Obesity, autonomy and the harm principle

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Autonomy and its limits

The value of patient autonomy and the respect due to it is by now well recognised in health care. This recognition is visible in requirements to obtain valid consent for treatment and to accept and respect the health-regarding decisions that patients reach. It is visible in efforts to enable patients to manage their own health and to make information about health and disease readily available. Of course, we all know that autonomy with respect to health status or outcomes is patchy: there are many factors that affect health which are, in practical terms, beyond the control of either patients or their physicians. Perhaps that makes the sphere of control that does exist all the more important. Where health-affecting decisions can be made, for the most part, (competent) patients ought to be the ones to make them.

Autonomy is limited practically and it is also limited in a moral sense. The requirement to respect autonomy ends where harm to others begins: we are not obliged to enable some to act in ways which compromise the interests of others. This idea is encapsulated in John Stuart Mill’s harm principle and has gained widespread endorsement. In a standard case, the application of the principle is clear: I am not obliged to stand by and watch one man attack another. In such a case, intervention is justified, perhaps even obligatory, even if the attack has all the hallmarks of autonomous action. I do not wrong the violent man by interrupting his attack, as his rights to act autonomously do not extend to harmful activity.

Applying the harm principle is not always such a walk in the park, however. In some cases it might not be clear whether harm has in fact occurred: it can be difficult to judge whether an action makes someone worse off than they otherwise would have been. Decisions about child rearing can have this quality: it may be unclear whether, for instance, a custody decision has harmed a child, because the outcomes associated with alternatives are uncertain. Part of the difficulty here is establishing what the relevant baseline is for identifying harm.

In other cases, an action may have harmful consequences without it being clear whether these consequences warrant intervention, or what kind of intervention might be appropriate. Mill specified that actions that merely cause offence to others do not warrant intervention, but others may disagree, or consider that some types of offence should be prevented, but not others. In some situations questions may arise about the severity, rather than the type, of harm. An appropriate response to very mild harms might be to point them out to the ‘perpetrator’, rather than to intervene to prevent them.

In other cases, it might not be clear who the relevant ‘perpetrator’ actually is. In situations involving numerous people, all of whom contribute in some way to the outcome, establishing whose contributions are harmful is no easy feat.
Ethical principles that everyone agrees apply, but disagrees about how, are worrying things indeed. They can generate serious ethical disputes. It seems to me that the harm principle falls into this category. It appears to support a number of conflicting claims about specific issues, depending upon the way in which it is unpacked and applied.

One debate that suffers in this way is that over the funding of treatment for health conditions that are in some way attributable to the choices that patients make. A good example of this, and one that has attracted quite a lot of attention recently, relates to the funding of treatments such as bariatric surgery for obesity. Some people object violently to the public funding of such procedures, suggesting that recipients are essentially doing harm to other citizens, by unfairly laying claim to shared resources. Others focus on the ways in which many obese people appear to be harmed by policies and facts about our society that increase the risk of developing obesity. Strong claims are lodged about the legitimacy of claims upon the public purse and all sorts of proclamations of wrongdoing and moral responsibility are hurled about. Opposing claims often appear to proceed on the basis of importantly different assumptions about how to identify and measure harm; how to respond to different kinds of harm, and where to locate responsibility for harm.

The dispute is likely to rumble along unproductively until key claims supporting opposing positions are presented and exposed to careful consideration. To that end, it is worth trying to identify and analyse the moral claims that support the many positions relating to publicly-funded obesity-related treatment. This involves some degree of inference and speculation, as people are not always very clear about the moral foundations of their position, and consistency and loyalty to underlying claims are sometimes absent in public debate. But as a tentative first step I’ll outline what I take to be a plausible account of the claims that people draw upon in opposition to publicly-funded treatment of obesity, and offer a few comments about them.

An argument against public funding of treatment for obesity

Claim 1: Competent adults have a responsibility to minimise their claims to limited public resources, such as those available for health care.

In a publicly-funded system in which scarcity exists, the claims that one person makes can impact upon what is available for others. Given this, it might be thought that we have an obligation to use only what we ‘need’ and to ensure that we do not act in ways that are likely to increase the amount of health resources that we need (or at least, that we do not act in these ways when we are able to avoid action without incurring significant costs). To fail to do this would be to wrong and to harm fellow citizens, by taking for oneself what one had no right to, to the potential detriment of others.

Claim 2: Obesity is a recognised and predictable source of elevated claims upon public resources, because it increases the risk of developing serious health conditions such as diabetes.

Claim 3: Claim 2 is widely recognised.

Claim 4: Obesity can be avoided through regulation of energy intake and output.

Claim 5: Claim 4 is widely recognised.

Claim 6: People should regulate their energy intake in this way, not only as a matter of expedience, but also as a matter of moral obligation, related to Claim 1.

Conclusion: Given claims 1–6, treatment for obesity should not be publicly funded.
Critique

If this account of the argument against public funding of treatments for obesity such as bariatric surgery is accurate, it exposes a number of points that warrant further investigation.

Claim 1 makes a substantive normative claim about the general duties of citizens. It is rather a plausible claim to make, tapping into easily accepted ideas about fair shares, and the moral importance of being attentive to the effect of one’s actions upon others. The idea is that claims to common resources that arise from genuine and unavoidable need are legitimate, and do not wrong or harm others, whilst claims that are not so based are illegitimate, and harm others by reducing available public funds without legitimate cause.

