

**BIOETHICS AND LIFESTYLE MANAGEMENT: THE THEORY AND PRAXIS OF
PERSONAL RESPONSIBILITY**

by

John Joseph Rief

B.A. Communication and Philosophy, Regis University, 2005

Ph.D., Communication, University of Pittsburgh, 2012

Submitted to the Graduate Faculty of
the Center for Bioethics and Health Law
in the Kenneth P. Dietrich School of Arts and Sciences
in partial fulfillment
of the requirements for the degree of
Master of Arts in Bioethics

University of Pittsburgh

2013

UNIVERSITY OF PITTSBURGH

Kenneth P. Dietrich School of Arts and Sciences

This thesis was presented

by

John J. Rief

It was defended on

April 8th, 2013

and approved by

Mark Wicclair, Adjunct Professor of Medicine, Center for Bioethics and Health Law;

Professor of Philosophy, West Virginia University

John Lyne, Professor, Department of Communication

Thesis Director: Lisa S. Parker, Associate Professor, Department of Human Genetics,

Director of the MA Program in Bioethics at the Center for Bioethics and Health Law

**BIOETHICS AND LIFESTYLE MANAGEMENT: THE THEORY AND PRAXIS OF
PERSONAL RESPONSIBILITY**

John J. Rief, M.A., Ph.D.

University of Pittsburgh, 2013

Copyright © by John J. Rief

2013

BIOETHICS AND LIFESTYLE MANAGEMENT: THE THEORY AND PRAXIS OF PERSONAL RESPONSIBILITY

John Joseph Rief, M.A., Ph.D.

University of Pittsburgh, 2013

As noted in previous scholarship, disagreements exist between various stakeholders in the effort to address obesity, especially in terms of its health consequences and its treatment. This thesis argues that bioethics and rhetoric may play a significant role in re-articulating and overcoming these disagreements. Bioethics, with its focus on the provider-patient relationship, has often been ignored as a potential site for the cultivation of ethical and effective therapeutic modalities for obesity given the overwhelming surge of work in public health and public policy. Rhetoric, with its focus on how communication and public discourse influence social, political, and even professional decisions, offers a robust methodological approach to dealing with the interplay between the larger public discourses that circulate around obesity and those that inhere in the moment of provider-patient communication. Thus, combining the two approaches of bioethics and rhetoric, this thesis argues that by going back to the provider-patient relationship and its communicative possibilities, many of the problems associated with population-wide management of the obesity problem may be addressed.

Accordingly, this thesis engages in this bioethical and rhetorical work in three phases. First, by engaging in an analytical review of the literature concerning the public conceptions of obesity and how these conceptions influence the chosen approaches to its management, this thesis draws on previous work to highlight the critical role that bioethics may play in cultivating a more effective and ethical approach to the obesity problem. Second, by directly challenging efforts to articulate responsibility as a matter of personal guilt, blame, or obligation, this thesis

confronts a major problem residing at the heart of the public campaign to address the obesity problem: stigmatization. However, unlike most previous efforts, this thesis relies on a turn to bioethics for the needed corrective. Third and finally, this thesis articulates lifestyle change therapy as an ethical clinical praxis rooted in the effort to enhance the responsibility of providers and patients for the cultivation of health while side-stepping coercion, thus maintaining the roles of patient autonomy and physician beneficence needed to make our approach to the obesity problem ethical and effective simultaneously.

TABLE OF CONTENTS

1.0	RHETORIC, BIOETHICS, AND THE “OBESITY PROBLEM”	1
1.1	THE OBESITY <i>PROBLEM</i>	2
1.2	RHETORICALLY ENGAGING THE OBESITY PROBLEM	11
1.3	BIOETHICS AND THE OBESITY PROBLEM	15
1.4	CHAPTER DESIGNS	24
2.0	DEFINING AND FRAMING OBESITY: AN ANALYTICAL REVIEW	27
2.1	INTRODUCTION	27
2.2	UNPACKING A TROUBLED TERMINOLOGICAL DOMAIN	30
2.2.1	Realism vs. Nominalism	33
2.2.2	Beyond Realism and Nominalism: Medical and Political Frames of Obesity	41
2.3	PUBLIC CONCEPTIONS OF OBESITY: THE PROSPECTS FOR COOPERATION	44
2.4	FROM PUBLIC TO CLINICAL UNDERSTANDINGS OF ILLNESS: OBESITY IN THE PROVIDER-PATIENT RELATIONSHIP	53
2.5	CONCLUSION	63
3.0	RE-ARTICULATING RESPONSIBILITY: PUBLIC HEALTH AND CLINICAL APPROACHES	66

3.1	INTRODUCTION	66
3.2	THE ROLE OF BIOETHICAL PRINCIPLES IN THE CONSTRUCTION OF A CONCEPT OF RESPONSIBILITY: AUTONOMY AND BENEFICENCE.....	72
3.3	DEFINING AND DEPLOYING “RESPONSIBILITY”	79
3.2.1	Philosophical Approaches to Responsibility: Causation, Accountability, and Agency.....	80
3.2.2	Responsibility and the Obesity Problem	89
3.4	(RE)ARTICULATING RESPONSIBILITY.....	103
4.0	LIFESTYLE CHANGE AS ETHICAL CLINICAL PRACTICE	107
4.1	INTRODUCTION	107
4.2	<i>EUDAIMONIA, PAIDEIA AND PHRONESIS: THREE FOCAL POINTS FOR LIFESTYLE CHANGE THERAPY</i>	111
4.3	THE ONLINE LIFESTYLE SUPPORT SYSTEM (OLSS).....	118
4.4	CONCLUSION	130
	BIBLIOGRAPHY	133

LIST OF TABLES

Table 1. Summary of Types of Responsibility	104
---	-----

PREFACE

When I started my PhD program in the Department of Communication at the University of Pittsburgh, the thought that I might pursue an MA in bioethics had never occurred to me. During my first few years at Pitt, I began to develop an interest in the relationship between medicine and rhetoric as overlapping arts in the ancient Greek world and how recovering this relationship might augment contemporary efforts to improve the communicative aspects of caring for patients. Unfortunately, I found that my lack of knowledge regarding medical practice would stand in the way of making substantial contributions not only to my home discipline but also to medical professionals. I began looking for various connections between rhetoric and the diverse health disciplines represented at the University of Pittsburgh to see if I might add some grounded knowledge of medicine to my training. In my third year, on the advice of one of my most trusted and respected mentors, John Lyne, I took the short trip down 5th Avenue to the Medical Arts building to begin my MA program in bioethics not really knowing what might happen.

Looking back on these events, I can now say without a doubt, that my time at the Center for Bioethics and Health Law (CBHL) has been well spent and has given me many opportunities for advancing my career and expanding my scholarly horizons. The faculty and students at the CBHL have been faithful and committed interlocutors, providing insightful commentary on my ideas and projects. I can only hope that my contributions to their scholarly work have been even

half as substantial. In particular, the opportunities to engage in observations of clinical practice, to follow ethics and palliative care professionals during their daily rounds, and to sit in on seminars and lectures regarding a vast number of topics related to the ethics and effectiveness of medical care in the 21st century made possible at the center opened up new relationships and career paths I might never have discovered on my own.

Several individuals who joined me on this journey merit direct and specific thanks. My thesis advisor, Lisa Parker, has been a constant advocate and supporter, patiently waiting for me to find my voice and complete this thesis. Her impressive seminars, constant efforts to provide me with opportunities to present my work at national conferences, and career guidance have been very much appreciated. I can never fully repay her kindnesses in this regard. I wish her all the best as she continues to impact the development of new generations of bioethics scholars and teachers. My long-time mentor and thesis committee member, John Lyne, is nearly without equal in terms of his support for my scholarly development and the many ways he has impacted my intellectual development and orientation. I cannot thank him enough. The third member of my committee, Mark Wicclair, is one of the most astute and careful readers I have ever encountered. His feedback during my time in his graduate seminar at the CBHL greatly improved my writing and thinking in ways that will remain with me as I start the initial years of my postgraduate career. These three individuals, more than any others, were centrally involved in my completion of this degree. I owe them all more than I can repay.

1.0 RHETORIC, BIOETHICS, AND THE “OBESITY PROBLEM”¹

The study of rhetoric, like the study of bioethics, attends to matters often shaped at the intersection of science with practical reasoning, where the constraints of time and circumstance put pressure on the possibilities for principled action. To think rhetorically is to reflect constructively on the habits of representation that position people for making judgments. Rhetoric is concerned with the invention of language that enables action, but also with the capacities of language to address and persuade.²

¹ I use the term “obesity problem” to point out that obesity remains a troubled terrain of analysis. While some wish to point to its epidemic proportions and others see it as a threat to the healthcare economy and to the possibilities for actualizing global health, others view such discourses as potentially problematic (see chapter 2). As such, and as a problem, obesity should not be reduced to mere numbers. We do better to remember the contested spaces of health and medicine and the individuals involved in the controversy over appropriate socio-political, economic, and health related policy-making surrounding obesity. I also use this term to point out that obesity needs to be critically interrogated from within the horizon of ethics if we are to avoid increasing forms of stigmatization that will undermine the autonomy of individuals marked as obese or overweight. A few excellent sources outline the issues discussed here. For a rhetorical defense of treating obesity as an epidemic, see Gordon R. Mitchell and Kathleen M. McTigue, “The U.S. Obesity ‘Epidemic’: Metaphor, Method, or Madness,” *Social Epistemology* 21, no. 4 (2007): 391-423. For a counter-argument concerning epidemic rhetoric and the cultivation of “moral panic,” see Emma Rich and John Evans, “‘Fat Ethics’ – The Obesity Discourse and Body Politics,” *Social Theory and Health* 3 (2005): 341-358. For an excellent description of the “variety of liabilities [that] attend the rhetorical power of the label of epidemic,” see Lisa S. Parker, “Breast Cancer Genetic Screening and Critical Bioethics’ Gaze,” *Journal of Medicine and Philosophy* 20 (1995): 313-337, 323. For an account of the various layers of meaning attached to the term “epidemic” in the context of obesity as well as a version of the critical skepticism that has been produced around the clinical and epidemiological evidence of the rising rates and health risks of obesity, see Michael Gard and Jan Wright, *The Obesity Epidemic: Science, Morality, and Ideology* (London/New York: Routledge, 2005); Paul Campos, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser, “The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic,” *International Journal of Epidemiology* 35 (2006): 55-60.

² John Lyne, “Contours of Intervention: How Rhetoric Matters to Biomedicine,” *Journal of Medical Humanities* 22, no. 1 (2001): 13. I begin this chapter with this quotation primarily because I am a rhetorician entering the fray of bioethical work. Thus, my starting point is rhetoric but my primary contribution in this thesis is to the bioethics of obesity treatment. Lyne’s work is in keeping with a substantial amount of scholarship that develops the importance of rhetorical work to the cultivation of effective and ethical clinical practices. See e.g., Judy Z. Segal, *Health and the Rhetoric of Medicine* (Carbondale, IL: Southern Illinois Press, 2008); Joan Leach and Deborah Dysart-Gale, eds., *Rhetorical Questions of Health and Medicine* (Lanham: Lexington Books, 2011).

1.1 THE OBESITY PROBLEM

According to medical experts, obesity is one of the most pressing issues facing healthcare practitioners in the 21st century.³ Given its correlation with multiple co-morbidities and its relationship to early mortality across multiple populations (even more severe in traditionally marginalized groups) it has attained a central place in contemporary efforts to improve global health.⁴ Unfortunately, obesity has so many causal factors that tracing its origins and understanding its epidemiological and etiological characteristics are highly complicated tasks.⁵ Furthermore, the ongoing search for effective therapeutic approaches to the consequences associated with being overweight or obese has led to conflicting evidence regarding the possibilities for actually losing weight in a sustainable way and whether such weight loss is connected with improved health outcomes.⁶ All of this has created a context of confusion for healthcare practitioners and the broader public regarding what works, what does not, and how to

³ Kathleen M. McTigue, Russell Harris, Brian Hemphill, Linda Lux, Sonya Sutton, Audrina J. Bunton, and Kathleen N. Lohr, "Screening and Interventions for Obesity in Adults: Summary of the Evidence for the U.S. Preventive Services Task Force," *Annals of Internal Medicine* 139, no. 11 (2003): 933-949; Cora E. Lewis, Kathleen M. McTigue, Lora E. Burke, Paul Poirier, Robert H. Eckel, Barbara V. Howard, David B. Allison, Shiriki Kumanyika, and F. Xavier Pi-Sunyer, "Mortality, Health Outcomes, and Body Mass Index in the Overweight Range: A Science Advisory from the American Heart Association," *Circulation* 119 (June 8, 2009): 3263-3271. For the counterargument that suggests obesity and being overweight may not correlate with significant health consequences, see Campos, Saguy, Ernsberger, Oliver, and Gaesser, "The Epidemiology of Overweight and Obesity," 55-60; Gard and Wright, *The Obesity Epidemic*. I will discuss this argument and additional authors who have generated controversy around the health consequences of weight later in this thesis (see especially chapter 2).

⁴ L. Pan, D.A. Galuska, B. Sherry, A.S. Hunter, G.E. Rutledge, W.H. Dietz, and L.S. Balluz, "Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults – United States, 2006 – 2008," *Centers for Disease Control Morbidity and Mortality Weekly Report* 58, no. 27 (July 17, 2009): 740-744. For more on the global effort to fight disease and improve health and the role of obesity prevention in these efforts, see the World Health Organization's, "Global Strategy on Diet, Physical Activity and Health," 2004, p. http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf (accessed February 26, 2013).

⁵ For an innovative account of how epidemiological methods might be used to approach the "obesity epidemic," see Mitchell and McTigue, "The U.S. Obesity 'Epidemic'" 391-423.

⁶ Campos, Saguy, Ernsberger, Oliver, and Gaesser, "The Epidemiology of Overweight and Obesity," 55-60.

proceed with addressing the obesity problem.⁷ As Abigail C. Saguy and Kevin Riley point out, “There is currently disagreement in the United States over many questions related to weight and health, including if or why higher weights have adverse health consequences, what an ideal weight is or whether a universal ideal weight even exists, why people gain weight, why some weigh more than others, and whether weight loss improves health.”⁸ Of course, as they point out, addressing these problems is further complicated when combining the evidence generated in medical research and practice with ethical considerations that challenge the appropriateness of medical and public reactions to the emergence of obesity as a major concern.

The scope of the overweight and obesity problem seems to cut across every conceivable group in stratified analysis. Children, marginalized populations (in terms of race, ethnicity, gender, and socioeconomic status), and those who live in unhealthy environments (e.g., places without adequate access to healthy food or an overabundance of unhealthy options, places that are unfriendly to physical activity due to problems with design or violence, and the like) seem to be at most risk.⁹ Moreover, being overweight or obese carries health burdens from the merely

⁷ Krista Casazza, Kevin Fontaine, Arne Astrup, Leann L. Birch, Andres W. Brown, Michelle M. Bohan Borwn, Negertiti Durant, Gareth Dutton, E. Michael Foster, Steven B. Heymsfield, Kerry McIver, Tapan Mehta, Nir Menachemi, P. K. Newby, Russell Pate, Barbara J. Rolls, Bisakha Sen, Daniel L. Smith, Jr., Diana M. Thomas, and David B. Allison, “Myths, Presumptions, and Facts about Obesity,” *New England Journal of Medicine* 268, no. 5 (January 31, 2013): 446-454; Emma Rich and John Evans, “‘Fat Ethics’ – The Obesity Discourse and Body Politics,” *Social Theory and Health* 3 (2005): 341-358.

⁸ Abigail C. Saguy and Kevin W. Riley, “Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity,” *Journal of Health Politics, Policy, and Law* 30, no. 5 (2005): 874.

⁹ For a summary of these issues and many others related to the widespread and often differential effects of obesity and its correlated causes and potential therapeutic modalities, see Sydne Newberry, “Preventing Obesity and Its Consequences: Highlights of RAND Health Research,” Research Highlights, RAND® Corporation, 2011, p. http://www.rand.org/pubs/research_briefs/RB9508.html (accessed February 26, 2013). In terms of the risks facing children, see Sameera Karnik and Amar Kanekar, “Childhood Obesity: A Global Public Health Crisis,” *International Journal of Preventive Medicine* 3, no. 1 (January 2012): 1-7; Elizabeth R. Pulgaron, “Childhood Obesity: A Review of Increased Risk for Physical and Psychological Comorbidities,” *Clinical Therapeutics* 35, no. 1 (January, 2013): A18-32; Joan C. Han, Debbie A. Lawlor, and Sue Y.S. Kim, “Childhood Obesity – 2010: Progress and Challenges,” *The Lancet* 375, no. 9727 (May 15, 2010): 1737-1748. For recent research on the higher prevalence of obesity in traditionally marginalized groups, see Pan, Galuska, Sherry, Hunter, Rutledge, and Balluz, “Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults,” 740-744. For excellent studies on the role of environment and food availability on obesity prevalence, see Kimberly Morland, Steve Wing, Ana

inconvenient to the deadly. Recent research demonstrates the extent to which overweight and obese individuals are at risk for early death, type II diabetes, and a variety of heart and breathing conditions.¹⁰ Furthermore, a variety of causal pathways have been traced to obesity. Everything from the built environment to poor nutrition, sedentary lifestyle, systematic oppression, and capitalist production and consumerism run amok have been linked to the emergence of obesity as a major health problem, especially in the United States.¹¹

Moving beyond the scope and potential causal pathways of obesity, a substantial amount of research has been conducted to catalogue and assess various therapeutic modalities for its treatment. In a 2003 report, the United States Preventive Services Task Force (USPSTF) engaged in a thoroughgoing analysis of these modalities in an effort to chart a set of guidelines for

Diez Roux, Charles Poole, "Neighborhood Characteristics Associated with the Location of Food Stores and Food Services Places," in *Race, Ethnicity, and Health: A Public Health Reader*, ed. Thomas A LaVeist (San Francisco: Jossey-Bass: A Wiley Imprint, 2002), 448-462; Deborah A. Cohen, Roland Sturm, Molly Scott, Thomas A. Farley, and Ricky Blumenthal, "Not Enough Fruit and Vegetables or Too Many Cookies, Candies, Salty Snacks, and Soft Drinks," *Public Health Reports* 125 (January-February, 2010): 88-95; Tamara Dubowitz, Melonie Heron, Chloe E. Bird, Nicole Lurie, Brian K. Finch, Ricardo Basurto-Davila, Lauren Hale, and Jose J. Escarce, "Neighborhood Socioeconomic Status and Fruit and Vegetable Intake Among Whites, Blacks, and Mexican Americans in the United States," *American Journal of Clinical Nutrition* 87 (2008): 1883-1891; Deborah A. Cohen, "Obesity and the Built Environment: Changes in Environmental Cues Cause Energy Imbalances," *International Journal of Obesity* 32, supplement 7 (2008): S137-142. Violence has also been shown to augment obesity prevalence, particularly domestic violence. On this issue, see A. J. Midei and K. A. Matthews, "Interpersonal Violence in Childhood As a Risk Factor for Obesity: A Systematic Review of the Literature and Proposed Pathways," *Obesity Reviews* 12 (2011): e159-e172. Obesity has also been linked to violence in a recent report – see Etienne G. Krug, James A. Mercy, Linda L. Dahlberg, and Anthony B. Zwi, "The World Report on Violence and Health," *The Lancet* 360 (October, 2002): 1083-1088.

¹⁰ Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, "Morality, Health Outcomes, and Body Mass Index in the Overweight Range," 3265-3268; U.S. Department of Health and Human Services, "Understanding Adult Obesity" (Fact Sheet), National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases (November, 2008): <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>. (Accessed March 4, 2013).

¹¹ For an excellent account of the many causes of and potential modes of prevention/treatment for obesity, see Elliot M. Blass, ed., *Obesity: Mechanisms, Prevention, Treatment* (Sunderland, MA: Sinauer Associates, Inc., 2008); McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, "Screening and Interventions for Obesity in Adults," 933-949. For a nice summary of the various factors that contribute to the increasing incidence and prevalence of obesity, see U.S. Department of Health and Human Services, "Understanding Adult Obesity," <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>.

healthcare practitioners.¹² In this systematic review, members of the task force analyze the use of pharmaceuticals, lifestyle counseling (including diet and physical activity and at “moderate” and “intense” levels), and bariatric surgery.¹³ They find that pharmaceuticals can be somewhat effective but carry a variety of health risks.¹⁴ In addition, they report that “intense counseling with behavioral therapy” seems to offer the best hope for “moderate” weight loss.¹⁵ The report also indicates that bariatric surgery may potentially bring about “dramatic improvements” in terms of weight loss and improved health.¹⁶ However, they also point out that surgery carries, “a low risk for severe complications and [is] expensive.”¹⁷ The report concludes that “body size, health status, and weight loss history may all influence obesity treatment.”¹⁸ Thus, this systematic review provides some evidence in favor of lifestyle change therapy but points out that other options with variable risk may also offer some hope for weight loss and improved health. This report has become a critical starting point for all those researchers and practitioners dedicated to the development of lifestyle change therapy as a primary therapeutic modality for obesity and diabetes. Furthermore, an earlier randomized controlled trial indicates that lifestyle change therapy may decrease the risk of diabetes in patients with known risk factors more effectively than pharmaceutical approaches.¹⁹ Additional research has addressed the positive

¹² McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 933-949.

¹³ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 934-936, 942.

¹⁴ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 936-942.

¹⁵ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 945.

¹⁶ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 943-944.

¹⁷ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 942, 944-945.

¹⁸ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 945.

¹⁹ William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin,

benefits of lifestyle change therapy in reducing the incidence, managing, and potentially contributing to the remission of diabetes.²⁰

In terms of the surgical options mentioned above, an additional systematic review has shown that bariatric surgery is a highly effective tool in promoting substantial weight loss as well as reversing diabetes, hyperlipidemia, and other associated co-morbidities.²¹ However, a recent cross-sectional survey has indicated that 5 years after Roux-en-Y (gastric bypass) surgery, there is some risk of regaining some weight.²² The study concludes that “major factors that influenced this failure to maintain weight loss, besides poor diet quality (characterized by excessive intake of calorie in the form of snacks, sweets, and fatty foods), were sedentary lifestyle and lack of follow-up nutritional counseling.”²³ The authors recommend that “attention to these factors soon after the RYGB procedure is necessary to prevent the reacquisition of body weight.”²⁴ Thus, despite the high level of effectiveness of surgical interventions for achieving initial weight loss and control of co-morbid conditions, evidence suggests that lifestyle change therapy may be needed to make its benefits long-lasting.

Elizabeth A. Walker, and David M. Nathan, “Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin,” *New England Journal of Medicine* 346, no. 6 (2002): 393-403.

²⁰ Edward W. Gregg, Haiying Chen, Lynne E. Wagenknecht, Jeanne M. Clark, Linda M. Delahanty, John Bantle, Henry J. Pownall, Karen C. Johnson, Monika M. Safford, Abbas E. Kitabchi, F. Xavier Pi-Sunyer, Rena R. Wing, and Alain G. Bertouni (for the Look AHEAD Research Group), “Association of an Intensive Lifestyle Intervention with Remission of Type 2 Diabetes,” *Journal of the American Medical Association* 308, no. 23 (2012): 2489-2496; Meropi D. Kontogianni, Stavros Liatis, Sofia Grammatikou, Desponia Perrea, Nikolas Katsilambros, and Konstantinos Makrilakis, “Changes in Dieting Habits and their Association with Metabolic Markers After a Non-Intensive, Community-Based Lifestyle Intervention to Prevent Type 2 Diabetes, in Greece (the DEPLAN Study),” *Diabetes Research and Clinical Practice* 95 (2012): 207-214.

²¹ Henry Buchwald, Yoav Avidor, Eugene Braunwald, Michael D. Jensen, Walter Pories, Kyle Farhbach, and Karen Schoelles, “Bariatric Surgery: A Systematic Review and Meta-analysis,” *Journal of the American Medical Association* 292, no. 14 (October, 13 2004): 1724-1728.

²² Rachel Horta Freire, Mariane Curado Borges, Jacqueline Isaura Alvarez-Leite, and Maria Isabel Toulson Davisson Correia, “Food Quality, Physical Activity, and Nutritional Follow-Up as Determinant of Weight Regain after Roux-en-Y Gastric Bypass,” *Nutrition* 28 (2012): 53-58.

