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The ethical implications of intervening in bodyweight

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This chapter is about the ethical implications of health sector actions intended to change individuals' or communities' weight. We consider these implications using two hypothetical cases. The first is Megan, a 15-year-old girl whose BMI is in the range defined as obese. She has been unable to lose weight and her parents are considering seeking clinical help. The second case is the population of the state where Megan lives, in which 35% of adults and 15% of children are reportedly overweight, and 17% of adults and 5% of children obese. The minister for health, prompted by these statistics, is determined to take action. What ethical issues are relevant for Megan, her parents, and the health professionals they may consult? What ethical issues are relevant for the citizens of the state, their minister for health and their bureaucrats? How does a focus on the care of individuals impact on public health, and how might community-level interventions affect people like Megan? Interventions designed to treat and prevent obesity in individuals and in communities raise important ethical issues. These issues are both distinct and overlapping; because the interventions have different goals, risks and benefits, moral compromise is always necessary. The central task is to think through the ethical and philosophical issues before action is taken: whether in clinical medicine or in public health. We present ethical approaches that can assist in such reasoning.

In this chapter we examine the ethical implications of intervening in weight, and the ethical difference between intervening in the weight of individuals and the weight of populations. We discuss these issues via two cases: Megan, a hypothetical 15-year-old girl, and Australia, the country where Megan lives. We conclude that there are distinct and overlapping ethical concerns at individual and population levels, and that at both levels moral compromise is necessary. Both clinicians and public health professionals need to consider the ethical issues and implications before action is taken. Using our two cases, this chapter provides examples of such reasoning.

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Megan

Megan is 15 and a high-school student. She is technically 'overweight': 165 cm tall and 76 kg, with a body mass index of 27.9 kg/m². Megan has always been larger than many of her peers. As a young child Megan wasn't aware of her weight, but began to be self-conscious in primary school after being teased by a fellow student for being fat. Since then she has become increasingly fearful of bullying. Megan has two close friends, but other students often tease her during breaks at school. In physical education classes she is often overlooked in team selections and teased by fellow pupils.

Megan's parents became worried about her weight when she was six. They enrolled Megan in several team sports over the years, but she begged to be allowed to discontinue each one: she felt uncoordinated and awkward and was resented by teammates, who saw her as a liability. When she was ten, her parents began putting her on diets. In the last four years she has tried a meal replacement product, Weight Watchers, a grapefruit diet and the Atkins diet: each time Megan lost weight but regained it. Friends, family members, teachers, or even complete strangers frequently comment about Megan's weight. When this happens, she thinks: 'Don't they realise? I already know I'm fat and I'm trying to fix it!' Megan's parents worry about her future; they hear constant media reports about health risks, depression and other problems associated with higher weights.

Someone suggests Dr Jim Spright – a general practitioner experienced in managing overweight in adolescence – as a good starting point to 'do something' about Megan's weight, and Megan's parents decide to seek his professional advice.

The population in which Megan lives

Megan lives in a metropolitan city in Australia, where approximately 21% of adults are considered obese and 35% overweight, and 25% of children aged five to 17 overweight or obese [1]. The hypothetical health minister, prompted by these statistics, public health officials and academics, decides that she wants a formal overweight and obesity strategy. An Obesity Summit is convened to discuss policy options. Academics, public servants, public health officials, commercial weight-loss service providers, exercise industry representatives, food industry manufacturing and retail representatives, surgeons, endocrinologists and general practitioners – including Dr Spright – are all invited.

Over the course of the summit, participants discuss many options. How should food be labelled and marketed? Should marketing for some foods be banned? Should healthy behaviours be mandated? Should health department money be spent on projects with departments of public transport and urban planning? Should spending be focused on kids or on adults? What should be done in schools? Should bariatric surgery be publicly funded, how and for whom? How should social marketing be used, and what can it achieve? Their goal is to produce feasible, acceptable recommendations for actions that will reduce the population prevalence of overweight and obesity significantly by 2020.

