood Obesity

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Objectives

- Explain ethical tensions between individual choice and public health initiatives
- Identify ethical issues that arise when law and policy speak to obesity and nutrition
- Discuss the morality of state-based efforts

Disclosures

I am an aging, balding, "widening," white, male academic and clinical ethicist who studied philosophy in order to solve "meaning of life" problems. I ended up reading about American Pragmatism and working in medical environments my entire professional career. So, I pretty much failed to achieve my initial dream.

I am not a lawyer; don't play one on TV. *If I say anything remotely sounding like the law, nothing I say should be construed as legal advice—seriously, *nothing*…*

I *may* mention a book, and possibly a paper or two, that I wrote—as if they have something useful to add to this presentation. (They probably don't.)

I have no financial conflicts of interest, though I wouldn't mind the opportunity to consider seriously having some financial conflicts of interest.

Now, my bosses do like that I give these talks as they believe it makes me (and them) look important. So, I do get "status points" from my institutional for giving these talks…but since they don't really know that it is all smoke-and-mirrors, I'd appreciate you not telling them. And as such, listen and "learn" at your own peril.

As you can tell already, my slides are always too busy

The Public and the Private: Balancing the Common Good and Individual Liberty

A LITTLE BACKGROUND

Individual vs. Society

Liberty Interests

- Personal autonomy
- Self-interest
- Unfettered access
- Parental rights

Common Good

- Benefit Society
- Equal Burdens
- Environmental considerations
- Protect children

Personal Care vs. Social Health

Patient

- Privacy
- Participatory choice
- Personal hygiene
- Freedom of movement
- Open access to treatment options

Society

- Mandatory Reporting
- ACA (Obamacare)
- Sanitation
- Involuntary commitment
- Resource management

From Nancy Kass, ScD (Johns Hopkins), 2001/2014

FRAMEWORK FOR PUBLIC HEALTH ETHICS

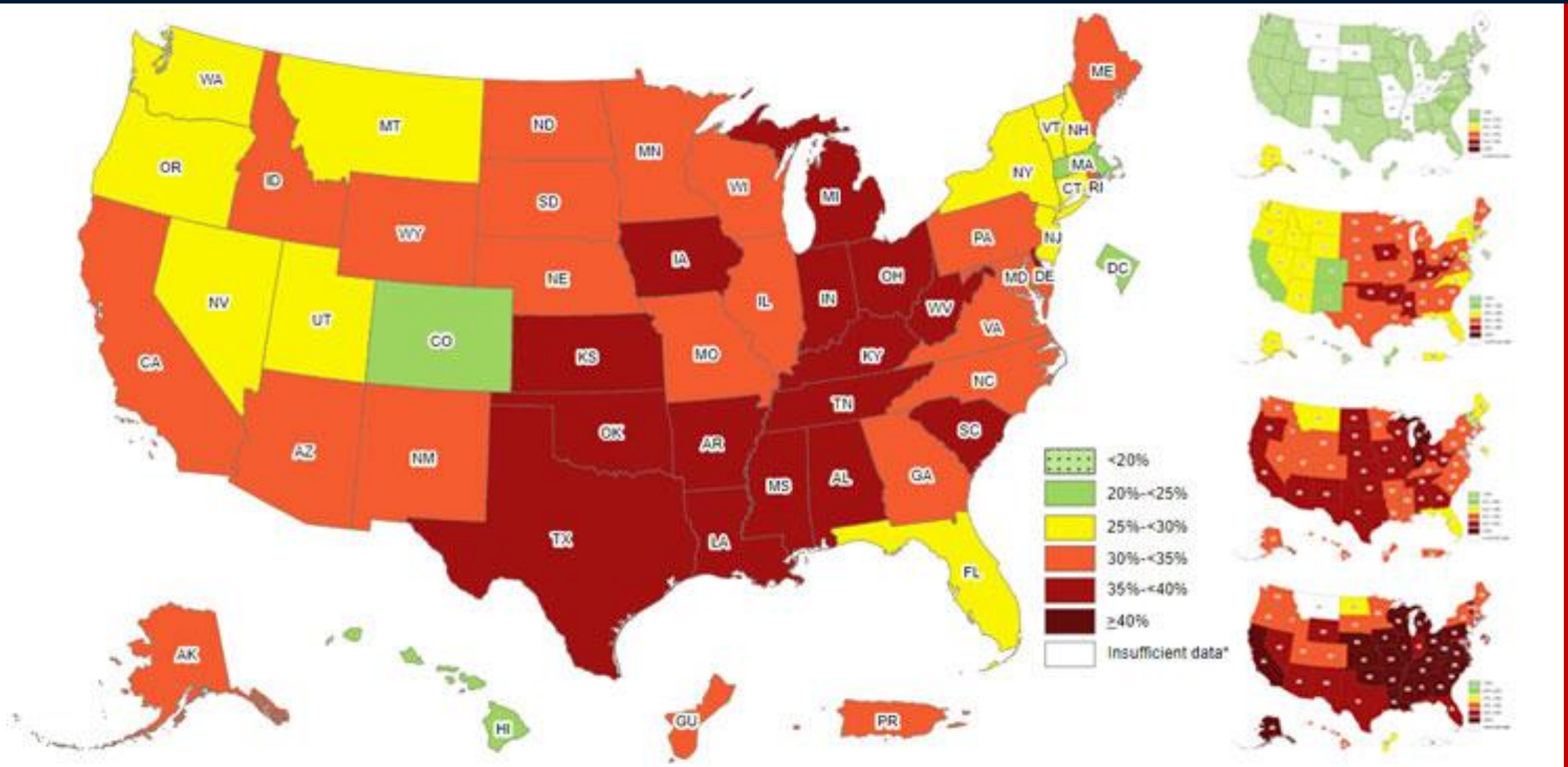
Six Principles for Public Health Ethics

- Establish Goals
- Determine Effectiveness/Benefit
  - Minimize Burdens
- Consider Burdens/Risks/Harms
  - Maximize Benefits
- Reduce Inequalities and Promote Justice
- Ensure Fairness in Procedures
- Follow the Evidence Where Possible

