The Child's Right to a Lean Future

Ethical Justification of State Interventions in Cases of Childhood Obesity

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CONTENTS

ABSTRACT: In response to a motion proposed in 2007 by the members of the British Medical Association to charge parents of obese children with neglect, this thesis explores whether or not the childhood obesity epidemic could justify state interventions. And if so: which kind of state interventions could be ethically justified and what conditions should these interventions meet? A comprehensive answer to this question is provided by analysing if childhood obesity could indeed constitute parental neglect and by applying the moral philosophy of Joel Feinberg. After discussing the necessary conditions state interventions aimed at preventing or decreasing childhood obesity should meet, a guideline is proposed to make a clear distinction between ethical and unethical forms of state intervention.

KEY WORDS: childhood obesity, state intervention, harm principle, welfare interests, parental neglect, open future, saggy skin, stewardship model, paternalism

1. INTRODUCTION

In 2005 the World Health Organization qualified the global obesity epidemic as one of today's "most blatantly visible yet most neglected"[1] public health problems. In later years the obesity epidemic was recognized as a public health issue not only concerning adults but adolescents and children as well. Initially cases of extreme childhood obesity and corresponding health problems seemed confined to the United States, but in 2007 the British media reported *en masse* on 'Connor McCreaddie,' a seven-year-old child so obese that his body weight rendered him unable to walk to his local school, and he was subsequently taken from his mother by child protective services[2]. As a result of the mass media focus on Connor McCreaddie, a motion at the annual meeting of the British Medical Association proposed that obesity in children under twelve years of age could provide a reason to charge parents with neglect. The members who proposed the motion claimed that parents who were unable to demonstrate the basic responsibility of providing a healthy diet and sufficient physical activity necessary to prevent the major health risks associated with obesity were guilty of neglect[3]. The members further claimed that this could allow for state intervention in the form of legal action towards the parents or removal of the children from their families for their own protection. Although the motion was eventually rejected, it raises a serious ethical question: does childhood obesity justify state intervention? The goal of my thesis will be to provide an accurate and

[1] World Health Organisation (2005)

[2] BBC News (2007a)

[3] British Medical Association (2007), p. 8

comprehensive answer to this question. In order to do so, I will analyse the scope of the problem of childhood obesity and discuss how much harm is exactly caused by childhood obesity; not just during childhood, but also in later life due to adult comorbidity, the social stigma of obesity and the aesthetic problem of saggy skin as a result of weight loss. I will review why it is problematic and ethically unjustified to qualify most cases of childhood obesity as cases of parental neglect, before examining why – and under which conditions – state intervention could still be a justified course of action. I will apply the moral philosophy of Joel Feinberg to establish on what grounds state interventions are justified, mainly by focussing on Feinberg's interpretation of the harm principle and his conceptualisation of the "child's right to an open future". The application of Feinberg's moral theory will provide a set of conditions that will serve as a guideline to determine what would be considered justified state interventions in cases of childhood obesity and will therefore aid in providing an answer to the main question.

2. THE HARM IN CHILDHOOD OBESITY

2.1 The Scope of the Problem

The common definitions for adult obesity are usually based on Body Mass Index (BMI) or percentage of body fat. The latter is unfortunately impractical to use in epidemiological studies[4], and the former is difficult to apply to children as they continually grow during childhood while the cut-off point for child obesity is based solely on BMI changes throughout the course of childhood[5]. The standard adult cut-off point for obesity is 30kg/m^2—which is usually simply referred to as a BMI score of 30—is not applicable to children as their average and normal BMI differs substantially with age. For instance, a normal BMI for children is as low as 13 kg/m^2 at birth, increases to 17kg/m^2 at age 1, decreases to 15kg/m^2 at age 6[6] and finally slowly increases from there to adulthood. Due to this inconsistency in normal BMI scores throughout childhood, a commonly used definition of childhood obesity is based on percentiles. In this definition, overweight children are defined as children with a BMI between the 85th and 95th percentile for age and gender, obese children are defined as children with a BMI greater than the 95th percentile and finally severely obese children are those that have a BMI greater than the 99th percentile for age and gender[7]. Since working with percentiles can give a

[4] Fu WPC, Lee HC, Ng CJ, et al. (2003), p. 1211

[5] Cole, TJ; Bellizzi, MC; Flegal, KM, et al. (2000), p. 1240

[6] Cole TJ, Freeman VJ, Preece MA (1995), p. 27

[7] Freedman DS, Mei Z, Srinivasan SR, et al. (2007), p. 13

somewhat skewed representation of obesity in a society with vastly growing obesity rates, the International Obesity Task Force (IOBTF) suggests the use of a new definition of childhood obesity for epidemiological studies. In this definition, a BMI cut-off point for childhood obesity is established for every year of age in both genders[8]. This definition has remained the most used definition for childhood obesity in peer-reviewed research since it was established in 2000[9]. Before analysing the specific health risks and medical harm associated with childhood obesity, the magnitude of the childhood obesity problem must also be addressed. The most worrying trends can be seen in the statistics of obesity in the United States, where adult obesity is the current second leading cause[10] of preventable death, surpassed only by smoking. If the problem of childhood obesity is not properly addressed, it might eventually become the leading cause of preventable death as obesity is currently the most prevalent nutritional disease[11] amongst children: currently 32% of all American children are overweight and a shocking 17% of children are obese[12]. The estimated figures for the medical costs of childhood obesity-related illnesses in the United States range between 10 billion[13] and 14 billion[14] dollars per year. Unfortunately, the problem of childhood obesity is not just confined to the United States. An enormous increase in the prevalence of childhood overweight and obesity has been reported worldwide in the last twenty years: the global increase in childhood obesity and overweight children rose 21% between 1990 and 2000, and increased 31% between 2000 and 2010[15]. These increases are also not limited to Western nations as China saw their childhood obesity rates climb from just over 1% in 1985 to 25% in 2000[16]. An elaborate study from the World Health Organization

[8] For instance, the BMI cut-off point for a two year old is a BMI score 20.0 kg/m2, the BMI cut-off point for obesity for a five year old is 19.3 for boys and 19.1 for girls and increases slowly from there on out. For more information: See Table 4 of Cole, TJ; Bellizzi, MC; Flegal, KM, et al. (2000), p. 1242.

[9] All the peer-reviewed researches and articles referred to in this thesis utilise one of these two definitions. I have decided not to use literature in which it was unclear which definition of childhood obesity was used, in order to maintain consistency

[10] Wang L, Lobstein T (2006), p. 11

[11] Dietz WH (1998), p. 518

[12] Ogden C, Carroll MD, Kit BK, et al. (2014), p. 810

[13] Trasande L, Chatterjee S (2009), p. 1753

[14] Cawley J (2010), p. 366

[15] Onis M de, Blössner M, Borghi E (2010), P. 1262

[16] Wang L, Kong L, Wu F (2005), p. 1822

showed that childhood obesity statistics in Europe differ greatly from country to country, but also show a high—and increasing—prevalence of childhood obesity[17].