One aspect of this claim that requires clarification relates to baselines for harm. In what sense are those in need of health care harmed by the claims of others? The intuitive response would be to say that the claims of one, P, reduce the funds available to satisfy the claims of another, Q. If that means that a lower standard of care is available to Q, perhaps Q is harmed by P.

But we wouldn’t normally think that patients harm each other by drawing on public resources. The resources are there for all who need them, and it is in the nature of communal resources that compromises in individual claims are sometimes required. The entitlement of Q is not reduced by P, since P was never entitled to more than a reasonable share, given competing demands.

But this does not fully diffuse Claim 1. The point it advances is that there is a difference between legitimate claims (those which could not reasonably be minimised) and illegitimate claims (those which the patient has in some way allowed to arise). Legitimate claims do not harm others, because they do not reduce entitlements, but illegitimate claims do: they wrongfully lay claim to resources that could otherwise have been used to satisfy truly unavoidable health needs.

The idea that we ought to minimise our claims on public resources has intuitive appeal. But if we consider the vast range of activities that we consider permissible, and even valuable in society, the idea that there is an absolute duty to minimise claims to public resources loses its lustre. Surely we are not required to refrain from absolutely every activity that might elevate claims to public resources, since many of the activities that we value—having children, playing contact sports, entering certain professions (the fire service; the military; and perhaps medicine)—harbour palpable health-related risks.

To rescue Claim 1 from the perils of implausibility, it is necessary to find some way to distinguish between worthwhile activity of the kind that is to be fostered by society and activity that does not justify the associated risks. Perhaps it should be rephrased as follows:

‘Claim 1: Competent adults have a responsibility to minimise their claims to limited public resources whilst pursuing worthwhile life goals.’

This rephrasing exposes its inevitably judgemental nature. To argue against funding treatment for obesity on the basis of Claim 1, one has to show that the actions and choices that lead to obesity are not compatible with the pursuit of worthwhile life goals. That may not be as easy as it seems. The reasons that people become obese may be much more value-laden than one might gather from some commentators. Eating is a source of enormous personal, social and cultural import and can solidify and confirm a sense of personal and group identity. In some cases, particular rituals and routines around food may be risky. One can object to the risk, and call for it to be reduced, without claiming that becoming obese is in contravention of a responsibility of the sort expressed in Claim 1.

Claims 2–5 take an empirical form and thus stand or fall according to the evidence. But even if it could be demonstrated that the vast majority of adults do recognise the health risks attached to obesity, these claims might remain problematic.

Obesity often has its roots in childhood and, once obesity is established, it is very difficult to banish through conventional means like dieting and increased physical activity. Although adults may well be expected to know that obesity
entails health risks, children will not necessarily know this, and messages of this kind may be confusing or difficult to interpret for children whose domestic and social experiences deliver conflicting food-related messages. Should adults be held responsible for failures to rid themselves of food-related attitudes and behaviours entrenched in childhood?

Claim 6 ties up the preceding claims with a normative bow, telling us that not only is successful regulation of weight possible, it is also morally required. In ethics, it is very often claimed that ‘ought implies can’; that is, that one can only be obliged to do what it is possible to do. The argument as cast above asserts that it is possible for individuals to avoid obesity through attentive regulation of energy intake and output. Clearly, at one level, this is true, but this account glazes over many of the forces that act upon individuals in ways which load the bases in favour of, or against, successful regulation of energy consumption and expenditure.

There is by now a great deal of evidence to suggest that obesity is not just a problem that society faces, but also a problem that society causes. The availability, pricing, and marketing of food, along with a slew of other factors (obeso-genic environments, changes in the nature of activities undertaken for work and recreation, genetic and familial predisposers; transport trends and familial predisposers; transport trends and important socioeconomic factors) combine forces in a way that encourages, or even produces, obesity. Some people are more exposed to these factors than others, or are less able to avoid their obesity-inducing effects. This means that obesity and the health problems associated with it occur unevenly across the population, in many cases consolidating and extending pre-existing health and other social inequalities.

Whilst it may be possible for most people to avoid obesity, some face many more obstacles to achieving this than others, many of which are not the result of personal choices. If we as a society accept certain social arrangements that increase the difficulty of avoiding obesity, it would seem unfair to then deny access to treatment for obesity on the basis that the obese have been morally irresponsible. In fact, it may be that the obese have a harm-based claim against society, or some parts of it, for the harm to which obeso-genic policies and arrangements have exposed them.

These comments reveal the difficulty, in the context of obesity at least, in establishing with certainty precisely what harms have occurred, who is responsible for them and what the appropriate response to them might be. If responsibility for harm is potentially disparate, it would be unduly harsh to distribute the full force of responsibility to identifiable individuals.

That is essentially what would happen if obese individuals were denied access to publicly-funded treatments like bariatric surgery on the grounds that to provide access would be to facilitate harm to others. The harms involved in obesity and the obligations that they produce are too debatable, and responsibility for the production of harm is too diffuse, to warrant refusal of public funding, at least on the grounds set out here.

References