Kass NE 2001

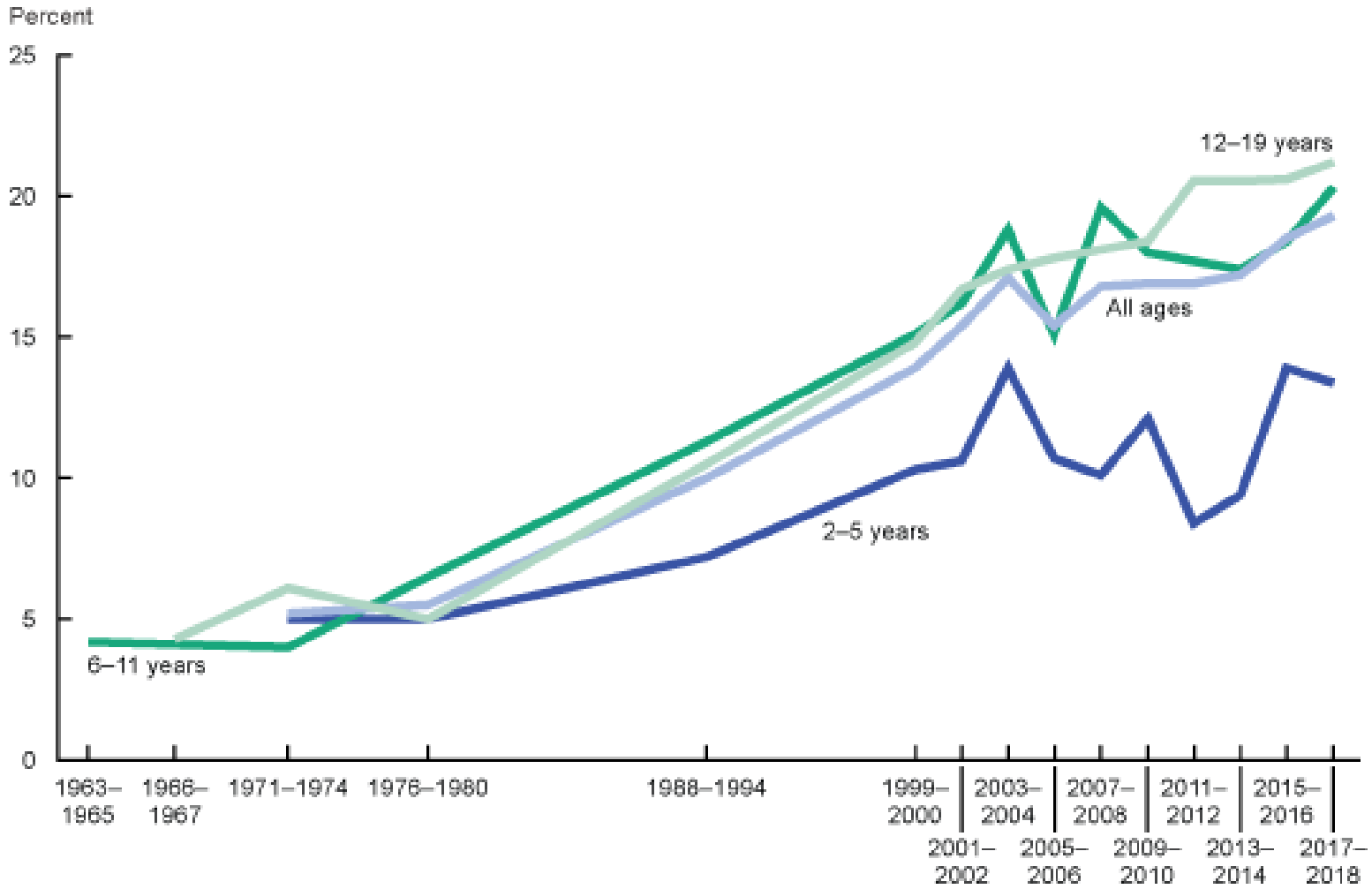
OBESITY AS A PUBLIC HEALTH ISSUE

Adult Obesity Prevalence in the US (2020)



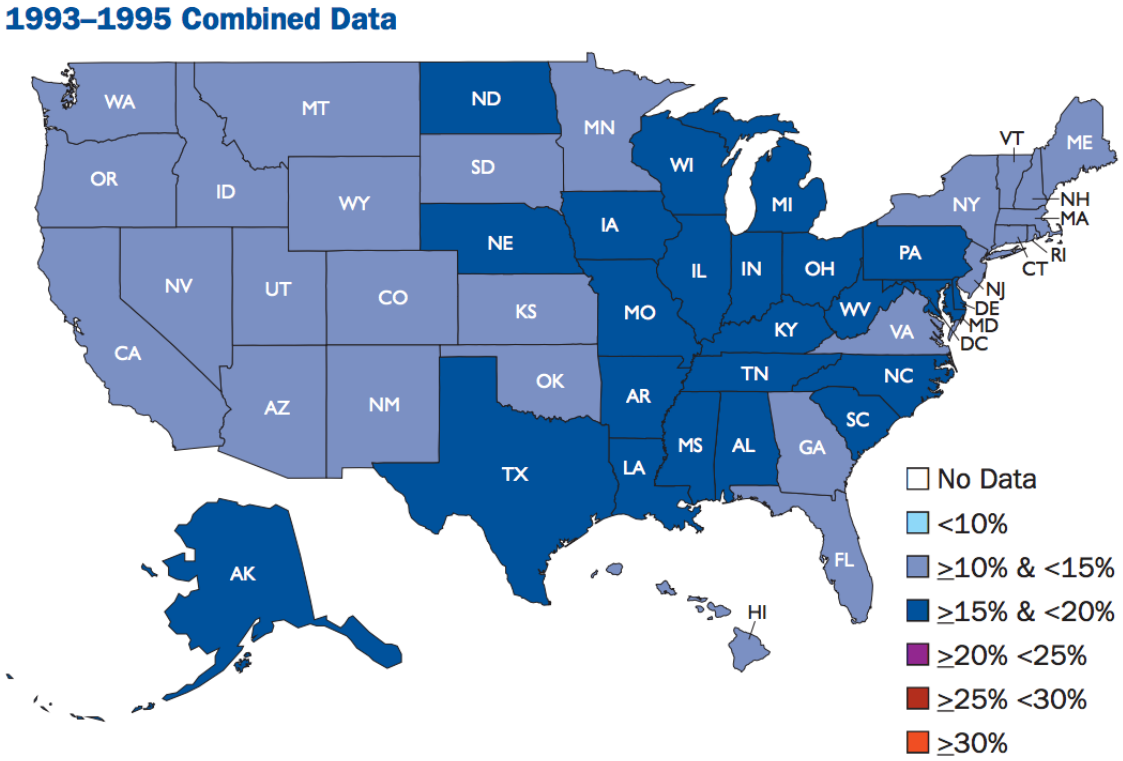
Source: CDC/Behavioral Risk Factor Surveillance System

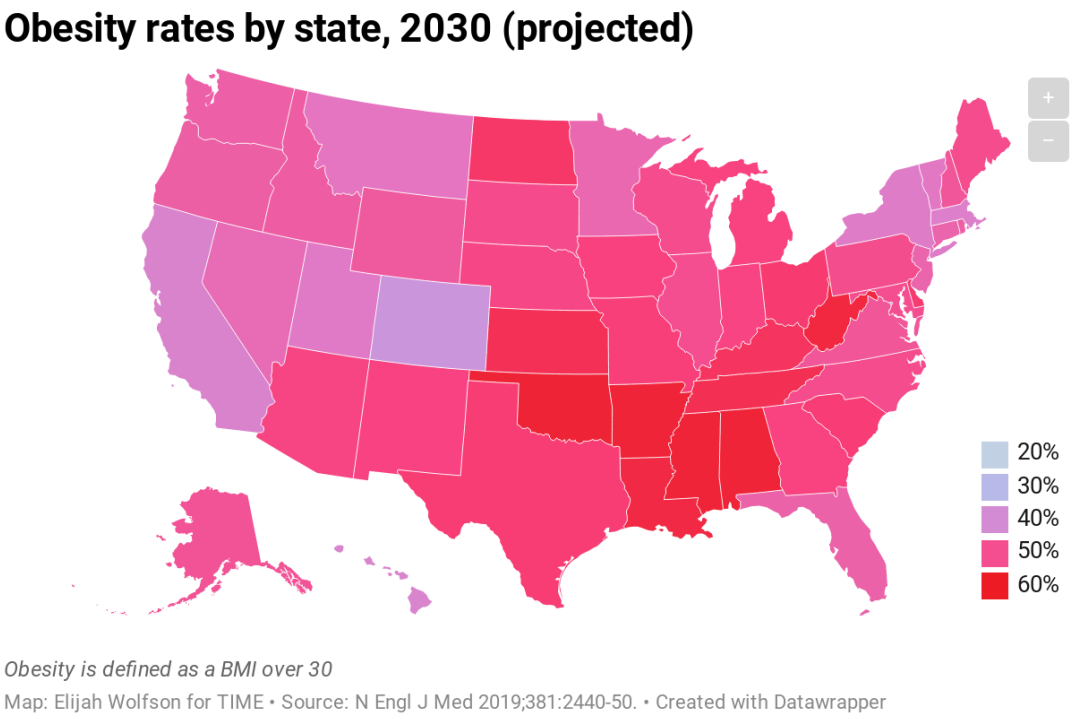
Obesity Trends in US (1963-2018)



Source: CDC

Obesity across the US (CDC)