2.2 Medical Harm and Comorbidity

With the alarming magnitude of the childhood obesity issue now established, how much ”harm” childhood obesity really causes can be assessed. Fortunately, there is a vast amount of conclusive research on this matter; however, the majority of this research sketches a grim image of the adverse health effects related to childhood obesity. Recent research shows that obese children have a significantly impaired health-related quality of life[18], reduced life expectancy[19] and an overall higher mortality risk[20] compared to non-obese children. Other research further evidences that childhood obesity is directly related to the worsening of cardiovascular health, both short term and long term[21], as well as an increased risk for coronary heart disease[22]. Other childhood obesity related comorbidities include sleep disordered breathing and sleep apnoea[23], hyperlipidaemia[24] and hyperinsulinemia—the latter two both being clear precursors to adult cardiovascular disease and type 2 diabetes[25]. Research also clearly links childhood obesity to an enormously increased risk of adult obesity[26], which in turn is responsible for an increased chance of dying from cancer[27] and an increased chance to suffer from diseases ranging from kidney disease[28] to hypertension[29]. This extensive list shows that obesity affects “almost all aspects of human function and physiology”[30]. The

[17] With some countries – Italy for instance – providing extremely high obesity (26%) and overweight (49%) rates amongst 8 year old boys. All the data about childhood obesity prevalance amongst European children can be found in Wijnhoven TM1, van Raaij JM, Spinelli A (2013)

[18] Hughes AR, Farewell K, Harris D, et al. (2007), p. 43

[19] Fontaine KR, Redden DT, Wang C, et al. (2003) even shows a direct relationship between estimated years of life lost and childhood BMI

[20] Masters RK, Reither E, Powers DA (2013), p. 1899

[21] Raj, M (2012), p. 19

[22] Christopher GO, Whincup PH, Orfei L, et al. (2009), p. 871-872

[23] Verhulst SL, Schrauwen N, Haentjens D, et al. (2007), p. 208

[24] Caprio S, Hyman LD, McCarthy S (1996), p. 17

[25] Schwimmer JB, Burwinkle TM, Varni JW (2003), p. 1818

[26] Baur LA (2005), p. 958

[27] Calle EE, Rodriguez C, Walker-Thurmond K, et al. (2013), p. 1632

[28] Bray GA (2004), p. 2588

[29] Kotchen TA (2010), p. 1176

[30] Hill JO, Wyatt HR (2013), p. 79

risks and harms associated with childhood obesity, both immediate and long-term, are so numerous and serious that an increasing number of childhood obesity cases ask for more intrusive and aggressive[31] medical interventions. In the United Kingdom, the National Institute of Health and Clinical Excellence stated they were already seeing such severe cases of childhood obesity as to recommend[32] surgical interventions, such as a gastric bypass or bariatric surgery[33], as the best solution to reduce weight.

2.3 Life After Childhood Obesity: Social Stigma and Saggy Skin

Since childhood obesity is one of the main predictors[34] for adult obesity, people who have already suffered from the health risks of obesity in childhood face the same health risks as adults. However, the harm done by obesity is not just limited to bodily harm: the psychological burdens of obesity should not be underestimated. Research shows that obesity makes people more prone to anxiety[35], dissatisfaction with their own bodies, self-esteem issues[36] and other psychological disorders[37]. Obesity is generally considered a socially undesirable condition as obese children often experience bullying, and obese adults often face social stigma. Indeed, overweight and obese individuals face anti-fat bias and discrimination in academic, social, healthcare and employment settings[38]— even more than other marginalized groups[39]. These negative consequences offer a lot of motivation for an obese adolescent to decide to lose weight; however, losing weight to prevent future physical and psychological harm from obesity is not without its own risks. The struggle to lose weight after a childhood of obesity in turn brings its own mental challenges and psychological stress[40], including a major issue that is the focal point of this chapter: excess—or "saggy"—skin. Since human skin only has limited elasticity, any person who has been obese, and through some way or another comes down to a healthy or normal weight, will develop the problem of redundant, saggy skin. In my personal view, this is one of the most overlooked and underestimated problem associated

[31] Raj M, Kumar MK (2010), p. 603

[32] The Guardian (2006)

[33] Dixon JB, Jones K, Dixon M (2009)

[34] Trojano RP, Flegal KM (1998), p. 502

[35] Cornette R (2008)

[36] Dietz W (1998), p. 519

[37] Mustillo S, Worthman C, Erkanli A, et al. (2003)

[38] Azétsop J, Joy TR (2011), p. 6

[39] For instance, recent research in the United States shows, obese individuals face more bias and discrimination than homosexuals and Muslims, as is discussed in Latner JD, O'Brien KS, Durso LE, et al. (2008)

[40] Dixon JB, Dixon ME, O'Brien PE (2003)

with obesity. Although excess skin is very common in both people who lose weight through diet and exercise, as well as people who lose the weight through bariatric surgery, documentation mainly focuses on the latter. Research shows that between 89%[41] and 96%[42] of obese patients undergoing bariatric surgery develop sagging skin. Most patients consider excess sagging skin as an abominable sight, which causes a considerable degree of discomfort for all body parts[43] and leads to significant psychological and functional impairment[44] and is why more than 95% of formerly obese people with excess skin desire body-contouring surgery[45]. In other words, practically all formerly obese people who have gone through the hardships of getting down to a healthy weight will still require surgery in order to feel good about themselves and their appearance. However, the body-contouring surgery[46] needed to remove excess skin is, again, not without its own risks and downsides. The medical risks of body-contouring surgery include the development of seroma[47], all risks associated with long operative times[48] and relatively high infection rates[49]. This surgery also requires lengthy post-operative treatment and management[50] and is an overall very expensive surgery[51]. To make it even worse, 92% of patients undergoing body-contouring surgery require more than one surgery[52] before the result is satisfactory since excess skin is not restricted to just one body part. Finally, this particular surgery is also notorious for its full-body scarring. Clearly, a person is not liberated from the burdens of childhood obesity once that person's childhood is over. Quite the contrary, an adult that has spent his or her childhood obese is faced with a harsh dilemma lacking any positive outcomes: face the physical and mental burdens of adult obesity, or take the long and rough path to weight loss with all the risks and harms stated above.

[41] Aldaqal SM, Makhdoum AM, Turki AM, et al. (2013), p. 301

[42] Kitzinger HB, Abayev S, Pittermann A (2012)

[43] Staalesen T, Fagevik OM, Elander A (2013), p. 1632

[44] Aldaqal SM, Makhdoum AM, Turki AM, et al. (2013), p. 301, p. 305

[45] Azin A, Zhou C, Jackson T (2014), p. 776

[46] A surgery performed more and more each year, with over 15.000 people undergoing this particular surgery in the UK alone over 2010

[47] Shermak MA, Rotellini-Coltvet LA, Chang D (2008)

[48] Friedman T, O'Brien Coon D, Michaels J, et al. (2010)

[49] Gusenoff JA, Coon D, Rubin JP (2009)

[50] Michaels JV, Coon D, Rubin J, et al. (2011)

[51] Azin A, Zhou C, Jackson T (2014), p. 779

[52] Staalesen T, Fagevik Olsén M, Elander A (2013), p. 1638

3 CHILDHOOD OBESITY AS PARENTAL NEGLECT

3.1 The Responsibility of Parents

Cases such as Connor McCreaddie's where a parent is charged with neglect due to the health problems related to the obesity of the child are not uncommon[53]. Just recently the BBC reported on another case where the parents of an eleven year old boy with a BMI of 42 were charged on counts of cruelty and neglect[54]. The reasoning in these cases—which is the same rationale provided by the members who proposed the motion at the aforementioned British Medical Association meeting—is that parents have full control over a child's nutrient intake and opportunities for physical activity[55]. They are therefore mainly responsible for the obesity-related harm done to their children. Those who support child obesity as parental neglect argue that children do not yet possess the capacity to make well-informed choices about their nutrition and level of activity in the scope of their current and future health, and their parents act as decision-makers on their behalf and as such are primarily responsible for their children's health and wellbeing. This line of argument is also followed in Mianna Lotz's article "Childhood Obesity and the Question of Parental Liberty" in which she claims that although obesity is caused by a multitude of factors, parents are still largely to blame for the obesity of their children. She attributes parents a "more potent causal role"[56] in the causation of childhood obesity. Lotz's argument allows parents of obese children to be charged with neglect and for the removal of the child in question from its family, as is typical in cases where parents are charged with parental neglect[57]. I disagree with the idea that parents are largely to blame for the obesity of their children and later on I will provide evidence to refute the claim that parents have such a 'potent causal role' in the causation of their children's obesity and will argue that because parents do not have full control over their children's bodyweight, state interventions in the form of removing the children from their parents are morally unjustified. Before I can do so, it is necessary to get a clearer grasp of how 'parental neglect' is actually defined and review why it is very problematic to consider childhood obesity as parental neglect.