²³ Freire, Borges, Alvarez-Leite, and Correia, “Food Quality, Physical Activity, and Nutritional Follow-Up,” 57.

²⁴ Freire, Borges, Alvarez-Leite, and Correia, “Food Quality, Physical Activity, and Nutritional Follow-Up,” 57.

As the previous paragraphs indicate, one common denominator in all the therapeutic approaches to managing obesity and its co-morbidities reviewed here is the need for some form of lifestyle change therapy; some effort to change the practices that are, at least in part, linked with being overweight and obese in the first place.²⁵ Unfortunately, the USPSTF reports that many doctors do not engage their overweight and obese patients in discussions about their weight, thus making the implementation of lifestyle change therapy difficult.²⁶ Thus, the physicians who stand at the front lines of primary and preventive care are unaware of cutting edge lifestyle change therapies, have undervalued their role as a means to lose weight, or are simply unwilling to address weight-related problems with their patients. Whether most physicians will ever be convinced to utilize lifestyle change therapies is an open question; however, there are efforts underway to create interventions that are not dependent on the actions of physicians but are rather co-clinical and delivered by specially trained lifestyle counselors, sometimes through electronic media.²⁷

Furthermore, there is disagreement in the literature as to whether weight loss itself or the healthy activities that can (but do not always) promote it are related to improved health outcomes. That is, some argue that actual weight loss is not in itself healthy or therapeutic; rather, improving diet and physical activity can improve health whereas sustained weight loss is

²⁵ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, "Screening and Interventions for Obesity in Adults," 933-949; Campos, Saguy, Ernsberger, Oliver, and Gaesser, "The Epidemiology of Overweight and Obesity," 55-60; Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, "Morality, Health Outcomes, and Body Mass Index in the Overweight Range," 3263-3271.

²⁶ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, "Screening and Interventions for Obesity in Adults," 933; Deborah A. Galuska, Julie C. Will, Mary K. Serdula, and Earl S. Ford, "Are Healthcare Professionals Advising Obese Patients to Lose Weight," *Journal of the American Medical Association* 282, no. 16 (1999): 1576-1578.

²⁷ Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey R. Simkin-Silverman, "Using the Internet to translate an evidence-based lifestyle intervention into practice," *Telemedicine & eHealth*, 15, no. 9 (2009): 851-858; Kathleen M. McTigue, Tina Bhargava, Cindy L. Bryce, Molly Conroy, Gary S. Fischer, Rachel Hess, Laurey R. Simkin-Silverman, and Susan Zickmund, "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care," *Patient Education and Counseling* 83 (2011): 261-264.

highly unlikely (and maybe not even a pathway to better health).²⁸ This controversy has created skepticism about weight loss interventions, especially among groups that challenge the medicalized view of obesity as a risky health state.²⁹ However, at least some of the oppositional groups and scholars that challenge the medicalized view of obesity have not rejected the healthy eating and physical activity promotion efforts that form the heart of lifestyle change therapy.³⁰ This seems to leave a door open for potential collaboration between medical researchers and “antiobesity” advocates on a solution to the health consequences that are either associated with obesity or that are its cause, depending on what evidence you tend to accept, a topic I address in chapters 2 and 3.³¹

Moving beyond the clinical domain, public health advocates and policy-makers have attempted to address the obesity problem by focusing on larger structural issues. The U.S. Department of Health and Human Services *Healthy People 2020* campaign, Michele Obama’s efforts to promote physical activity in youth across the nation as part of the “Let’s Move” program, and New York Mayor Michael Bloomberg’s effort to tax sugary drinks (known as the “soda tax”) fit into this larger category of public health efforts to promote weight loss (or at least influence individuals’ choices that are associated with weight gain).³² In addition, some

²⁸ Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, “Morality, Health Outcomes, and Body Mass Index in the Overweight Range,” 3263-3271.

²⁹ Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Saguy and Riley, “Weighing Both Sides,” 869-921.

³⁰ Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60.

³¹ Saguy and Riley, “Weighing Both Sides,” 872.

³² *Healthy People 2020* is the federal government’s “framework” for addressing new and emerging diseases as well as long-term chronic health problems through improving the use of technology and synergizing various levels of care. For the general features of this “framework,” see U.S. Department of Health and Human Services (Office of Disease Prevention and Health Promotion), “*Healthy People 2020* Framework: The Vision, Mission, and Goals of *Healthy People 2020*,” no date, p. <http://www.healthypeople.gov/2020/Consortium/HP2020Framework.pdf>. (Accessed March 5, 2013). For the specific “nutrition and weight status” goals of *Healthy People 2020*, see U.S. Department of Health and Human Services, “Nutrition and Weight Status,” September 6, 2012, p.

researchers have approached the obesity problem and other health conditions related to nutrition by increasing access to healthier foods. For example, RAND investigators have recently initiated an effort to address the “food desert” conditions in the Hill District in Pittsburgh, PA.³³ Whether these efforts aim to curtail or enhance food choices, improve the opportunities for physical activity, constrain certain kinds of consumption, or engage in widespread public education, they are primarily public and population-focused, thus occurring in a separate sphere of human activity from the more clinically oriented efforts detailed in the previous paragraphs. However, we shall shortly see how these two spheres interact in potentially productive and, in some cases, problematic ways. Crucially, these efforts seem to be at the forefront of public conversation about obesity, at times marginalizing or ignoring approaches that are oriented around the provider-patient relationship in the clinical domain.³⁴

Given the acceleration of research findings and therapeutic approaches in the area of obesity, finding the correct starting point for thinking about what one might call the obesity

<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>. (Accessed March 5, 2013). On the “Let’s Move” program, see the main website at www.letsmove.gov (Accessed March 5, 2013). Michael Bloomberg’s quest to establish a soda tax in New York has been in the national news for some time. For an early account of the emergence of Bloomberg’s advocacy in this area, see A. G. Sulzberger, “Bloomberg Says a Soda Tax ‘Makes Sense,’” *The New York Times*, March 8, 2010, p. A18. This article is also available at http://www.nytimes.com/2010/03/08/nyregion/08soda.html?_r=0 (Accessed March 5, 2013). On the overall effectiveness of such the “tax” model on reducing consumption, see Eric A. Finkelstein, Chen Zhen, James Nonnemaker, and Jessica E. Todd, “Impact of Targeted Beverage Taxes on Higher- and Lower-Income Households,” *Archives of Internal Medicine* 170, no. 22 (2010): 2028-2034. In addition, a recent editorial section of the *New England Journal of Medicine* details the various arguments (legal, ethical, and medical) related to the use of a tax to address unhealthy consumptions. See Thomas Farley, David R. Just, and Brian Wasink, “Regulation of Sugar-Sweetened Beverages,” *New England Journal of Medicine* 367, no. 15 (2012): 1464-1466.

³³ Jeremy Boren, “Researchers to Study Impact of New Grocery on Pittsburgh’s Hill District Residents,” *TribLive:News*, November 21, 2012, p. <http://triblive.com/news/allegheeny/2963727-74/hill-grocery-homewood-health-residents-shop-store-district-eating-shopping#axzz2D6rpEoak>. (Accessed March 5, 2013). This effort is known as “Pittsburgh Hill/Homewood Research on Eating, Shopping & Health (PHRESH)” and is being facilitated by a senior RAND researchers and epidemiologist, Tamara Dubowitz. See the PHRESH website for more details at <http://www.rand.org/health/projects/phresh.html>.

³⁴ Edmund D. Pellegrino, “The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions,” *Journal of Medicine and Philosophy* 26, no. 6 (2001): 559-579; F. Daniel Davis, “Phronesis, Clinical Reasoning, and Pellegrino’s Philosophy of Medicine,” *Theoretical Medicine* 18 (1997): 173-195.

“epidemic,” but what I have chosen to call for the purposes of this thesis “the obesity problem,” is a necessary first step if public health advocates, physicians, institutions, and most importantly, individuals who are overweight or obese are to find an ethically sound path to a healthier future.³⁵ While there is more research on the obesity problem than can possibly be read and fully understood by any one person, this evidence does not provide a clear answer to the question, “What is the most effective and most ethical approach to the treatment of obesity?” That is, new research findings about the causes and therapeutic modalities for obesity are initial elements of an overall decision-making process. It provides the ground upon which to make sense of a problem and begin the necessary work to address it. However, as I will show throughout this thesis, the data that have been cultivated to address the obesity problem do not provide clear or objective answers in the realm of policy-making or clinical care. That is, the “data” do not always directly support the “warrants” provided for various actions.³⁶ Disagreements abound regarding the definition of the term “obesity,” whether or not it is a health problem, whether there are effective and/or ethical approaches that might be used in its treatment, and whether it should be a concern for the public or for the individual. None of these disagreements is fully resolvable; however, a better understanding of how language functions within and around the obesity problem (as a method for interpreting and putting research findings into practice or deliberating about adequate public policy approaches) may begin the process of coming to some

³⁵ Mitchell and McTigue, “The U.S. Obesity ‘Epidemic,’” 391-423. See FN 1 for more on this.

³⁶ These are Stephen Toulmin’s words and the heart of his project to energize argumentation theory in the middle of the 20th century. See Stephen E. Toulmin, *The Uses of Argument*, up. ed. (Cambridge: Cambridge University Press, 2003); Wayne Brockriede and Douglas Ehninger, “Toulmin on Argument: An Interpretation and Application,” *Quarterly Journal of Speech* 48, no. 1 (1960): 44-54.

clarity regarding how bioethicists should proceed in dealing with it as an ethical concern within the domain of clinical care.³⁷

1.2 RHETORICALLY ENGAGING THE OBESITY PROBLEM

One of my primary claims in this thesis that in coming to understand the obesity problem, it is critical to come to grips with the power of language surrounding obesity, particularly its obscuring and clarifying aspects (chapter 2).³⁸ Excellent scholarship has shown that the meaning making and interpretive processes surrounding disease and illness have played a central role in constructing public health policies and the practices of clinical care throughout the history of medicine.³⁹ Following the quotation at the beginning of this chapter, I view the art of rhetoric as an appropriate method for addressing such processes of meaning making and interpretation.⁴⁰ The art of rhetoric focuses on the use of language to persuade and the ability to determine the most effective persuasive approaches for specific audiences.⁴¹ In this sense, rhetoric may be said to play an “architectonic” role in the construction of scientific and public orientations to disease

³⁷ Lyne, “Contours of Intervention,” 3-13.

³⁸ I am certainly not the first to engage the discourses circulating around the obesity problem as the following pages indicate (especially chapter 2); however, the ways in which these discourses are framed and circulated as a matter of public policy tends to occlude consideration of how they influence the clinical environment, a claim I develop in this chapter and throughout the rest of this thesis.

³⁹ Extended historical studies indicating the connection between language choices and the understanding of illness are almost too numerous to cite. For several excellent exemplars, see Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: University of North Carolina Press, 2003); Scott L. Montgomery, *The Scientific Voice* (New York: The Guilford Press, 1996); Keith Wailoo, *Drawing Blood: Technology and Disease Identity in Twentieth-Century America* (Baltimore: The Johns Hopkins University Press, 1997); Susan Sontag, *Illness as Metaphor and Aids and Its Metaphors* (New York: Anchor Books, 1990).

⁴⁰ Lyne, “Contours of Intervention,” 3-13.

⁴¹ Aristotle, *Art of Rhetoric*, Loeb Classical Library 193, trans. John H. Freese (Cambridge: Harvard University Press, 1926/2000), I.i.14.

and illness.⁴² It builds sites for meaning, conflict, and resolution that frame the development and overall progress of medical knowledge and praxis.⁴³ Scientific and technological development have played a role as well; however, we should not ignore the ways that the manner in which we talk about an illness, disease or bodily state affect our responses to it from clinical and public health perspectives.⁴⁴ Moreover, certain linguistic choices may lead to misconceptions and unreflective practices while others may prove useful and productive both for practitioners and for the patients they are charged with helping.⁴⁵ For this reason, I concentrate throughout this thesis not only on the ethical and policy-based concerns surrounding obesity (including the effectiveness of various approaches to caring for obese individuals) but also on the rhetorical concerns that help to “frame” ongoing social, political, and cultural approaches to the obesity problem that are relevant to bioethical analysis.⁴⁶ By engaging the use of rhetoric in the construction of the obesity problem, I mean to focus on the processes of “persuasion” and “identification,” of gaining the “adherence” of an audience to a particular point of view, and of creating spaces of shared understanding and action.⁴⁷

⁴² Richard McKeon is best known for defining rhetoric as an architectonic art that “structur[es] all principles and products of knowing, doing, and making” (45). For his complete argument, see Richard McKeon, “The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts,” in *The Prospect of Rhetoric: Report of the National Developmental Project*, ed. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63. I have more fully addressed this claim in my dissertation. See John J. Rief, “Searching for the Good Life: Rhetoric, Medicine, and the Shaping of Lifestyle” (PhD diss, University of Pittsburgh, 2012).

⁴³ Lyne, “Contours of Invention,” 3-13; Richard McKeon, “Creativity and the Commonplace,” *Philosophy and Rhetoric* 6, no. 4 (1973): 199-210.

⁴⁴ Stanley Joel Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978).

⁴⁵ In the context of breast cancer research and treatment, Lisa Keränen argues that rhetoric plays such a role, in this case in terms of either increasing or undermining public participation. Lisa Keränen, *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research* (Tuscaloosa: The University of Alabama Press, 2010), 159.

⁴⁶ This is in keeping with previous work. See Saguy and Riley, “Weighing Both Sides,” 869-921.

⁴⁷ I have drawn this definition from several sources. On the notion of rhetoric as a way to promote “adherence” (1) to a particular idea, belief, or chosen path of action, see Chaïm Perelman and Lucie Olbrechts-Tyteca, *The New Rhetoric: A Treatise on Argumentation* (Notre Dame: The University of Notre Dame Press, 2003). On the notion of rhetoric as a means to produce shared action through “identification,” see Kenneth Burke, *A Rhetoric of Motives* (Berkeley: The University of California Press, 1969). For the best treatment of rhetoric in terms

Throughout this thesis, my rhetorical approach overlaps directly with bioethical concerns, primarily those having to do with the clinical and extra-clinical attempts to define obesity as a medical problem and craft responses to it including the cultivation of practices among patients that assist in the “care of the self.”⁴⁸ This phrase has come into vogue among scholars committed to Michel Foucault’s historical analysis of power but my focus is on the “care of the self” as a central and animating concern of contemporary medicine. While we may take issue with attempts to promote or enforce “the care of the self” as a mode of exerting control over the practices of individual lives, this does not, in my mind, get us any closer to helping individuals currently dealing with chronic disease for whom lifestyle change is a necessary ingredient in any effective approach to addressing their health concerns.⁴⁹ In order to keep at least some of the critical edge of this scholarship alive but simultaneously address the problems facing contemporary healthcare in an accessible and practical way, I argue throughout this thesis that we should avoid the extrication of bioethics from its rhetorical situatedness in the communicative encounter of the clinic. That is, as we develop therapeutic approaches to obesity, we should keep the linguistic choices being made about how obesity is defined and described in professional and public understandings in mind.⁵⁰ In addition, the rhetorical elements of the obesity problem have implications for the various norms and concepts that form the foundation of not only bioethical

of audience, persuasion, and proof, see Aristotle’s *Rhetoric*, a text upon which all of these authors draw in their definitional work.

⁴⁸ Foucault made this term famous based on his work on Greek and Hellenistic understandings of bodily practices surrounding sexuality and intellectual development. For the development of his philosophical insights regarding the “care of the self,” see Michel Foucault, *The Hermeneutics of the Subject: Lectures at the College de France 1981-1982*, ed. Frederic Gros, trans. Graham Burchell (New York: Picador, 2005); Michel Foucault, *The Care of the Self: Volume 3 of the History of Sexuality* (New York: Vintage Books, 1988).

⁴⁹ For an account of self-care and personal responsibility as highly problematic ways to deflect societal responsibility for health and other human problems, see Dana L. Cloud, *Control and Consolation in American Culture and Politics: Rhetorics of Therapy* (Thousand Oaks: Sage Publications, 1998).

⁵⁰ The notion that language is used to “frame” obesity in a variety of ways has been extensively developed by Abigail C. Saguy and Kevin W. Riley in their “Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity,” *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 869-921.

theory and praxis but also the rights and obligations central to democratic, communal life.⁵¹ Such issues as autonomy, personal responsibility, and the fiduciary relationship between providers and their patients are all affected by the rhetorical work done by individuals and collectivities attempting to address any health concern, including the obesity problem. As such, these primary elements of bioethical analysis frame the analytical work of this thesis and provide context for promoting a specific and, it is argued, ethical orientation to obesity care.

For all of these reasons, the proceeding chapters engage in an analysis of the rhetorical, epistemological, and ethical choices that currently “frame” obesity in particular ways and to promote potential alternatives that I feel are needed in coming to a truly bioethical account of the treatment of obesity in the clinical setting.⁵² Thus, while I spend ample time on the public discourses that surround the effective and ethical treatment of obesity, I do so to show that they are often in tension (sometimes productive, sometimes not) with the promotion of ethically sound clinical approaches. In so doing, I carve out a space for bioethics in the ongoing public discussion about obesity, a space that has long been occluded by an over-emphasis on attempting to address obesity at the systemic level. Systems are the traditional concern of public health ethics, health economics, and public policy (as discussed above) and, as I will show throughout this thesis, these arenas provide important insights in the effort to address the obesity problem but fall short as guides to the appropriate care and concern clinicians, family members, and friends should exercise in their interactions with overweight and obese individuals.⁵³ Before moving into my chapter designs, I briefly introduce my theoretical commitments in carving out a

⁵¹ Thomas B. Farrell, *Norms of Rhetorical Culture* (New Haven: Yale University Press, 1995).

⁵² Mitchell and McTigue, “The U.S. Obesity ‘Epidemic’” 391-423; Saguy and Riley, “Weighing Both Sides,” 869-921.

⁵³ Joan C. Tronto, “An Ethic of Care,” in *Ethics in Community-Based Elder Care*, ed. Martha B. Holstein and Phyllis B. Mitzen (New York: Springer Publishing, 2001), 60-68.

new bioethical approach to obesity, one informed by the methods of rhetorical analysis described in this section but simultaneously grounded in traditional bioethical principles and concepts.⁵⁴

1.3 BIOETHICS AND THE OBESITY PROBLEM

As briefly discussed in the previous section, the role that bioethics might play in understanding obesity and its contemporary “framings” both in the clinic and beyond, has not received enough attention.⁵⁵ In fact, most of the research on the ethics of managing obesity tends to focus on the public health domain.⁵⁶ One might at first glance believe that bioethics has little to say in response to the obesity problem. Its concern is in the clinical domain and the obesity problem seems to be one dominated by the larger structures of society and patterns of consumption and lifestyle. In addition, the application of already well-established normative principles (e.g., respect for autonomy) will seem to suffice if the goal is to understand the ways in which physicians should interact with and treat obese and overweight patients.⁵⁷ However, obesity shares the stage with a host of controversial and ethically complex transformations in human existence, most notably the increasing incidence of multiple chronic conditions, which are

⁵⁴ Primarily, I draw on the following foundational works: Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009); Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986).

⁵⁵ One notable exception is Joanna Zylińska’s work which takes up obesity as one element in the overall contemporary concern with lifestyle management. Joanna Zylińska, *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009). In terms of the literature regarding the various “frames” used to discuss and understand obesity in contemporary American culture, see in particular Saguy and Riley, “Weighing Both Sides,” 869-921. Unfortunately, the “frames” literature does not have much to say about how bioethics itself might intervene or otherwise engage the question of meaning in the controversies surrounding the obesity problem. Hence, the following arguments.

⁵⁶ See chapter 2 for more on this argument.

⁵⁷ Such a method might be cultivated from the principlist approach to bioethics. See Beauchamp and Childress, *Principles of Biomedical Ethics*.

putting the acute model of care to the test.⁵⁸ In addition, due to this emergence of chronic disease as one of the primary concerns of contemporary medicine, additional work to make the principles central to bioethics relevant to the problem of “lifestyle” and its relation to health may be needed; indeed, working with someone to change his lifestyle stretches to the limit bioethical principles such as the respect for patient autonomy.⁵⁹ This is the case because lifestyle change therapy requires providers to actively engage in the renegotiation of the values, aspirations, and ways of life of the patient. All of these require persuasion and ongoing deliberation, both of which test the provider-patient relationship and put pressure on providers to challenge the autonomy of patients who might be seen as *in the wrong* or *wrongheaded* when it comes to their daily life activities.⁶⁰ In addition, the various therapeutic options that are now available for obese patients, including the increasing ubiquity of various approaches to lifestyle change and bariatric

⁵⁸ On the problem of chronic disease and the failures of the acute model, see, e.g., David B. Morris, *Illness and Culture in The Postmodern Age* (Berkeley: University of California Press, 1998); David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991); Arthur Kleinman, *The Illness Narratives: Suffering, Healing, & The Human Condition* (Basic Books, 1988). On the contemporary effort to understand the role of the patient in their own care, especially when considering chronic conditions, see Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, “Patient self-management of chronic disease in primary care,” *Journal of the American Medical Association*, 288 no. 19 (2002): 2469-2475; Edward H. Wagner, “Chronic disease management: What will it take to improve care for chronic illness?” *Effective Clinical Practice*, 1, no. 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, “Improving chronic illness care: Translating evidence into action,” *Health Affairs (Millwood)*, 20, no. 6 (2001): 64-78; Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, “Current Perspectives on Patient Education in the U.S.,” *Patient Education and Counseling* 44 (2001): 79-86.

⁵⁹ On the principles of biomedical ethics, see Beauchamp and Childress, *Principles of Biomedical Ethics*. Furthermore, the issue of whether the “specification” of principles to particular cases is useful or achieves any real substantive outcomes has been debated. In particular, casuistry is seen by some scholars as more productive given its focus on the unique case. I do not intend to address these debates directly here. Suffice it to say that I believe principles are good for focusing attention on particular elements of moral actions but that specific problems require specific solutions that cannot rely solely on background principles and theories. On the debate about “specification” and “casuistry” in bioethics, see e.g., Carson Strong, “Specified Principlism: What it is, and Does it Really Resolve Cases Better than Casuistry,” *Journal of Medicine and Philosophy* 25, no. 3 (2000): 323-341; Carson Strong, “Justification in Ethics,” in *Moral Theory and Moral Judgments in Medical Ethics*, ed. Baruch A. Brody (Kluwer Academic Publishers, 1988), 193-211; Carson Strong, “Critiques of Casuistry and Why They Are Mistaken,” *Theoretical Medicine and Bioethics* 20 (1999): 395-411; Albert R. Jonsen, “Casuistry and Clinical Ethics,” *Theoretical Medicine and Bioethics* 7, no. 1 (1986): 65-74; Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley: University of California Press, 1990).

⁶⁰ Faden and Beauchamp, *A History and Theory of Informed Consent*; David H. Smith and Loyd S. Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” *Theoretical Medicine and Bioethics* 7 (1986): 127-146.

surgery, indicate the need for new bioethical approaches that go beyond the provider-patient dyad into the broader sphere of ethical responsibility, individual autonomy (limited by relational consequences) and lifestyle decision making at both the personal and social levels.⁶¹ Moreover, because obesity resides in a contested domain that resides somewhere between public health and clinical care, it requires a sort of “casuistic stretching” of the tools of bioethics to figure out how it might work in the new matrix of the obesity problem.⁶²

For these reasons, my approach in this thesis adopts and extends the excellent work done by Donald Cameron Ainslie to uncover the paternalism and, what he calls “managerialism,” implied in the treatment of the ethics of HIV/AIDS and bioethics more generally.⁶³ I view the obesity problem as sharing in the same kinds of judgments about collective safety, personal responsibility, and overwhelming acceptance of a medicalized point of view that Ainslie catalogues in the context of HIV/AIDS.⁶⁴ Thus, in the context of obesity, bioethicists may discover an approach that does not unwittingly subscribe to paternalistic assumptions about the scope of medicine, the rights of the patient, the capability of individuals to act as caregivers for themselves, and the methods through which health is to be defined and achieved.⁶⁵ In short, bioethicists must take note of competing definitions and “frames conflicts” circulating around obesity (detailed in the previous section) and construct ethical approaches that do not unwittingly

⁶¹ Zylinska makes this a primary concern of her discussion of bioethics and lifestyle management. Zylinska, *Bioethics in the Age of New Media*. For contemporary efforts to develop lifestyle management technologies, see McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Milas, and Simkin-Silverman, “Using the internet to translate an evidence-based lifestyle intervention into practice,” 851-858.