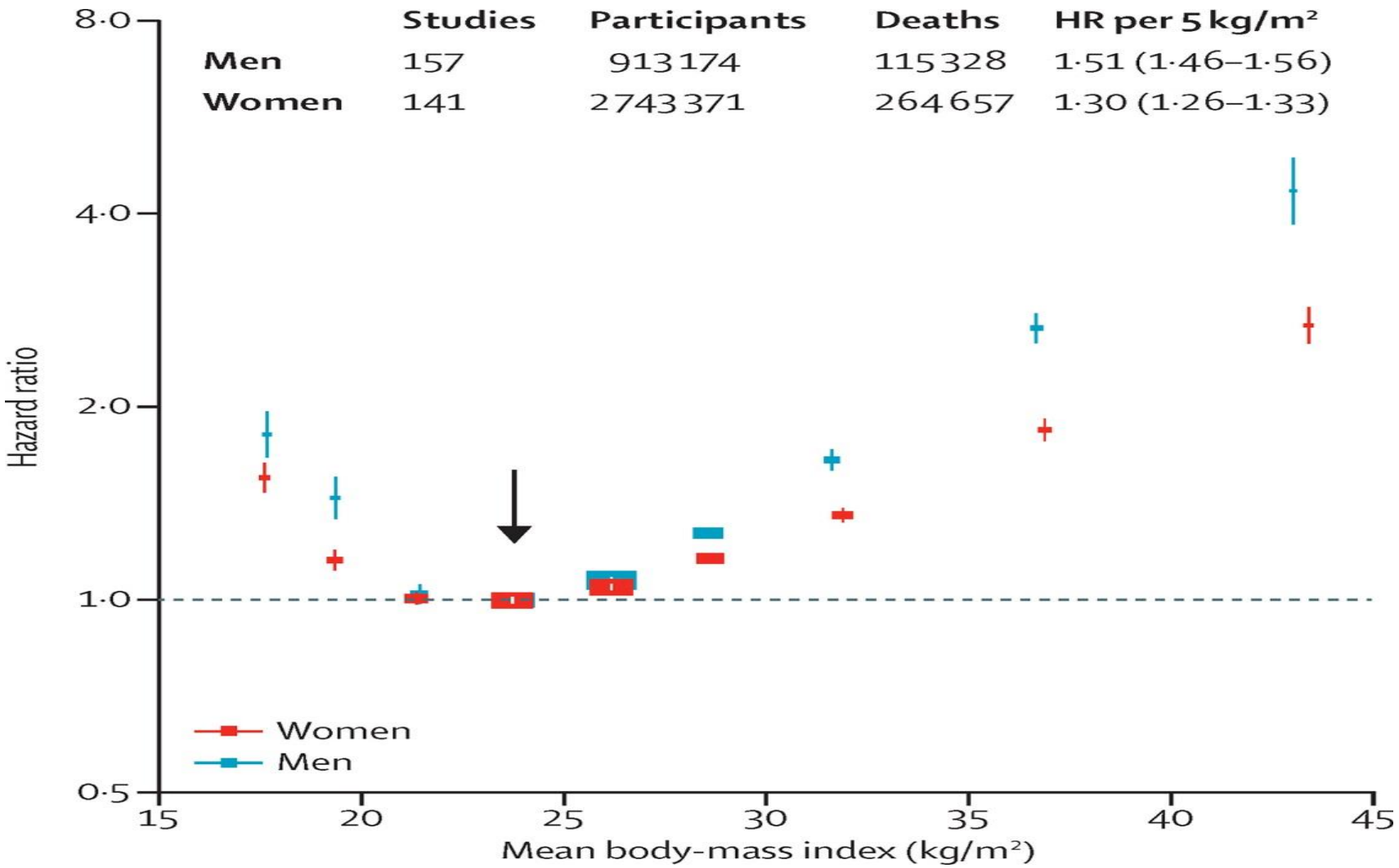


Obesity is defined as a BMI over 30

Map: Elijah Wolfson for TIME • Source: N Engl J Med 2019;381:2440-50. • Created with Datawrapper

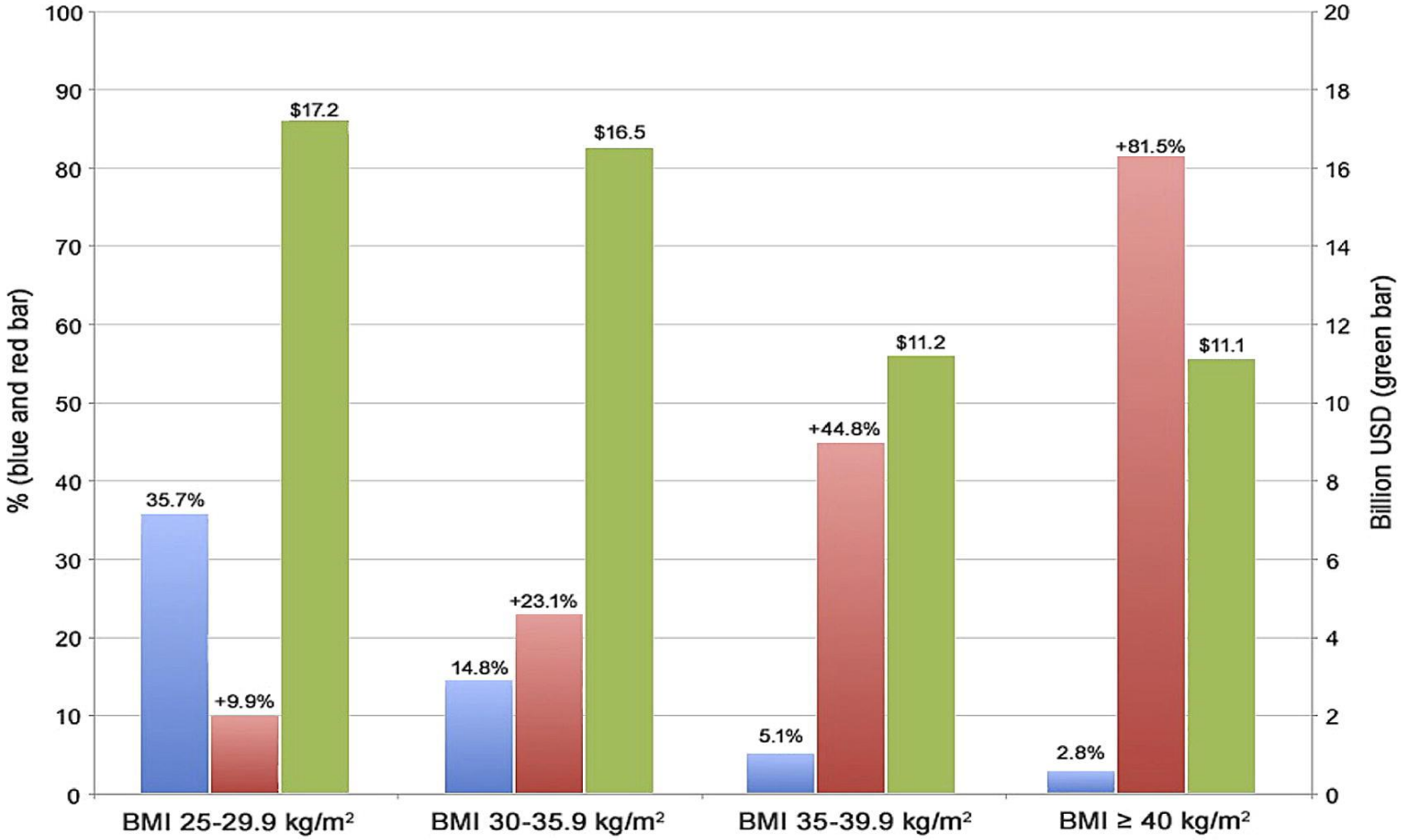
BMI Associate “Hazard Ratio”: Mortality Risk