3.2 Defining Parental Neglect

A study of the ethical and legal framework of parental neglect shows that the existing definitions of parental neglect or medical neglect (parental neglect of a child's medical needs) are not

[53] BBC News (2007b)

[54] BBC News (2014)

[55] Holm S (2008), p. 24

[56] Lotz M (2004), p. 293

[57] Wald MS (1996), p. 626

universally consistent[58]. An all-encompassing, single definition of neglect does not exist, and the current definitions in use are vague and limited in their effectiveness[59]. The current definitions of neglect are so limited, in fact, that even experts assert that the lack of precision has hampered adequate research about the topic of parental neglect[60] for a long time. The World Health Organization also provides a broad definition of neglect as an aspect of child maltreatment[61]: "Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible"[62]. An alternative and more modern definition of parental neglect focuses more on the parents' failure to act by defining neglect as when parenting gives way to the "potential for injury resulting from omissions on the part of the caregivers in meeting the child's basic needs"[63]. The definition that is most commonly and frequently used in the ethical and legal discussion surrounding parental neglect is the one provided by Kantor and Straus. They define neglectful behaviour as "behaviour by a caregiver that constitutes a failure to act in ways that are presumed by the culture of a society to be necessary to meet the developmental needs of a child and which are the responsibility of a caregiver to provide"[64]. These existing definitions of neglect provide a basis for regarding childhood obesity as parental neglect. The definition provided by the World Health Organization clearly mentions health and nutrition as fields where the parents should provide proper care to their children, and a line can be drawn from the harm associated with childhood obesity and not providing adequate nutrition to not meeting a child's basic needs. Examining Kantor and Straus' definitions reveals the same: by arguing that the failure to provide a setting in which a child grows up in good health without the risks associated with childhood obesity can be equated with not meeting the "developmental needs of a child". However, the currently used definitions of parental neglect as discussed above are so broad as to be unsuitable for making assertions about childhood obesity, and they do not provide a solid basis to regard childhood obesity as parental neglect. Even Kantor and Straus claim that the

[58] National Association for Prevention of Child Abuse and Neglect (2008)

[59] Watson J (2005), p. 1

[60] Dubowitz H, Pitts SC, Litrownik AJ, et al. (2005), p. 494

[61] WHO (2009)

[62] WHO (1999)

[63] Giardino AP, Lyn MA, Giardino ER (2010), p. 51

[64] Straus MA, Kantor GK (2005), p. 20

"heterogeneity of the phenomenon" parental neglect brings "[an] inherent difficulty"[65] in specifying which kind of unmet needs actually constitute parental neglect, especially when compared to abusive actions. In other words, failing to do something as a parent is harder to ethically assess or reject than the intentional harming of a child. Parents of obese children should not be characterized as *evil-doers*[66] in the same sense as parents that deliberately hurt or neglect their children in most typical neglect or abuse cases. The vague and broad definitions of parental neglect alone might call for assessment of individual cases rather than considering every case of childhood obesity a reason to suspect parents of—or charge parents with—neglect. Before making such an assumption, it is important to first review the existing literature on the topic of regarding obese children as neglected children.

3.3 Why Childhood Obesity Does Not Necessarily Constitute Neglect

During the last few years, several publications in well-established peer-reviewed journals featured ethicists and paediatricians discussing the issue of charging parents of obese children with neglect, undoubtedly in part due to the media coverage of cases like Connor McCreaddie's. In 2009 Dr. Tod Varness from the University of Wisconsin proposed a scale of childhood obesity consisting of four categories ranging from obese children who have no comorbid conditions at all (category 1) to children who have comorbid conditions to the extent that it constitutes serious imminent harm in childhood (category 4)[67]. *Imminent* harm is relevant because Varness argues that one of the most important conditions for removing a child from his or her home is the high likelihood that "serious imminent harm will occur"[68]. In most cases of childhood obesity, assessing exactly when harm will occur is difficult, and hence resorting to state interventions such as removing a child from his or her parents is problematic as the mere presence of childhood obesity does not predict *imminent* harm. Varness claims that because childhood obesity is a condition with a spectrum of severity, determining when a likelihood of serious imminent harm is present[69] is difficult, and therefore defining all cases of childhood obesity as a legitimate basis for charging parents with neglect is highly problematic. Although Varness claims that there is no clear threshold level of childhood obesity that automatically predicts serious imminent harm, he does believe that in some cases where children fall into category 4 the parents could be charged with parental neglect. He does, however, make an

[65] Ibid., p. 20

[66] Johnstone MJ (2008), p. 25

[67] Varness T, Allen DB, Carrel AL, et al. (2009), p. 406

[68] Ibid., p. 309

[69] Ibid., p. 401

important side note, arguing that even in these grievous 'category 4' cases, the first response to severe cases of childhood obesity should always be less invasive alternatives than charging parents with neglect[70]which is something I whole heartedly agree with and shall provide extensive reasoning for later in this thesis. Dr. Shirley Alexander from the University of Sidney agrees with Varness in her article, "When does Childhood Obesity become a Child Protection Issue?" which she wrote in the same year as Varness', asserting that health care professionals should only consider notifying child protection authorities in the most extreme cases of child obesity "in which all other measures[71] available to the health care professional have failed"[72]. One of the major reasons for refraining from taking legal action against the parents—apart from the invasiveness and threat to parental autonomy—is to avoid disincentives for parents to report health problems related to their children's obesity as this could result in fewer parents seeking medical help to treat their severely obese child[73]. Professor Russell Viner coincidentally published an article with the exact same title as Alexander's in the British Medical Journal in 2010, in which he agrees that childhood obesity on its own should not be considered an issue of parental neglect, since the aetiology of obesity is so complex that it is "untenable to institute child protection actions relating parental neglect to the cause of their child's obesity"[74].He adds the important argument of simple impracticality: considering childhood obesity as a cause for charging parents with neglect would mean that even with the most conservative definitions of severe childhood obesity—such as the one provided by the International Obesity Taskforce—over 5% of parents in the United Kingdom could be charged with neglect[75]. This argument of impracticality is shared across the ocean by Harvard situated paediatrician Lindsey Murtagh, who in her 2011 article, "State Intervention in Life-Threatening Childhood Obesity", agrees that state intervention in the form of child removal, even in severe instances of childhood obesity, is neither desirable nor practical nor legally justifiable, as it would encompass approximately two million children in the in the United States alone[76]. A review of relevant literature and professional opinions on childhood obesity as parental neglect shows that parental neglect is not only a vague and hard to define concept, but charging parents of obese children with neglect is inappropriate and

[70] Ibid, p. 404

[71] These "other measures" are an important factor in the answering of the main question of this thesis. An elaborate analysis of possible other non-invasive measures will be discussed in "Other Means: Alternative Solutions and Interventions"

[72] Alexander SM, Baur LA, Magnusson R, et al. (2009), p. 138

[73] Ibid.

[74] Viner R (2010), p. 376

[75] Ibid.

[76] Murtagh L, Ludwig DS (2011), p. 207

impractical. This does not, however, completely address the issue of whether or not childhood obesity justifies state intervention in some cases—it only proves that it is hard to intervene in the same way as with cases of obvious parental neglect. While childhood obesity is clearly a substantial problem that calls for action and perhaps even for state intervention, in order to establish when and under what conditions the state is ethically allowed to intervene when harm is being done the moral philosophy behind justified state intervention must first be analysed.