⁶² Kenneth Burke, *Attitudes Toward History*, 3rd ed. (Berkeley: University of California Press, 1937/1984), 229-232.

⁶³ Donald Cameron Ainslie, “Redefining Bioethics in the Age of AIDS,” (Masters Thesis, Center for Bioethics and Health Law,” University of Pittsburgh, 1996. Ainslie uses the term “managerialism” throughout this text.

⁶⁴ Saguy and Riley also make note of this connection in their work “Weighing Both Sides,” see especially 870-871.

⁶⁵ Chris Feudtner, *Bittersweet*.

inscribe stigmatization and oppression.⁶⁶ This may seem obvious, and yet, in a recent article, the bioethicist, Daniel Callahan, argues that the use of “social pressure” as a public health tactic may be justified by the increasing incidence and prevalence of obesity.⁶⁷ This underscores the importance of my previous discussion regarding the tensions between the ethics of clinical care and public health ethics and suggests that we need to think clearly and consistently about how these two may be at odds and how to bring them into alignment in the provision of better care for the millions currently affected by lifestyle-related illness, especially obesity and its co-morbidities. Callahan’s arguments will take center stage in my analysis in chapter 3.

In addition (and related to the issues already mapped above), Joanna Zylińska notes several risks to the traditional model of the provider-patient relationship currently lurking beneath the surface of widespread efforts to engage in the practice of securing public health, an issue that is increasingly salient for healthcare practitioners attempting to deal with the obesity problem.⁶⁸ She notes that in the same way governments manage citizen and non-citizen bodies (e.g. terrorists, enemy combatants, non-enemy combatants, and the like) due to the risk they represent to state security, so too can medicine manage the diseased, unhealthy bodies of citizen-patients, especially if these patients are constructed as a threat to the health of the body politic: “Medicine becomes one of the techniques through which power is exercised not just over individual bodies but also over bodies en masse, with increased focus on public hygiene,

⁶⁶ Saguy and Riley, “Weighing Both Sides”; Mitchell and McTigue, “The U.S. Obesity ‘Epidemic’”; Donald A. Schön, “Generative metaphor: A perspective on problem-setting in social policy” in *Metaphor and Thought*, ed. A. Ortony. 2nd ed. (Cambridge, MA: Cambridge University Press, 1993).

⁶⁷ Daniel Callahan, “Obesity: Chasing an Elusive Epidemic,” *Hastings Center Report* 43, no. 1 (2013): 34-40.

⁶⁸ Zylińska, *Bioethics in the Age of New Media*.

accidents, infirmities, and various anomalies, as well as issues connected with reproduction.”⁶⁹

Susan Bordo makes a similar argument in the context of “self-management in consumer culture”:
“Ultimately, the body (besides being evaluated for its success or failure at getting itself in order) is seen as demonstrating correct or incorrect attitudes toward the demands of normalization itself.”⁷⁰ According to Zylinska, in order to push back against a mode of biomedical control run amok, it is necessary that bioethics (as the critical counterpart to medical praxis) take on a much broader perspective that goes beyond the provider-patient dyad and the principles of clinical ethics. To achieve this perspective, Zylinska argues that bioethics should go “beyond its traditional homes of analytical philosophy and disciplines related to medicine and into those fields where questions of the human and human life have been addressed from a different angle.”⁷¹ Such a move is viewed by Zylinska as a necessary precondition for understanding the wider frames that inform bioethics, medicine, philosophy, and strategies for managing bodies (especially in the context of lifestyle change). In other words, while the problems of paternalism and overly “managerialist” models of obesity treatment should be part of any analysis of the efforts to achieve public health through interventions into the lifestyles of citizens, the wider discussions of responsibility, bodily states, and social control surrounding obesity should be accounted for, critiqued, and deconstructed as part of this process lest they reemerge in the clinical domain.⁷²

⁶⁹ Zylinska, *Bioethics in the Age of New Media*, 69. Also, it is important to recognize that there is a contemporary pushback against the broadest conceptions of patient autonomy. See David H. Smith, “Ethics in the Doctor-Patient Relationship,” *Critical Care Clinics* 12, i. 2 (January, 1996): 179-197.

⁷⁰ Susan Bordo, *Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley: University of California Press, 1993).

⁷¹ Zylinska, *Bioethics in the Age of New Media*, 175.

⁷² See Saguy and Riley’s discussion of personal responsibility in their “Weighing Both Sides,” 887 and throughout; Ainslie, “Redefining Bioethics in the Age of AIDS.”

Put another way, bioethics has emerged as the primary arbiter of the ethics of clinical praxis. Its humanistic and social scientific approaches have revealed the gaps in patient protections in the clinic and research settings over the past century.⁷³ However, its intellectual home involves an appreciation for the philosophical construction of principled moral and ethical action within the clinic, a site that only sometimes has relevance for the obese person.⁷⁴ In fact, many patients who fit the medically configured definitional contours of obesity do not seek care for this condition at all, at least not within the confines of the clinic. This may be due to the fact that they do not see their weight as a health problem, because they are unaware of the health problems associated with obesity, because they are uncomfortable approaching the problem with healthcare providers, or because of lack of resources and time.⁷⁵ Furthermore, given that obesity is a chronic condition, it is something that does not admit of immediate care in the clinic.⁷⁶ As noted previously, clinicians at times fail to even discuss the issue of weight and its management with patients, leaving this job to other healthcare practitioners (further down the implied hierarchy) or to non-clinical solutions, resources, and approaches such as the diets and exercise programs available online and at the local book store.⁷⁷ Given that its causes as well as its implications and treatment mechanisms reside in the unruly site between clinical care and the

⁷³ On the birth and growing relevance of bioethics in this regard, see Stephen Toulmin, "Preface, 1986," in his *The Place of Reason in Ethics* (Chicago: The University of Chicago Press, 1986), xvi.

⁷⁴ Beauchamp and Childress, *Principles of Biomedical Ethics*.

⁷⁵ A. C. Ciao, J. D. Latner, L. E. Durso, "Treatment Seeking and Barriers to Weight Loss Treatments of Different Intensity Levels Among Obese and Overweight Individuals," *Eating and Weight Disorders* 17, no. 1 (2012): e9-16.

⁷⁶ This is the defining feature of chronic disease. See Wagner, "Chronic Disease Management"; Wagner, Austin, Davis, Hindmarsh, Schaefer, Bonomic, "Improving Chronic Illness Care."

⁷⁷ McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, "Screening and Interventions for Obesity in Adults," 933; Deborah A. Galuska, Julie C. Will, Mary K. Serdula, and Earl S. Ford, "Are Healthcare Professionals Advising Obese Patients to Lose Weight," *Journal of the American Medical Association* 282, no. 16 (1999): 1576-1578.

world external to it, obesity will need to be treated and understood differently from other bodily states and diseases.⁷⁸

It is for this reason that obesity requires what Chris Feudtner has called a “metabiotic” perspective that shows appreciation for not only the physical aspects of disease, but also its cultural, social, economic, personal, and, I would add rhetorical, characteristics.⁷⁹ While Feudtner is writing about diabetes as he develops this “metabiotic” perspective, his point is relevant in the context of obesity as well, given that diabetes is related to obesity as a co-morbid condition and is similarly treated as a matter of lifestyle change and patient self-care. As such, unpacking the problem of obesity will require attention to details beyond the clinical relationship. However, when engaging in such analysis, one may unwittingly provide the linguistic materials and material justifications for “expanding clinical concern,” “control,” “management” and “personal responsibility” beyond the clinical setting and into our communities and homes, something that Feudtner warns against (in a way similar to that undertaken by Zylinska as detailed above).⁸⁰ By questioning the previously unquestioned growth of “clinical concern,” Feudtner’s study tends to provide at least some support for the arguments advanced by the “fat acceptance movement,” that obesity is inappropriately “medicalized” or subjected to the “gaze” and control of medical providers, especially when lifestyle change is seen as a necessary activity and one that individuals must take on both in and outside the clinic on a daily basis.⁸¹ While I do not have a simple way around the problem of medicalization, it informs

⁷⁸ Saguy and Riley, “Weighing Both Sides,” 915.

⁷⁹ Feudtner, *Bittersweet*, 40.

⁸⁰ Feudtner, *Bittersweet*, 65.

⁸¹ Feudtner, *Bittersweet*, 65. On the medicalization of bodily states and conditions, especially obesity and diabetes, see Jeffrey Sobal, “The Medicalization and Demedicalization of Obesity,” in *Eating Agendas: Food and Nutrition as Social Problems*, ed. Donna Maurer and Jeffrey Sobal (New York: Aldine De Gruyter, 1995): 67-90; Saguy and Riley, “Weighing Both Sides,” 870. On the process of medicalization and its implications for bioethics, see John Z. Sadler and Simon Craddock Lee, “Can Medicalization be Good? Situating Medicalization within

my skepticism (especially of public health ethics and policy) throughout this thesis and indicates the degree to which the public health and clinical approaches to the obesity problem need additional attention as interpenetrating domains.

As Zylinska, Bordo, and Feudtner point out, there are potentially problematic applications of the cultural and scientific *technologies* that have been and might be deployed in the effort to eradicate obesity (or *discipline* the obese body) there is hope that a bioethics which moves beyond the patient/provider dyad and into the aspirational ethics of daily life can achieve an approach that values the role of the individual in (re)creating her own life.⁸² I use “(re)creating” here to leave the question open about whether lifestyle change is a necessary outcome. We are all creating lives for ourselves. Recreating our lives implies there is a problem that must be addressed and I leave that question to the individual and their network of friends, family members, doctors, and other close relations.⁸³ Here, I am pushing back against a claim made by many scholars but put most succinctly by Saguy and Riley in their critically important essay on the various discourses surrounding the obesity problem: “Popular lifestyle theories –

Bioethics,” *Theoretical Medicine and Bioethics* 30 (2009): 411-425. I have borrowed the somewhat ambiguous and critical term “gaze” from Lisa Parker’s excellent work on breast cancer. See Parker, “Breast Cancer Genetic Screening and Critical Bioethics’ Gaze.”

⁸² Here, I am drawing on two conceptions that are central to the works of Michel Foucault. First, the notion of discipline (or the creation of contexts for disciplining the body as a practice of the self) is fully developed and historically situated in Foucault’s work on the changing dynamics of imprisonment and corporeal punishment. See Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage Books, 1995). Second, the notion of “techniques” or technologies of the self which can be deployed as a form of discipline or, alternatively, transformation is a concept that inheres throughout Foucault’s later works. For me, the concept receives one of its best and most sustained treatments in Foucault’s lectures at the *College de France*. See Foucault, *The Hermeneutics of the Subject*. In his analysis of the concept of technology from a Foucauldian perspective, Nikolas Rose offers a short definition that will be of some service here: “Technology, here, refers to any assembly structured by a practical rationality governed by a more or less conscious goal . . . hybrid assemblages of knowledges, instruments, persons, systems of judgment, buildings and spaces, underpinned at the programmatic level by certain presuppositions and assumptions about human beings.” Nikolas Rose, *Inventing Our Selves: Psychology, Power, and Personhood* (New York: Cambridge University Press, 1996), 26. Finally, the communication scholars, Darrin Hicks and Ronald Walter Greene have argued that communication itself is a technology, one that crafts our interactions and lives in particular ways. See Ronald Walter Greene and Darrin Hicks, “Lost Convictions: Debating Both Sides and the Ethical Self-Fashioning of Liberal Citizens,” *Cultural Studies* 19, issue 1 (2005): 100-126.

⁸³ Rose, *Inventing Our Selves*.

which attribute illness to personal lifestyle – may be more likely to imply blame for illness, for instance, than, say, germ theories.”⁸⁴ I agree with Saguy and Riley (as well as Feudtner and Zylinska) that blame and stigmatization are risks of lifestyle change therapy; however, they are not entailed by it. One primary claim of this thesis is that lifestyle change can ultimately enhance the empowerment of patients seeking to lose weight or manage co-morbid conditions related to their diet, physical activity, and/or other health-related activities.⁸⁵ This view does not necessarily end with individuals exerting complete control over all aspects of their lives. This is an impossibility given the highly interconnected relationship individuals have with their socio-cultural and political milieus.⁸⁶ Furthermore, such a perspective on patient empowerment will need to address the institutional and socio-political arrangements that energize or enervate the individual fulfillment we all seek.⁸⁷ However, the move to revalue the individual agent’s role in crafting her own way of life in response to potential or real health problems is in keeping with the historical emergence of bioethics in response to human rights abuses and the use of research *subjects* as a means to an end.⁸⁸ Thus, I plan to add substance and value to the notion that self-care and agency are central elements of a bioethical approach to lifestyle management and the obesity problem. Combining this view with rhetorical work and constant skepticism provides a methodological approach that will yield pragmatic answers to the pressing ethical questions that face contemporary medicine and the society that it serves.

⁸⁴ Saguy and Riley, “Weighing Both Sides,” 871.

⁸⁵ Roter, Stashefsky-Margalit, and Rudd, “Current Perspectives on Patient Education in the U.S.”

⁸⁶ Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958).

⁸⁷ Samuel Weber, *Institution and Interpretation*, exp. ed. (Stanford: Stanford University Press, 2002); Kenneth Burke, *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952).

⁸⁸ Immanuel Kant, *Grounding for the Metaphysics of Morals*, 3rd ed., trans. James W. Ellington (Indianapolis/Cambridge: Hackett Publishing Company, Inc., 1993).

1.4 CHAPTER DESIGNS

The following chapters spin out various elements of this introduction in order to promote a particular conception of bioethics in the realm of obesity, a conception built through the use of rhetorical analysis and the application of important bioethical principles and concepts. In doing this work, I extend upon the excellent work of others, showing key points of stasis and articulating potential solutions that might address widespread disagreements between different stakeholders invested in resolving the obesity problem and form the basis for potential consensus. However, as I (and others) view it, this consensus must be distributed among medical researchers and practitioners, bioethicists, cultural critics, and, most importantly, the individuals who are currently marked as overweight and obese and who may be experiencing the negative health consequences of this status (both physiological and psychic in nature).⁸⁹

The second chapter of this thesis (“2.0 – Defining and Framing Obesity: An Analytical Review”) discusses the ongoing public arguments regarding the definitions of such terms as BMI, obesity, and health. These terms are deeply contested, primarily by those committed to the public health effort to address obesity and those who feel that this effort is a sort of “moral panic” that should be rejected.⁹⁰ Building on the work of Saguy and Riley, among others, I suggest that one way to address such disagreements is to grant the point that obesity is to a certain extent socially constructed while simultaneously taking the health risks associated with

⁸⁹ Saguy and Riley, “Weighing Both Sides,” 869-921.

⁹⁰ Campos, Saguy, Ernsberger, Oliver, Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Rich and Evans, “Fat Ethics” 341-358. On the original development of the concept of “moral panic,” see Erich Goode and Nachman Ben-Yehuda, *Moral Panics: The Social Construction of Deviance* (Malden, MA: Blackwell Publishers, 1994), also cited by Campos et al.; Stanley Cohen, *Folk Devils and Moral Panics* (New York: Routledge, 1972).

obesity (or with activities associated with obesity) seriously.⁹¹ Furthermore, I argue that whether or not we can reach consensus about the health benefits of weight loss, there seems to be very little disagreement about the health benefits of exercise and a healthy diet.⁹² Thus, changing the focus from BMI and overall weight to the practices that might enhance health, something that the National Association for the Advancement of Fat Acceptance and other fat advocacy groups already seem to accept, might assist in crafting a more humane and acceptable public health message and may also frame clinical care in more inviting and productive ways for those who might seek care for obesity-related illness.⁹³ It is this last point that requires more development as clinical care is often given short shrift in discussions about how obesity is framed. Likewise, bioethics has not been adequately utilized as a perspective from which to counter the problems with larger public conversations and beliefs about obesity, a point to which I turn in the second part of the chapter.

The third chapter of this thesis (“3.0 - Re-Articulating Responsibility: Autonomy and Capability”) responds to perhaps the most difficult question in the overall effort to frame the obesity problem and care for overweight and obese individuals: responsibility. As Saguy and Riley and a host of others have argued, “responsibility” is a troubled term, especially when used to coerce or shame individuals into changing their behaviors as Callahan has suggested we do in the context of obesity.⁹⁴ Importantly, responsibility tends to be a primary feature of public discourses about obesity; however, this does not mean it lacks relevance in the clinical domain. I

⁹¹ Saguy and Riley, “Weighing Both Sides,” 869-921.

⁹² See e.g., Campos, Saguy, Ernsberger, Oliver, Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, “Morality, Health Outcomes, and Body Mass Index in the Overweight Range,” 3265-3268

⁹³ National Association for the Advancement of Fat Acceptance, “Health At Every Size,” (2011): <http://www.naafaonline.com/dev2/education/haes.html> (Accessed March 7, 2013).

⁹⁴ Saguy and Riley, “Weighing Both Sides,” 870-871, 875, 887, 889-891; Rich and Evans, ““Fat Ethics,”” 345, 350-354; Fabrizio Turollo, “Responsibility as an Ethical Framework for Public Health Interventions,” *American Journal of Public Health* 99, no. 7 (2009): 1197-1202.

show that there is tension between the use of responsibility in public health policy on one hand, and the principle of respect for patient autonomy and the caring that should define the clinical environment on the other. I argue that this tension must be analyzed and resolved, especially because public conceptions leak into the domain of the clinic causing negative and potentially damaging experiences for patients.⁹⁵

The final chapter (“4.0 – Conclusion: Lifestyle Change as Ethical Clinical Practice”) provides an example of the sort of capability enhancing pedagogical practice I defend at the end of chapter 3. It utilizes as an example an ongoing lifestyle intervention study at the University of Pittsburgh. Thus, this last chapter has the most direct clinical relevance and provides a clear map of how to achieve an ethical pedagogical strategy aimed at the renegotiation of a patient’s everyday practices and the cultivation of her conception of a healthy and overall good life.⁹⁶ This work is achieved by returning to the ethical, philosophical, and rhetorical theories of the ancient Greeks in an effort to find critical terms that may focus lifestyle management toward the development of patients who can actively change their lives to meet the goals they have set in terms of weight loss or general health and wellbeing (or both when they coincide). In this way, I conclude this thesis by tying its various critical and practical layers together in a brief prescription for the ongoing development of lifestyle management strategies. The hope is that this final statement will contribute to the cultivation of better practices for ethically applying lifestyle change therapies as a means to address the obesity problem.

⁹⁵ While I will defend a view that supports acceptance of both medical and public values in the cultivation of a bioethics for obesity, I feel that in the status quo, the implications of public discourse about obesity entering the clinical domain have a negative bent. See chapter 2 for more details about this. For the view of medicine as influenced by external values and public beliefs, see Franklin G. Miller and Howard Brody, “The Internal Morality of Medicine: An Evolutionary Perspective,” *Journal of Philosophy and Medicine* 26, no. 6 (2001): 581-599.

⁹⁶ Norman Daniels, “Health-Care Needs and Distributive Justice,” *Philosophy & Public Affairs*, 10, no. 2 (1981): 146-179.

2.0 DEFINING AND FRAMING OBESITY: AN ANALYTICAL REVIEW

We cannot afford to wait for this [new] research to begin addressing the problem of overweight in our patients and in our society. Both healthy eating patterns and physical activity have roles in managing weight and CVD risk and should be encouraged by all. Because physical inactivity and excess weight have been independently associated with mortality in several studies, there are additional advantages to overweight and obese persons adopting an active lifestyle, as well as healthy eating habits. In the long term, because weight gain is progressive and weight loss is difficult to maintain, it is vitally important that effective weight maintenance and obesity-prevention approaches be developed and implemented for all individuals above normal weight.¹

Given the limited scientific evidence for any of these claims, we suggest that the current rhetoric about an obesity-driven health crisis is being driven more by cultural and political factors than by any threat increasing body weight may pose to public health.²

2.1 INTRODUCTION

In this chapter, I argue (following substantial work by others) that disagreement about the meaning of the term “obesity,” as well as the various approaches to managing it implied by the chosen meaning, has serious implications for the ethical approaches deemed relevant (and potentially necessary) to its treatment as a medical problem and to the treatment of obese

¹ Cora E. Lewis, Kathleen M. McTigue, Lora E. Burke, Paul Poirier, Robert H. Eckel, Barbara V. Howard, David B. Allison, Shiriki Kumanyika, and F. Xavier Pi-Sunyer, “Mortality, Health Outcomes, and Body Mass Index in the Overweight Range: A Science Advisory from the American Heart Association,” *Circulation* 119 (June 8, 2009): 3268.

² Paul Campos, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser, “The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic,” *International Journal of Epidemiology* 35 (2006): 55.

individuals as members of larger institutional, cultural, social, political, and economic communities. As such, “obesity” is a critical terminological starting point for the cultivation of a bioethical approach to the obesity problem. How we choose to define and deploy the term (and several related terms) has consequences for clinical and public approaches to its definition, diagnosis, and treatment. That is, different conceptions of the term obesity point the way to webs of interconnected meanings and modes of understanding that prompt action for both healthcare practitioners and their patients.³ Thus, while the discourses under investigation in this chapter are found largely outside the clinic in the public domain, there is a risk that they may inform clinical decision making and practice thus having negative consequences for patients and undermining some of the root principles of bioethics, primarily the principles of respect for patient autonomy and beneficence.⁴

The first section details several of the definitional problems surrounding obesity that influence responses by public health officials, healthcare practitioners and researchers, and obese individuals regarding rising rates of obesity. I view these definitional issues as rhetorical. By this, I mean that a definition for obesity (and related terms such as “overweight”) with it a variety of assumptions rooted in the epistemological and ethical foundations from which the definition is drawn.⁵ To provide evidence for this, I detail the various arguments in the literature that suggest the definitions of obesity and body mass index (BMI), one measure used to determine the clinical existence of obesity, are fundamentally rhetorical and open to contestation and critique. I do this

³ My strategy here should be familiar to anyone who has engaged in the analysis of public discourse through the lens of rhetorical criticism. According to Kenneth Burke, rhetorical criticism is primarily motivated by the tracking of terms and “terminological clusters.” See Kenneth Burke, “The Philosophy of Literary Form,” in his *The Philosophy of Literary Form: Studies in Symbolic Action*, third ed. (Berkeley: University of California Press, 1973), 1-137. I conform to this basic idea in the pages ahead.

⁴ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009).

⁵ John Lynch, *What Are Stem Cells? Definitions at the Intersection of Science and Politics* (Tuscaloosa: The University of Alabama Press, 2011).

by organizing these various arguments into two primary definitional strategies that I refer to as *realist* (i.e., the belief in the objective and irrefutable existence of obesity as a health problem that needs to be addressed medically) and *nominalist* (i.e., the belief that obesity is a constructed).⁶

In the next section, I move beyond the problem of definition into the vast literature that now details the various “frame conflicts” that circulate around the obesity problem, most notably those that erupt between the medical establishment and social movements such as the National Association for the Advancement of Fat Acceptance (NAAFA).⁷ While ample literature has covered this ground before, I review it here in order to begin the process of disentangling the discourses of public health and policy from those of the clinical environment, thus paving the way for understanding how bioethics might address the obesity problem differently than public health advocates, ethicists, and policy makers. Furthermore, I show how the strategies of social movements that reject the medicalization and health risks of obesity may create a perilous situation of ongoing disagreement that leaves us without a way of speaking about and addressing the obesity problem upon which all of the stakeholders can agree. I say this is perilous because it undermines potential avenues for agreement that might enhance the ability of healthcare practitioners to work with their patients in cultivating ethical and effective responses either to their weight or to the health consequences so often correlated with weight. In other words, ongoing disagreement undermines our ability to address the obesity problem in a way that

⁶ These organizing terms are used to aid the reader in distinguishing different definitional and rhetorical strategies. Others use different terms to divide the various stakeholders in the controversy that largely fit into the categories I have crafted here, most notably Abigail C. Saguy and Kevin Riley. I shall discuss their work in the pages ahead. Abigail C. Saguy and Kevin W. Riley, “Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity,” *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 869-921.