Individuals and populations as a focus for action

A distinction between intervening in the lives of individuals – like Megan – and intervening in populations – like Australia – is fundamental to public health practice. An iconic statement of this was made by Geoffrey Rose in his 1985 paper ‘Sick individuals and sick populations’ [2]. Rose noted that within our population, we tend to treat average states as ‘normal’, and deviation from such states as ‘abnormal’ [2]. We present to doctors as patients because we perceive ourselves to be ‘abnormal’. The goal of clinicians is to determine whether we are ‘abnormal’, and if so, explain why. Rose argued that this is an investigation of why variation occurs *within* a population [2]; in the case of weight, for example, a doctor tries to determine why a patient is fatter than the rest of the population. This is done through direct clinical interaction – a relatively intimate and proximal exchange. The clinician’s problem-solving is based on examination of the patient and listening to the patient’s story, and can take into account many aspects of their lives. The clinician attempts to determine causes for that individual, and achieve the best outcome for them. This might require advocacy for that person against systems designed to ration services.

Rose argued that this important clinical process provides only partial understanding of health problems. If a causal factor is distributed evenly throughout a population, everyone in that population is equally exposed to it. Thus a clinician is unlikely to ‘see’ it as a causal factor for a patient like Megan, because, within the doctor’s population of patients, it does not explain why some patients are thin and others fat. The only way we can ‘see’ the effect of such an omnipresent factor is to compare a whole population that is heavier on average – say Australia – with one that is leaner on average – say Japan [3]. To make such a comparison changes the key question from ‘Why do some Australian individuals weigh more than their peers?’ to ‘Why is overweight more common in Australia and less common in Japan?’ These two explanations, Rose argued, may rest on different causal factors [2]. This led Rose to distinguish between two kinds of intervention: the ‘high-risk’ strategy, in which individual cases in the high-risk ‘tail’ of a distribution were identified and treated, and the ‘population strategy’ where root causes were identified and altered to potentially shift the entire distribution slightly towards lower risk [2]. Although Rose noted strengths and weaknesses of each, he proposed that the ‘population strategy’ could lead to a greater average improvement in health because of its radical intervention in root causes for whole populations.

Clinicians must act in the best interests of a patient, within a health system inevitably constrained by resource limitations. In contrast, population health interventions focus on whole populations, and public health policy-makers on allocating resources to maximise efficiency; this means such policy-makers may need to be less sensitive to the complexities of individuals’ lives, and more conscious of equity and opportunity cost across whole populations. In the clinical case, the patient presents to the clinician and asks for treatment. In the case of public health, the population is unlikely to have asked to have its ‘incidence’ reduced, making the rights and responsibilities of all involved less clear.

Clinical ethics and public health ethics

Ethics is the study of *what should be done*: a prescriptive, systematic analysis of what is required for human wellbeing [4]. The descriptions above reveal the potential for incompatibility between the ethics of clinical medicine and the ethics of public health. They occur in a different milieu, take different objects, seek different objectives, and work from different information. It is perhaps unsurprising then that the development of clinical ethics has been reasonably distinct from the development of public health ethics.

Ethics has been a concern of the medical profession for over two millennia: in this sense, medical ethics is not new. However the focus on ethical analysis and reform of clinical medicine and biotechnology has intensified since the development of bioethics in the 1960s [5]. Clinical ethics grew and developed during the second half of the 20th century but during this period public health ethics was relatively neglected [6–8]. Systematic attempts to establish an ethic for public health began in earnest in the 21st century producing, for example, a specialist journal [9], full-length books [10] and technical reports [11, 12].