	Studies	Participants	Deaths	HR per 5 kg/m²
Men	157	913 174	115 328	1·51 (1·46–1·56)
Women	141	2 743 371	264 657	1·30 (1·26–1·33)



The Lancet 2016 388, 776-786DOI: (10.1016/S0140-6736(16)30175-1)

Obesity-associated Costs



Prevalence (blue bar), percentage increase in per capita expenditures (compared to BMI 18.5–24.9 kg/m^2; red bar), and aggregate expenditures (in 2000 USD; green bar)

Lehnert, at al., 2013, citing data from Arterburn, et al., 2005

Obesity and COVID-19

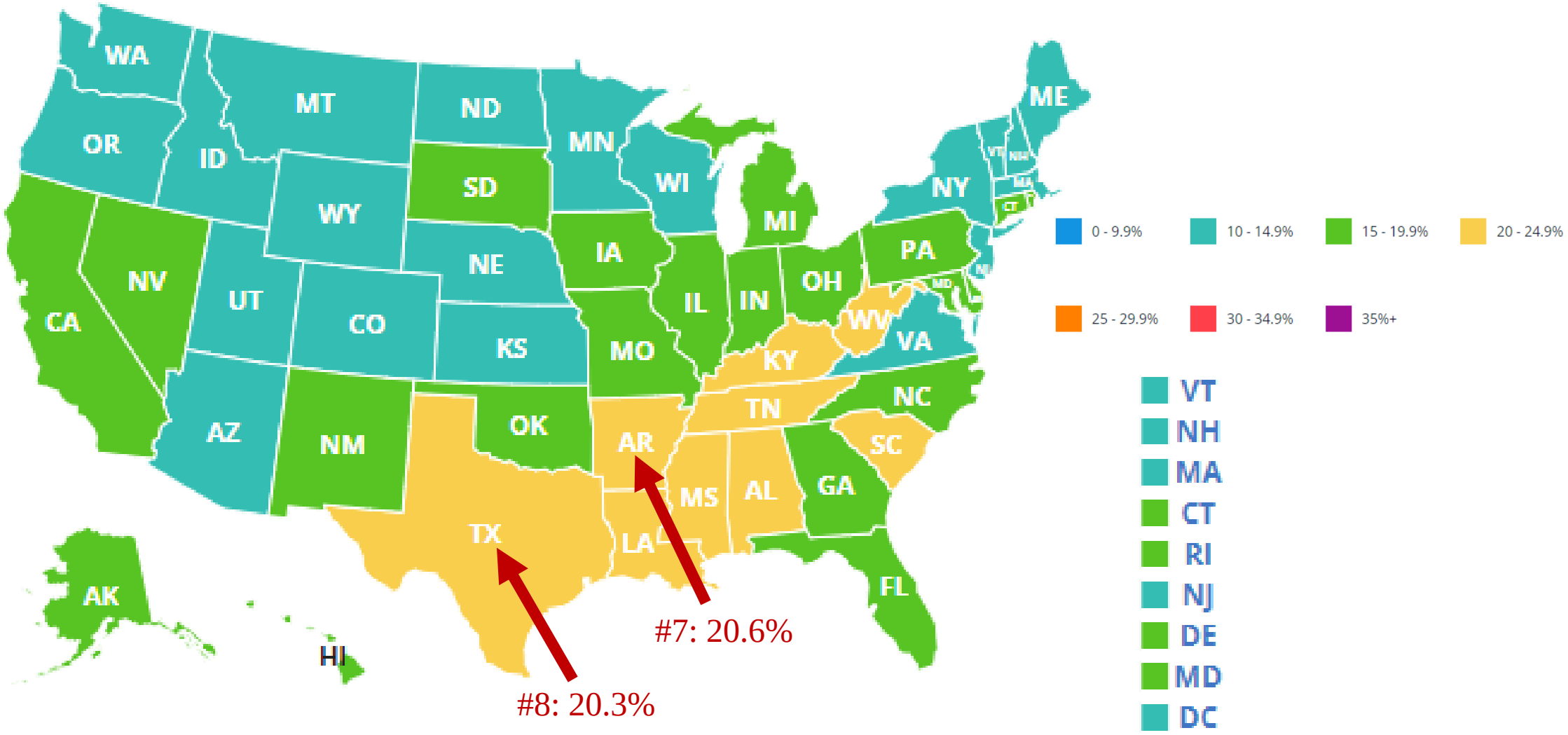
Intervention	Author	Year	Month	Hosp.	ICU	IMV	SO	Mortality	Qualitative appraisal
QUANTITATIVE STUDIES									
Obesity vs. without obesity	Hoong et al[21]	2021	Jan.						Low
	Yang Jiao et al[24]	2020	Oct.						Low
	Ho et al[22]	2020	Dec.						Moderate
	Pranata et al[32]	2020	June						Low
	Yang Jun et al[27]	2020	Sept.						High
	Chu et al[25]	2020	Oct.						Low
	Földi et al[33]	2020	June						Low
	Zhang et al[17]	2021	March						Low
	Helvaci et al[19]	2021	Feb.						Low
	Noor et al[26]	2020	Sept.						Low
	Chang et al[35]	2020	May						Low
	Huang et al[30]	2020	Aug.						Low
	Zhao et al[29]	2020	Aug.						High
	Sales-Peres et al[31]	2020	July						High
	Poly et al[18]	2021	Feb						Low
	Zhou et al[37]	2020	April						Low
	Figliozzi et al[36]	2020	May						Moderate
	Mesas et al[23]	2020	Nov.						High
	Deng et al[20]	2021	Jan.						Low
	Raeisi et al[14]	2021	July						Low
	Dessie et al[13]	2021	Aug.						High
Severe obesity vs. without severe obesity	Booth et al[16]	2021	March						High
BMI ≥ 30 kg/m^2 vs. BMI < 30 kg/m^2	Du et al[28]	2020	Sept.						Low
	Li et al[15]	2021	March						High
BMI ≥ 25kg/m^2 vs. BMI < 25kg/m^2	Seidu et al[34]	2020	June						Moderate
QUALITATIVE STUDIES									
Obesity and/or overweight vs. normoweight	Peres et al[39]	2020	Aug.						Moderate
Obesity vs. without obesity	Tamara et al[38]	2020	May						Moderate

No association between intervention and outcome is assessed, $p > 0.05$, if quantitative synthesis is provided

The intervention increases risk for outcome: $1 < OR$ or $RR < 2$, $p < 0.05$, if quantitative synthesis is provided

The intervention increases risk for outcome: $2 \leq OR$ or RR, $p < 0.05$, if quantitative synthesis is provided