⁷ Saguy and Riley, “Weighing Both Sides”; Mitchell, Gordon R., and Kathleen M. McTigue, “The U.S. Obesity ‘Epidemic’: Metaphor, Method, or Madness,” *Social Epistemology* 21, no. 4 (2007): 391-423; Donald A. Schön, “Generative metaphor: A perspective on problem-setting in social policy” in *Metaphor and Thought*, ed. A. Ortony. 2nd ed. (Cambridge, MA: Cambridge University Press, 1993).

protects individuals from problematic interventions into their daily lives. Such ongoing disagreement also undermines efforts to understand why obesity seems to be on the rise and whether it can be legitimately linked to health consequences.

I conclude this chapter with a shift to the clinical environment, the primary focus of bioethics, and the problems facing healthcare practitioners related to both the broader public discourses detailed in previous sections and the gap between their understanding of illness and that of their patients.⁸ These elements stand in the way of crafting an ethical and effective approach to the clinical treatment of obesity.

2.2 UNPACKING A TROUBLED TERMINOLOGICAL DOMAIN

In his book *What Are Stem Cells?* John Lynch argues that definitions play a central role in the controversy over the use of embryonic stem (ES) cells for medical research. He shows how various stakeholders utilize a litany of definitions of ES cells in order to support or reject their ongoing use in medical research.⁹ While his book focuses on ES cells, his case study supports a much larger point about the rhetorical role of definitions in framing and managing disagreement in public controversies about science. He argues that major public controversies invite the use of “‘real definitions,’ [that represent] argumentative strategies establishing quasi-stable points from which individuals can make sense of the world and argue for various courses of action.”¹⁰ His use of the term “real definitions” is meant to indicate that definitional work, especially when it is

⁸ Edmund D. Pellegrino, “The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of Helping and Healing Professions,” *Journal of Medicine and Philosophy*, 26, no. 6 (2001): 559-579.

⁹ Lynch, *What Are Stem Cells?*, 4-6 and throughout.

¹⁰ Lynch, *What Are Stem Cells?*, 4.

aimed at large public audiences, is fundamentally a process of crafting reality, of making sense of what the world is and how we should respond to it. In this way, such definitions act “as the precondition for collective social action.”¹¹ They affect the way we think and therefore act in response to a variety of problems facing contemporary culture. Saguy and Riley make a similar point when they point out that “different frames [a term that corresponds with definitions here but has a wider circumference as I show below] imply not only different ways to understand social problems but also different courses of action.”¹² As such, understanding them is critical to unlocking answers in the ongoing effort to address the obesity problem.

The definitional work surrounding obesity inhabits a highly contested terrain, one fraught with questions about personal choice, the complexity of causation, and the ethics of public health interventions.¹³ Much like “embryonic stem cell,” “obesity” is a controversial term, one that remains unstable and open to alternative meanings and responses.¹⁴ Obesity is defined rather straightforwardly by medical science based on calculations of BMI and co-morbid conditions; however, the term is murkier when considered from the perspective of socio-cultural and political beliefs.¹⁵ Moreover, the obese body has gone through many different historical manifestations and attributions of medical and moral status over the course of centuries. While obesity has, since the emergence of the medical arts, been considered a concern for medical

¹¹ Lynch, *What Are Stem Cells?*, 5.

¹² Saguy and Riley, “Weighing Both Sides,” 873.

¹³ Saguy and Riley, “Weighing Both Sides,” 869-921; Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Emma Rich and John Evans, “‘Fat Ethics’ – The Obesity Discourse and Body Politics,” *Social Theory and Health* 3 (2005): 341-358; Michael Gard and Jan Wright, *The Obesity Epidemic: Science Morality and Ideology* (London/New York: Routledge, 2005); Gordon R. Mitchell and Kathleen M. McTigue, “The U.S. Obesity ‘Epidemic’: Metaphor, Method, or Madness,” *Social Epistemology* 21, no. 4 (2007): 391-423.

¹⁴ Saguy and Riley, “Weighing Both Sides,” 869-921.

¹⁵ For a discussion of defining obesity and calculating body mass index (BMI), see Centers for Disease Control (CDC), “Defining Overweight and Obese,” April 27, 2012, <http://www.cdc.gov/obesity/defining.html> (Accessed March 8, 2013); Centers for Disease Control (CDC), “BMI Definition,” September 13, 2011, <http://www.cdc.gov/healthyweight/assessing/bmi/index.html> (Accessed March 8, 2013); Saguy and Riley, “Weighing Both Sides,” 869-921.

practitioners, it has not always been viewed as a medicalized bodily state.¹⁶ In fact, depending on the historical moment and the specific community understandings at play in a given era, obesity has been considered a sign of great wealth, a sign of moral decay, and a sign of possible disease and early death to name only a few interpretive possibilities.¹⁷ In particular, “fatness has been considered both evidence of medical pathology and moral turpitude in the United States since the turn of the twentieth century.”¹⁸ It has also been rhetorically deployed in various terrains of human action including medicine, religion, and politics, and public health.¹⁹ Those who see obesity as a real and dangerous bodily state view it as a problem in need of moral, medical, or socio-political management. Those who see obesity as a social construction tend to view it as one way of life among many options that may not be connected to health concerns.²⁰ The next section unravels these viewpoints and their various analyses articulated in the literature using different terms.

¹⁶ For discussion of historical views of obesity as a threat to health, see R.E. Abdel-Halim, “Obesity: 1000 Years Ago,” *Lancet* 366, no. 9481 (2005): 366-204. For an excellent discussion of the history of obesity as a medicalized bodily state, see Jeffrey Sobal, “The Medicalization and Demedicalization of Obesity,” in *Eating Agendas: Food and Nutrition as Social Problems*, eds. Donna Maurer and Jeffrey Sobal (New York: Aldine De Gruyter, 1995), 67-90. On the potential value and pitfalls of medicalization as a general tactic, see John Z. Sadler and Simon Craddock Lee, “Can Medicalization be Good? Situating Medicalization within Bioethics,” *Theoretical Medicine and Bioethics* 30 (2009): 411-425.

¹⁷ The literature on this subject is vast. For a critical interrogation of obesity and body image in general as social constructs from a feminist perspective, see Susan Bordo, *Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley: University of California Press, 1993). For an illuminating study of the unfolding of obesity as a social and political phenomenon in the United States including its institutional, historical, and gendered components, see Jeffrey Sobal and Donna Maurer, eds., *Weighty Issues: Fatness and Thinness as Social Problems* (New York: Aldine De Gruyter, 1999); Peter N. Stearns, *Fat History: Bodies and Beauty in the Modern West* (New York: New York University Press, 1997). In terms of the contemporary critique of obesity in light of bio-power and bio-citizenship, see Jan Wright and Valerie Harwood, eds., *Biopolitics and the ‘Obesity Epidemic’: Governing Bodies* (New York: Routledge, 2009). For an analysis of contemporary cultural and political efforts to “redefine” fatness, see Kathleen LeBesco, *Revolting Bodies? The Struggle to Redefine Fat Identity* (Amherst/Boston: The University of Massachusetts Press, 2004).

¹⁸ Saguy and Riley, “Weighing Both Sides,” 871. See also (cited by Saguy and Riley) Stearns, *Fat History*.

¹⁹ This topic is discussed in more detail in chapter 3.

²⁰ These two trajectories are detailed in Saguy and Riley, “Weighing Both Sides,” 869-921.

2.2.1 Realism vs. Nominalism

There are those who understand obesity from a realist perspective and believe that it is a description of a fundamentally real bodily state (i.e., beyond contestation and confirmed scientifically). When someone has a high enough BMI, she has entered into that state and is therefore obese. One can find realist definitions of obesity circulating at the very highest levels of the healthcare establishment. For example, the World Health Organization (WHO) defines obesity in the following way:

Overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health. A crude population measure of obesity is the body mass index (BMI), a person's weight (in kilograms) divided by the square of his or her height (in metres). A person with a BMI of 30 or more is generally considered obese. A person with a BMI equal to or more than 25 is considered overweight.

Overweight and obesity are major risk factors for a number of chronic diseases, including diabetes, cardiovascular diseases and cancer. Once considered a problem only in high income countries, overweight and obesity are now dramatically on the rise in low- and middle-income countries, particularly in urban settings.²¹

This definition accomplishes several rhetorical tasks. It begins with a tendentious claim that obesity involves “abnormal or excessive fat accumulation” and that this “presents a risk to health.” To say that “fat accumulation” is “abnormal or excessive” is to suggest that it is beyond the norm, that it is pathological. This is, as many have argued (see below), a contentious claim that is often ignored in policy-based definitions such as those cited in this section.²² The WHO definition goes on to invoke BMI as one of the primary tools for determining whether a person is

²¹ World Health Organization, “Health Topics: Obesity,” 2013, <http://www.who.int/topics/obesity/en/> (Accessed March 8, 2013).

²² Saguy and Riley, “Weighing Both Sides,” 869-921; Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Emma Rich and John Evans, “‘Fat Ethics’ – The Obesity Discourse and Body Politics,” *Social Theory and Health* 3 (2005): 341-358; Michael Gard and Jan Wright, *The Obesity Epidemic: Science Morality and Ideology* (London/New York: Routledge, 2005).

obese. In other words, it sets basic measures of BMI that constitute the distinction between “obese” and “overweight” individuals. It then concludes with the claim that “overweight and obesity are major risk factors for a number of chronic diseases” and that “overweight and obesity” are now a problem that impacts individuals from multiple nations and classes.

From a realist perspective, this definition would go without much comment. It is not exclusively rhetorical but is rather a basic summary of the very best information that has been accumulated about obesity by medical and public health researchers. However, this definition accomplishes a great deal more. It advances the view that obesity is a medical problem that can be measured and correlated with other diseases, and that obesity is in some real way a kind of disease (or a state preceding disease) requiring management. Most clinical researchers tend toward realist definitions of obesity and thus would find the arguments of this thesis unfamiliar and perhaps unacceptable. When I say that claims such as those made in the WHO definition are tendentious and controversial, I am suggesting that they are not objectively valid but are made up of an intermeshing of scientific findings and normative beliefs about the importance of health and the need to act to resolve problems that might influence health, as well as the belief that science can answer such questions well.²³ None of these are unacceptable arguments; my point here is that they are indeed *arguments* and, as such, are not without potential counter-points. Furthermore, as my goal is to work out a bioethical approach to the treatment of obesity, remaining tied to the science as such is not sufficient. Some work will need to be done to link public conceptions of obesity with the best science has to offer in order to develop an ethically and socially acceptable platform for the development of obesity treatments. This is, in short, my view of the task of bioethics in the context of the obesity problem.

²³ A point rigorously analyzed in Saguy and Riley, “Weighing Both Sides,” 869-921.

The WHO's definition is not unique. Many other major healthcare research and delivery institutions have defined obesity in similar ways. The Centers for Disease Control (CDC), for example, define "overweight" and "obesity" as "labels for ranges of weight that are greater than what is generally considered healthy for a given height."²⁴ The CDC definition then articulates the same health risks found in the WHO language: "The terms [overweight and obesity] also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems."²⁵ It goes on to discuss the use of BMI in the same fashion as the WHO. Similarly, the National Institutes of Health (NIH) have used the rhetorical equation between obesity and health risk to justify public action to address the obesity problem. In a recent fact sheet produced by the U.S. Department of Health and Human Services (DHHS), the NIH, and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), obesity is defined as: "an excessive amount of body fat."²⁶ The fact sheet goes on to suggest: "Obesity is more than a cosmetic problem. Many serious medical conditions have been linked to obesity, including type 2 diabetes, heart disease, high blood pressure, and stroke. Obesity is also linked to higher rates of certain types of cancer."²⁷ The WHO, CDC, and NIH definitions offered here present obesity as a medical problem. While these definitions do not go into the causes of obesity, they do present it as a relatively stable bodily category with fairly predictable co-morbid conditions. In so doing, they take a bodily state and connect it to health problems in such a way as to demand the attention of medical research and practice into the domain of public health

²⁴ CDC, "Defining Overweight and Obese," <http://www.cdc.gov/obesity/defining.html>.

²⁵ CDC, "Defining Overweight and Obese," <http://www.cdc.gov/obesity/defining.html>.

²⁶ U.S. Department of Health and Human Services, "Understanding Adult Obesity" (Fact Sheet), National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases (November, 2008): <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>. (Accessed March 4, 2013).

²⁷ U.S. Department of Health and Human Services, "Understanding Adult Obesity," <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>.

advocacy.²⁸ These definitions have not simply sprung out of the ether and are not used lightly by any of the institutions previously mentioned. They are based on years of medical research indicating that obesity is connected to a variety of health problems.²⁹ In addition, these health problems are not simply felt by individuals but by society as a whole, thus justifying the public interest in addressing obesity.³⁰ However, it is crucial to understand that these definitions are offered from a particular point of view, one not shared by all of the stakeholders in the growing controversy over defining and treating obesity.³¹

In contention with the realists are those who take a nominalist stance and believe that obesity is a culturally and historically constructed notion. Whatever visual cues or weighing mechanisms we rely on at this particular time to tell us whether someone is obese or not, these are as variable as the creative and interpretive powers of human thought and language. On this view, in the sheer act of naming, we have constructed this bodily state as something that is, if nothing else, quite real to us within our linguistic and social practices. Kenneth Burke, a 20th century literary and rhetorical critic, following the basic trajectory of this viewpoint, opines:

²⁸ This augmentation of medical concern has been observed during other moments in the history of medicine. For example, Chris Feudtner details this problem and its consequences in the context of diabetes care in the early 20th century. Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: University of North Carolina Press, 2003). See also, footnote 30 in this chapter.

²⁹ Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, "Morality, Health Outcomes, and Body Mass Index in the Overweight Range," 3265-3268; McTigue, Kathleen M., Russell Harris, Brian Hemphill, Linda Lux, Sonya Sutton, Audrina J. Bunton, and Kathleen N. Lohr, "Screening and Interventions for Obesity in Adults: Summary of the Evidence for the U.S. Preventive Services Task Force," *Annals of Internal Medicine* 139, no. 11 (2003): 933-949.

³⁰ Multiple studies confirm the degree to which the public interest in obesity is on the rise in legal and political venues. See e.g., Rogan Kersh and James A. Morone, "Obesity, Courts, and the New Politics of Public Health," *Journal of Health Politics, Policy and Law* 30, No. 5 (2005): 839-868; J. Eric Oliver and Taeku Lee, "Public Opinion and the Politics of Obesity in America," *Journal of Health Politics, Policy and Law* 30, No. 5 (2005): 923-954; Kelly D. Brownell, "The Chronicling of Obesity: Growing Awareness of Its Social, Economic, and Political Contexts," *Journal of Health Politics, Policy and Law* 30, No. 5 (2005): 955-964. Beyond the scope of obesity, other researchers have commented on the growing importance of health as a social value and the implications this has for individuals and the public at large. See Jonathon M. Metzler and Anna Kirkland, eds., *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

³¹ Saguy and Riley, "Weighing Both Sides," 869-921.

“eliminate the medical terminology and you eliminate the disease.”³² That is, without the term “obesity” we would have no obesity epidemic, no conception of BMI, and no need to address this health concern. In this way, the nominalist position reveals that which the realist obscures. While there may be particular physiological and clinical markers for obesity, these are linguistic choices that are made real through our discourse, experiences, decisions, and technologies.

Following this basic trajectory, Christine Halse points out that BMI “is premised on the assumption that there is an identifiable ‘normal’ weight that is ‘true’ across genders and across different cultural, socio-economic, and geographical groups.”³³ While Halse may be obscuring the fact that differential weighing standards exist across at least some of the identity markers she mentions, her point about the realist position is important.³⁴ From the viewpoint of medical science, obesity has a specific clinical definition and various “normal” weights have been established that appear real. In other words, the realist perspective purports to give a scientifically grounded definition of overweight and obese bodies. However, Halse suggests that “even scientific experts who advocate the use of BMI as an epidemiological tool concede that it is an ‘arbitrary’ measure.”³⁵ This arbitrariness is precisely the opening that nominalists use to make their arguments regarding the underlying ideological or moral judgments that realist arguments tend to mask.³⁶

³² Kenneth Burke, *Counter-Statement* (Berkeley/Los Angeles/London: University of California Press, 1968), 74.

³³ Christine Halse, “Bio-Citizenship: Virtue Discourses and the Birth of the Bio-Citizen,” in *Biopolitics and the ‘Obesity Epidemic,’* ed. Jan Wright and Valerie Harwood (New York: Routledge, 2009), 45-59, 47.

³⁴ The idea that BMI calculations may differ between different groups has been understood for some time. See e.g., P. Deurenberg, M. Yap, and W. A. Staveren, “Body Mass Index and Percent Body Fat: A Meta-analysis Among Different Ethnic Groups,” *International Journal of Obesity* 22 (1998): 1164-1171.

³⁵ Halse, “Bio-Citizenship,” 47. Here, Halse describes the scientific problems with the definition (e.g. that it does not account for different kinds of bodies and proportions); however, one can also defend the notion that it does not account for different cultural values and socio-political norms.

³⁶ Saguy and Riley, “Weighing Both Sides,” 869-921.

Moreover, those who fall within the nominalist camp have pointed out that the easy association made by medical providers and researchers between obesity and morbidity and mortality should be questioned.³⁷ Halse opines that the relationship between BMI and ill health is not straightforward:

Genetics and activity levels are important mediating factors for good health, and British researchers warn that a normative BMI can disguise the nature of weight because many slim people can store dangerous levels of fat in their bodies that can trigger heart conditions and diabetes.³⁸

Paul Campos, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser, some of the primary critics of the public health establishment's move to craft obesity as an epidemic in need of public and medical management, articulate a similar view: "the available scientific data neither support alarmist claims about obesity nor justify diverting scarce resources away from far more pressing public health issues."³⁹ Furthermore, in their analysis of the moralizing discourses surround the obesity problem, Emma Rich and John Evans contend that "the relationships between obesity and health are far more tenuous, complex, and contradictory than the 'obesity epidemic' discourse would have us believe."⁴⁰ All of these scholars view obesity as at least in part a constructed problem, one that is not fully established by science and that may have more to do with the ideological views of those mobilizing the healthcare industry and government to take action than with anything else.⁴¹ On the nominalist view, while there are certainly correlations between obesity and increased health risk, these correlations should not be taken as evidence that

³⁷ Saguy and Riley, "Weighing Both Sides," 869-921; Campos, Saguy, Ernsberger, Oliver, and Gaesser, "The Epidemiology of Overweight and Obesity," 55-60; Emma Rich and John Evans, "'Fat Ethics' – The Obesity Discourse and Body Politics," *Social Theory and Health* 3 (2005): 341-358; Michael Gard and Jan Wright, *The Obesity Epidemic: Science Morality and Ideology* (London/New York: Routledge, 2005).

³⁸ Halse, "Bio-Citizenship," 47.

³⁹ Campos, Saguy, Ernsberger, Oliver, Gaesser, "The Epidemiology of Overweight and Obesity," 55.

⁴⁰ Rich and Evans, 342-343; Gard and Wright, *The Obesity Epidemic*.

⁴¹ Gard and Wright, *The Obesity Epidemic*; Sylvia N. Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick, NJ: Rutgers University Press, 1988).

obesity is something that has been and shall forever be a concern for medical science. As Michael Gard and Jan Wright point out, “rather than a global health crisis or an ‘objective’ scientific fact, the ‘obesity epidemic’ can be seen as a complex pot-pourri of science, morality, and ideological assumptions about people and their lives which has ethically questionable effects.”⁴² Interestingly, the fact sheet produced by DHHS, NIH, and NIDDK described above openly admits to a lack of evidence directly linking weight with disease: “There are few studies in humans that link direct measurements of total body fat to morbidity and mortality.”⁴³ Thus, even those we would expect to fall directly and soundly within the realist camp show some deference to the nominalist position, especially in terms of the evidence linking weight to health. Moreover, according to the nominalist view, the realist stance may be employed to justify ever-increasing intervention by scientists into the domain of public health with no sound evidence to do so.⁴⁴ Some nominalists view the realist definition (and associated management) of obese bodies as an effort to exert power over individuals because they do not conform to the socio-cultural norms of the day.⁴⁵ The threat of stigmatization is a primary means of exerting such power and has been problem for obese individuals since the middle of the last century.⁴⁶ I will return to the question of stigmatization in a later section as well as in chapter 3.

⁴² Gard and Wright, *The Obesity Epidemic*, 3.

⁴³ U.S. Department of Health and Human Services, “Understanding Adult Obesity,” <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>.

⁴⁴ Campos, Saguy, Ernsberger, Oliver, Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Rich and Evans, 341-358; Gard and Wright, *The Obesity Epidemic*; Feudtner, *Bittersweet*.

⁴⁵ This is one of the primary concerns raised by Joanna Zylynska in her *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009). See chapter 1 for more discussion of her work and its relationship to the arguments I am advancing in this thesis. In addition, Bordo’s work raises a similar set of concerns about the management of bodies. Bordo, *Unbearable Weight*, 202-204.

⁴⁶ For an excellent early paper on the problem of stigmatization in the context of obesity, see Werner J. Cahnman, “The Stigma of Obesity,” *The Sociological Quarterly* 9, no. 3 (1968): 283-299. For contemporary accounts that show the degree to which stigma is a problem in public health efforts to address obesity, see Rebecca M. Puhl and Chelsea A. Heuer, “Obesity Stigma: Important Considerations for Public Health,” *American Journal of Public Health* 100, no. 6 (2010): 1019-1028; Rebecca M. Puhl and Chelsea A. Heuer, “The Stigma of Obesity: A Review and update,” *Obesity* 17 (2009): 941-964. On the original development of “stigmatization” in sociological

In sum, the obscuring and clarifying elements of the definitional work done by the realist and nominalist positions on obesity point to broader problems that healthcare practitioners and policy makers must face: primarily, how to approach the obesity problem and potentially solve it. Those who fall within the realist camp see very little reason to engage in cultural and ethical critique regarding the nature of obesity. For them, obesity is not a rhetorically constructed term but is instead an objectively valid and scientifically supported clinical definition. Realists point to the risks of obesity to individual and public health. They argue that the correlations (and in some cases proven causality) between obesity and other health conditions show that action by medical institutions and government is necessary and justified to promote individuals' health and to sustain the solvency and longevity of our healthcare economy and society as a whole.⁴⁷ For the realists, the nominalist position is a kind of *reductio ad absurdum* of broader discussions about the social construction of illness and disease.⁴⁸ To question obvious somatic differences and medical science is to deny reality itself, making nominalists appear misguided and potentially dangerous to public health and wellness. As Cora E. Lewis, Kathleen M. McTigue, Lora E. Burke, Paul Poirier, Robert H. Eckel, Barbara V. Howard, David B. Allison, Shiriki Kumanyika, and F. Xavier Pi-Sunyer argue, "we cannot afford to wait for this [new] research to

theory, see Erving Goffman, *Stigma: Notes on the Managements of Spoiled Identity* (New York: Simon and Schuster, First Touchstone Edition, 1986).

⁴⁷ On this point, see Michelle M. Mello, David H. Studdert, and Troyen A. Brennan, "Obesity – The New Frontier of Public Health Law," *The New England Journal of Medicine* 354, no. 24 (June 15, 2006): 2601-2609; Lawrence O. Gostin, "Law as a Tool to Facilitate Healthier Lifestyles and Prevent Obesity," *Journal of the American Medical Association* 297, no. 1 (2007): 87-90.

⁴⁸ The most robust critique of "social constructionism" I have found is offered by Ian Hacking who points out that merely saying something is a "construction" does not do very much analytical work. This is definitely the case, and I hope to point out how the framing of obesity operates to create certain conditions that otherwise might not obtain. This seems to indicate, at least to a certain extent, that the socially constructed nature of obesity has meaning for healthcare workers and patients. On this issue, see Ian Hacking, *The Social Construction of What?* (Cambridge: The Harvard University Press, 2001).

begin addressing the problem of overweight in our patients and in our society.”⁴⁹ This statement stands at the heart of the realist approach to the obesity problem. While, for nominalists, the definitional work done by the realists obscures the fact that medicine has yet to provide a stable and fully-fledged account of what obesity is and how it can be treated. In addition, they point to larger social, cultural, and political issues involved in the expansion of medicine that are masked by the realist rhetoric of BMI, co-morbidity, and the like. This debate points to a larger disagreement about the intermeshing of medicine and politics to which I turn in the next section.