Approaches to clinical ethics

A number of moral frameworks have been proposed to guide clinical decision-making, including casuistry (case-based reasoning), narrative ethics and the ethics of care [4]. The most dominant framework, however, has been principle-based ethics (sometimes referred to as ‘principlism’ [12]). Much-criticised, much-revised and extremely influential, it focuses on four central and two derived principles for ethical conduct (hence the name): respect for the autonomy of the patient, beneficence (doing good for the patient), non-maleficence (not doing harm to the patient), ensuring justice, veracity (practicing honestly) and respect for the patient’s privacy and confidentiality. While each of these principles is important, they are, in themselves, not action-guiding and must always be specified and balanced and supported by rules that describe their scope, authority and relevant processes. Respect for autonomy, therefore, requires that a patient’s consent is sought before commencing treatment, but does not demand that a patient’s decisions always be respected, irrespective of the cost. Likewise, rules for consent must be clearly articulated to outline who can consent, what capacities are required before one can consent, and what should be done where a person is unable, because of illness, to consent. While this approach is deceptively simple, and may obscure considered ethical critique, the fact that it provides a moral framework that appears consistent with clinical practice has led to its widespread adoption by the health professions.

Approaches to public health ethics

In contrast to clinical ethics, there is little consensus on the best approach to ethics in public health, except for a general agreement that public health ethics requires its own framework [7, 13]. To date the literature has suggested five key issues in evaluating public health actions: benefits and harms of intervention (or non-intervention), problem definition and telos (ultimate purpose), fairness and distributive justice, process and procedural justice, and rights [5, 11, 14–20].

Maximising benefit, minimising harm

The framework most commonly associated with public health is utilitarianism, a consequentialist and welfarist philosophical position that emphasises achieving the greatest good for the greatest number of people. Utilitarians are firstly concerned with the effectiveness or benefit of an intervention [5, 14, 17, 19, 21] and the balance of any benefits to the attendant burdens [5, 14]. Possible concerns here include coercion, infringement, intrusion or undermining of human rights (see below) [11, 14, 16, 17] whether the response is proportional to the problem [14], whether the action is necessary [14, 19], and the cost of the intervention, including the opportunity cost [17, 19]. It is also important here to consider the quality of evidence on matters of ethical concern [15, 19, 20].

Problem definition and telos

Some writers emphasise the severity of the problem or risk addressed [17] and the goals of intervention as key issues for ethical evaluation. More ethical interventions are thought to relate to severe problems, fundamental causes, conditions and environments, and/or to address the ill-health that people impose on each other rather than the ill-health people impose upon themselves, because this is more respectful of the autonomy of individuals [5, 15].

Increasing fairness or distributive justice

Other writers have argued that social justice, community, common good and/or recognition of mutual vulnerability are the best basis for public health ethics [6, 22, 23]. These writers suggest that it is most important to evaluate the fairness of goals and interventions, and the distribution of benefits and burdens, especially with regard to vulnerable groups and health inequalities [5, 11, 14, 15, 17, 19, 21]. For these writers, goods in public health may be more valuable if they can be obtained only, or more efficiently, through collective action or if benefits pertain to whole communities [5, 14, 17, 19, 21], such as through provision of supportive environments or assisting communities to act [11, 16].

Process and procedural justice

Another approach is less concerned with principles, values or justifications, and more with processes and procedural justice. This approach values collaboration and participation [14, 15], transparency and accountability (including informing or disclosing, speaking truthfully, and providing public justification) [14–16, 19, 20] acknowledging and accommodating diversity, applying fair process when consensus cannot be reached [14, 15], obtaining consent, determining community acceptance or ensuring adequate mandate for intervention [11, 15, 19], and building and maintaining trust [14, 15].

Rights as a basis for public health

The final domain argues – broadly – that human rights provide the most coherent, egalitarian, universalisable and critical framework for public health [7, 17]. These rights generally include protection of privacy and confidentiality [15] and respecting the ‘right to health’ enshrined in some international agreements, which entails a ‘positive right’ to health

improvement [7, 17, 24]. Limiting an individual's freedoms is justified only to prevent harm to others, that is, respecting their 'negative right' to non-interference – sometimes called the Millian harm principle, after John Stuart Mill [7, 16, 21, 24].