4 HARM AND STATE INTERVENTION

4.1 Joel Feinberg, the Harm Principle and Welfare Interests

In 1859 the British philosopher John Stuart Mill provided one clear and simple principle that he believed could serve as the sole ethical framework for justified state intervention which he named the Harm Principle. He relates the Harm Principle to state intervention as being " the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others"[77]. Although Mill is the founding father of the Harm Principle and his moral discourse on harm and state intervention are still very relevant to this day, Mill's work is not comprehensive and modern enough to fully address the problem of state intervention in cases of child obesity. In order to get a better grasp of when state intervention might be justified and what 'being harmed' exactly means- which is necessary to provide an answer to the main question of this thesis – a more contemporary moral and legal philosopher's ethical theories should be examined, namely: Joel Feinberg. Feinberg is possibly the most authoritative philosopher on "harm" and has written an enormous four-volume study on the concept of harm titled, "The Moral Limits of Criminal Law", in which he addresses the limitations that should be placed on the use of coercion by the state and exactly what sorts of conduct the state may rightfully consider to be criminal[78]. The first volume in his four volume opus, 'Harm to Others', focuses on answering what constitutes harm and legitimizes state intervention. Like John Stuart Mill, Feinberg opposes most forms of legal paternalism[79] and rejects the need for state interventions for 'people's own good', but agrees with Mill that the focus of criminal law should be to prevent harm from being done by one person to another. Feinberg believes that Mill's formulation of the harm principle might be too inclusive as what exactly constitutes 'harm' is not adequately defined by Mill. Before Feinberg sets apart what kinds of acts exactly constitute 'harming' to the extent of calling for state intervention, he provides a new and more nuanced definition of the harm principle: "It is always a good reason in support of

[77] Mill JS (1859), p. 13

[78] Feinberg J (1984), p. 3

[79] Arneson RJ (2005), p. 259

penal legislation that it would probably be effective in preventing (eliminating, reducing) harm to persons other than the actor (the one prohibited from acting) and there is no other means that is equally effective at no greater cost to other values"[80]. Feinberg also redefines harms as 'setbacks to interests' in order to differentiate between harming and 'wronging'. According to Feinberg, the interests of a person can be divided into two important groups: *welfare interests*, which are minimal but non-ultimate goods such as living in minimal political liberty or being free from pain and coercion[81], or *ulterior interests*, which are related to one's personal projects and goals. Whereas welfare interests are a basic pre-requisite of any person's general well-being[82], ulterior interests consist of things like one's desire to write a good book or strive for high political office one day[83]. Every person has the right to pursue at least welfare interests, and when welfare interests are blocked or damaged a person is "very seriously harmed indeed"[84]. Damaging welfare interests not only hurts those minimal welfare interests but also defeats his or her ultimate aspirations. Setbacks to *ulterior interests*, on the other hand, do not damage the entire network of interests to the same degree. While Feinberg's description of different forms of harms, wrongs, hurts and offenses is very elaborate, what essentially constitutes 'harming' is a setback to a person's welfare interests. Feinberg also defines physical health and vigor[85], as well as the "the integrity and normal functioning of our body"[86], as being important welfare interest. Since childhood obesity has been established as causing immediate as well as long-term harmful effects into adulthood, through Feinberg's application of the harm principle childhood obesity could be argued to directly set back a person's welfare interests. Therefore, childhood obesity and all its related medical harm and comorbidity could indeed constitute true harm and justify some form of state intervention through penal legislation, since Feinberg states that these "acts of harming […] are the direct objects of criminal law"[87]. While Feinberg does not address the issue of childhood obesity (since most likely childhood obesity was a non-issue during the writing of Feinberg's work in 1984) he addresses another important child-related right that relates to whether childhood obesity can be a justification for state intervention.

[80] Feinberg J (1984), p. 26

[81] Ibid., p. 37

[82] Rescher N (1972), p. 6

[83] Feinberg J (1984), p. 37

[84] Ibid.

[85] Ibid., p. 60

[86] Dwyer JG (2002), p. 71

[87] Feinberg (1984), p. 31

4.2 The Child's Right to an Open Future

One aspect of childhood obesity is usually overlooked and remains undiscussed in ethical discussions of the harms of childhood obesity: the effects of obesity on the choices a person who grows into adulthood being obese has, specifically in regards to the aforementioned social stigma and saggy skin. These issues can lead to an infraction of what Feinberg calls the 'child's right to an open future'. The "child's right to an open future" is defined and explained by Joel Feinberg in his similarly titled 1980 paper and is part of what Feinberg calls *C-rights*—rights that are generally characteristic of children. These C-rights are divided into two separate sub classes: dependency rights and rights-in-trust. Dependency rights are rights derived from a child's dependence upon others for basic goods such as food and shelter, and rights-in-trust are rights that the child does not yet possess but must be preserved for exercise by the adult the child will become in the future[88]. Protecting these C-rights-in-trust forms the basis of the child's right to an open future. From the moment a child is born, the parents will make choices the child himself cannot yet make and hereby powerfully shape his or her future[89]. Parents must acknowledge and respect the rights-in-trust of their children—even before the holder of these rights exists as an adult—so the future holder of these rights cannot be deprived of the ability to exercise them[90]. This means that the parents, or any other parties that have significant influence in the lives of children, should refrain from making serious and final decisions for the child until he grows to maturity and is mentally and legally capable of making these decisions himself[91]. This way, Feinberg states, protecting the child's rights-in-trust will assure that a child is permitted to reach maturity with as many open options, opportunities and advantages as possible[92]. Essentially, a child's right to an open future is violated prematurely[93] when, by the time the child in question is an autonomous adult, "certain key options will already be closed to him"[94]. As demonstrated earlier, being obese throughout childhood and adolescence will limit one's options as an adult. By the time an obese adolescent reaches the maturity to make his or her own decisions about physical activity and food intake, his or her freedom in determining how they want their body to look aesthetically and physically is severely limited. The choices for someone who is obese in early adulthood is limited to either staying obese while facing social stigma, adverse health effects and likely dissatisfaction about his or her appearance, or to attempt to achieve a healthy weight. The

[88] Feinberg J (1980), p. 125

[89] Levy N (2002), p. 284

[90] Lotz M (2006), p. 539

[91] Feinberg J (1980), p. 129

[92] Ibid., p. 130

[93] Orenstein AA (2002), p. 2

[94] Feinberg J (1980), p. 126

latter option brings its own hardships with it, as weight loss through diet and exercise can be extremely mentally challenging and weight loss through bariatric surgery is not without its own risks. Even when weight loss is achieved, the vast majority of formerly obese persons will still not be satisfied with their appearance due to the phenomenon of saggy skin and will require additional costly and risky surgery. Needless to say, an obese young adult is very limited in his or her choices when it comes to deciding about their own bodily health and physical appearance, compared to young adults of a normal weight. An obese child can be seen as a child that has an option that other individuals will have in adulthood—but option to be an adult of a healthy bodyweight without having to go through surgery or extreme weight loss and all its risks and hardships is irrevocably foreclosed[95]. Creating the conditions in which a child or adolescent will become or stay obese can therefore be considered a direct infringement upon the right to an open future as "critical life-decisions will have been made irreversibly for a person well before he reaches the age […] when he should be expected […] to make them himself"[96].

4.3 Conditions for State Intervention

Apart from being an infraction upon the child's right to an open future, childhood obesity can be regarded as causing a setback to a child's welfare interests, and hence—adhering to Feinberg's legal philosophy—constitutes 'harm' to such an extent that state intervention might be justified. But does the presence of childhood obesity also justify harsh and invasive state intervention or penal actions such as charging parents with parental neglect or removing the child from its home as was the case with Connor McCreaddie and as was suggested in the motion proposed by the British Medical Association in 2007? In order to answer this question we need to consider the conditions that state interventions have to meet in order to be ethically justified, before seeing which kind of state interventions could possibly meet this criteria. Most importantly, before undertaking any legal action or intervention, the person or party the intervention is directed at must be established as genuinely responsible for the harm being caused. In other words, a clear causal component[97] in the harming must be established before an intervention can be directed at a possible guilty party. As Feinberg explains in the traditional formula for establishing who, from a legal perspective, caused the harm: "The wrong doing must have been a genuine causal factor […] in the production of the harm, and it must be an especially substantial […] causal contributor"[98]. In order to blame and subsequently

[95] Davis DS (1997), p. 95

[96] Feinberg J (1980), p. 132

[97] Feinberg (1984), p. 118

[98] Ibid., p. 119

penalise parents of obese children, the parents' actions should be the most clear and substantial cause of their children's obesity. Another necessary condition for the justification of state interventions is in the last part of Feinberg's definition of the Harm Principle; to reiterate: "[…] it would probably be effective in preventing harm to persons other than the actor and there is no other means that is equally effective at no greater cost to other values"[99]. In order for any kind of penal legislation or state intervention to be justified the intervention with the least cost or damage to other values whenever other equally effective interventions should be utilized. The two conditions – the condition that interventions should be aimed at the party that is a substantial causal contributor to the harm being done and the condition that there should be no other effective interventions available at a lesser cost to other values – will be the focal point of the entire next chapter. Before analysing the question of blame and causation of childhood obesity and exploring which 'other means' and solutions might be available apart from charging parents with neglect or removing a child from its home, discussing Feinberg's 'other values' that might be under threat during coercive state intervention in will shed more light on the downsides of state intervention in childhood obesity.