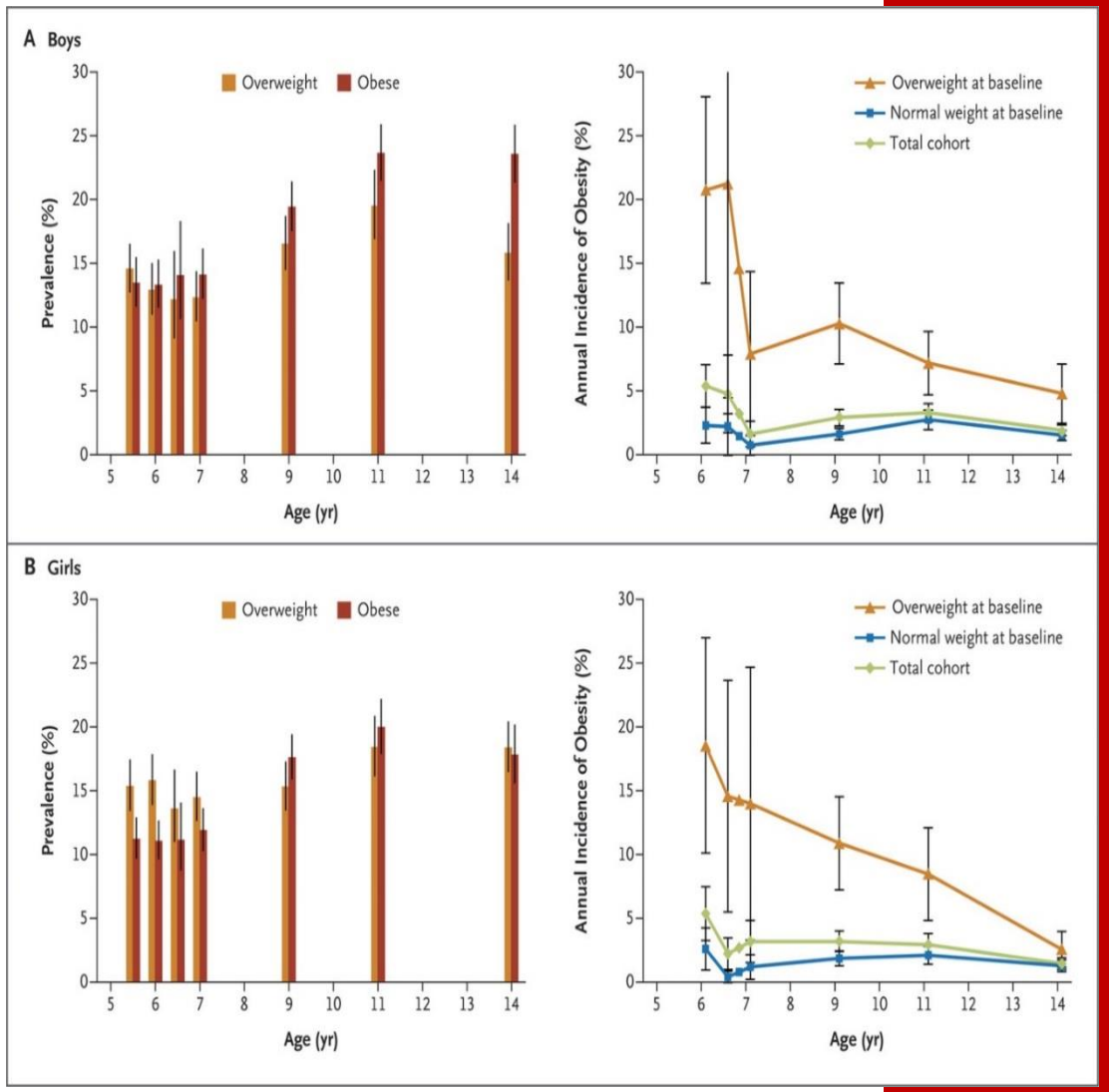
Childhood Obesity (2020)



Source: stateofchildhoodobesity.org

Childhood Obesity: As Kids Grow (NEJM 2014)

- Obesity (BMI ≥ 95th percentile)
  - Kindergarten: 12.4%
  - Eighth grade: 14.9%
- Overweight (85th < BMI > 95th percentile)
  - Kindergarten: 20.8%
  - Eighth grade: 17.0%
- Overweight → Obesity
  - Overweight 5yo 4 times more likely than normal weight to be obesity as a 14yo
  - 75% of obese 14yo were above 70th percentile at 5yo

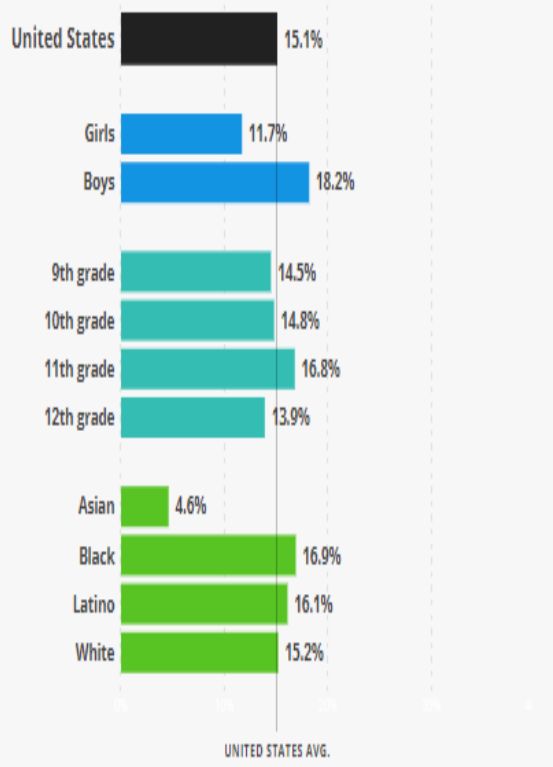


Cunningham, et al. NEJM 370(5):403-411

Some More Stats (2019)

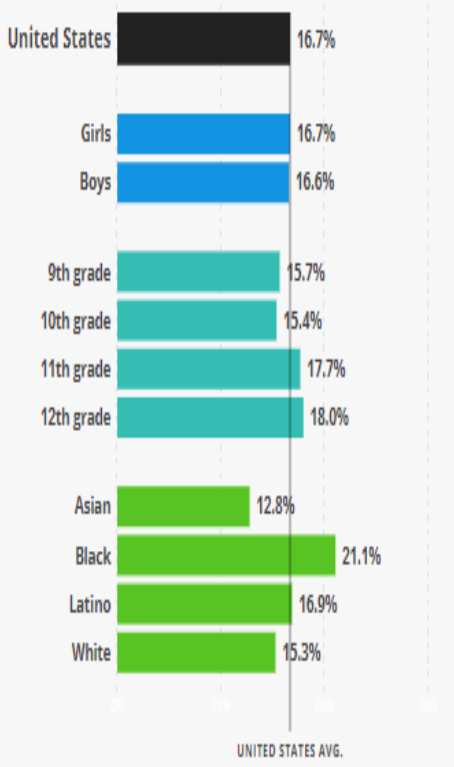
High Soda Consumption

Students who drank one or more cans, bottles or glasses of soda daily (not counting diet soda or diet pop) for the seven days before the survey)



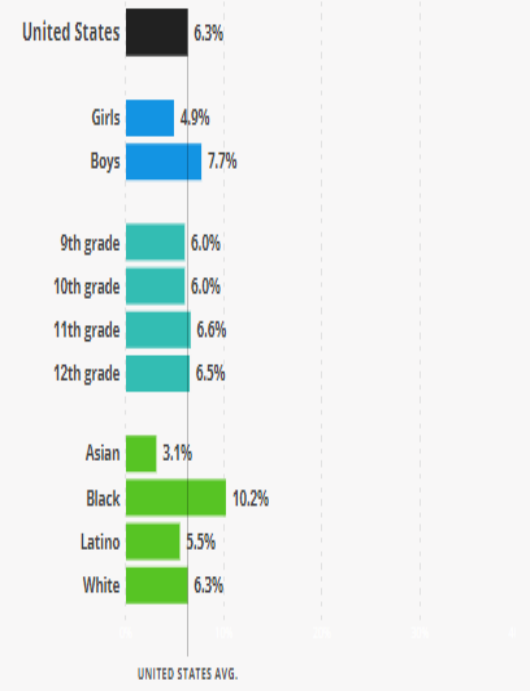
No Breakfast

High school students who did not eat breakfast during the seven days before th survey