A central problem for all approaches to public health ethics

Consideration of each of these domains is necessary for a comprehensive account of any public health intervention. All approaches, arguably, can inform decisions regarding a key problem in public health ethics: the degree to which coercion – forcing someone to act against their own will – or paternalism – interfering with someone's liberty or autonomy without their consent to make them better off – are ethically permissible in public health [25, 26]. This is a central issue because degrees of coercion and paternalism have been key to the successes of public health [7, 11, 21] – think of seatbelt laws, gun control, fluoridation, sanitation and food hygiene regulations. A central challenge for public health is thus to define exactly when paternalism and/or coercion are permissible, and under what conditions, and what responsibilities this may entail for governments and individuals [18].

Some public health actions are justified by qualifying the paternalism involved. Three justificatory qualifications are made. The first is that the paternalism is 'soft' – that is, that it restricts only ill-informed and involuntarily actions. The second is that the paternalism is 'weak' – that is, that it interferes only when a person's actions are inconsistent with their own goals. The final justification is that the paternalism is 'welfare oriented' – that is, that those intervening are concerned only for a person's physical and psychological condition, as opposed to preventing them from being 'morally corrupted' [11, 18, 21]. These distinctions are a matter of degree and need to be argued on a case-by-case basis.

Some, particularly those concerned with rights and with procedural justice, argue that a simplistic opposition – paternalism or coercion versus freedom – obscures the complex relationship between these concepts, and de-emphasises the positive freedoms that public health interventions can promote [21]. Although voluntarism is not always effective [6], freedoms can decrease the need for coercion. If states engage communities, earning trust that negative freedoms will be respected, individuals may be more likely to seek help; conversely coercive interventions may be less effective or drive epidemics underground [7, 14, 17]. In addition, even strongly paternalistic actions could be moderated by democratic oversight or a community-level mandate [27]. These scholars would argue that by engaging communities paternalism can be lessened and better justified.

We have now considered both clinical and public health ethics. In clinical ethics, a clinician engages directly with a patient and the problem she presents. The clinician attempts to act in the patient's best interests and to advocate on her behalf. The clinician seeks to determine what has made that individual patient atypical – 'high risk' – in the distribution of her peers. More ethical clinical conduct, broadly speaking, will be that which respects the patients' autonomy, does her good, does not harm her, treats her justly and honestly, and respects her privacy and confidentiality. In public health, the situation is different. A decision-maker engages with 'problems' that are most likely to be defined statistically by the state, and may not be priorities for the community. The public health professional – if applying

a ‘population’ strategy – will seek to determine what makes this population different from other populations in regard to that problem, and to intervene in these ‘root causes’, ideally in a way that maximises benefit, minimises harm, seeks justice, is procedurally transparent, minimises violation of the rights of individuals, and can justify any coercion or paternalism entailed.

What ethical issues are relevant for Megan, her parents and Dr Spright?

Megan and her parents attend Dr Spright’s office for a long appointment. Spright’s training, as Rose would say [2], is to find the ‘causes of Megan’s case’, that is to find a causal explanation for why Megan, as an individual, deviates from the average or desired weight for her age. During the appointment he asks many questions about Megan – about her development, diet, exercise, other illnesses, symptoms, schooling, friends and family. He takes measurements and samples. He discusses the evidence for, and his experience with, a variety of approaches and services – dietary regimens, weight-loss clubs, specialist physicians and centres and exercise programs.

Dr Spright – Jim – has done continuing education courses in clinical ethics. He is keenly aware that his interactions with Megan and her mother are ethically charged, and that bioethical principles are expressed daily through the actions of doctors like him. Jim tries to conduct himself ethically, as he would with any other patient. In the interests of non-maleficence, he recommends actively against some programs and services that he thinks are non-evidence based and exploitive. His beneficence is expressed through offering evidence-based options that he thinks will help. He tries to respect the autonomy of both Megan and her parents in their conversation. Jim knows that Megan has her own opinions and goals and tries to draw her out whenever he can. He tries to inform but not over-inform, pulling back when they seem to be overwhelmed. He offers his own opinion – with clear reasons – when Megan and her mother ask for it. He is careful not to act in ways that could undermine Megan’s self-esteem, and he gently asks questions about the role of her family in her daily habits, not assuming that she is completely independent in her choices [28]. Apart from being sensitive to whether or not Megan’s family can afford private services, and whether they are insured, Jim doesn’t consider the cost of different treatments when making his recommendations – he considers only whether or not he thinks they are best for Megan.