5 JUSTIFYING STATE INTERVENTION

5.1 "At No Great Cost to Other Values": Parental Autonomy

The main justification for invasive state interventions within the family lies in the doctrine of *parens patriae*, which is the doctrine that applies to the state's power to substitute its own authority for the authority of the natural parents over their children[100] in order to safeguard the child's wellbeing or to protect child from harm. However, the doctrine of *parens patriae* and its legitimization of state intervention in the private realm of family has always been a controversial topic[101] as it clashes with the right parents have to raise their children as they see fit and undermines the important value of parental autonomy[102]. Feinberg defines respect for a person's autonomy as respect for "his unfettered voluntary choice as the sole rightful determinant of his actions"[103] and argues that autonomous self-regarding conduct should be immune from coercive interference from the state[104]. Parental autonomy can be regarded as an extended form of autonomy where parents are not just free from state coercion when it comes to self-regarding conduct but also concerning

[99] Ibid., p. 26

[100] Curtis LB (1978), p. 195

[101] Curtis GB (1976), p. 915

[102] Blustein J (1983), p. 39

[103] Feinberg (1986), p. 59

[104] Malm H (2005), p. 193

conduct with regards to their children. This extended autonomy encompasses the parent's right to raise children as they see fit without being hindered by the government or other parties outside of the family as this might jeopardize the norms of freedom, autonomy and intimacy[105] of the family. The generally recognised right[106] of parental autonomy is based on the same liberal ideal of personal sovereignty as Mill's harm principle and comports well with a child's biological and psychological need for unthreatened and unbroken continuity of parental care[107]. The value of parental autonomy is the main value being threatened by state intervention within the family—in this case the removal of an obese child from its parents. The respect for parental autonomy, as well as the risk of psychological harm of the child, is why the threshold for state intervention in the form of child removal is usually very high[108]. The right to parental autonomy also means that parents are allowed to raise their child in their own way *even if* this means that it is not in the best interest of the child. As paediatrician and bioethicist Douglas Diekema from the University of Washington explains in his article, "Parental refusals of medical treatment: the harm principle as threshold for state intervention": "There are few situations in which society actually requires parents to always act in a way that is optimal for their children, [the state] is not justified in intervening simply because parental decisions may compromise the interests of a child in favor of those of the family".[109] As an example, Diekema mentions college education. Although a college education would be in the best interest of most children, the state cannot force parents to provide a college education for their children. So what kind of conduct *does* justify a breach of parental autonomy in the form of state intervention? According to Diekema, the harm principle can provide us with an answer to this question. State intervention is not justified when a parent's conduct is contrary to a child's best interest, but can be justified when "the child [is] at significant risk of serious preventable harm"[110]. But exactly how much can the parents do to prevent the harm associated with childhood obesity and—more importantly—how much influence do the parents have on a child becoming obese in the first place? Are parents really such "substantial causal contributors" to their children's obesity?

[105] Minow M (1985), p. 946-947

[106] Beauchamp TL (2003), p. 271

[107] Goldstein J (1977), p. 649

[108] Varness T, Allen DB, Carrel AL, et al. (2009), p. 401

[109] Diekema DS (2004), p. 247

[110] Ibid., p. 258

5.2 "A Causal Component": Who is to Blame for Childhood Obesity?

Public opinion focuses on the primary responsibility of parents to provide healthy food choices and physical activities for their children[111]. The existing idea proposes that parents are primarily responsible for the obesity of their children, especially if they fail to provide food choices and activities. Although the relationship between parental obesity and the obesity of children[112] seems to be clear, and some families can be qualified as *obesigenic families*[113], whether the lifestyle, behaviour and choices of the parents are truly the main cause of childhood obesity remains to be seen. First, the exact degree to which lifestyle is actually a matter of conscious choice[114] is unclear as the relationship between the socioeconomic status of the parents and the rate of obesity of the children[115] is significant as well as the strong relationship between the level of education of parents and the rate of childhood obesity[116]. Essentially, the 'worse off' the parents are, the higher the likelihood of childhood obesity will be. Moreover, the majority of parents—especially parents of 3 to 5 years olds[117]—show poor awareness of whether their child is at an unhealthy or healthy weight. Ironically, this is the age group at which one of the highest risks for developing lasting childhood obesity occurs[118]. An in-depth study of the existing literature on the exact causes of childhood obesity suggests that the influence of parental obesity on childhood obesity results most likely from a mixture of environmental and genetic influences[119] and this conclusion leaves most people more confused than informed. For instance, to add to the complexity of the origins and causes of childhood obesity, certain researchers believe that both genetic[120] and epigenetic[121] factors play a

[111] Lee T, Oliver J (2002)

[112] Svensson V, Jacobsson JA, Fredriksson R, et al. (2011), p. 46

[113] "Obesigenic families" is a term used more and more often in paediatric obesity research, to describe families that have all the conditions to create a high likelihood of childhood obesity. They are characterized by parental behaviour that includes "high levels of dietary intake and low levels of physical activity" as discussed in Krahnstoever Davison K, Lipps Birch L (2002), p. 1186

[114] Holland S (2012), p. 394

[115] Danielzik S, Czerwinski-Mast M, Langnäse K, et al. (2004), p. 1499-1500

[116] Lamerz A, Kuepper-Nybelen J, Wehle C, et al. (2005), p. 377

[117] Carnell S, Edwards C, Croker H, et al. (2005), p. 353

[118] Whitaker RC, Wright JA, Pepe MS, et al. (1997), p. 872

[119] Strauss RS, Knight J (1999), p. 5

[120] Research done among children adopted at birth suggests that the familial risk for obesity is largely genetic as there seemed to be little or no correlation between the weight of the adoptive parents and the weight of the adopted children, but a high correlation between the weight of the adopted children and their biological

role in the causation of childhood obesity. The famous Framingham Children's Study even suggests that children of parents who have a high self-reported amount of dietary restraint and focus a lot on losing weight themselves are *more* prone to childhood obesity[122] which seems counterintuitive. Apart from all of this, a child's birth weight can be a major determinant of a child's weight in later life[123]. Additionally, other factors, such as whether or not the mother is smoking tobacco during pregnancy or whether the child is formula-fed or breastfed, can have a significant effect on the causation of a child's obesity during infancy[124]. Amongst the publicity of the McCreadie case, Brian Dow from the United Kingdom's School Trust Fund, offered an idea on who, other than the parents, might be to blame for childhood obesity: there is "[…] an element of parental responsibility here, but it's hard for a child to go out of the school gates now without being bombarded by messages about the wrong kinds of food"[125]. This claim is supported in the United States as well. In 2006 members of the US Institute of Medicine (IOM) released a report in which they concluded that the marketing of unhealthy food contributes to the childhood obesity epidemic in the United States[126]. Not only is fast food marketing for children (who of our last generation did not grow up with Happy Meals?) rampantly present in traditional media such as television and print ads, but fast food marketing strategies have evolved in an effort to more effectively target children as fast food consumers. Examples of this are internet-based *advergamin*g or the more novel marketing strategy of

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parents; see Grilo CM, Pogue-Geile MF (1991). Apart from studies with adopted children, studies with twin children seem to suggest that the heritability of obesity is estimated at about 70%; see Maes HH, Neale MC, Eaves LJ (1997).