2.2.2 Beyond Realism and Nominalism: Medical and Political Frames of Obesity

Working beyond the coordinates of realism and nominalism, though engaging some of the same issues, Abigail C. Saguy and Kevin W. Riley offer an extensive account of the various “obesity frames” used by different groups to manage the terms and policies surrounding obesity.⁵⁰ Saguy and Riley suggest that the arguments regarding obesity in contemporary U.S. culture largely revolve around the distinction between medical arguments about “health risks” and political arguments regarding the “rights” of individuals:

We suggest that in the case of obesity, debates over the nature of the condition have largely hinged upon underlying moral assumptions about fat individuals and their behaviors. To date, *medical* arguments about the health risks of obesity have been effectively used to stymie *political* arguments about rights for fat individuals.⁵¹

Instead of focusing primarily on the definition of obesity, as I have done in the previous section, Saguy and Riley offer a wider net of frames that extend into the politics and ideological

⁴⁹ Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, “Morality, Health Outcomes, and Body Mass Index in the Overweight Range,” 3268.

⁵⁰ Saguy and Riley, “Weighing Both Sides,” 869-921.

⁵¹ Saguy and Riley, “Weighing Both Sides,” 871.

commitments surrounding obesity, thus cashing out many of the claims made by realists and nominalists of various stripes. They argue that there are two primary approaches to the obesity problem that are summed up in the labels “*anti-obesity*” and “*fat acceptance*.”⁵² While charting the distinctions between these approaches, Saguy and Riley detail three primary frames: “fatness as body diversity, obesity as risky behavior, and obesity as disease.”⁵³ To these, they add another that is a more specific form of the “obesity as disease” frame: “obesity as epidemic.”⁵⁴ They argue that these various frames are deployed across the medical and political divide, thereby indicating the extent to which obesity tests this boundary and calls for wider perspectives that do not follow the narrow coordinates of one sphere of human activity and understanding. Finally, they point out that these various frames influence another important concept – responsibility.⁵⁵ Whether one views obesity as a “risky behavior” or as a form of “body diversity” has consequences for whether or not one views obese individuals as responsible for their health, for changing their ways in order to avoid disease, and for the added healthcare and other costs associated with their choices. As Saguy and Riley point out,

A personal behavior theory of illness, which the risky behavior frame of obesity exemplifies, sees people as responsible for their own ill health. In that the poor or minority groups are more likely to be ill, this allows one to blame them for their misfortune. Moreover, in that an unhealthy lifestyle is taken as evidence of personal and civic (because of public health costs) responsibility, this perspective suggests that the poor are to blame for their disadvantaged social position.⁵⁶

In this passage, Saguy and Riley view the “personal behavior theory of illness” as immediately suspect given its potential to shift all responsibility to individual people, especially the least powerful. I return to this point and offer a different take on it in chapter 3.

⁵² Saguy and Riley, “Weighing Both Sides,” 874.

⁵³ Saguy and Riley, “Weighing Both Sides,” 881-882.

⁵⁴ Saguy and Riley, “Weighing Both Sides,” 882.

⁵⁵ Saguy and Riley, “Weighing Both Sides,” 870-871, 875, 887, 889-892.

⁵⁶ Saguy and Riley, “Weighing Both Sides,” 875, 887.

Saguy and Riley detail a variety of groups that agree with the nominalist rejection of obesity as a major health concern.⁵⁷ For example, Fat Studies as well as public movements such as the National Association for the Advancement of Fat Acceptance (NAAFA)—two groups detailed in Saguy and Riley’s analysis—attack efforts to define obesity as a disease to be managed primarily by science and politics.⁵⁸ Simply put, against the realist medical paradigm, “the fat acceptance movement has countered . . . by saying that one can be healthy at any size and that claims about obesity being a health risk are simply overblown.”⁵⁹ The movement disputes the notion that health should be the “ultimate” or “god” term for valuing and understanding the practices of human life and contends that adopting health as primary value or goal devalues other aspects of human living that might work in tandem with or against the grain of attaining perfect health.⁶⁰ In this same vein, some scholars have pointed to the risks of allowing health to become the new “norm” or mechanism through which the morality, worth, rationality, and goodness of life is *weighed* (absent other factors).⁶¹

Saguy and Riley’s work provides additional context for the troubled term “obesity.” First, they show that the realist vs. nominalist debate is only one trajectory of the contestation over the meaning of obesity. Stakeholders do not simply disagree about whether obesity is real or constructed. They also disagree about how the various constructions of obesity should be judged

⁵⁷ On this, also see Emma Rich and John Evans. “Fat Ethics’ – The Obesity Discourse and Body Politics.” *Social Theory and Health* 3 (2005): 341-358.

⁵⁸ For the primary web home of the National Association for the Advancement of Fat Acceptance (NAAFA), see www.naafa.org. For a nice survey of the ground in Fat Studies, see Esther Rothblum and Sondra Solovay, eds., *The Fat Studies Reader* (New York/London: New York University Press, 2009). NAAFA and its “Health at Every Size” viewpoint is described in detail in Saguy and Riley, “Weighing Both Sides,” 879-880, 897, 903, 911.

⁵⁹ Saguy and Riley, “Weighing Both Sides,” 871.

⁶⁰ On the idea that terms can have an “ultimate” or even “god-like” impact on the ways in which people think and act, see Kenneth Burke, *A Rhetoric of Motives* (Berkeley: The University of California Press, 1969), 183-189; Richard M. Weaver, “Ultimate Terms in Contemporary Rhetoric,” in his *The Ethics of Rhetoric* (Davis, CA: Hermagoras Press, 1985), 211-232.

⁶¹ Jonathan M. Metzler and Anna Kirkland, eds., *Against Health: How Health Became the New Morality*, (New York: New York University Press, 2010).

and whether they should be used to make policy decisions in terms of medical care and public health. Second, in their analysis of the various frames used to make sense of obesity, Saguy and Riley show that some stakeholders actually reject the use of the term “obesity”: “fat acceptance activism has long rejected the term obese because its participants claim that this term pathologizes heavier weights and that weight should be a political rather than medical issue.”⁶² Finally, Saguy and Riley’s findings confirm that more needs to be done to chart how language choices impact policy: “Further work on this topic is critical, not only for advancing sociological understanding of framing contests, but also for evaluating the social impact of current approaches to the obesity epidemic.”⁶³ I would add that scholars should focus on how frames influence the ethical evaluation of treatment modalities offered in the clinical setting to individuals who are overweight. I address this topic later in this chapter. Saguy and Riley’s analysis, like that of so many nominalists, brings us back to the problem of moral judgment and the question of how healthcare researchers, providers, and policy-makers may either augment or alleviate the stereotyping and stigmatization that affect obese individuals.

2.3 PUBLIC CONCEPTIONS OF OBESITY: THE PROSPECTS FOR COOPERATION

There is no complete resolution for the debates between realists and nominalists or “anti-obesity” and “fat acceptance” advocates described in the literature and reviewed in this thesis.⁶⁴ It is the case that caloric imbalance, lack of exercise, genetic disposition, and disease can all create the

⁶² Saguy and Riley, “Weighing Both Sides,” 877.

⁶³ Saguy and Riley, “Weighing Both Sides,” 915.

⁶⁴ Saugy and Riley, “Weighing Both Sides,” 869-921.

conditions for the emergence of the bodily state that is generally called obesity.⁶⁵ It is also the case that what we call obesity, how we frame it and what it means for us as a society, shifts and changes over time and influences how we respond to it.⁶⁶ Medical, social, cultural, and political efforts to define obesity all draw on different resources and have different consequences. We should acknowledge this and work to craft ethical responses that are attuned to such pluralism.⁶⁷ As Saguy and Riley note, “If the truth lies in the middle, the policy challenge will require finding a more integrative perspective.”⁶⁸ However, what this perspective looks like is not well developed in their work. Their penultimate paragraph suggests that there is still a great deal of uncertainty regarding the health risks associated with obesity as well as the appropriate treatments that might be deployed in response to it:

Currently, there is no magic cure for obesity so there are few perceived benefits for fat people in framing obesity as a disease. Weight-loss surgery can result in dramatic weight loss but is only recommended for people who are at least one hundred pounds over the current weight guidelines. Moreover, its long-term efficacy is not known and it has major associated health risks including a relatively high rate of death. Despite its limitations, the perceived benefits of weight-loss surgery do seem to be leading some individuals to assert that obesity is a disease to advocate reimbursing weight-loss surgery by health insurance. If a pill were discovered that produced major weight loss, we would expect to see more groups organized around the assertion that obesity is a disease. There are many diseases for which available medical treatments are ineffective, but, unlike, say, cancer, people categorized as obese can live long lives without medical treatment for their weight. If being diagnosed as obese implied a quick and certain death, we would expect people so diagnosed to embrace the disease category and clamor for any available treatment no matter how ineffective.⁶⁹

⁶⁵ Elliot M. Blass, ed., *Obesity: Mechanisms, Prevention, Treatment* (Sunderland, MA: Sinauer Associates, Inc., 2008).

⁶⁶ Sobal and Maurer, eds., *Weighty Issues*; Stearns, *Fat History*; Wright and Harwood, eds., *Biopolitics and the ‘Obesity Epidemic’*; LeBesco, *Revolting Bodies?*

⁶⁷ The “philosophy of pluralism” on which this claim rests is excellently developed in Chaim Perelman work. His primary contribution is to suggest that even mutually exclusive viewpoints may be correct simultaneously, that they may harbor some truth and thus have value in the ongoing effort to craft an ethical and productive society. See Chaim Perelman, “The Philosophy of Pluralism and the New Rhetoric,” in *The New Rhetoric and the Humanities* (Dordrecht, Holland: D. Reidel Publishing Company, 1979), 62-72.

⁶⁸ Saguy and Riley, “Weighing Both Sides,” 874.

⁶⁹ Saguy and Riley, “Weighing Both Sides,” 915.

They then end their paper with a call for more research and discussion of the role of frames in the ongoing effort to craft policy-based solutions for the obesity problem. While they catalogue many of the same questions and points of uncertainty I detail in chapter 1, they leave us with very little in terms of how to approach the obesity problem aside from ongoing contestation, negotiation, and study. In fact, the arguments advanced by Saguy and Riley may simply generate additional contestation and uncertainty regarding how to approach the obesity problem. Marcus Paroske calls this sort of argumentative strategy an “epistemological filibuster” that he defines as a situation in which, “one side in a policy controversy exploits uncertainty over how thoroughly to deliberate as a means to preclude the resolution of that issue in government action.”⁷⁰ The problem with postponing judgment or engaging in ongoing research before making policy decisions is that we “may indefinitely delay action by forcing a search for the kind of indubitable evidence that may never materialize.”⁷¹ Thus, we should move beyond Saguy and Riley’s claim that “in such cases [as the obesity problem], it may be prudent to counsel patience in policy making until a more balanced perspective emerges,” because it leaves us with little chance for action in the short-term, especially when it comes to individuals seeking care for obesity and its related co-morbidities.⁷²

Accordingly, ending on a note of uncertainty and a call for cooperation may not bring us any closer to an ethically sound and effective path toward addressing the obesity problem, one for which there appears to be sufficient evidence for some level of action (see chapter 1). In my view, Saguy and Riley do not adequately engage the clinical question of how providers should

⁷⁰ Marcus Paroske, “Deliberating International Science Policy Controversies: Uncertainty and AIDS in South Africa,” *Quarterly Journal of Speech* 95, no. 2 (May, 2009): 151.

⁷¹ Paroske, “Deliberating International Science Policy Controversies,” 151-152.

⁷² Saguy and Riley, “Weighing Both Sides,” 874.

approach their patients. Their focus, like that of so many nominalists, is on the public contestation over the meaning of obesity as opposed to working out ethical approaches to dealing with it in the interpersonal dimension of the clinic, although they do describe some promising trends in making clinical sites and professionals slightly more accepting and respectful of obese and overweight patients.⁷³ This gap points to the need to more fully develop bioethical approaches to obesity that might work between the public and policy-making domain and the clinical domain.

Furthermore, in terms of the views espoused by those I have termed nominalists in this chapter, it is critical to recognize that the meaning making process has its limitations. As Kenneth Burke points out, the “anti-essentialist” and symbolic view of human life “does not imply that the universe is merely the product of our interpretations. For the interpretations themselves must be altered as the universe displays various orders of recalcitrance to them.”⁷⁴ Thus, in my view, the various advocates in this controversy should admit the weaknesses inherent in the most polarized versions of their arguments given that obesity is neither a fully medicalized bodily state nor simply another way of life that is not qualitatively different from any other.⁷⁵ In short, what may be needed is not simply an “integrative perspective” but also an honest attempt to investigate how and to what extent the various perspectives described in the

⁷³ Saguy and Riley, “Weighing Both Sides,” 907-912.

⁷⁴ “Anti-essentialist” is Kathleen Lebesco’s term and is used to indicate the ongoing contestation over the meaning of obesity in her work. She juxtaposes it with “essentialist” strategies. See Lebesco, *Revolting Bodies?*, 14. I should also note that her distinction between “essentialist” and “anti-essentialist” views on obesity largely corresponds with my own “realist” and “nominalist” distinction as well as the variety of frames that Saguy and Riley describe. Saguy and Riley, “Weighing Both Sides,” 869-921. Kenneth Burke, *Permanence and Change: An Anatomy of Purpose*, 3rd ed. (Berkeley/Los Angeles: University of California Press, 1984), 256.

⁷⁵ For work on the need to proportionalize the symbolic and material elements of meaning making, see J.E. McGuire and Trevor Melia, “How to Tell the Dancer from the Dance,” in *Science, Reason, and Rhetoric*, eds. Henry Krips, J.E. McGuire, and Trevor Melia (Pittsburgh: The University of Pittsburgh Press, 1995), 73-93.

previous section yield better or worse approaches to the obesity problem, especially from the perspective of providers and patients who are looking for some way to achieve better health.⁷⁶

Put another way, human knowledge and praxis are bound up in a cycle of “permanence and change.”⁷⁷ Humans often want to think of norms, conventions, practices, habits, and modes of interpretation as timeless and fundamentally real and unchanging; however, as Kurt Baier notes,

We should distinguish between on the one hand, the conventionally established practices and institutions that make up a society’s custom and law, each characterized by its peculiar ways of generating and enforcing the society’s requirements, and on the other hand a moral point of view from which these actually existing, conventionally established practices and institutions can be critically examined and improved.⁷⁸

Following Baier, we should understand human knowledge and praxis as a series of norms, propped up by our collective efforts to craft a moral way of life. These norms; however, are not timeless and beyond the fray of critique.⁷⁹ In other words, as the literature I review above suggests, the constructive efforts of the realist camp to identify a problem and resolve it (using relatively stable and unquestioned modes of justification rooted in the Western scientific project) should be tempered with deconstruction, critique, and a wider conception of what obesity is and how it should be understood and managed in both scientific and non-scientific domains. However, this does not mean constant uncertainty. Action will happen, including in the context of obesity policy and treatment. Such action will not always be perfectly ethical; however,

⁷⁶ Saguy and Riley, “Weighing Both Sides,” 874.

⁷⁷ I have taken the language of “permanence and change” from the title of one of Kenneth Burke’s early works. What it is meant to point to is the idea that socio-cultural moirés, norms, and practices have a kind of permanence to them (various stabilities sustained over time) but that they also shift and change to fit new circumstances. See Burke, *Permanence and Change*.

⁷⁸ Kurt Baier, “Moral and Legal Responsibility,” in *Medical Innovation and Bad Outcomes: Legal, Social and Ethical Responses*, ed. Mark Siegler, Stephen Toulmin, Frank E. Zimring, and Kenneth F. Schaffner (Ann Arbor: Health Administration Press, 1987), 113.

⁷⁹ On this, see e.g. Jürgen Habermas, *The Structural Transformation of the Public Sphere: An Enquiry into a Category of Bourgeois Society*, trans. Thomas Burger (Cambridge: MIT Press, 1991).

delaying action seems untenable given the prevalence of obesity and its associated co-morbid conditions.

Furthermore, multiple modalities of understanding and rhetorical framing will be needed in any effort to solve the social, political, or medical dilemmas surrounding obesity.⁸⁰ As rhetorical theorist Michael J. Hyde argues, the most moral approach to social and political critique will involve both “deconstructive” and “reconstructive” efforts.⁸¹ There will be “punctuated equilibria” in our conventions and ways of life, and these are good if we are to ever have political, social, and medical “homes” from which to engage in our everyday tasks; however, we also need to break down these conventions from time to time in order to both understand their constructed nature and provide room for the cultivation of new and better sites for action.⁸² For these reasons, I do not presume to once and for all define obesity, medicalize or de-medicalize obesity, or find a new path on which all parties are likely to fully agree. Instead, my role as a rhetorical theorist and bioethicist is to understand how, when an individual has entered the clinical setting, she is to be treated, understood, and made capable of participation in her own healthcare without assuming that all of these questions are always already answered by the current conventions and scientific understandings of the clinic or the larger socio-cultural understandings of health.⁸³ This does not necessitate adoption of a final stance on the question of

⁸⁰ This view is largely in agreement with Saguy and Riley. Saguy and Riley, “Weighing Both Sides,” 869-921.

⁸¹ Michael J. Hyde, *The Life-Giving Gift of Acknowledgment* (West Lafayette, IN: Purdue University Press, 2006), 86.

⁸² On the notion of finding a “home” either medical or otherwise, see Hyde, *The Life-Giving Gift of Acknowledgment*, 98-116. I have borrowed the term “punctuated equilibria” from the history of evolutionary theory. On this term and its role in that history, see Michael Ruse, “The Theory of Punctuated Equilibria: Taking Apart a Scientific Controversy,” in *Scientific Controversies: Philosophical and Historical Perspectives*, ed. Peter Machamer, Marcello Pera, and Aristides Baltas (New York: Oxford University Press, 2000): 230-240; John Lyne and Henry F. Howe, “ ‘Punctuated Equilibria’: Rhetorical Dynamics of a Scientific Controversy,” *Quarterly Journal of Speech* 72 (1986): 132-147.

⁸³ In this sense, I think of bioethics as starting at the event of the clinical encounter and then moving outward. For an argument in favor of the dyadic encounter as the primary cite for medical ethics (a view with which

what obesity *really is* as opposed to what it can be or should be when viewed not simply from the standpoint of medicine but also the individuals for whom medicine is not the primary lens through which life choices should be made. This is something that will be constantly renegotiated as we find more effective and ethical approaches.

More directly, once patients have determined that their bodily state is unwanted, that it does not conform with their goals in life or their vision what life should be like, they have begun to open themselves to transforming their own practices, habits, and dispositions in order to realize their own goals of care and overall health. This is, at its most rudimentary level, the autonomous action that is the ideal of clinical care.⁸⁴ When patients choose to engage in an intervention, to take a particular drug, or to seek counseling, they exercise their right to make choices about what is best for them and their health (of course, with the help of trusted healthcare providers). What is left is a deliberative encounter with their most trusted healthcare practitioners in order to make decisions and plans for treatment.⁸⁵ This deliberative encounter should proceed along a variety of axes, some involving the clinical possibilities and modes of understanding held by the physician, some involving the goals and understandings of the individual (and their friends and family), and still others involving the policy-based and precedential concerns involved in selecting certain kinds of treatment goals and modalities. In this case, we can say that obesity represents something that is medically defined, socially constructed, and individually understood (akin to many other chronic conditions).⁸⁶ Sustaining this unstable ground seems

I agree to the extent that it is a starting point, but not the only starting point or site, for medical ethics), see Pellegrino, "The Internal Morality of Clinical Medicine," 559-579.

⁸⁴ On this, see Beauchamp and Childress, *Principles of Biomedical Ethics*, 99-148.

⁸⁵ David H. Smith and Loyd S. Pettegrew, "Mutual Persuasion as a Mode for Doctor-Patient Communication," *Theoretical Medicine and Bioethics* 7 (1986): 127-146.

⁸⁶ I hope to show that the arguments I am currently making about obesity may also have applicability to some other chronic conditions. I believe that diabetes, chronic pain, and even some terminal diseases such as

advisable, especially when it comes to preserving the autonomy and humanity of individual patients.⁸⁷ Thus, for the purposes of this thesis, I understand obesity as a kind of bodily state that is socially, culturally, scientifically, and individually experienced and managed (again, as is the case with many chronic conditions). Understanding obesity as a problem to be discussed, interrogated, and renegotiated across time and for specific purposes is, then, the skeptical and open-ended method of this thesis. It informs the ethical work in chapters 3 and 4 as I continue to unpack the tensions that reside, in particular, between the public health responses to obesity (discussed above) and the ways in which particular providers should approach the care of their patients. However, such skepticism does not stand in the way of developing therapeutic options that work in the moment, a point with which at least some nominalists disagree.

Fortunately, there appears to be some agreement between nominalists and realists that lifestyle therapy promotes health whether it actually reduces weight or not. Campos, Saguy, Ernsberger, Oliver, and Gaesser argue that, “it seems probable that body weight, like height and baldness, is for the most part a proxy for many unmeasured variables. From a public health perspective, the most significant aspect of these unmeasured variables, especially the lifestyle factors, are more readily modifiable than body mass.”⁸⁸ Thus, for at least some nominalists, elements of lifestyle therapy are acceptable so long as they are not connected solely or primarily

HIV/AIDS and cancer involve some level of self-care and some element that is not reducible to medical, social, political, or cultural perspectives but interacts with all of these.

⁸⁷ When I use the term “autonomy,” I do not necessarily mean “patient autonomy” as understood in traditional bioethics literature. Instead, I mean to suggest the reflective, informed, and self-conscious attributes of the individual agent.

⁸⁸ Campos, Saguy, Ernsberger, Oliver, and Gaesser, “The Epidemiology of Overweight and Obesity,” 56; Saguy and Riley discuss this argument as well, citing Glen Gaesser’s work that appears to offer the most sustained defense of exercise and nutrition (not weight loss) as the best approaches for achieving improved health. Saguy and Riley, “Weighing Both Sides,” 895-896. See Glen A. Gaesser, *Big Fat Lies: The Truth About Your Weight and Your Health* (New York: Fawcett Columbine, 2002).

to weight. Compare this sentiment with that expressed by those in the realist camp, for example, by Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer:

Both healthy eating patterns and physical activity have roles in managing weight and CVD risk and should be encouraged in all. Because physical inactivity and excess weight have been independently associated with mortality in several studies, there are additional advantages to overweight and obese persons adopting an active lifestyle, as well as healthy eating habits. In the long term, because weight gain is progressive and weight loss is difficult to maintain, it is vitally important that effective weight maintenance and obesity-prevention approaches be developed and implemented for all individuals above normal weight.⁸⁹

Removing the issue of weight from this statement regarding the need for treatment for lifestyle-related illness would resolve most of the tensions between the nominalist and realist camps with regard to lifestyle-related health issues. This view is gaining ground. As Saguy and Riley point out, “surprisingly, considering their small numbers, we found that fat acceptance arguments are actually having some influence on authoritative approaches to weight.”⁹⁰ They also detail several changes in public health campaigns, government documents, and clinical strategies that seem to be moving in the direction of shifting the focus away from weight and weight-loss.⁹¹

Regardless of whether the shift away from weight as the focal point for public health or clinical care is ever fully achieved, providers and researchers may adopt a less judgmental attitude of their overweight and obese patients if they recognize the ways in which larger public discourses impact their approaches to the treatment of specific patients. Thus, while this section has addressed the larger public health arguments circulating around the obesity problem, an additional issue that needs some investigation in this chapter is whether or not the negative consequences of the various definitional and framing contests above have crept into the

⁸⁹ Lewis, McTigue, Burke, Poirer, Eckel, Howard, Allison, Kumanyika, and Pi-Sunyer, “Morality, Health Outcomes, and Body Mass Index in the Overweight Range,” 3268.