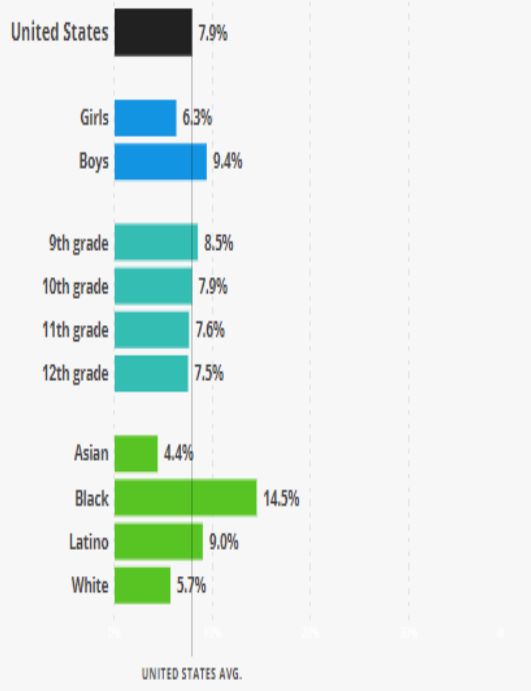
Low Fruit Consumption

Students who did not eat fruit or drink 100% fruit juices during the seven days before the survey



Low Vegetable Consumption

Students who did not eat vegetables (green salad, potatoes — excluding French fries, fried potatoes and potato chips — carrots or other vegetables) during the seven days before the survey



Source: CDC

Childhood Obesity: Health Consequences

Pulgaron in *Clinical Therapeutics* (2013)

- Correlations between childhood obesity and
  - Metabolic risk factors
  - Cardiovascular risk factors
  - Asthma
  - Dental Health
  - ADHD
  - Depression
  - Behavioral problems

Reilly, et al. in Archives of … (2003)

- Obesity co-morbidities in childhood
  - Cardiovascular risk factors
  - Type-II diabetes
  - Asthma
  - Shortened life-span
  - Low self-esteem
  - Behavioral problems

Taxation

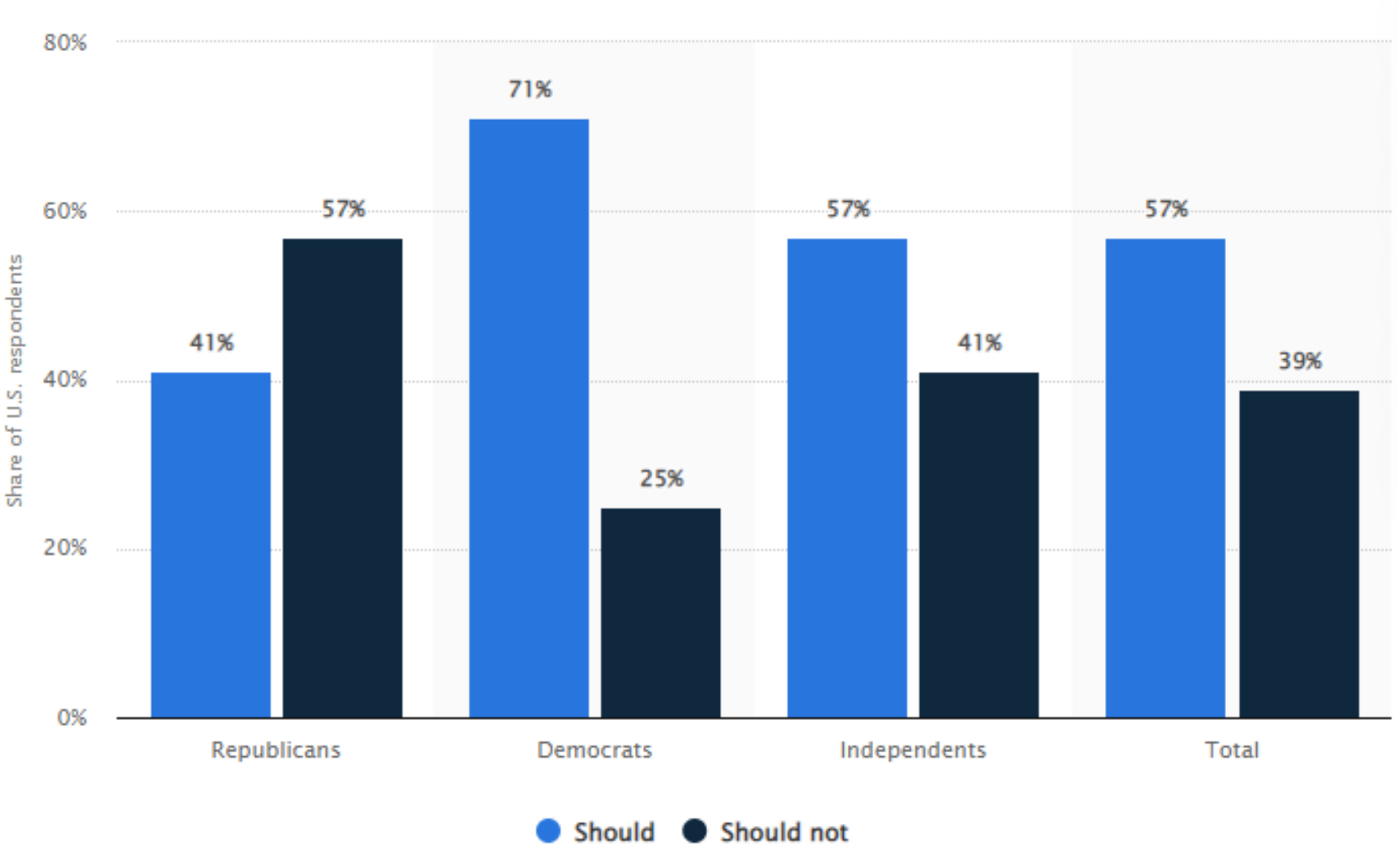
Restricting Access

Intervention

Education/Information/Persuasion

FOUR POSSIBLE SOCIETAL RESPONSES TO OBESITY

Should the state play a significant role in reducing childhood obesity?