In this sense, Megan is like any one of Jim’s patients. However Megan is also unlike many of Jim’s patients. Megan is apparently well. If she suffers from any current condition, it is the psychological effects of the stigma commonly experienced by fat people [29]. Jim is not being asked to treat a current, urgent medical condition like a broken finger or an acute infection. Instead he is being asked to ‘treat’ two problems: a future risk (that Megan will experience future weight-related health problems), and a socially produced psychological condition (the product of her stigmatisation). Jim does not think about Megan in this way, however. Because of his expertise and training, because he has read many reports showing that obesity is potentially damaging for health, and because Megan and her mother are asking him for assistance he defines Megan’s weight as ‘a problem’. He sets about explaining

why she is fatter than other 15-year-olds, and seeks to provide an individually tailored solution in the most ethical way possible. This individualism is a natural product of case analysis, attention to ethical principles and clinical problem-solving. It is, however, very different from what happens at the Obesity Summit.

What ethical issues are relevant for Australian citizens, their minister for health and their bureaucrats?

The week after Jim sees Megan, he attends the Obesity Summit. Before he goes he reads some of the preparatory material, but it doesn't seem clear to him which strategies are evidence based and which are not. A lot of evidence is presented for the prevalence of overweight and obesity, but not much about the effectiveness or implementation of programs. Megan is on his mind as he travels to the meeting in Canberra. What good will this do her, he wonders? In fact, what difference will this make for anyone?

There are several hundred people at the summit. Jim notices that not many of the participants seem to be obese themselves. After the Welcome to Country ceremony the health minister is introduced. She stands amid the applause, walks to the microphone and begins her opening speech.

We face a crisis in this country. Two-thirds of Australian men are overweight. Half of Australian women are overweight. A quarter of our children are overweight. Many of us are dying of the diseases that are complications of obesity, such as diabetes and cardiovascular disease.

The question is what we do about it. Answering that question is what we are here for.

Australians are simply eating more kilojoules than they are burning. Everyday foods that have become part of our daily diet are laden with kilojoules. Most ordinary snacks – ice-creams, chocolate bars, soft drinks – would require an hour of fast walking to burn off. We are adding these snacks to our diets and simultaneously doing less and less exercise.

Somehow, we have to find a way to eat less and move around more. We need to lose some weight. I don't think the answer is banning things. We don't want to shut down industries, or gag their right to advertise. We don't want to tell people that they can't have treats, that they can't celebrate with their families. We need to find ways to make people feel responsible for their own actions. We need to encourage industries to self-regulate. We need to encourage people to make better choices. We need to give people better information.

Your job is to work out how best we can do that. It's the most important health challenge facing this country today. I will look forward to receiving the recommendations from the meeting. Thank you for agreeing to be a part of it.

Over the next few days, health bureaucrats, consumer advocates, representatives of industry, and experts from public health, epidemiology, nutrition, health economics, exercise physiology, health education and law rise to the minister's challenge – presenting

sometimes conflicting data regarding the costs to the community, and to individuals, of the 'obesity epidemic' and calling for support for a range of interventions to meet it.

The summit concludes with a resolution calling upon the federal and state governments to prioritise two strategies: 1) a large, persuasive social marketing campaign aimed at raising awareness of the problem and motivating individuals to do something about their diet and sedentary behaviours; and 2) greater funding for obesity-related medical consultations and for bariatric surgery, including for adolescents. These recommendations are broadly acceptable to most political interests at the summit. They give something to both public health professionals and clinicians. They locate the problem and its solution with individual citizens; they permit egalitarian rhetoric via statistics showing equal 'reach' and 'access'; they appear to be minimally restrictive on people's freedoms; and they provide new income streams for some interests while not limiting the income streams of commercial interests. And, perhaps most persuasively, they are framed as being 'evidence based' – although in reality they are no more or less evidence based than other possibilities considered at the summit.