⁹⁰ Saguy and Riley, “Weighing Both Sides,” 872.

⁹¹ Saguy and Riley, “Weighing Both Sides,” 907-912.

assumptions of physicians and providers who are charged with implementing treatment modalities (including lifestyle change). Thus, the next section departs from my review of the literature and public discourse surrounding obesity and into the realm of the clinic and the provider-patient relationship.

2.4 FROM PUBLIC TO CLINICAL UNDERSTANDINGS OF ILLNESS: OBESITY IN THE PROVIDER-PATIENT RELATIONSHIP⁹²

Research suggests that physicians largely embrace the realist view but are often unwilling or unable to help their patients in their efforts to lead healthier lives.⁹³ In addition, physicians may actually embrace or unwittingly subscribe to the most problematic elements of the public understandings of obesity described in the nominalist literature (see previous sections). One study, for example, found that “physicians view obesity largely as a behavioral problem, with physical inactivity as the most important cause . . . These beliefs about the etiology of obesity likely influence physician’s beliefs about the personal characteristics of obese patients.”⁹⁴

According to their research, these beliefs tend to produce “negative attitudes [that are] likely to

⁹² Elements of this section have previously appeared in my dissertation project. John J. Rief, “Searching for the Good Life: Rhetoric, Medicine, and the Shaping of Lifestyle,” (PhD diss., University of Pittsburgh, 2012).

⁹³ J. L. Kristeller and R. A. Hoerr, “Physician Attitudes Toward Managing Obesity: Differences Among Six Specialty Groups,” *Preventive Medicine* 26, no. 4 (1997): 542-549; McTigue, Harris, Hemphill, Lux, Sutton, Bunton, and Lohr, “Screening and Interventions for Obesity in Adults,” 933; Deborah A. Galuska, Julie C. Will, Mary K. Serdula, and Earl S. Ford, “Are Healthcare Professionals Advising Obese Patients to Lose Weight,” *Journal of the American Medical Association* 282, no. 16 (1999): 1576-1578.

⁹⁴ Gary D. Foster, Thomas A. Wadden, Angela P. Makris, Duncan Davidson, Rebecca Swain Sanderson, David B. Allison, and Amy Kessler, “Primary Care Physicians’ Attitudes About Obesity and Its Treatment,” *Obesity Research* 11 (2003): 1168-1177, 1174.

adversely affect physicians' interest in treating obesity.”⁹⁵ Unfortunately, other research confirms that physicians often embrace the negative ideological elements of public obesity discourse. For example, one study indicates that physicians do not show appropriate respect for their obese patients, a definite cause for concern as this may undermine the provider-patient relationship.⁹⁶ Moreover, substantial research indicates the degree to which physician attitudes toward obese patients and ability to treat them appropriately is directly related to their level of expertise. Thus, training seems to be one corrective for the interaction between physician attitudes and beliefs and their treatment of actual patients in the clinical setting.⁹⁷ However, whether such training is undertaken and with what effect is unclear.

These findings are concerning for a variety of reasons; however, the one that is most distressing to me is the risk that, due to physician attitudes, patients may not seek care in the first place. As Saguy and Riley note, “fat acceptance activists . . . say that fears about being harangued about their weight contribute to the reluctance of many fat people, especially women, to seek preventive medical care.”⁹⁸ This provides even more evidence that work should be done to establish ethical and effective clinical practices that might better address patient needs by counteracting the coercive and judgmental attitudes of at least some physicians. Furthermore, there is some evidence that physicians provide poor care for their chronic patients due to their

⁹⁵ Foster, Wadden, Makris, Davidson, Sanderson, Allison, and Kessler, “Primary Care Physicians’ Attitudes About Obesity and Its Treatment,” 1174.

⁹⁶ Mary Margaret Huizinga, Lisa A. Cooper, Sara N. Bleich, Jeanne M. Clark, Mary Catherine Beach, “Physician Respect for Patients with Obesity,” *Journal of General Internal Medicine* 24, no. 11 (November, 2009): 1236-1239.

⁹⁷ Elissa Jelelian, “Survey of Physician Attitudes and Practices Related to Pediatric Obesity,” *Clinical Pediatrics* 42, no. 3 (April, 2003): 235-245; Gregory D. Salinas, Terry A. Glauser, James C. Williamson, Goutham Rao, Maziar Abdolrasulnia, “Primary Care Physicians Attitudes and Practice Patterns in the Management of Obese Adults,” *Postgraduate Medicine* 123, no. 5 (2001): 10.3810/pgm.2011.09.2477; Melanie Jay, Adina Kalet, Tavinder Ark, Michelle McMacken, Mary Jo Messito, Regina Richter, Sheira Schlair, Scott Sherman, Sondra Zabar, Colleen Gillespie, “Physician Attitudes About Obesity and Their Associations with Competency and Specialty: A Cross-Sectional Survey,” *BMC Health Services Research* 9, no. 106 (2009): 10.1186/1472-6963-9-106.

⁹⁸ Saguy and Riley, “Weighing Both Sides,” 901.

lack of understanding about patients' lived experience of both chronic disease and lifestyle change to address chronic illness. Recent research about physicians and their understanding of lifestyle change indicates the degree to which many of them do not understand the difficulties their patients face or the need for more than adequate information delivery in the maintenance of lifestyle change.⁹⁹

Moreover, while patient-provider communication is now an important element in the healthcare practitioner's armamentarium, it is unclear whether communication skills are effectively taught (in medical schools or through clinical and experiential learning) and whether providers truly can communicate with patients when they cannot adequately empathize with them.¹⁰⁰ In addition, even if certain communication techniques are shown to be effective and in use, the issue of whether adequate communication between provider and patient actually produces improved chances of productive and effective lifestyle changes is in need of additional research.¹⁰¹ Ultimately, the problem of providers failing to augment and reinforce the health

⁹⁹ Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs* 20, no. 6 (2001): 64-78. Other scholars have noted the degree to which information-only approaches are lacking. See Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 307-311; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach. "Patient Self-management of Chronic Disease in Primary Care." *Journal of the American Medical Association* 288 (2002): 2469-2475.

¹⁰⁰ For an excellent survey of work concerning the problems with provider-patient communication, see Timothy Edgar, Seth M. Noar, and Vicki S. Freimuth, eds., *Communication Perspectives on HIV/AIDS for the 21st Century* (New York: Lawrence Erlbaum Associates, 2008); Stephen Rollnick, William R. Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008); Debra L. Roter and Judith A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, 2nd ed. (Westport, CT: Praeger, 2006); Stephen Rollnick, Pip Mason, and Chris Butler, *Health Behavior Change: A Guide for Practitioners* (New York: Churchill Livingstone, 1999); Thomas Gordon and W. Sterling Edwards, *Making the Patient Your Partner: Communication Skills for Doctors and Other Caregivers* (Westport, CT: Auburn House, 1995).

¹⁰¹ For example, Robert Klitzman notes that the concept of "dignity" has not yet received enough attention. While this chapter does not focus on dignity, I believe that the overall argument will tend toward a more dignified role for patients in the clinical setting. See his *When Doctors Become Patients* (Oxford: Oxford University Press, 2008), 306-308. In addition, I view this chapter as adding to the call for more research noted above by developing the contributions of rhetorical theory to the issue of provider/patient interaction in the clinical setting and beyond.

activities of their obese (and other chronic) patients revolves around knowledge and communicative competence. Having the right sort of knowledge “ready to hand” is one aspect of clinical care for chronic diseases; however, the capacity to speak about this knowledge and share it with other practitioners and patients is also important, especially in the context of chronic disease.¹⁰² Knowledge of the terrain of chronic disease and a capacity to speak about it are critical for promoting a praxis capable of addressing the needs of patients in the effort to discover a more fulfilling life.¹⁰³

One way to address the complex problems facing physicians is to discover how physicians themselves think about disease, how they experience it, and how they might think about managing their own lifestyles. If physicians, for whom knowledge about the consequences of unhealthy activities has been ingrained through years of training and experience with ill patients, cannot effectively engage in healthy behaviors on their own, patients face an even more Sisyphean task. Additionally, if physicians must deal with the same sorts of problems facing their patients when making health-related decisions in daily life, then it becomes clear that knowledge alone is inadequate when it comes to the daily treatment of chronic disease.

In his extensive and groundbreaking study of physician experiences with illness, Robert Klitzman opines that in the effort to, “improv[e] doctor-patient relationships and communication, and the healthcare system as a whole, knowledge alone is not enough. Attitudes of physicians

¹⁰² Michel Foucault makes much of this notion of having certain ideas or techniques of life “ready to hand,” a translation of the Greek term *prokheiron ekhien*. See Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège De France 1981-1982*, ed. Frédéric Gros, trans. Graham Burchell (New York: Picador, 2005), 499.

¹⁰³ I have made this claim elsewhere. See John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue, “Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care,” *Health Education & Behavior*, forthcoming.

need to shift as well.”¹⁰⁴ As he analyzed the many narratives about illness shared with him by physicians, Klitzman began to realize that this insight eluded individual physicians until they actually experienced disease, in many cases terminal illness.¹⁰⁵ Addressing this problem, Klitzman suggests that “*Physicians should at least be made more aware of the limitations they confront – from patients’ perspectives. Healers need to realize the impact of their constrained time and resources – how patients at the other end of the stethoscope see their treatments and providers.*”¹⁰⁶ Physicians are often not provided, through traditional curricular means, with the tools needed to understand how their diagnoses, prognostications, and treatments actually impact their patients’ lives. Such perceptions, Klitzman suggests, play an important role in the overall context of care, the extent to which patients feel their needs are being met, and the degree to which patients believe they can deal with their disease conditions.

Klitzman’s study suggests that healthcare providers are frequently not thinking about how they use their medical knowledge (or fail to do so) in their own everyday lives. He argues, “many doctors did not practice what they preached, particularly regarding diet, treatment adherence, and preventive care. Changing unhealthy behavior proved hard. These physicians tended to feel invulnerable, and the demands of medical training facilitated poor health behavior.”¹⁰⁷ It was not until the physicians he interviewed experienced illness that they began to understand these issues. For instance, Klitzman recounts the story of one physician he interviewed who transformed his approach to patient adherence by acknowledging every good

¹⁰⁴ Klitzman, *When Doctors Become Patients*, 307-308.

¹⁰⁵ Klitzman, *When Doctors Become Patients*, 294-296.

¹⁰⁶ Klitzman, *When Doctors Become Patients*, 296.

¹⁰⁷ Klitzman, *When Doctors Become Patients*, 82.

action that his patients took, instead of seeking “100%” success.¹⁰⁸ This new approach emerged from his experience actually trying to change his own lifestyle, his own daily behaviors.¹⁰⁹

Klitzman is not the first to note such a divide between patients and physicians.¹¹⁰ However, he is one of the first to study this problem through direct interviews with sick physicians and with a pedagogical focus in hand. Klitzman’s work is important because he turns to the perspective of the “wounded healer,” one developed by Carl Jung to describe the ways in which healers draw on their own wounds, their own pain, and their own diseases in the construction of their healing practices. His work to uncover the ways that “wounds” can improve the healer’s perspective indicates the powerful role of *experience* in shaping understanding, even for physicians.¹¹¹ To treat patients effectively—particularly those with chronic conditions that require lifestyle change—physicians require a deeper sense of empathy with patients and a better understanding of what it is they go through. Such knowledge is not something easily distributed or learned; in the case of Klitzman’s research participants, it took grave illness to initiate the learning process. Thus, providing such understanding or knowledge, and encouraging empathy, are a major problem for medical education. For practical and ethical reasons, medical schools cannot provide personal illness experiences to trainees. Nevertheless, Klitzman’s work provides not only a realistic appraisal of medical education, but also an alternative way of viewing the issue of adequate medical pedagogy that does not rely on physicians or other practitioners actually becoming ill. Klitzman suggests,

¹⁰⁸ Klitzman, *When Doctors Become Patients*, 285-286.

¹⁰⁹ Klitzman, *When Doctors Become Patients*, 285-286.

¹¹⁰ See e.g., Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 1995); Arthur Kleinman, *The Illness Narratives: Suffering, Healing, & The Human Condition* (Basic Books, 1988).

¹¹¹ Klitzman, *When Doctors Become Patients*, 4-5. Klitzman uses Jung to introduce the concept. For more on the “wounded healer,” see Carl Jung, *The Practice of Psychotherapy: Essays on the Psychology of the Transference and Other Subjects*, 2nd ed., trans. Gerhard Adler and R. F. C. Hull (Princeton: Princeton University Press, 1985).

These doctors [his interviewees] illuminate, too, how and why book and experiential learning differ. As patients, these doctors learned much that they had not fully realized before. Not until now did they truly see and learn what it was like to be in the opposite role. *Illness taught them what books failed to.* Thus, these doctors limned the divide between intellectual and experiential knowledge, and the extent to which experience involves emotions and deeper layers of self. The discrepancies can be vast. Yet awareness of this gap can help bridge it.¹¹²

One of the primary elements of the divide between physicians and their patients has to do with the distinction between “book learning” and “experience” as ways of forming professional and patient roles. Recognizing that distinction and seeking to provide both forms of education to physicians, may help to bridge the physician-patient divide. What many call the “partnership” between chronic patients and their providers cannot be produced through a more refined explanation of chronic care in a textbook or more time spent simply talking about these issues during rounds.¹¹³ Lifestyle change is also not something that chronic patients can come to on their own through the use of manuals and paying close attention to the instructions of their many providers.

Indeed, as Socrates suggests in Plato’s dialogue, the *Phaedrus*, we are not in a position to learn, especially about practical matters such as how to live one’s life, from a text or from the dissemination of information as text. The most effective learning, Plato suggests, comes from the give and take experience of conversation, from the shared effort at coming to knowledge, from the dialectical exchange of teachers and students. While Plato’s corpus never defends experience as the ultimate guide for learning and wisdom, the character Socrates places a high degree of value in an educational platform that valorizes the agonistic relationship between mutually

¹¹² Klitzman, *When Doctors Become Patients*, 274.

¹¹³ See e.g., Bodenheimer, Lorig, Holman, and Grumbach, “Patient Self-management of Chronic Disease in Primary Care,” 2469.

engaged agents committed to their collective moral and intellectual development.¹¹⁴ As such, Socrates provides part of the argument that I wish to make in the next two chapters, that is, we may not learn as much from texts and from calcified principles as we do from people, from our shared worlds. In the *Phaedrus*, Socrates initiates his critique of “book-learning” early when he cajoles Phaedrus for enticing him away from the people and into the country, away from those with whom he might learn through conversation (dialectic):

Forgive me, my good man. You see, I’m a lover of learning, and country places and trees won’t teach me anything, which the good people of the city will. But you seem to have found the prescription to get me to go out. Just like people who lead hungry animals on by waving a branch or some kind of vegetable in front of them, so you seem to me to be going to lead me round all of Attica and wherever else you please by doing as you are now and proffering me speeches in books. In any case, now that I’ve got here, I think I’m going to lie down for the present, and you chose whatever pose you think easiest for reading, and read.¹¹⁵

Of course, any reader of this dialogue knows that Socrates does not really want to listen to Phaedrus read from a book. He actually wants to engage him in conversation, in an experientially rich process of give-and-take argument. Self-care and the emotional and experiential elements that inform this care are a central but often elided element of training practitioners. Perhaps more importantly, patients fail to receive such training. Furthermore, the emotional and experiential elements of such training cannot be conveyed in a single counseling session, in a single manual, or on the page of any text or pamphlet.

Klitzman’s ill physicians learned Socrates’ lesson well.¹¹⁶ Yet physicians need not experience illness in order to gain the attitudes and experiences they need to assist with chronic patient care. What some physicians lack in terms of experience of illness, they may find in the

¹¹⁴ Rubinelli, Schulz, and Nakomoto mention the importance of seeking counsel from expert providers but not of the mutual negotiation of meaning and collaborative learning that may accrue from the provider – patient relationship. Rubinelli, Schulz, and Nakomoto, “Health Literacy,” 310-311.

¹¹⁵ Plato *Phaedrus* 230d4-e4.

¹¹⁶ Klitzman, *When Doctors Become Patients*, 294-296.

experiences of their patients. It is literally the dialectical exchange between physicians and patients that makes possible the experiential learning needed for adequate chronic care. Reevaluation of the kind of knowledge patients have of their own conditions should form the basis of any strategy to reform the roles, modes of learning, and overall orientation of efforts to achieve lifestyle change.¹¹⁷ Physicians, especially healthy ones, need something like Arthur Frank's vision of the patient as "wounded storyteller" who is capable of providing experiential wisdom about her disease and life plan in the formation of adequate treatment.¹¹⁸ Patients should be given space to tell their stories and to have these stories impact both their own conception of their illness and the kinds of therapeutic interventions they and their physicians use throughout the course of an illness. As Frank suggests, "Because stories can heal, the wounded healer and the wounded storyteller are not separate, but are different aspects of the same figure."¹¹⁹ Patients certainly can provide critical health-related information and contextual details that may improve the diagnostic and prognostic activities of their physicians.¹²⁰ In this sense, they act as "data point[s]" in the construction of individualized care.¹²¹ But, they can and should do more. Telling stories is important but so is action. Patients may find themselves in the situation of not just providing narrative resources to physicians, but also becoming caregivers for and of

¹¹⁷ A normative view that I share with Rubinelli, Schulz, and Nakomoto, "Health Literacy," 308.

¹¹⁸ Frank, *The Wounded Storyteller*. A similar view is developed by Rita Charon in her *Narrative Medicine: honoring the Stories of Illness* (Oxford: Oxford University Press, 2006).

¹¹⁹ Frank, *The Wounded Storyteller*, xii.

¹²⁰ On this point, see Jerome Groopman, *How Doctors Think*. In particular, see the story of "Anne Dodge" that begins on the first page and continues throughout the book. Her experience confirms the need for extensive and accurate storytelling by patients and attention to these stories by physicians in order to produce workable diagnoses and treatment plans. Jerome Groopman, *How Doctors Think* (Boston: Houghton Mifflin Company, 2007).

¹²¹ Kathryn Montgomery uses this language to describe the role of patients in the cultivation of physician *phronesis*. Kathryn Montgomery, "Thinking about Thinking: Implications for Patient Safety," *Healthcare Quarterly* 12, special issue (2009): e194. She develops her argument regarding the importance of patient narratives in the construction of clinical knowledge and judgment in her *Doctor's Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991).

themselves.¹²² Thus, self-care emerges from the combined knowledge of providers and their patients. In addition, self-care requires the cultivation of responsible patients who are able to make decisions on a daily basis to improve their health (a subject of chapters 3 and 4).

Klitzman's insights, as well as the research summarized at the beginning of this section, provide a critical starting point for re-engaging the question of defining and framing obesity, this time at the level of the clinical partnership between providers and patients. What is needed is productive interaction between providers who are not unreflectively engaging in the judgments and beliefs about obesity readily available in the public controversy surrounding obesity. In addition, providers will do well to embrace the experiences of patients, to understand their specific definitions and interpretive framings of their own conditions. This will yield not only more effective interactions but also more ethical application of the therapeutic modalities available for the treatment of obesity. We must guard against unreflective replication of the various definitions and frames of obesity described in previous sections. More thorough training and development of more empathetic physician-patient relationships may help to avoid such unreflective replication in clinical encounters. Finally, lifestyle change enhances the role of the patient in their own care, a process that implies both the responsibility and capability to act (a topic that takes center stage in the next chapter). Ultimately, what we have seen is that clinician's adoption of public framings of obesity, and lack of understanding of the experiences of obesity and lifestyle change, can impede effective and ethical treatment of patients by decreasing the likelihood of that clinicians will engage with their patients in the first place or by undermining the goals, aspirations, and needs of specific patients. Indeed, the only productive option left in

¹²² Michel Foucault's work charts the broader issue of self-care under the rubric of "the care of the self" providing a critical and historical account of ancient Greek and Roman texts regarding human sexuality and philosophical education. On this, see especially, Foucault, *The Hermeneutics of the Subject*; Michel Foucault, *The Care of the Self*, vol. 3 of *The History of Sexuality*, trans. Robert Hurley (New York: Vintage Books, 1988).

response to the obesity problem may be to embrace the idea that lifestyle change is an ethically acceptable and effective form of treatment (as suggested in section 2.3), that it must accompany other interventions if they are to be successful, and that patients deserve respectful assistance in the promotion of their own care goals.

2.5 CONCLUSION

This chapter has elucidated empirical and conceptual uncertainties that reside at the heart of the obesity problem. Is obesity truly a health risk? Are there effective treatments for obesity? Does the mere use of the term obesity and the suggestion that it is a health risk simply extend a net of political and medical control into a domain that should be left alone? To what extent do public discourses about obesity influence the provider-patient relationship? What other problems face medical practitioners in attempting to address the obesity problem (and chronic disease in general)? Can providers actually understand what it is like to undergo lifestyle change therapy and provide needed support to their patients without having experienced such therapeutic intervention themselves? Whether the realists or nominalists are finally correct and whether obesity is primarily a medical or political problem are issues that cannot be resolved here. What is clear is that the medical effort to address obesity will not go away, nor will the growing evidence that obesity is at least correlated with disease and early death.

Therefore, I have argued, a conceptual and practical path must be charted that capitalizes upon both the areas of overlap in the realist and nominalist positions detailed throughout the first half of this chapter and the as yet latent prospects for a bioethical treatment of the obesity problem. Building upon this conceptual common ground is a practical path to address the obesity

problem that focuses on lifestyle (e.g., diet and exercise). Charting this path may provide one resolution to the ethical quandaries surrounding obesity. Instead of focusing on weight in public discourse or the clinical setting, elements of both the nominalist and realist positions seem open to the possibility of focusing on how to lead a healthy life regardless of whether weight loss is truly possible and sustainable. This common ground opens up a possibility for potential collaboration between realist and nominalist stakeholders and provides a map for an ethically sound route toward health and wellbeing.¹²³ To this argument already circulating in the literature, I add that focusing on the needs and aspirations of autonomous patients may provide a corrective for the larger ideological forces detailed by the nominalists.¹²⁴ That is, whether or not Saguy and Riley (among others) are ultimately right about the need to shift away from weight in our larger discussions about obesity, we may benefit from a turn to bioethics due to its ability to shape the conversation about obesity differently.¹²⁵ That is, instead of wondering about larger policies or public health interventions, bioethics may reorient us to the primary task of medicine: caring for patients based on their goals and aspirations. This, in turn, may make the question of how obesity is defined and understood a matter for providers and their patients to negotiate as they seek better health outcomes and wellbeing together (chapters 3 and 4).

In the next chapter, I spin out this viewpoint in the context of one term: responsibility. As numerous scholars have already noted, responsibility is one of the key terms in the ongoing contestation over the obesity problem.¹²⁶ Some argue that obese individuals must take responsibility for the ways in which their personal choices influence their weight and health.

¹²³ Saguy and Riley, "Weighing Both Sides," 874.

¹²⁴ This is one element of the "paradigm shift" described and defended by Saguy and Riley. Saguy and Riley, "Weighing Both Sides," 907-912.

¹²⁵ Saguy and Riley, "Weighing Both Sides," 907-911; Campos, Saguy, Ernsberger, Oliver, Gaesser, "The Epidemiology of Overweight and Obesity," 55-60; Glen A. Gaesser, *Big Fat Lies: The Truth About Your Weight and Your Health* (New York: Fawcett Columbine, 2002).

¹²⁶ Saguy and Riley, "Weighing Both Sides," 875 and throughout.

Others argue that the rhetoric of responsibility is itself the problem because it tends to place blame and undermine the sorts of cooperative efforts that will be needed, in the end, to address the obesity problem.¹²⁷ I take a slightly different stance that acknowledges the centrality of responsibility to the obesity problem but that attempts a redefinition of the term that enhances the patient's role in her own care and leaves the question open as to whether obese individuals must seek treatment to address their weight problem (or related health concerns). I also argue that a reworking of the current understanding of responsibility may help to tease out who can and who should take action to address the obesity problem.

¹²⁷ Saguy and Riley, "Weighing Both Sides."