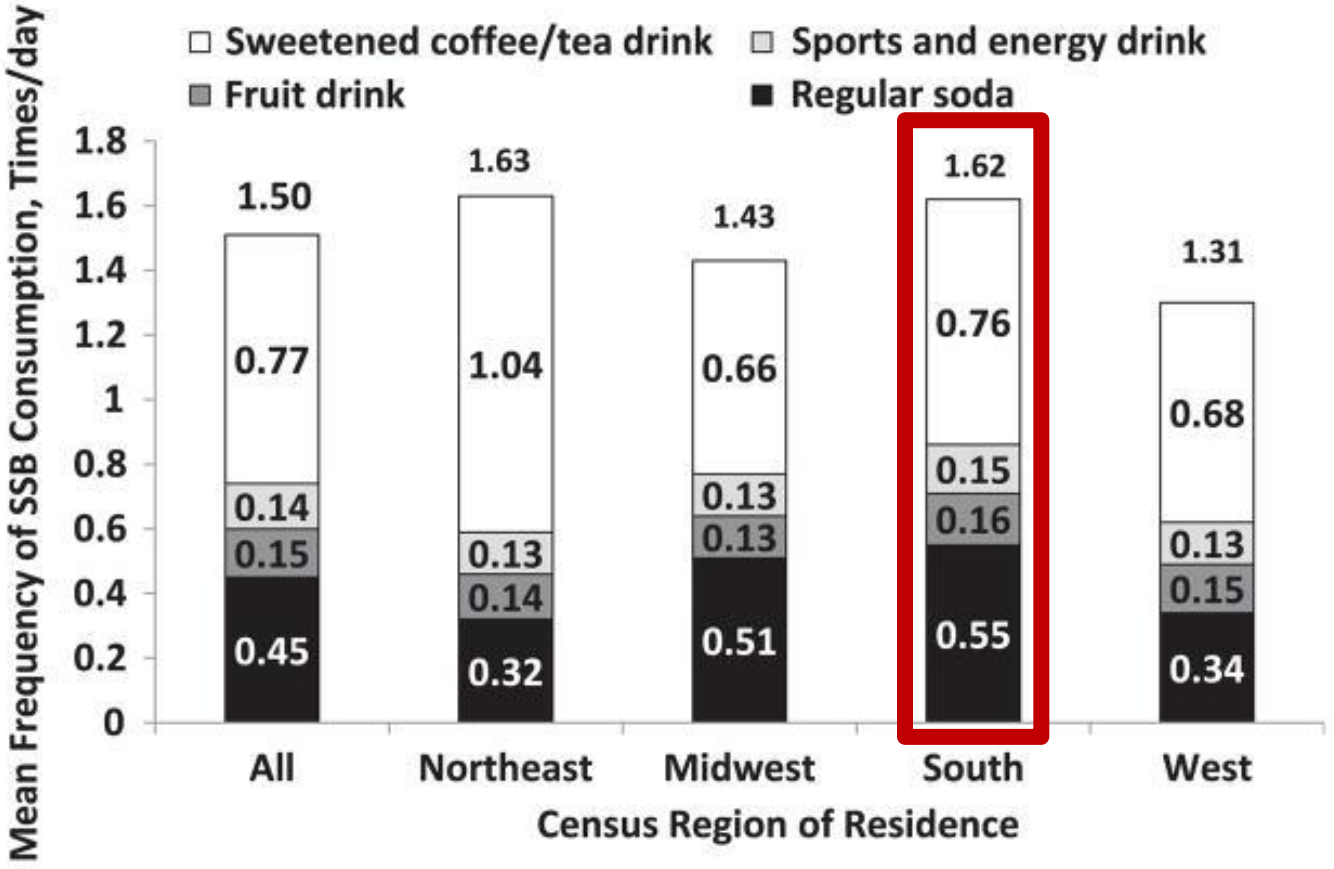
Statista Research Department, 2011

TAXATION

- Taxing consumers
  - “Unhealthy” foods sales tax
- Taxing producers
  - SSB excise tax
- Restricting sizes and quantities
  - NYC failed attempt to reduce SSB sizes
- Restricting offerings in public schools
  - Eliminating vending machines, SSBs
  - Nutritional Standards for National School meals
- Restricting SNAP benefits
  - AR failed attempt at AR Healthy Food Improvement Act (HB 1035, 2017)

Sugar-Sweetened Beverage Consumption

- SSBs account for approx. 7% of youth and 6-7% of adult caloric intake daily (Rosinger, et al 2014/2017)



Park, et al. J Acad Nutr Diet, 2015

AR Soft Drink Tax Act

a) There is hereby levied and there shall be collected a tax upon every distributor, manufacturer, or wholesale dealer, to be calculated as follows:

(1) One dollar and twenty-six cents ($1.26) per gallon for each gallon of soft drink syrup or simple syrup sold or offered for sale in the State of Arkansas

(2) Twenty and six-tenths cents (20.6¢) per gallon for each gallon of bottled soft drinks sold or offered for sale in the State of Arkansas;…

As of 2017, SSBs and candy is taxed at 6.5% (normal state rate), not the reduced grocery rate of 1.5%

Problems with AR SDTA

- All “universal” taxes are regressive
  - Lower income people are disproportionately affected
- Tax only on distributors
  - Lay public may not feel effect of tax
    - Estimates for effective taxation would be around 15-20% of purchase price (Brownell, et al. *NEJM*, 2009)
      - Taxation has led to reduction in tobacco use (cf. WHO; CDC)
    - AR tax is only about
      - $0.02 per 12 oz. can ($0.12 per 6-pack)
      - $0.05 per 20 oz. drink
      - $0.08 per 32 oz. drink
- Definition of SSBs is limited
  - Sodas, punches, and fruit drinks with less than 10% fruit juice
    - Fruit juices also contribute to obesity (Wojcicki/Heyman, *American J of Pub Health*, 2012; cf. AAP; IOM; AHA)
  - No coffees or teas

Can an SSB Tax Be Ethical?

- Addressing scope of tax (Wetter/Hodge, JLME, 2016)
  - Broad definition of SSB w/narrow exceptions is better than narrow w/broad exceptions
- Addressing liberty concerns (Kass, et al. American J of Pub Health, 2013)
  - Food consumption is highly affected and constrained
    - Cultural beliefs about the importance of foods
    - Enlarged food portions
    - Social-economic determinants
  - SSBs are not a “basic need”
- Addressing justice concerns (Wetter/Hodge, JLME, 2016)
  - Revenue allocation from taxes can be used as incentives for lower-income individuals/households

RESTRICTING ACCESS

- Restricting sizes and quantities
  - NYC failed attempt to reduce SSB sizes
- Restricting offerings in public schools
  - Eliminating vending machines, SSBs
  - Nutritional Standards for National School meals
- Restricting SNAP benefits
  - AR failed attempt at AR Healthy Food Improvement Act (HB 1035, 2017)

SNAP

- US Citizens on SNAP ($70 billion in funding for FY15)
  - approx. 45 million persons
    - $125/month
  - approx. 22 million households
    - $255/month (household)
- AR Citizens on SNAP ($650 million in funding for FY15)
  - approx. 470,000 persons
  - approx. 155,000 households

SECTION 1. Legislative findings and intent

(a) The General Assembly finds that:

(1) The Supplemental Nutrition Assistance Program, formerly known as the food stamp program, assists eligible low-income individuals with the purchase of food.

(2) Overconsumption of excessively sugared foods, food products, and beverages increases the risk of obesity and other diseases;

(3) People living in poverty are more likely to consume nutrient-poor food; and

(4) The rate of obesity in Arkansas has increased while the obesity rate across the United States have remained level, according to a recent study.

(b) It is the intent of the General Assembly that:

(1) The Supplemental Nutrition Assistance Program, formerly known as the food stamp program, align with other programs and initiatives aimed at improving the health and welfare of Arkansas citizens; and

(2) Insufficient nutritional value foods, food products, and beverages are endangering the health of Arkansas residents.

SECTION 2. Arkansas Code Title 20, Chapter 76, Subchapter 2, is amended…:

(a) The Supplemental Nutrition Assistance Program, formerly known as the food stamp program, shall only allow benefits to be used only for foods, food products, and beverages that have sufficient nutritional value.

(b)

(1) The Department of Health shall identify specific foods…that have sufficient nutritional value.

(2) The Department of Health shall use the federal guidelines for the Special Supplemental Food Program for Women, Infants, and Children as a basis for identifying foods…with sufficient nutritional value.

…

SECTION 2. Arkansas Code Title 20, Chapter 76, Subchapter 2, is amended…:

(c) The Department of Human Services shall prohibit the use of benefits under the Supplemental Nutrition Assistance Program, formerly known as the food stamp program, for foods, food products, and beverages with insufficient nutritional value based on rules implemented by the Department of Health.

(d) The Department of Human Services shall request a waiver from the Secretary of the United States Department of Agriculture to allow the implementation.

Problems with SNAP Legislation

- Problems with Section 1
  - Obesity rate is increasing across the US and across populations
  - Other programs in “healthy AR” initiative are not analogous
    - Tobacco, for example, is not “basic need” like food; and second-hand smoke directly affects others
  - Text implies it is helping all AR citizens
    - Affects only 15% of the state
- Problems with Section 2
  - Puts state (Dept. of Health, specifically) in charge of determining what is a food with “sufficient” nutritional value
    - Is steamed broccoli in cheese sauce nutritious? Are fruit juices? (cf. AAP; IOM; AHA)
  - Restricts food options of the poorest citizens only
  - Federal exemption to SNAP program is not guaranteed

The (Failing) Ethics of SNAP Legislation

- Liberty (Kass, et al. American J of Pub Health, 2013)
  - Government restrictions of food choice unduly undermines self-determination
- Justice (Kass, et al. American J of Pub Health, 2013)
  - Does not apply equally to all citizens
    - Places greater burden on poor
      - Nutrient “rich” foods are more expensive – approx. $550/yr. (Cade, et al. *Public Health Nutrition*, 2007; Rao, et al. *BMJ Open*, 2013)

Childhood obesity as medical neglect

INTERVENTION

Sample Cases of Obesity as Abuse/Neglect

(Garrahan/Eichner, *Yale J of HPLE*, 2012)

- *In re L.T.* (Iowa 1992)
  - 10yo, 290 lbs.
- *In re D.K.* (Pennsylvania 2002)
  - 16yo, 450 lbs., 5'3"
- *In re Ostrander* (Michigan 2004)
  - 4yo, 120 lbs.
- *Jose G. v. Superior Court* (California 2008)
  - 11yo, 200 lbs.
- *In re Brittany T.* (New York 2008)
  - 11yo, 240 lbs.