In many ways the Obesity Summit is a success. It stimulates passing media interest in obesity, it brings together a range of disciplinary and sectional interests into open dialogue about obesity, and it generates clear recommendations for action. But closer examination of the summit reveals many of the assumptions that underpin policy-making around obesity, the limitations of this model of analysis and decision-making, and the potential value of a framework for explicit consideration of issues of ethics and evidence in public health.

The minister's opening speech is familiar to anyone who has been audience to such occasions. It begins – as such speeches often do – by conflating overweight and obesity, associating overweight or obesity with death, and suggesting a need for weight loss, or at least behaviour change. Although the rhetorical power of this is clear, the evidence suggests that it is somewhat misleading. Many systematic reviews distinguish between the health effects of obesity versus overweight (showing overweight to be significantly less risky or even, at some ages, and in some situations, protective) and there are contradictory findings about the benefits of weight loss [eg 30–34]. The speech also frames individual actions as the key problem to be solved, and implicitly advocates a purpose for intervention: encouraging individuals to change their actions. Indeed, the minister explicitly guards the audience against restriction of trade and commerce, makes no mention of environmental contributors to obesity and (implicitly) restricts the critique of government. It is easy to argue that this fails to address the fundamental root causes, conditions and environments that might stimulate such behaviours, ignores the ill-health that people impose on each other, and in fact focuses on preventing people from harming themselves.

The speech also emphasises that obesity is harmful and suggests that public health action will be beneficial. Throughout the summit, experts present competing accounts of the benefits and harms of various interventions, and many of the small group discussions focus on these evaluations. Such evaluative practices are fundamental in both public health planning and utilitarianism. Inasmuch as there is a positive right to health improvement,

or responsibility for public health practitioners to improve health, then advocacy for action – including advocacy of its benefits – is reasonable and required. Yet while there is much optimistic talk of benefits, there is often very little focus on potential harms. Jim might well think about Megan – an overweight but not obese adolescent coping with teasing, anxiety and reduced self-esteem – and wonder how some of the interventions proposed at the summit might affect her. Interventions such as the withdrawn Singaporean school-based program Trim and Fit have been empirically associated with negative outcomes such as bullying and eating disorders for young people [35], often while producing the desired reductions in weight. This demonstrates the importance of going beyond ‘effectiveness’ – for example, measures of desired behaviour change – by employing ethical reasoning. It also suggests the need for better measurement of potential harms, including stigmatisation [20].

Public health decisions should rely on evaluations of harm and benefit [5, 11, 14, 16, 17, 19]. But the utilitarian ideal of balancing all relevant benefits and harms based on evidence is unlikely to be achieved [36]. Evidence is consumed in the context of political, social, media and lobbying pressures. Our hypothetical Obesity Summit is a conglomeration of interest groups jostling for prime position, and threatening harms such as job losses, restrictions on commercial freedom of speech, or damage to economic productivity. Little wonder then that public health professionals, with the best intentions, feel a responsibility to provide the most compelling evidence they can about the health benefits of interventions! Even the purest utilitarian decision-making requires weighing up of non-equivalent, and perhaps non-comparable, benefits and harms. Simple utilitarianism can also be limited by inattention to egalitarian ideals. Fairness is rarely measured [23] or addressed in mainstream public health strategies [eg 37], despite its rhetorical prominence in public health documents [38]. Although recent commentaries have asserted Rose’s deep concern for egalitarianism [39], the idea of shifting an entire population towards slightly lower risk is sometimes used to justify prioritising utilitarian average benefit over greater fairness in distribution of benefit. This is a values-based rather than an empirically based commitment [6, 22, 23]. Regarding weight, empirical evidence suggests that – for example – higher weight is associated with lower educational achievement [40], that the poorest Australian neighbourhoods have 2.5 times as many fast-food outlets as the richest neighbourhoods [41], and that the objective weight and subjective perception of the acceptability of weight in adolescents varies according to their socioeconomic status [42]. Thus, fair distribution may be at least as ethically important as average benefit.