[121] Epigenetic influences differ from genetic influences in the way that they concern genes that can be (in laymen's terms) 'switched on or off'. Svensson V, Jacobsson JA, Fredriksson R, et al. (2011) believe that there are indications that gene-environment interaction—such as extreme weightloss of the parents during their lifetime—can influence the actual obesity phenotype. They refer to a research done by Kral JG, Biron S, Simard S, et al. (2006) in which the prevalence of obesity was normalized among children born after their mothers had undergone obesity surgery with substantial weight loss as a result. After personally analysing the research from Kral et al., I believe that this could also be prove of the effect of awareness and behavioural chances of the mother attributable to the education that is part of bariatric surgery. However, even if my personal believe would be true, this would still show the inherent difficulty of changing one's lifestyle, since in these cases surgical intervention was necessary to change one's habits and behavioural patterns.

[122] Hood MY, Moore LL, Sundarajan-Ramamurti A, et al. (2000), P. 1321-1323

[123] Danielzik S, Czerwinski-Mast M, Langnäse K, et al. (2004), p. 1502

[124] Moschonis G, Grammatikaki E, Manios Y (2008), p. 42-43

[125] BBC News (2007a)

[126] McGinnis JM, Gootman JA, Kraak VI (2006)

neuromarketing[127], a marketing form that appeals to the subconscious and emotional effects of food and beverage products to which children may be particularly vulnerable[128]. The focus on fast food chains and their marketing strategies as, in Feinberg's words, "causal contributors" to childhood obesity is not as inappropriate as it might seem. Recent research demonstrates direct causal effects of exposure to food advertising on young people's diet and health, for example watching a television program with food advertising increases consumption of high caloric food during and after viewing as compared to watching the same program with other types of advertising[129]. Another contributing factor to childhood obesity present in the food industry is the increase in portion size—that is, a correlation exists between the increase in availability in larger portion sizes and the increase in the prevalence of childhood obesity[130]. Indeed, research shows that children will eat a significantly larger amount of calories when the option for larger portions is offered[131]. The wider variety and larger availability and proximity of fast food establishments also contributes to fewer meals being eaten in the home and as a family group[132], which in turn decreases the opportunity for the parents to provide a model of healthy and conscious eating. Apart from the influence an environment can have on the dietary cause of childhood obesity, the environment that a child lives in can also have an adverse effect on the amount of physical activity that children are able to enjoy. Examples of this that directly contribute to childhood obesity are the lack of access to parks and recreation centres[133] or the presence of heavy motorised traffic between the child's residence and the child's school[134]. Although I am not disregarding the parents' personal responsibility when it comes to their own or their children's bodyweight, it should be clear that obesity is not just caused by individual-level behaviour, but has a very strong environmental aspect to it. The complexity of the medical aetiology of childhood obesity, combined with the variety of environmental influences contributing to the development of obesity in children, makes it ethically problematic to regard the actions of parents as the main cause for children's obesity and gives enough reason to omit the claim that parents are mainly responsible for the obesity of their children. Because of the difficulty to attribute blame mainly to the parents, state interventions in the form of legal action towards the parents or other invasive interventions within the family seem ethically unjustified.

[127] Jain A (2010), p. 427

[128] Ibid., p. 425

[129] Goren A, Harris JL, Schwartz MB et al (2010), p. 419

[130] Young LR, Nestle M (2002)

[131] Fisher JO, Kral TV (2008), p. 41-42

[132] Benton D (2004), p. 864

[133] Singh GK, Siahpush M, Kogan MD (2010), p. 505-508

[134] Timperio A, Salmon J, Telford A, et al. (2005), p. 170

5.3 Other Means: Alternative Solutions and Interventions

Having established that placing the entire blame on parents is problematic after identifying the other main causal contributors to childhood obesity, other solutions and interventions targeting childhood obesity that do not infringe upon parental autonomy yet still focus on the other causal contributors to childhood obesity must be examined. The UK's Royal College of Paediatrics and Child Health agrees that the solutions for the problem of childhood obesity should not be sought in the realm of intervening directly in the family. In response to the motion proposed by the British Medical Association to remove obese children from their homes, they argued that "obesity is a public health problem, not a child protection issue"[135]. Indeed, numerous less invasive forms of state interventions and alternative solutions are available to confront and prevent the harm done through childhood obesity. Although most of these interventions focus on the nutritional aspect of childhood obesity prevention, some interventions also target increasing the amount of physical activity for children as a lack thereof is a large contributor to childhood obesity[136]. These kinds of interventions to improve the amount of time kids partake in physical activity could be both community-focused and school-focused. Community-focused interventions to improve physical activity consist of creating playgrounds and recreational facilities and improving the existing trail or path system, sidewalks and bike trails[137] in order to increase the number of children who safely walk or bicycle to school[138], while school-focused interventions consist of implementing (more) mandatory physical activity in schools and preschools with structured daily activity sessions[139]. In general, school-based interventions prove to be an effective tool against childhood obesity due to children spending up to half of their waking hours in school and consuming one-third to one-half of their daily calories[140] there. Public schools have an obligation to protect students, for whom school attendance is mandated, from harm[141]. Due to this fact, schools can be considered as having an ethical obligation to act in response to the significant increase in the incidence of childhood obesity and could have a potent role in the improvement of the nutritional quality of their students' diets. Since food sold at school cafeterias and school vending machines are usually high calorie products with a high sugar content[142], these

[135] Royal College of Paediatrics and Child Health (2007), p. 1

[136] Langnäse K, Mast M, Müller MJ (2002), p. 568-569

[137] Singh GK, Siahpush M, Kogan MD (2010), p. 519

[138] Kumanyika SK (2001), p. 2

[139] Kaphingst KM, Story M (2009), p. 5

[140] Crawford PB, Gosliner W, Kayman H (2011), p. 2

[141] Ibid., p. 1

[142] Larson N, Story M (2010), p. 431-432

have a direct adverse effect on child obesity rates. As a response to this, the state could intervene in the school system by including provisions in vending machine contracts, limiting the sale and advertising of obesogenic foods and beverages on school property[143], as well as ban or limit food advertising for obesogenic foods in or around school property. Controlling the kinds of food choices children have is important in the prevention of childhood obesity as research shows that children who purchase their meals or snacks at school are substantially more likely to be obese[144], and previous interventions in food choices available at schools have been proven effective in the United States[145]. Considering the young age at with children start attending school, school-based programs and interventions can be one of the most effective ways to overcome social health inequalities[146] early in childhood. Another reason why school-based interventions might be preferable over family-based interventions is that the state has legitimate power over the rules and regulations within a school in most Western nations and intervening within the rules of a school does not normally infringe upon parental autonomy. Exercising control over what children will be able to eat when they are at school is less of an intrusion of the state into the private realm than determining what children eat when they are at home is. Although school-focused intervention programs are both effective and easy to implement, community-based interventions should not be underestimated. Community-based public health programs can help empower entire communities and their families to reduce sedentary behaviour, such as watching television and playing video games, and help to increase healthy nutritional habits[147]. Community-based health programs have shown to do especially well when driven by a sense of "community responsibility"[148] and can call upon the help of third parties like social workers, home health nurses and community-based social service agencies[149]. Examples of these community-based interventions are attempting to increase access to healthy foods in socioeconomically disadvantaged neighbourhoods by encouraging the development of grocery stores and farmers' markets through grants, loans, and tax benefits[150], controlling the density and proximity of fast food chains in a community and devoting additional resources for state and local agencies to

[143] Harris JL, Graff SK (2011), p. 7

[144] Schanzenbach DW (2009), p. 703

[145] An example of this a 2010 study amongst young school children in the United States in which the restriction of high fat milk, high caloric competitive foods and desserts showed a clear increase of fruit and vegetable consumption both in and out of school, see Ishdorj A, Crepinsek MK, Jensen HH (2013), p. 356-357