3.0 RE-ARTICULATING RESPONSIBILITY: PUBLIC HEALTH AND CLINICAL APPROACHES

The most promising directions [to address the problem of obesity], I believe, fall into three categories. Strong and most likely somewhat coercive public health measures, mainly by government but also by the business community; childhood prevention programs; and social pressure on the obese.¹

The language of risk not only suggests that intervention may be needed to regulate the body, but it also imparts notions of what is right and wrong, good or bad, normal or abnormal. It serves to pathologize those whose bodies fall outside of the norm by reducing bodily difference to a matter of personal responsibility and choice about lifestyle.²

3.1 INTRODUCTION

As the previous chapters argue, the complicated therapeutic problems and causal factors circulating around obesity and weight loss have produced large-scale debates over the definition of obesity and about the appropriateness of various therapeutic options that might adequately address it at the individual, community, and socio-political levels.³ Thus far, I only briefly note the role that responsibility might play in these debates. The definition of responsibility and its

¹ Daniel Callahan, "Obesity: Chasing and Elusive Epidemic," *The Hastings Center Report* 43, no. 1 (2013): 36.

² Emma Rich and John Evans, "'Fat Ethics' – The Obesity Discourse and Body Politics," *Social Theory & Health* 3 (2005): 341-358.

³ Abigail C. Saguy and Kevin W. Riley, "Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity," *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 869-921.

application to the obesity problem form the subject of this chapter and, in part, the next. Responsibility deserves such extensive treatment because I see it as central to explaining how lifestyle change therapies might be ethically and effectively designed. At the same time, the assignment of responsibility in the context of obese and overweight persons in particular involves risks because certain deployments of responsibility and the material consequences that flow from it may lead us down the path of stigmatization and therapeutic failure, while others may buttress the efforts of autonomous agents to take action to improve their own health and wellbeing.⁴ Furthermore, the locus of responsibility, where it is placed and with what scope, may influence the degree to which a variety of health interventions are deemed ethical, effective, and appropriate, as well as indicate whether a bioethical or public health framework should be applied.⁵

⁴ On the risks of responsibility rhetoric and lifestyle change approaches to obesity treatment, see Saguy and Riley, "Weight Both Sides," 869-921; Rich and Evans, "'Fat Ethics,'" 341-358; Werner J. Cahnman, "The Stigma of Obesity," *The Sociological Quarterly* 9, no. 3 (1968): 283-299; William DeJong, "The Stigma of Obesity: The Consequences of Naïve Assumptions Concerning the Causes of Physical Deviance," *Journal of Health and Social Behavior* 21 (1980): 75-87; Rebecca M. Puhl and Chelsea A. Heuer, "Obesity Stigma: Important Considerations for Public Health," *American Journal of Public Health* 100, no. 6 (2010): 1019-1028; Rebecca M. Puhl and Chelsea A. Heuer, "The Stigma of Obesity: A Review and update," *Obesity* 17 (2009): 941-964. On the issue of foisting responsibility for health problems (among others) onto individuals and its deleterious political and social consequences, see Dana L. Cloud, *Control and Consolation in American Culture and Politics: Rhetorics of Therapy* (Thousand Oaks: Sage Publications, 1998); Joanna Zylinska, *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009); Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: University of North Carolina Press, 2003).

⁵ On the relationship between bioethics and responsibility and the degree to which the "public interest" should play a role in determining ethical and effective approaches to public health, see e.g., Fabrizio Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," *American Journal of Public Health* 99, no. 7 (2009): 1197-1202; Daniel Callahan and Bruce Jennings, "Ethics and Public Health: Forging a Strong Relationship," *American Journal of Public Health* 92, no. 2 (2002): 169-176; Betty Wolder Levin and Alan R. Fleischman, "Public Health and Bioethics: The Benefits of Collaboration," *American Journal of Public Health* 92, no. 2 (2002): 165-167; James F. Childress, Ruth R. Faden, Ruth D. Gaare, Lawrence O. Gostin, Jeffrey Kahn, Richard J. Bonnie, Nancy E. Kass, Anna C. Mastroianni, Jonathon D. Moreno, and Phillip Nieburg, "Public Health Ethics: Mapping the Terrain," *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 170-178; Onora O'Neill, "Public Health or Clinical Ethics: Thinking Beyond Borders," *Ethics & International Affairs* 16, no. 2 (2002): 35-45; R.E.G. Upshur, "Principles for the Justification of Public Health Intervention," *Canadian Journal of Public Health* (March/April, 2002): 101-103.

While I will mention various public health approaches to the obesity problem throughout this chapter, my primary interest is to shift the discussion about obesity back to the clinical setting. I am invested in this shift because I view it as a productive trajectory for the development of an ethics of obesity care rooted in the caring relationship between providers and patients (a topic for further development in chapter 3).⁶ Furthermore, given the high volume of research done to address obesity in the public health domain, shifting attention back to bioethics and how its tools might be adapted to the obesity problem in the clinical context fills an important gap in the current literature (especially when adding in the questions of responsibility and lifestyle change therapy).

The way the issue of responsibility is generally presented in the context of the obesity problem depends on the assumed causal linkages between obesity, health, and the therapeutic modalities that might be used to achieve weight loss or promote a healthier lifestyle.⁷ If policymakers and healthcare professionals locate the problem on an individual level, then they tend to locate the solution on an individual level. In this case, the individual would be viewed as the primary caregiver of and for the self who should take action to lose weight on her own (of course, with the help of a trusted medical professional) or seek specific kinds of intervention such as weight loss surgery. If communities or even larger institutions are implicated in the production of obesity, then they should take action.⁸ If a kind of shared responsibility is identified, in which multiple groups and individuals play a role in addressing the problem, then a

⁶ Joan C. Tronto, "An Ethics of Care," in *Ethics in Community-Based Elder Care*, ed. Martha B. Holstein and Phyllis B. Mitzen (New York: Springer Publishing Company, Inc., 2001), 60-68.

⁷ Paul Campos, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser, "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic," *International Journal of Epidemiology* 35 (2006): 55-60.

⁸ This is a central element of public health ethics and the interventions it develops in response to population level disease risks. See FN 5. See also Abigail C. Saguy and Kevin W. Riley, "Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity," *Journal of Health Politics, Policy, and Law* 30, no. 5 (2005): 888.

primary concern is to develop a method or some set of criteria for establishing who should be responsible and for what element(s) of the problem.⁹

In each case, locating the problem and the individuals or groups that are responsible for it is primarily an ethical endeavor, one that involves determining the extent to which an individual or group of individuals has some obligation to resolve or otherwise manage a problem or its contributing elements.¹⁰ So, in each of the locutions above, I have used the term “should” to indicate that assignment of responsibility almost always involves some element of judgment either regarding someone’s causal or contributory role in creating a problem, or someone’s breach of a social norm that then results in the problem. In either case, identifying that causal or norm-breaching party suggests that the party play a role in the problem’s potential solution.¹¹ Put another way, responsibility is often established through rhetorical work that engages in practices of other-oriented blaming, self-blame, other-oriented correcting, and self-correction.¹² In some cases, responsibility can carry with it a kind of moral judgment about the individual or group of individuals found to be blameworthy.¹³ Such judgments, regardless of the individual or group found responsible, indicate the need for the individual or larger network of individuals to take some kind of action to address the harms caused or to face some form of punishment or

⁹ Tuoldo, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202.

¹⁰ Cloud, *Control and Consolation in American Culture and Politics*; Zylinska, *Bioethics in the Age of New Media*, Feudtner, *Bittersweet*.

¹¹ Marina A.L. Oshana, “Ascriptions of Responsibility,” *American Philosophical Quarterly* 34, no. 1 (1997): 71-83; Kurt Baier, “Moral and Legal Responsibility,” in *Medical Innovation and Bad Outcomes: Legal, Social and Ethical Responses*, ed. Mark Siegler, Stephen Toulmin, Frank E. Zimring, and Kenneth F. Schaffner, (Ann Arbor: Health Administration Press, 1987), 101-130.

¹² On the “ascription” view of responsibility, see Oshana, “Ascriptions of Responsibility,” 71-83; Baier, “Moral and Legal Responsibility,” 101-130.

¹³ Saguy and Riley, “Weighing Both Sides,” 869-921; Rich and Evans, ““Fat Ethics,”” 341-358; Campos, Saguy, Ernsberger, Oliver, Gaesser, “The Epidemiology of Overweight and Obesity,” 55-60; Oshana, “Ascriptions of Responsibility,” 71-83; Baier, “Moral and Legal Responsibility,” 101-130.

consequence, whether coercive or implied.¹⁴ This common view of responsibility as an “ascription” of a causal role in or obligation to address a problem is useful in certain domains, especially when one is attempting to determine guilt or liability in a court of law.¹⁵ However, in this chapter, I seek to move beyond these simplistic coordinates and suggest that in the context of the obesity problem, responsibility may have a much more nuanced and productive role to play not in terms of assigning guilt but rather in terms of cultivating individual empowerment.

Thus, I begin this chapter with a question: what possibilities exist for a bioethical conception of responsibility that addresses the obesity problem? Based on the common view of responsibility briefly sketched above, one can imagine a situation in which individuals are held responsible, are saddled with guilt, and are then scapegoated all in the name of the greater good.¹⁶ Alternatively, it is possible to imagine collectivities or larger institutions being found responsible for the obesity problem; however, this may lead, ultimately, to the displacement of responsibility onto larger social mechanisms or institutions whose role in the production of obese bodies is partial and whose action may be insufficient in terms of ameliorating the health effects

¹⁴ Oshana, “Ascriptions of Responsibility,” 71-83; Baier, “Moral and Legal Responsibility,” 101-130. In addition, such modes of management are of course situated and have more to do with normalization and self-discipline than anything else. Foucault argues that power does its work “at its extremities, in its ultimate destinations, with those points where it becomes capillary, that is, in its more regional and local forms and institutions.” Michel Foucault, “Two Lectures,” in *Power/Knowledge: Selected Interviews & Other Writings 1972-1977*, ed. Colin Gordon (New York: Pantheon Books, 1980), 96.

¹⁵ Oshana, “Ascriptions of Responsibility,” 71-83; Baier, “Moral and Legal Responsibility,” 101-130.

¹⁶ This is a view largely defended by Daniel Callahan, aside from the admission that it leads to scapegoating. See Daniel Callahan, “Obesity,” 34-40; Daniel Callahan, “Private Choice and Common Good,” *The Hastings Center Report* 24, no. 3 (1994): 28-31. On the risks of viewing individuals as somehow beholden to the needs of the broader community, see Teresa Iglesias, “Bedrock truths and the dignity of the individual,” *Logos* 4, no. 1 (2001): 114-134. For an excellent discussion of the “scapegoat function” in public discourse, see Kenneth Burke, “The Rhetoric of Hitler’s Battle,” in his *The Philosophy of Literary Form: Studies in Symbolic Action, 3rd Edition* (Berkeley: University of California Press, 1973), 191-220. Also see Kara Shultz, “Every Implanted Child a Star (and Some Other Failures): Guilt and Shame in the Cochlear Implant Debate,” *Quarterly Journal of Speech* 86, no. 3 (2000): 251-275.

and social degradation wrought by ill health.¹⁷ Making a decision between these two extremes is dangerous because it may tend to push society (and the individual members that make it up) in directions that are more or less therapeutically effective and more or less ethical. Thus, this chapter does not imagine finding a single solution to the question of responsibility. Instead, it opens up a dialogue with the bioethics and public health literatures in order to investigate the various approaches to determining or otherwise assigning responsibility in the context of the obesity problem.

In the sections that follow, I first discuss two principles of bioethics that play a determinative role in my unfolding of the concept of responsibility.¹⁸ I then describe the basic understanding of responsibility as a determination of “cause” and “accountability” currently available in the literature.¹⁹ Using the definitions of responsibility and the principles of bioethics previously described, I then move directly into a discussion of the distinction between public health and bioethical approaches to responsibility in addressing the obesity problem. Here, I add an option not yet fully developed but quite important for the development of a bioethical approach to the concept (i.e., “capability”-building).²⁰ In the final section, I argue that responsibility can be rearticulated in order to promote an agency-centered approach to health and wellbeing in the context of obesity.

¹⁷ As Callahan rightly points out, many of the efforts to address the obesity problem have produced few if any reductions in its prevalence. See Callahan, “Obesity,” 34-40.

¹⁸ Turolto mentions these principles as critical to the development of a conception of responsibility that combines public health and bioethical concerns. I utilize them here as well, but the trajectory of my argument works in the opposite direction (continue reading). Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1198.

¹⁹ Oshana, “Ascriptions of Responsibility,” 71-83; Baier, “Moral and Legal Responsibility,” 101-130.

²⁰ I am using the term “capability” following Martha Nussbaum in her discussion of the “capability theory.” On this, see Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2001), 418. This view is also developed in her book *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000). The only literature directly addressing the notion of “responsibility as capability” that I have found in the literature has to do with corporate responsibility. See Leeora D. Black, “Corporate Social Responsibility as Capability: The Case of BHP Billiton,” *Journal of Corporate Citizenship* (Autumn, 2006): 25-38.

Finally, and to clarify the primary trajectory of this chapter, the view of responsibility I tend toward throughout is not necessarily exclusive of other options and does not render them entirely moot. My point is to argue for a conception of responsibility that is useful and workable in the context of bioethics and, in particular, the therapeutic relationship between providers and patients who seek care for their health problems. I move in this direction because, as I have said before, it is an underdeveloped area in the overall discussion about obesity. Furthermore, given the increasing importance of public health and population-based strategies in addressing the obesity problem, it is time to carve out space for a more clinically oriented approach to the ethics of obesity care.

3.2 THE ROLE OF BIOETHICAL PRINCIPLES IN THE CONSTRUCTION OF A CONCEPT OF RESPONSIBILITY: AUTONOMY AND BENEFICENCE

While my method in this chapter, as in past chapters, remains skeptical and open-ended, I do begin with a basic assumption about the role that responsibility should play in a bioethical account of the obesity problem. My view is that bioethicists must take care that the activities of healthcare professionals lead to agency-enabling and healthy action and that they do not erode the autonomous decision-making powers of reasoning agents.²¹ This is a central element of bioethics and one that should remain, in my opinion, sacrosanct. As Tom L. Beauchamp and James F. Childress write,

²¹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009), 103; Faden, Ruth R. and Tom L. Beauchamp. *A History and Theory of Informed Consent*. Oxford: Oxford University Press, 1986; Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (New York: Cambridge University Press, 1990).

To respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their personal values and beliefs. Such respect involves respectful *action*, not merely a respectful *attitude*. It requires more than noninterference in others' personal affairs. It includes, in some contexts, building up or maintaining others' capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt autonomous action. Respect, in this account, involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, demean, or are inattentive to others' rights of autonomous action.²²

In this passage, respect for autonomy is described as both an “action” and an “attitude.” This is critically important in the context of the obesity problem. When considering how to apply the concept of responsibility and whom we should hold responsible, the action must be tempered with the right attitude. As Kenneth Burke points out, “attitude” is something that we portray not simply in actions but in words and the wider world of symbolic creation.²³ This brings back the importance of the art of rhetoric in my overall project. As I unfold my account of responsibility, certain actions will be deemed appropriate and acceptable but so too will the attitudes with which these actions are undertaken both in terms of intention and in terms of rhetorical framing.²⁴ The attitude with which providers approach their obese patients is an essential element in my account, particularly given the need to carefully avoid any action that would tend in the direction of stigmatization. Avoiding stigmatizing attitudes seems to be at the heart of the nominalist position on obesity and indicates the degree to which attitude is an important ingredient for at least some obese individuals in the adequate provision of care (chapter 2).

²² Beauchamp and Childress, *Principles of Biomedical Ethics*, 103.

²³ Kenneth Burke, *Attitudes Toward History*, 3rd ed. (Berkeley: University of California Press, 1937/1984); Kenneth Burke, *The Philosophy of Literary Form: Studies in Symbolic Action*. 3rd ed. (Berkeley: University of California Press, 1973).

²⁴ This point builds on the work previously done in chapters 1 and 2 to suggest just how important rhetorical action is in the cultivation of bioethics. John Lyne, “Contours of Intervention: How Rhetoric Matters to Biomedicine,” *Journal of Medical Humanities* 22, no. 1 (2001): 3-13.

Furthermore, Beauchamp and Childress go on to underscore the degree to which the principle of respect for autonomy is bidirectional. That is, it includes a “*negative* obligation” to avoid “controlling constraints by others” and a “*positive* obligation” to “foster autonomous decision making.”²⁵ Thus, the principle requires both an effort to protect individual patients from inappropriate uses of authority or impediments to their choice-making and also an effort to help individual patients where possible to exercise this autonomy by requiring “professionals in healthcare and research involving human subjects to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision making.”²⁶ Take note especially of the term “voluntariness” in this passage. It will also be my argument that we should do all we can to maintain such voluntariness as opposed to the simpler tactic of taking choices away, a point made in a recent editorial in the *New England Journal of Medicine* by David R. Just and Brian Wansink.²⁷

Especially given the increasing public interest in managing obesity, I should note here that the principle of respect for autonomy “will incorporate valid exceptions.”²⁸ For example, Beauchamp and Childress argue that “if our choices endanger the public health, potentially harm innocent others, or require a scarce resource for which no funds are available, others can justifiably restrict our exercises of autonomy.”²⁹ My view is that these exceptions should be few and far between. They must also be based not simply on one viewpoint but rather on an intermingling of social, individual, and medical views.³⁰ As Franklin G. Miller and Howard

²⁵ Beauchamp and Childress, *Principles of Biomedical Ethics*, 104.

²⁶ Beauchamp and Childress, *Principles of Biomedical Ethics*, 104.

²⁷ David R. Just and Brian Wansink, “Do Not Support Regulation of Sugar-Sweetened Beverages,” *New England Journal of Medicine* 367, no. 15 (2012): 1465-1466.

²⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, 104.

²⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 105.

³⁰ The “integrative perspective” defended by Saguy and Riley. See Saguy and Riley, “Weighing Both Sides,” 874.

Brody contend, our goal should be “accommodating and balancing values and norms proper to medicine with the common morality external to medicine in light of changing conditions of social life. As in the case of any evolving tradition, the debate over medical morality calls for continuity and adaptation.”³¹ However, in accepting Miller and Brody’s view, I do not recommend playing fast and loose with this artful “balancing.” Instead, the process of balancing and the final decision about how it is to be achieved in any particular case should be carefully scrutinized and open to revision, a point with which I think they would probably agree.

Furthermore, in balancing such views, we should not imagine that because we are working from one point of view, it should hold sway over others. That is, even if healthcare practitioners and policy-makers think individuals are wrong about their preferences, we should not, as George Sher, Lisa Parker, and Susan Wolf have variously argued, give up on the idea that such individuals are autonomous agents capable of making their own decisions. Likewise, following these authors, we should not imagine that simply because there are many social pressures in the world, that it is impossible to hold a view or preference outside of or in spite of these pressures.³² Thus, the concept of responsibility developed here must follow through on the important project of finding a way to ethically treat obese patients but must also remain true to their autonomy. Doing so will require traversing and managing the fraught terrain between public health and clinical approaches to obesity (as detailed in chapter 2 and below).³³

Moreover, this task will also require a reworking of the roles of bioethicists and clinicians in the promotion of health when responding to the obesity problem. This brings me to the second

³¹ Franklin G. Miller and Howard Brody, “The Internal Morality of Medicine: An Evolutionary Perspective,” *Journal of Philosophy and Medicine* 26, no. 6 (2001): 598.

³² Parker, Lisa S. “Breast Cancer Genetic Screening and Critical Bioethics’ Gaze.” *Journal of Medicine and Philosophy* 20 (1995): 313-337; George Sher, “Our Preferences, Ourselves,” *Philosophy and Public Affairs* 12, no. 1 (1983): 34-50; Susan Wolf, “The Importance of Free Will,” *Mind* 90 (1981): 386-405.

³³ Turolto attempts to manage this terrain by moving in the direction of public health. I move in the opposite direction. Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202.

of the principles of bioethics that must be addressed in this analysis: beneficence.³⁴ As Beauchamp and Childress point out, “morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contribute to their welfare.”³⁵ In other words, based on the principle of beneficence, “agents must take positive steps to help others, not merely refrain from harmful acts.”³⁶ Of course, this means that “agents” or, in this case, providers, are bound to do more than simply follow through on the wishes of their patients. They must also take positive steps to promote their wellbeing. In fact, as Beauchamp and Childress argue, the principle of beneficence potentially allows for provider paternalism in the provision of patient welfare given certain conditions:

Accordingly, the most plausible justification of paternalistic actions places benefit on a scale with autonomy interests and balances both: As a person’s interests in autonomy increase and the benefits for that person decrease, the justification of paternalistic action becomes less plausible; conversely, as the benefits for a person increase and that person’s autonomy interests decrease, the justification of paternalistic action becomes more plausible.³⁷

Using this basic reasoning, many have argued that the health risks associated with obesity justify some level of paternalism, some amount of pressure to change the activities of others.³⁸ What’s more, as Fabrizio Turolto suggests, autonomy and beneficence provide grounding for patient and provider interests respectively, thus requiring an act of balancing:

The physician acts for the good of the patient, and his or her ethical point of view is prevalently oriented toward the principle of beneficence. By contrast, autonomy is a value claimed by patients who want to be able to establish what is in their interests and not simply undergo that which the physician considers best.³⁹

³⁴ Beauchamp and Childress, *Principles of Biomedical Ethics*, 197-239.

³⁵ Beauchamp and Childress, *Principles of Biomedical Ethics*, 197.

³⁶ Beauchamp and Childress, *Principles of Biomedical Ethics*, 197.

³⁷ Beauchamp and Childress, *Principles of Biomedical Ethics*, 214.

³⁸ Most notably Callahan in “Obesity,” 34-40; Beauchamp and Childress, *Principles of Biomedical Ethics*,

³⁹ Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197.

This tension between autonomy and beneficence, as Turoldo notes, is a critical starting point for understanding the distinction between public health and bioethics.⁴⁰ The degree to which medical providers and public health advocates are required to intervene into the choices of their patients increases the more that one takes a population-based view. For this reason, it will be of concern throughout the rest of this chapter. Despite the need to find balance, I also depend on the claim that promoting autonomy is itself a beneficent act, one that we should praise and support wherever possible. Thus, we again return to my skeptical attitude toward efforts to expand medical authority.⁴¹

Taking into account these two principles (although I am sure others would be of interest here as well), I argue that any concept of responsibility used in the clinical domain and sanctioned by bioethics must attend to the tension between autonomy and beneficence and must do so in a way that is distinct from the kinds of arguments made in the domain of public health.⁴² This is so because, as I have said before, in bioethics our concern is with the patient and his or her adequate care.⁴³ For these reasons, I argue that instead of scapegoating and displacement, both negative implementations of responsibility, responsibility should be a positive (as opposed to punitive or consequential) and productive (as opposed to socially disabling) concept.⁴⁴ I further argue, in agreement with previous scholarship addressing the meaning and use of the concept of responsibility, that taking responsibility for those things one can control and that fit into one's overall life goals and plan can be an important socio-cultural convention that helps to

⁴⁰ Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1198.

⁴¹ Feudtner, *Bittersweet*; Zylinska, *Bioethics in the Age of New Media*; Jonathon M. Metzl and Anna Kirkland, eds. *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

⁴² Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1202.

⁴³ Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of Helping and Healing Professions," *Journal of Medicine and Philosophy*, 26, no. 6 (2001): 559-579.

⁴⁴ Saguy and Riley, "Weighing Both Sides," 869-921; Kenneth Burke, "The Rhetoric of Hitler's Battle," 191-220.

focus our efforts to address harm, health, and wellbeing in cooperative and agency-enabling ways.⁴⁵

What is of great import here is how responsibility ends up being defined and employed in any given situation. If understood as a negative judgment that is coercively engaged to change the actions of individual obese or overweight persons, it may play a negative social role and extend what Donald Cameron Ainslie has called a sort of “managerialism” that seeks to control and even dominate the decision making of individuals.⁴⁶ Alternatively, if responsibility is understood as the individual’s variable power over her own decisions and environment, it provides a way to think about the role of the individual as an autonomous, voluntary, choice-making agent who, based on her own wishes and her sense of the good life, can take action to resolve or otherwise manage her weight and other health-related problems. This could promote a positive conception of responsibility that transcends common discussions of the term. It is this final version of responsibility that I end up defending over the course of this chapter and the next. It is the version that appears most consistent with the bioethical commitment to autonomy and the ethics of the provider-patient relationship. As such, it offers the best hope for overcoming the negative consequences and epistemological lacunae that exist within and among the various definitional disputes, “frame conflicts,” and negative physician attitudes that currently plague efforts to craft an ethically sound, clinically effective, and publically acceptable response to obesity.⁴⁷ Thus, the rest of this chapter investigates the question of responsibility

⁴⁵ In this, I stand largely in agreement with Baier. Baier, “Moral and Legal Responsibility,” 101.