And what of rights, freedoms, coercion and paternalism? Although many scholars interested in these areas have focused on pandemic contagious disease [16, 43], the issues are also critical in chronic states such as overweight, for which the threat of harm is less immediate and less certain. Tobacco and alcohol provide examples of risk factors for which an argument can perhaps be made that behaviour constitutes a threat to others (environmental tobacco smoke and violence, respectively). At the Obesity Summit, economists attempt to provide arguments about such other-regarding harms, including costs to the taxpayer, caring burdens on families and work absenteeism. But while each of these issues seem relevant, for the most part they fail to gain traction in discussions regarding how the government should

intervene in response to obesity, in part, because these are; a) non-health costs; b) based on highly abstracted models; and c) vulnerable to the way in which overweight versus obese individuals are classified. Any empirical uncertainties regarding differential risks between these groups become highly ethically relevant to these debates, raising questions about the basis for justification of intervention.

One group of scholars has answered this question with procedural justice. If, they argue, decision-makers make themselves accountable to communities, or can demonstrate a community mandate for action, they are justified in acting. Models for such mandates can range from the most broad (eg democratic election of a government) to the most specific (eg deliberative processes that actively inform and engage a representative sample of citizens and seek consensus on a course of action for a specific problem such as overweight). Summits – like our hypothetical one – can help to meet the more limited requirements of transparency in decision-making. However, they also raise questions about the circumstances under which mandate can be said to have been achieved. If summits are populated entirely by ‘experts’ – even if that includes ‘expert’ consumer advocates – can they be said to provide a real mandate? Who should legitimately make decisions about public health priorities? [44] Is it realistic to expect ordinary citizens to engage in public health decision-making? Could such engagement be achieved under the right conditions? These questions are yet to be answered; they bring us to the relationship between individual and community-level intervention.

Individual and community-level intervention: thinking across boundaries

Jim Spright feels strangely unsatisfied with the whole process. It felt to him like a ‘political exercise’, and he is not convinced by the outcome. He thinks about what these strategies might do for Megan, and for Australia. The campaign may increase the stigma that Megan experiences at school. Greater funding for surgery and consultations may increase healthcare costs, expectations of services and distribution of services across the population. Spright is conservative with referrals for surgery, as he’s concerned about potential, as yet unknown, future harms of the procedure. He’s also concerned that the increased healthcare costs may have only a marginal impact on the weight or health of the population. In fact, he muses, the campaign might inspire Megan to assent to more radical interventions, like surgery, whether or not that is in her best interests. He also thinks about his poorer patients, because he knows that they are less likely to respond to this campaign, and have less access to surgery. And he wonders whether these strategies might prove to be of most benefit to those who are already receptive to health messages, who already think about their health, and who already have reasonable access to healthcare.

Jim then thinks about how health fits into the lives of his patients. He has been reading lately about ‘healthism’ [45], the accusation that public health prioritises health outcomes over other outcomes regardless of the goals of the individuals and populations they serve. People clearly value their ‘health’, he thinks, but what does this mean? ‘Health’ and ‘public health’ can be defined very narrowly or very broadly [44, 46, 47]. Jim can see that these strategies serve narrow definitions of health as physical health, but he wonders whether

they are good for people's health more broadly: for their wellbeing. In his consultations with a patient like Megan, he can carefully explore life goals, values, what her weight means and how this relates to her emotional wellbeing, fulfilment and happiness. This is difficult, and time consuming, but it can be done. However Jim knows that weight is not simply an individual matter [48]. If we're going to intervene in weight in communities, how can we think about the relationship between community and individual goals and freedoms?