[146] Lamerz A, Kuepper-Nybelen J, Wehle C, et al. (2005), p. 379

[147] Perryman ML (2011), p. 2

[148] Goren A, Harris JL, Schwartz MB, et al. (2010), p. 423

[149] Varness T, Allen DB, Carrel AL, et al. (2009), p. 404

[150] Singh GK, Siahpush M, Kogan MD (2010), p. 510

increase their capacity for surveillance, monitoring, prevention and intervention research on childhood obesity[151].Food marketing targeted at children almost exclusively promotes calorie-dense, nutrient-poor foods[152] and is—by taking advantage of children's vulnerability to persuasive messages—also a clear causal contributor to childhood obesity. The American government agrees with this, as in 2010 The White House Task Force on Childhood Obesity released a report in which they called for immediate interventions targeting food marketing to children: "Key actors—from food and beverage companies, to restaurants, food retailers, trade associations, the media, government and others—all have an important role to play in creating a food marketing environment that supports, rather than undermines, the efforts of parents and other caregivers to encourage healthy eating among children and prevent obesity"[153]. These interventions include possible nutrition standards for children's meals that include incentives, like a toy, as well as limiting the sales of obesogenic food and beverages near schools during and around school hours[154]. Other possible interventions include an extra sales tax on unhealthy food choices such as the tax on other unhealthy products like alcohol or tobacco[155], or using pricing strategies—both incentives and disincentives—to promote the purchase[156] of more healthy food options. Even less invasive options for interventions to promote healthier food purchases include promoting personal choice and responsibility by "ameliorating information asymmetries"[157] in the market place through arming consumers with more accurate information about their nutritional purchases. Further analysis of articles and other existing literature on this topic shows that a wide range of interventions could be considered before moving onto invasive state interventions like child removal or charging parents with neglect. In her 2011 dissertation on the ethics of obesity interventions[158], Marieke provides a wide selection of over fifty different obesity prevention interventions, including most of the interventions already discussed. These examples of interventions range from information campaigns calling for parents to take reasonability for the obesity of their child and campaigns that show the dangers of obesity in the

[151] Ibid.

[152] Harris JL, Graff SK (2011), p. 1

[153] White House Task Force on Childhood Obesity (2010), p. 28

[154] These suggestions are coming from an extensive list provided by Samantha Graff and Rebecca Harris in their 2010 article, "Protecting Children From Harmful Food Marketing: Options for Local Government to Make a Difference", in which they provide a table with possibly effective interventions the state could consider as effective tools to combat childhood obesity in American society

[155] Leicester A, Windmeijer F (2004) p. 10

[156] Govea J (2011), p. 11

[157] Brownell KD, Kersh R, Ludwig DS, et al. (2010), P. 384

[158] ten Have M (2011)

same way that the dangers of smoking are presented, to interventions like offering free swimming sessions and providing children with a 'weight report card' alongside their school grade report card[159]. With the qualification of the obesity epidemic as one of the biggest current public health issues, the pressure on both local and national governments to engage in adequate interventions to combat obesity as early as possible is significant. Because the institutional and legal framework of primary obesity prevention in children is currently insufficient[160] in many countries, the state must focus on new dietary, physical activity, behavioural, environmental, and pharmacological approaches[161] for the prevention of childhood obesity. Although a relatively scarce amount of research providing long-term results for intervention programs exists – mostly due to the fact that childhood obesity is a relatively 'new' problem – the amount of research supporting that non-invasive state interventions are helping children (particularly low-income children[162]) to stay at a healthy weight is growing. The Institute of Medicine (IOM) and Centre for Disease Control (CDC) in the United States—where childhood obesity rates are still the highest—agree with this research as they have made a clear outline of healthy eating and physical activity strategies to improve healthy behaviour amongst children and parents alike, as well as emphasize the breadth of environmental chances necessary for obesity prevention[163]. In conclusion, I believe that with all the interventions discussed in this paragraph, it is clear that there are, in the words of Feinberg, "other means equally effective" available to prove "no greater cost" to values like parental autonomy and actually target "causal contributors" to childhood obesity.

5.4 A New Take on Paternalism: The Stewardship Model

Based on these conditions, the concept of paternalism—especially the distinction between 'hard' and 'soft' paternalism—can help provide a guideline for which interventions are ethically justified in the public health issue of childhood obesity and which are not. Paternalism was best defined by ethicist Gerald Dworkin as the interference "with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced"[164]. Just as parental autonomy can be regarded as an extended version of individual autonomy, a parallel can be drawn between paternalistic interventions not interfering with a

[159] ten Have M (2011), p. 52-59, Table 1, Appendix 1

[160] Hilbert A, Ried J, Schneider D, et al. (2008), p. 16

[161] Ebbeling CB, Pawlak DB, Ludwig DS (2002), p. 478

[162] Kimbro RT, Rigby E (2010), p. 416

[163] Klein JD, Dietz W (2010), p. 389

[164] Dworkin G (1972), p. 65

person's autonomy and also with a family's autonomy. Indeed, replacing the word 'person' with 'family' defines a paternalistic intervention as an intervention that interferes with a family's liberty justified by reasons referring exclusively to the welfare and interests of the family being coerced. In 2007 and 2008 prominent bioethicist professor Søren Holm wrote two corresponding articles addressing the legitimacy of state interventions targeted towards the prevention of childhood obesity. According to Holm, soft paternalism in public health interventions are almost always justified, especially in the case of the childhood obesity problem, while interventions that would fall under hard paternalism would only be justifiable in very extreme cases. Soft paternalistic interventions involve the giving of – perhaps even unwanted – information and the foreclosing of certain options for action[165], such as the ability to purchase unhealthy food options in low-income areas or at school. Most of the health promotion campaigns and interventions outlined in the previous paragraph are paradigmatic examples of soft paternalism as they either include the foreclosing of certain options, the provision of disincentives (like the increased price of unhealthy food) and the provision of information. The added advantage of these kinds of soft paternalistic interventions is that their justifications do not have to "rely on correct analysis of the causal complex in any individual case"[166]. Hard paternalistic interventions, on the other hand, involve direct coercion and involve the denial of self-determination[167]. A clear example of hard paternalistic interventions is forcing the parents to treat their children in a certain way by threatening them with either child removal or the possibility of parental neglect charges. In the distinction between the easily justifiable soft public health interventions and the harder to ethically justify hard paternalistic interventions, "choice" rises as a key term. State interventions that focus on the informed choice of the consumer, like proper food labelling and nutrition education campaigns, are the most ethically justified kind of state interventions to combat childhood obesity as they still leave room for parental autonomy and are focused more on choice than on coercion. Joel Feinberg shares this view in his paper on legal paternalism: "if adults are treated as children they will come in time to be like children, […] deprived of the right to choose for themselves, they will soon lose the power of rational judgment and decision"[168]. In 2007 the Nuffield Council on Bioethics provided a model that uses this distinction of hard and soft paternalistic interventions, as well as the harm principle[169], to create a guideline for public health interventions. This guideline is called the *Stewardship Model* and is based on the idea

[165] Holm (2007), p. 207

[166] Holm (2008), p. 27

[167] Holm (2007), p. 207

[168] Feinberg J (1971), p. 105

[169] Kersh R, Stroup DF, Taylor WC (2011), p. 2

that the state should act as a steward to individuals and communities. The model provides a guideline for which kind of state interventions are justified, in targeting public health issues such as childhood obesity and which are not, basically providing a checklist of *do's* and *dont's* for public health interventions. The Stewardship Model (see: Appendix I) prescribes that state interventions should aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain and promote good health not only by providing information and advice alone, but also with programmes to help people get rid of unhealthy behaviour. Furthermore, interventions should aim "to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise" [170] while also aiming to reduce health inequalities. State interventions should in turn refrain from "attempts to coerce adults to lead healthy lives"[171] and minimise interventions that are introduced without the individual consent of those affected and minimise interventions that are perceived as unduly intrusive and in conflict with parental autonomy[172]. To assist in thinking about the acceptability and justification of different policy initiatives to improve public health, the Nuffield Council on Bioethics has included a so-called 'intervention ladder' (see: Appendix II) as part of the Stewardship Model[173]. The first and least-intrusive step on the ladder is to simply monitor a public health issue, without taking any action as a state or local government. The most intrusive step on the ladder is legislating laws that restrict freedoms significantly in order to achieve gains in population health[174]. The interventions highest on this ladder are interventions that would fall under hard paternalistic interventions, while the lower interventions are typical examples of soft paternalism. The higher an intervention would rank on the ladder, the stronger the justification needs to be. The presence of childhood obesity as a reason to either charge parents with neglect or remove a child from his or her home would be ranked on the highest step on the ladder and would therefore be hardest to ethically justify. Hard paternalistic interventions such as child removal or charging parents with neglect should only be an option in absolute severe cases of childhood obesity where the parents are refusing any help or cooperation and there is a clear

[170] Nuffield Council on Bioethics (2007), p. 26

[171] Ibid.