Calls to Intervene

- Varness, et al. *Pediatrics*, 2009
  - Immanent harm
  - Effective treatment
  - No better alternatives
- Murtagh/Ludwig, *JAMA*, 2011
  - Immanent risk
  - Least intrusive measures first
  - Only alternative
- Garrahan/Eichner, *Yale J of HPLE*, 2012
  - Obesity as nutritional neglect
  - Neglect as “failure to follow medical advice”
  - Condition is “serious and threatening”
  - Consultation before removal

Ethics of CPS Interventions

- Establish Goals
  - To protect children from harms that result from obesity
- Determine Effectiveness/Benefits
  - May help some children eat better and exercise
  - May harm some children by taking them away from their families
  - May have no health-beneficial effects for some children
- Consider & Minimize Burdens
  - Taxes system of foster care
  - Places requirements on parents regardless of socio-economic conditions
  - Takes children away from families
  - Is a CPS intervention the least restrictive way to have a positive effect?
- Promote Justice
  - No clear guidelines (from statutes or courts) about when to call CPS
- Fair Procedures
  - Must establish transparent guidelines, applicable without bias
- Follow the Evidence
  - Anecdotal evidence shows some positive results in relationship to obesity

School-provided programs

- BMI measurements
- PE requirements

PSAs

EDUCATION / INFORMATION / PERSUASION / DIRECTIVENESS

Social Pressure and Fear as "Persuasion"

- Obesity as an Epidemic
  - Rates are rising
    - However, Higher (>35) BMIs are rising faster than lower and middle (between 20 and 30) BMIs, thus skewing the mean (Campos, et al. *Intnl J of Epidemiology*, 2009)
      - Does that undermine the "epidemic" concern?
- "Showing/Seeing" Obesity
  - "Necessity" of social pressure (Callahan, *Hastings Cntr Rpt*, 2013)
  - Children's Healthcare Atlanta campaign
    - Parents should be the target of campaigns (Callahan, *JAMA Pediatrics*, 2013)
- Fear as Efficacious (Bayer/Fairchild, *J of Med Ethics*, 2016)
  - Fear as positively motivating (Tannenbaum, et al., *Psychological Bulletin*, 2015)
  - Positive smoking cessation outcomes (Witte/Allen, *Health Educ. Behavior*, 2000)

What Makes Persuasion Ethical?

- Facts
  - Data must be “objective”
    - Meaning of data must speak to its audience
      - Crafting the narrative is value-laden (Rich/Evans, *Social Theory & Health*, 2005)
- Values
  - Public health campaigns champion the common good
    - Can this be balanced with personal liberties?
  - Must avoid stigmatization (Maclean, et al. *Health Promotion Intrnl*, 2009)
    - Train publicity and public health personnel
    - Include community stakeholders
    - Avoid stereotyping
- Success
  - Ends: Must establish and work towards an ethically acceptable goal
    - Changing parental/personal eating and exercise behaviors may not always prove worth achieving if they are only achievable through questionable means
  - Means: Must use ethically acceptable approaches/tools
    - Shaming may create a public backlash and undermine buy-in (Puhl/Heuer, *Amer J of Pub Health*, 2010)

Being Directive

- Non-directive Counseling
  - An approach that has therapist/clinician avoid taking control in order to allow the client/patient to come to revelations on his/her own.
    - "*The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to my experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming in me.*" -- Carl Rogers (1961)
- Directive Counseling
  - An approach where the therapist/clinician offers advice based on expertise and insight.
    - Directiveness must be adapted to the context of patient/family/culture

The Continuum of Directiveness

Why Be Directive?

Premise: obesity is a public health concern

Premise: obesity is a personal health issue

Premise: childhood obesity has negative health consequences

Preliminary Conclusion: there must be a (public and personal) healthcare response to childhood obesity

Premise: state-based responses are coercive and ineffective

Premise: Healthcare providers have a responsibility to address positive change when a patient's behavior has evidenced-based negative healthcare consequences

Premise: Ethically grounded directiveness by a healthcare provider is less coercive and more effective than state-based responses

Conclusion: Healthcare providers should be directive regarding childhood obesity.

Directiveness in the Face of Challenges

- Medical Biases
  - Physicians have lower respect for overweight patients (Huizinga MM, et al. *JGIM* 2009)
  - Students have bias against overweight persons (Phelan SM, et al. *Obesity* 2014
- Parental Authority
  - Wide scope – limited by The Harm Principle (Diekema D, *TMB* 2004)
- Parenting Style and Culture
  - Lack of parental limitations (Braet, et al. *Obesity Facts* 2014)
    - Overweight parents → overweight children (Garrahan/Eichner, *YJHPLE* 2012)
  - Food as common and as comfort for parents of overweight/obese children (Syrad, et al. *PHNE* 2014)
    - Happiness and lifestyle matter more
    - Treated as “natural” or “inherited”
    - Not “seen” as overweight
- Access
  - Limited nutritional options (Larson/Story, *CNP* 2015)
    - Association with obesity in children (Larsen, et al. *IJPH* 2015)
  - Food insecurity (>10% of US households with children)
    - Correlation with obesity in children 6-11yo (Kaur, et al. *JAND* 2015)

Clinical Directiveness: Some Ethical Requirements

- Facts
  - Data must be “objective”
    - Meaning of data must speak to its audience
      - Crafting the narrative is value-laden (Rich/Evans, *Social Theory & Health*, 2005)
- Values
  - Must avoid stigmatization and bias (Maclean, et al. *Health Promotion Intrnl*, 2009)
    - Train in crafting the message (“microethics” matter here – Truog, et al. 2015)
      - Avoid stereotyping
- Success
  - Ends: Must establish and work towards an ethically acceptable goal
    - Changing parental/personal eating and exercise behaviors may not always prove worth achieving if they are only achievable through questionable means
  - Means: Must use ethically acceptable approaches/tools
    - Shaming may create a backlash and undermine buy-in (Puhl/Heuer, *Amer J of Pub Health*, 2010)

Directiveness As Patient-Centered

Medicine must provide its expertise (within its limited domain), but living healthily…

"…requires the promotion of patient [and parental] agency, the providing of space for expressions of patient [and parental] interests and values in medical decision making, and the support for active participation by the patient [and parent] in his/her own healing process. It means finding and promoting shared experience among all participants in the medical encounter—particularly between physicians and [families]—working to adjust the many on-going narratives to account adequately for each other."

Hester DM, *Community As Healing* 2001

Expert Directiveness

- Competent Directiveness
  - Self-developed, rule-based, engaged
    - Rule/guideline-centered: Discloses information; checks on understanding; provides EBM recommendation
- Proficient Directiveness
  - Adaptive, habituated, means-limited/challenged
    - Myopic-context-centered: Addresses familial context; suggests alternate courses of action
- Expert Directiveness
  - Recognizes goals, grasps means
    - Patient/Situation-centered: Sensitive to the cultural, social, and economic factors; integrates both EBM and creative considerations from clinical judgment to fashion a mutually developed and agreed upon plan

Adapted from Dreyfus H, "How Far is Distance Learning from Education?" (2001/2006)