We suggest that the best way of thinking about the ethics of intervening in individuals' weight and communities' or populations' weight is to think about both at once, and to consider the relationship between them. This is surprisingly rare, perhaps because few individuals work across the clinical–population health boundary. However, as is clear from the summit recommendations to support both an extensive social marketing campaign and the medical and surgical management of obesity, it is readily apparent that individuals and communities mutually interact.

This suggests that it is a mistake to understand issues like obesity, and the public health responses to them, as simply a contest between respect for individual liberty (or autonomy) and our responsibilities as citizens, and that there is merit in exploring some of the various 'third way' positions between individualism and collectivism that have been suggested in public health ethics [6, 7, 14, 17, 21, 27, 36, 49–52]. This work suggests several answers for Jim's concerns that might help public health strategies to be more ethically justifiable. Respect for individual autonomy is, largely, a concern with freedom – with the freedom to be and to do as one wishes. However, as relational approaches to autonomy have shown us, these freedoms are not a purely individual matter: they are constituted in relationships. The communities that we belong to produce goods: things that we value. It has been proposed that these goods are of two kinds: aggregative and corporate [52]. Aggregative goods are simply the aggregation of individual goods. Corporate goods, however, are an 'emergent social property' of communities: they can only be obtained through community collaboration or cooperation [52]. Corporate goods of public health interventions might include, for example, the creation of conditions that support sustainable future improvements in health, the development of new shared and valued cultural practices, or community attributes like solidarity or diversity. Corporate goods have a future orientation – rather than simply providing a present benefit, they provide a benefit available to future communities. This distinction resonates with Munthe's call for public health interventions that both 1) promote population health, and 2) promote 'equal (and real) opportunities for everyone to be more healthy' [50]. For Munthe, this required providing the freedom to be healthy or unhealthy (including by preventing others from constraining our health opportunities), but the means only to be healthy [50].

To take such a 'third way' position on intervention in weight would assist decision-making for both individual and population-level interventions. It provides an ethical rationale that resonates with Rose's concern for intervention in 'root causes'. Changing the price structure and composition of the food sold in supermarkets, providing usable public transport, or designing a local community to provide healthier food outlets and better opportunities for walking would be recognisable interventions in root causes – of health, not just of

weight. Critically, they are also corporate goods – the kind that can only be achieved through collective effort and which provide sustainable future benefit. They provide opportunities for health and prevent others – like food producers – from constraining our health opportunities; however they do not constrain individuals' freedoms to live unhealthily if that is what they desire. Mulvaney-Day has shown, on the basis of social network analyses, that the people one cares about – that is, one's affective network – may be a more important influence on weight than the people who live nearby [53]. They suggest that ethical interventions engage at a meso-level – the level of community – leveraging existing relationship networks to change the opportunities available to people. This may, at least in part, explain the popularity of programs such as School Kitchen Gardens [54] which provide opportunities for existing affective networks to make changes together. Such programs also potentially provide both opportunities and corporate goods by changing the norms and practices in a social group, allowing those to be handed down through generations.

The solutions chosen by the summit provide none of these collective community-level goods. Instead, the summit used a collective process to support individualistic solutions, with little evidence of engagement with the important ethical issues raised for clinical or public health practice. This does not, of course, suggest that participants were ignorant of, or insensitive to, many of the ethical issues that underpin medicine and public health, but rather, that these issues were not explicitly addressed, that the limitations of 'evidence' were not made clear, that the complex relationships between individuals and the communities in which they live were not fully exposed and that the socio-moral goals of healthcare were not made explicit. These are important failings, because the values, focus, scope and goals of clinical medicine and public health are both distinct and overlapping; because interventions to address problems affecting individuals and communities may have different goals, risks and benefits, and because moral compromise in the design and delivery of healthcare is always necessary. For both clinicians and public health decision-makers, the central task is to think through the ethical and philosophical basis for actions before they are taken.

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