[172] A full schematic overview of the Stewardship Model as provided by in the report of the Nuffield Council on Bioethics, can be found at the end of this thesis: Appendix I.

[173] The Stewardship Model seems to be more than just a theoretical model as its practical applicability is recognised by one of the biggest public health institutes in the world: the United States National Institute for Health and Clinical Excellence (NICE). In 2010 they adopted the Stewardship Model as a "as a reference point for guiding decisions about what types of intervention may be justified", Nuffield Council on Bioethics (2010)

[174] Nuffield Council on Bioethics (2007), p. 41-42

indication of imminent and severe harm to the child, and these cases prove to be "very rare"[175]. Before the state is warranted to legally pursue the parents of an obese child, the state must first have made every available effort to change those risk factors for childhood obesity that the state itself controls. Joel Feinberg agrees that "the criminal law is not the state's primary tool for the reduction of harms generally" as the state shares this function "with public health agencies […], regulatory commissions, and like agencies"[176].

6. CONCLUSION

Childhood obesity is clearly both a problematic and urgent public health issue that calls for at least some form of state intervention in order to prevent the problem from escalating even further. By applying Feinberg's moral philosophy, the harm caused by childhood obesity can be regarded as a setback to welfare interests when the medical comorbidity of obesity during childhood is taken into account, as well as the complications it will provide in his or her adult life. An obese child can be regarded as a child whose right to an open future has been denied due to the medical risks of adult comorbidity, the social stigma involved and the aesthetic problem of saggy skin as a result of weight loss in later life. The fact that the harm of childhood obesity is not just experienced during childhood, but also severely limits the future quality of one's adult life, gives viability to the claim that state intervention is justified in order to deal with the growing and complex problem of childhood obesity. However, considering the mere presence of childhood obesity as a reason to charge parents with neglect is ethically unjust and legally impractical. Hence, intervening within the family in the same way as is intervened in cases of clear parental neglect is not ethically justifiable. Furthermore, numerous effective public health interventions that the state could engage in without infringing on parental autonomy are available. This elaborate list of potentially effective public health interventions attests to the fact that sufficient 'soft paternalistic' interventions are available. While childhood obesity does justify state intervention, it does not justify 'hard paternalistic' interventions. The only legitimate state interventions that can be ethically justified as appropriate measures to combat childhood obesity are interventions that meet the previously outlined conditions of soft paternalistic interventions. These interventions should not target the parents of obese children alone as they are not sole party responsible for not preventing their children's obesity. The state should always first consider less invasive solutions, such as efforts to create a more informed and educated consumer and possibilities for restrictive legislation for nutritional corporations and fast food chains, before considering any interventions that infringe upon parental autonomy. A new interpretation on

[175] BBC News (2014)

[176] Feinberg (1984), p. 31

paternalism within a public health guideline, like the Stewardship Model, can provide proper grounds to understand which interventions are justified. Only in very rare and extreme cases of severe childhood obesity, where parents are uncooperative and their actions provide a clear reason to suspect immediate and serious harm to the child, should hard paternalistic interventions be considered by the state. The mere presence of childhood obesity does not justify the kind of intrusive state interventions that were suggested in the rejected motion during the British Medical Association m eeting in 2007.

7. FURTHER DISCUSSION

Although the conditions that could serve as a guideline for which state interventions could be justified to deal with childhood obesity has been adequately addressed, the problem of childhood obesity remains a very complex one. Since childhood obesity is still a relatively new problem, further research on both the exact causes of childhood obesity as well as which interventions are effective or ineffective must be performed. A number of issues have been deliberately unaddressed, either for the sake of brevity or the sake of staying on a focused topic. The first issue that should not be left unaddressed is the issue of the inherent differences in policies, political climate and general lifestyle differences per country. Although childhood obesity is a global problem affecting the entire developed world, each country has different levels of state control of schools and public health agencies, as well as different lifestyles and habits when it comes to diet and physical activity. The difference between countries where children eat their lunches and even dinner at schools and countries where children eat the vast majority of their meals at home is a very relevant one. Another aspect of this problem is that different nations have different ideas of how far the influence of the state can reach when it comes to price regulation, advertising of competitive foods and restricting free market choices for consumers. Another relevant issue is the risk of limiting personal liberty by eliminating certain choices to combat public health issues. For example, unhealthy and high caloric fast food is consumed not only by obese people but by people who live an otherwise healthy lifestyle as well. Although anti-obesity interventions such as the restriction of fast food sales are not directed at those who are not obese, they could still feel infracted upon their liberty when they are unable to buy their preferred ‘guilty pleasure’ foods. Lastly, the relatively comparable issue of child vaccination relates to this topic as well. Although this is a very extensively researched and discussed topic within bioethics, to the issue of state intervention is not documented enough to draw a parallel between parents refusing to incorporate a healthy lifestyle and parents who refuse to vaccinate their children against infectious diseases. In both cases, the refusal of parents contributes negatively to a major

public health issue while claiming their right to parental autonomy and an unclear threshold of 'harm'.

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9. APPENDIX I: NUFFIELD COUNCIL ON BIOETHICS - THE STEWARDSHIP MODEL

Box 1: The stewardship model (see paragraph 2.44)

Core characteristics of public health programmes carried out by a stewardship-guided state can be summarised as follows:

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and appropriate housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also by programmes to help people overcome addictions and other unhealthy behaviours;
- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate;
- seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values.

Note that the positive goals and negative constraints are not listed in any hierarchical order. The implementation of these principles may, in theory, lead to conflicting policies. However, in each particular case, it should be possible to resolve these conflicts by applying those policies or strategies that, in the circumstances, enable the desired social goals to be achieved while minimising significant limitations on individual freedom (see Box 2). We illustrate the role of particular components in the discussion of the case studies considered in Chapters 4–7.

Source: Nuffield Council on Bioethics (2007). Public Health: Ethical Issues. Cambridge, UK: Cambridge Publishers Ltd, p. 26

10. APPENDIX II: NUFFIELD COUNCIL ON BIOETHICS - THE INTERVENTION LADDER

Box 3.2: The intervention ladder

The range of options available to government and policy makers can be thought of as a ladder of interventions, with progressive steps from individual freedom and responsibility towards state intervention as one moves up the ladder. In considering which 'rung' is appropriate for a particular public health goal, the benefits to individuals and society should be weighed against the erosion of individual freedom. Economic costs and benefits would need be taken into account alongside health and societal benefits. The ladder of possible policy action is as follows:

Eliminate choice. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.

Restrict choice. Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.

Guide choice through disincentives. Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.

Guide choices through incentives. Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.

Guide choices through changing the default policy. For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).

Enable choice. Enable individuals to change their behaviours, for example by offering participation in an NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools.

Provide information. Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.

Do nothing or simply monitor the current situation.

Source: Nuffield Council on Bioethics (2007). Public Health: Ethical Issues. Cambridge, UK: Cambridge Publishers Ltd, p. 42