⁴⁶ Donald Cameron Ainslie, “Redefining Bioethics in the Age of AIDS” (MA thesis, Center for Bioethics and Health Law, University of Pittsburgh, 1996).

⁴⁷ Saguy and Riley, “Weighing Both Sides,” 869-921; Rich and Evans, “Fat Ethics,” 341-358; Gordon R. Mitchell and Kathleen M. McTigue, “The U.S. Obesity ‘Epidemic’: Metaphor, Method, or Madness,” *Social Epistemology* 21, no. 4 (2007): 391-423; Donald A. Schön, “Generative metaphor: A perspective on problem-setting in social policy,” in *Metaphor and Thought*, ed. A. Ortony. 2nd ed. (Cambridge, MA: Cambridge University Press, 1993), 137-163.

with regard to obesity as a bodily state in the context of the clinical relationship between provider and patient (or, healthcare team and patient), as well as in the wider context of obesity management involving both individuals who are obese and the relational networks and social and legal institutions that surround them.⁴⁸

3.3 DEFINING AND DEPLOYING “RESPONSIBILITY”

Ascribing responsibility is part of a much broader social practice whose overall aim is to minimize the mutual infliction of harm, loss, or damage, to maximize desirable mutual help in attaining personal ends, and, when necessary, to provide adequate redress. Achieving these aims depends on causal knowledge. We must know what sorts of events bring about or prevent what sorts of harm; we must know how to intervene suitably in the natural course of events so as to prevent such harm or avoid bringing it about; and we must know how suitably to allocate this task of intervening.⁴⁹

In this section, I unpack several layers of the meaning of responsibility including the basic notions of “causation” and “accountability,” public health accounts of the meaning of responsibility, and, finally, a different path that accords with the bioethical principles I have outlined in the previous section.⁵⁰ As Baier points out in the quotation above, responsibility is a “social practice” that allows us to determine how to address harm by locating the individuals that

⁴⁸ On the relational network of the chronic patient (certainly applicable to the situation faced by obese and overweight individuals), see Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, “Patient self-management of chronic disease in primary care,” *Journal of the American Medical Association*, 288 no. 19 (2002): 2469-2475; Edward H. Wagner, “Chronic disease management: What will it take to improve care for chronic illness?” *Effective Clinical Practice*, 1, no. 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, “Improving chronic illness care: Translating evidence into action,” *Health Affairs (Millwood)*, 20, no. 6 (2001): 64-78. Here, I am also drawing on Hannah Arendt’s understanding of the relational bonds between humans in the cultivation of “action.” Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958).

⁴⁹ Baier, “Moral and Legal Responsibility,” 101.

⁵⁰ Oshana, “Ascriptions of Responsibility,” 71-83.

can take action to resolve, ameliorate, or avoid it.⁵¹ While this seems to be the singular focus of all accounts of responsibility in the philosophical and public health literature, I rearticulate it in the context of autonomy and beneficence, the two bioethical principles that most substantially inform the provider-patient relationship. Thus, I will put pressure on the notion of responsibility as “social practice” and instead move into the realm of responsibility as a form of self-cultivation and the development of “capability” to achieve one’s goals.⁵²

Before I proceed, I should note that the development of the concept of responsibility in the history of philosophy is beyond the reach of these sections. Instead, I work through various contemporary approaches to understanding what we mean when applying the term responsibility to agents. I then offer what I view as a new way to understand the concept of responsibility that avoids the potential pitfalls noted by the nominalists discussed in chapter 2, especially stigmatization and the ongoing contestation over the meaning of obesity and its appropriate treatment. I do this by imagining a role for responsibility that comes into play only after an individual has made the choice to engage in some form of lifestyle change therapy because it accords with their goals. This will set up the arguments I make in chapter 4 about the ethics of lifestyle change therapy and its relationship to responsibility.

3.2.1 Philosophical Approaches to Responsibility: Causation, Accountability, and Agency

Understanding the role of responsibility in the context of the obesity problem requires unpacking both its common understanding in the philosophical literature and its application in the context of

⁵¹ Baier, “Moral and Legal Responsibility,” 101.

⁵² Nussbaum, *Upheavals of Thought*; Nussbaum, *Women and Human Development*; Martha Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 2003).

public health and clinical care. Thus, this sub-section outlines the elements of two contemporary philosophical approaches to defining and applying responsibility as developed by Marina A. L. Oshana and Kurt Baier.⁵³ Both provide accounts of responsibility that flesh out three critical components of the meaning of the term: causation, “accountability” (Oshana’s term), and agency. In addition, Baier articulates a taxonomy of various approaches to defining and applying the term responsibility to which I will refer throughout the rest of this chapter. I proceed by unpacking the contributions of each theorist in turn. In the next section, I connect these philosophical conceptions of responsibility to those that are currently being applied in the public health approach to the obesity problem and suggest an alternative that lines up with a bioethical approach rooted in the principles discussed in the previous section of this chapter.

In its most basic application, when we say that someone or something is responsible for some outcome, what we mean by this is that he, she, or it is the proximate cause of this outcome and that this outcome is harmful in some way to others.⁵⁴ Of course, it is possible to say that someone is responsible for some good outcome in the world, but the general tendency of the term is toward judgment, social sanction, and obligation.⁵⁵ This understanding of responsibility is based on a common understanding of causality, primarily that agents and objects can be said to *cause* certain outcomes.⁵⁶ However, as we shall see, the notion of causation cannot stand on its own in meting out determinations of responsibility. This is so because causation does not in itself imply the quality of the outcome or the thing that is its cause.

Oshana’s view of responsibility, what she terms an “accountability approach” relies on causation but moves beyond its determination in order to deal with the problem described in the

⁵³ Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

⁵⁴ Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

⁵⁵ Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

⁵⁶ Baier, “Moral and Legal Responsibility,” 101; Oshana, “Ascriptions of Responsibility,” 71.

previous paragraph.⁵⁷ Regarding causation, Oshana notes, “According to causal agency analysis, responsibility ascriptions credit a person (or a thing) with a role in bringing about an event or state of affairs, and nothing more. Ascribing causal responsibility consists in identifying the factor that must actually operate in order for an event to transpire.”⁵⁸ That is, the basic starting point for understanding the meaning of responsibility is rooted in some determination of cause whether by a thing or a person.⁵⁹ However, Oshana rightly argues that such a causal approach is limited in fully conceptualizing responsibility. She proffers three arguments. First, she argues that a determination of cause is not in itself sufficient to “say that the agent can be *held* morally responsible, or can be responsible to someone.”⁶⁰ As she points out, there are things and agents in the world whom we cannot rightly hold responsible either because they are not human and thus do not meet the basic parameters of moral agency or because they are not competent to be held responsible.⁶¹ She further contends that causation does not “allow for moral evaluation.”⁶² That is, we cannot necessarily judge someone as “good or bad, praiseworthy or blameworthy” simply based on our belief that they have caused an outcome.⁶³ Finally, she contends that determining causation “does not single out a class of things that might properly be described as moral agents, or members of a moral community.”⁶⁴ That is, simply following through on an adequate analysis of causation does not provide us with any information that might allow us to determine who has moral agency or how the community involved should mete out its judgments,

⁵⁷ Oshana, “Ascriptions of Responsibility,” 71-83.

⁵⁸ Oshana, “Ascriptions of Responsibility,” 72.

⁵⁹ Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

⁶⁰ Oshana, “Ascriptions of Responsibility,” 72.

⁶¹ Oshana, “Ascriptions of Responsibility,” 72. Her examples are children and animals. More to the point in terms of bioethics would be those deemed incompetent to make their own decisions; however, in this case, we would not be speaking of causation but rather of responsibility as ability to make choices on one’s own behalf. See Buchanan cite.

⁶² Oshana, “Ascriptions of Responsibility,” 72.

⁶³ Oshana, “Ascriptions of Responsibility,” 72.

⁶⁴ Oshana, “Ascriptions of Responsibility,” 73.

punishments, or other corrective activities. Thus, following Oshana, some notion of moral agency and the existence of a moral community must be posited in order to fully define and apply responsibility in any given context.

Recognizing some of the problems with causal accounts of responsibility, Oshana articulates a notion of “accountability” that she feels is a more accurate representation of “what is meant by ascriptions of responsibility.”⁶⁵ For Oshana, “when we say a person is morally responsible for something, we are essentially saying that the person did or caused some act (or exhibits some trait of character) for which it is *fitting that she give an account*.”⁶⁶ She goes on to suggest that, “a person is responsible for an act if and only if it ought to be the case that the person account for her behavior, where doing so involves giving some statement of the person’s beliefs or intentions regarding the act.”⁶⁷ Thus, according to Oshana, responsibility involves more than the cultivation of some causal story. Of course, individuals must be seen as somehow involved in bringing about the state of affairs for which they are being held accountable. However, there must be some added element in the determination of responsibility that includes attention to whether or not the state of affairs or outcome that has occurred is *worthy* of an “account.”⁶⁸

Oshana’s perspective is developed with a background assumption that stands at the heart of moral and ethical analysis in general. As briefly noted above, in order to determine whether “it is fitting that [the agent] give an account” (or, be held responsible), there must be some

⁶⁵ Oshana, “Ascriptions of Responsibility,” 80.

⁶⁶ Oshana, “Ascriptions of Responsibility,” 77. Emphasis added.

⁶⁷ Oshana, “Ascriptions of Responsibility,” 77.

⁶⁸ Oshana, “Ascriptions of Responsibility,” 71-83. It is unclear to me whether Oshana means that individuals should simply provide an “account” for what they have done (this seems to be the case in passages quoted above) or whether “account” might mean something more as in make amends (that is, to make payment or accept punishment). This seems to be the logical extension of her argument and is one that Baier develops as well. Baier, “Moral and Legal Responsibility,” 101-130.

framework in place to define and apply moral agency to the individual and place her within a larger community from whose perspective her actions may be evaluated.⁶⁹ Oshana describes such a framework in three parts:

In judging that an account ought to be given, we presume that the individual from whom an account is expected has (a) antecedently met the requirements of responsible agency, and (b) has performed some act (or has exhibited some characteristic) of the sort subject to certain accepted standards of morality and, (c) typically has fallen short of these standards.⁷⁰

That is, we cannot adequately determine whether someone is responsible or “accountable” if there is no background moral community of which an individual is a member and to which one owes an explanation or some other “account” of her actions given a perceived violation. Oshana does not directly deal with the issue of how one can account for this background moral community; however, it is a highly relevant and complicated problem in the literature. For example, various conceptions of morality are often posited or implicitly accepted by those who make arguments grounded in responsibility.⁷¹ The degree to which such conceptions are implicit and not necessarily established either as fact or as a necessary good may tend to undermine or otherwise render questionable some notions of responsibility. We will see this at play in the next section when I unpack various public health approaches that rely on notions of responsibility for their justification.

Kurt Baier offers an account of responsibility that is largely in keeping with Oshana’s.⁷² I detail Baier’s arguments here because, in addition to developing similar arguments to those presented by Oshana, he also provides a nice taxonomy of different forms of responsibility from

⁶⁹ Oshana, “Ascriptions of Responsibility,” 77.

⁷⁰ Oshana, “Ascriptions of Responsibility,” 77.

⁷¹ See e.g., Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202; Callahan, “Obesity,” 34-40.

⁷² Baier, “Moral and Legal Responsibility,” 101-130.

which I will draw extensively throughout the rest of this chapter. Baier begins with what he calls “thing-responsibility” which is, in large part, the name for the specific causal element, the thing that has caused an outcome in itself, or the “culprit.”⁷³ He suggests that, “the general purpose of identifying such a culprit is to prevent future damage” and is “similar to identifying cause.”⁷⁴ That is, according to Baier, one way to think about responsibility is to attach it to a notion of causation and to find the “thing” that is the cause of the state of affairs or outcome we are most interested in addressing.⁷⁵ This method for determining responsibility is rooted in what Baier terms a “backward-looking” orientation.⁷⁶ He applies this orientation not only to “things” but also to “agents” and suggests that “agent-responsibility” accepts the basic assumption that “human beings cannot only be blamed, they can be found *blameworthy*; not only have faults, but be at *fault*; and not only be due for repair but be *culpable* and deserving of *condemnation* or *punishment* or liable to payment of damages.”⁷⁷ That is, while things can cause a particular outcome and can thus be blamed for it, they cannot “be found *blameworthy*.” This is the special domain of human agents who are capable of making choices and being corrected for choices they have made. Where one might simply change a thing, for example, improve the functioning of safety belts that are causing injury to car passengers, finding a person blameworthy might entail a variety of moral and legal actions that would in various ways hold them, as Oshana suggests, accountable.⁷⁸ Baier calls this element of human agency “answerability.”⁷⁹

⁷³ Baier, “Moral and Legal Responsibility,” 103.

⁷⁴ Baier, “Moral and Legal Responsibility,” 103.

⁷⁵ Baier, “Moral and Legal Responsibility,” 103.

⁷⁶ Baier, “Moral and Legal Responsibility,” 103.

⁷⁷ Baier, “Moral and Legal Responsibility,” 103.

⁷⁸ Oshana, “Ascriptions of Responsibility,” 71-83.

⁷⁹ Baier, “Moral and Legal Responsibility,” 105.

Baier describes a special form of “agent-responsibility” that he calls “task-responsibility” which “may be a duty, an obligation, or a responsibility in the forward-looking sense.”⁸⁰ In doing so, he articulates a view of responsibility grounded in the duties we have to both one another and ourselves. However, as Baier points out, “task-responsibility” is not simply a general duty to the community, such as “one must not lie” but instead implies that the duty must “be performed for a particular end or purpose . . . without requiring that it be attained by particular means.”⁸¹ He then describes various professional duties one may have that could be called “task-responsibilities,” including the duty of a “ship’s captain . . . for the safety of passengers, a ship’s doctor for their health.”⁸² Whether we accept Baier’s narrow definition of the term “task-responsibility” we can see in it the rudiments of a slightly different conception of responsibility than that proffered by Oshana.⁸³ This “forward-looking” version of responsibility is grounded in the notion that individuals are not simply responsible for actions they have undertaken in the past. They may also be responsible for either avoiding future actions that are problematic or fulfilling future obligations.

Baier articulates this view by broadening his perspective beyond “task-responsibility.” He contends that, “agent-responsibility gives rise to a new quasi-causal relationship, namely, a duty-breaching failure to use one’s power to prevent.”⁸⁴ This notion of responsibility is rooted in the distinction,

[b]etween *having* causal power over an event and *exercising* that power. We may think of some parts of the universe as systems which in the normal course are

⁸⁰ Baier, “Moral and Legal Responsibility,” 104. That “task-responsibility” is one element of “agent-responsibility” should be relatively obvious given that things cannot perform tasks, only human agents can: “Moral agents must also be capable of understanding guidelines for action, of being able to act on them, and of understanding that they ought to do so.” Baier, “Moral and Legal Responsibility,” 104.

⁸¹ Baier, “Moral and Legal Responsibility,” 104-105.

⁸² Baier, “Moral and Legal Responsibility,” 105.

⁸³ Baier, “Moral and Legal Responsibility,” 104.

⁸⁴ Baier, “Moral and Legal Responsibility,” 108.

headed for some predictable event . . . or as systems that in the normal course maintain themselves in a certain state . . . In such cases, some people may have and either exercise or fail to exercise causal power over some events in the system.⁸⁵

At another point in the text, Baier suggests that such a view might be referred to as “capacity-responsibility” which he defines, following H. L. A. Hart, as “ascribing responsibility not for a particular past event or state of affairs but for a certain basic ability presupposed by all such particular ascriptions.”⁸⁶ Thus, part of the “forward-looking” notion of “agent-responsibility” is the belief that the agent has the “capacity” to take action in response to the perceived harm. In this way, Baier engages the discussion of moral agency: to be able to act is just as important as one’s potential obligation to do so. One can immediately grasp the potential connection between this view of responsibility as somehow preventing future harms and the problems facing an obese person (or, to employ a nominalist frame, the person with problematic eating and physical activity behaviors as seen from a healthcare perspective). Without action, she may end up suffering from a variety of co-morbidities that not only undermine her health but also consume resources within the healthcare economy. Thus, we might say, she has a form of “agent-responsibility” that is “forward-looking” and rooted in her “capacity” to resolve the potential harm of ill health and consumption of resources. This is, at its heart, the primary use of the term responsibility in the public health literature; however, it also provides the rudiments for a quite different perspective that I develop in the next section.

In short, these philosophical discussions of the term responsibility highlight three main components of the concept: causation, accountability, and agency. Both Oshana and Baier root responsibility in the notion that someone has somehow brought some state of affairs into

⁸⁵ Baier, “Moral and Legal Responsibility,” 108-109.

⁸⁶ Baier, “Moral and Legal Responsibility,” 104; H. L. A. Hart, *Punishment and Responsibility* (Oxford: Oxford University Press, 1968): 227-230 (as cited by Baier).

existence or has failed to take action that would avoid it (causation). They also articulate a view of responsibility that has the primary purpose of determining who should be held accountable for taking action (“accountability” or “answerability”). Finally, they both provide a basic understanding of the moral agency involved in being a responsible agent, that is, both being a member of community to which one is morally obligated and having the capacity to act in response to one’s perceived obligations.

Were we to apply this schematic understanding of responsibility in the context of the obesity problem, we would need to deal with four problems (each of which will be developed in the next section). First, we would need to consider who or what is the cause of the bodily state of obesity. Second, we would also have to consider whether this bodily state has brought about any negative consequences. As I discuss in chapters 1 and 2, these are highly confounding questions that are not conducive to simple answers. Third, we would need to work out whether it is appropriate in this case to ask the causal actor to “account” for his actions, that is, to justify, explain, or provide an excuse for the actions he has taken leading to the bodily state of obesity.⁸⁷ The problem is that we may never reach this level, at least not in a clear and distinct way, with obesity. We would face the problem of either distributing responsibility across a wide array of things and actors in the world, or we might just continue to endlessly debate regarding the nature of causation in general or the evidence in favor of one causal narrative of obesity over another. Finally, we would need to determine the moral agency of obese individuals. Do they have the power to act in response to their condition and are they beholden to a moral community for whom they are obligated to exercise this agency? I will investigate these issues more fully in the next section.

⁸⁷ Oshana, “Ascriptions of Responsibility,” 76-80.

3.2.2 Responsibility and the Obesity Problem

To date, the discussion about the role of responsibility in addressing the obesity problem has largely focused on public health efforts to change the actions of government, corporations, and individuals so as to achieve better health. As noted in chapter 1, there are a variety of efforts in this regard, most notably efforts to change the built environment, to challenge corporations regarding their advertising and sales activities, and to incentivize changes in the daily activities of individuals. While I cannot consider each of these (and other possibilities) fully in this section, I do engage in some analysis of the public health justification for efforts to curb rising rates of obesity and problematic health activities. This justification is grounded in the notion that individuals bear some responsibility to their larger community. It is thus largely “communitarian” in orientation and spans the gulf between more and less coercive efforts to bring about changes that might address the obesity problem.⁸⁸

Daniel Callahan has promoted what is the most coercive and “communitarian” model of responsibility in the case of the obesity epidemic.⁸⁹ His recent article “Obesity: Chasing an Elusive Epidemic” argues that resolving the obesity problem will require, “social pressure combined with vigorous government action.”⁹⁰ He grounds this view in the idea that individuals are largely responsible to their larger community to engage in the cultivation of their own health.⁹¹ Thus, while he does not directly employ the term responsibility throughout his work (it receives only passing mention), his overall perspective relies on a combination of “backward”

⁸⁸ On the “communitarian” perspective, see Tuoldo, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202; Callahan, “Bioethics: Private Choice and Common Good,” 24, no. 3 (1994): 28-31; Ezekiel Emmanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge: Harvard University Press, 1991).

⁸⁹ Callahan, “Obesity,” 34-40; Callahan, “Bioethics,” 28-31.

⁹⁰ Callahan, “Obesity,” 39.

⁹¹ Callahan, “Bioethics,” 28-31.

and “forward-looking” accountability.⁹² That is, he views obese individuals as largely responsible for their health state and argues that they should take action in the future to address this state so as to avoid overusing the scarce resources available for treating their co-morbid conditions.⁹³ His defense of “social pressure,” among a variety of other possible strategies, indicates the degree to which he feels individuals are in part responsible for their health activities and are thus to an extent blameworthy.⁹⁴

While one might argue that his proposed *actions* emerge out of a concern for the health of the millions of people who might be impacted by obesity and its potentially related co-morbid conditions, the *attitude* with which his message is delivered is problematic.⁹⁵ At one point, he declares,

Whether or not they recognize their [obese individuals’] role in it, they need to understand that obesity is a national health problem, one that causes lethal diseases, shortens lives, and contributes substantially to rising health care costs. Not just their own welfare is at stake. They no less need to understand that, whatever they may think about the power and excess of government, it is inescapable in this case, as much as with national defense.⁹⁶

This rhetorical flourish is common throughout Callahan’s arguments and indicates the degree to which he feels obese individuals who are not taking responsibility for their health are blameworthy. He even goes so far as to suggest that, despite the risks of stigmatization bound up in his “social pressure” argument, there is every reason to proceed because, “the fact of the matter is that they are already stigmatized, and notably among health care workers.”⁹⁷

Furthermore, he identifies research that suggests some stigmatization may be acceptable or even

⁹² Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

⁹³ Callahan, “Obesity,” 36.

⁹⁴ Callahan, “Obesity,” 34-40.

⁹⁵ Beauchamp and Childress, *Principles of Biomedical Ethics*, 103.

⁹⁶ Callahan, “Obesity,” 37.

⁹⁷ Callahan, “Obesity,” 38.

useful in changing unhealthy behaviors.⁹⁸ While I see in Callahan a sort of beneficence, and perhaps even an attempt to enhance the autonomy of individuals whose efforts to maintain a healthy life are overwhelmed by advertising and other elements of their environment, it should be obvious that such actions will tend increase stigmatization and undermine collaborative care.⁹⁹ In addition, he glosses over the complexities of obesity in terms of its causal mechanisms and therapeutic possibilities. Thus, in responding to the four problems introduced in the last section, Callahan glosses over the evidence and largely asserts that obese individuals are, at least in part, responsible for their health and in need of prompting to change it. While I cannot forcefully disagree with all of his proposed approaches, especially “childhood [obesity] prevention programs,” the idea that resolving a health problem requires undermining the voluntariness and autonomy of individuals on such a vast scale raises major red flags, especially from a bioethical perspective.¹⁰⁰

Of course, some level of persuasion is assumed in the provider-patient relationship, but sanctioning large-scale shaming of obese individuals modeled, as Callahan suggests, on the anti-smoking campaigns that emerged during the last century, would seem to work against the grain of persuasion.¹⁰¹ Such shaming and “stigmatization lite” also stand in direct tension with the goals of the clinical encounter.¹⁰² In addition, Callahan relies on a largely negative and coercive model of responsibility that tends in the direction of scapegoating and promulgates an *attitude*

⁹⁸ Callahan, “Obesity,” 38. He cites the following supporting article: Ronald Bayer, “Stigma and the Ethics of Public Health: Not Can We But Should We,” *Social Science and Medicine* 67 (2008): 463-472.

⁹⁹ Saguy and Riley, “Weighing Both Sides,” 869-921.

¹⁰⁰ Callahan, “Obesity,” 36.

¹⁰¹ Callahan, “Obesity,” 38. David H. Smith, “Ethics in the Doctor-Patient Relationship,” *Critical Care Clinics* 12, i. 2 (January, 1996): 179-197; David H. Smith and Loyd S. Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” *Theoretical Medicine and Bioethics* 7 (1986): 127-146. Interestingly, the use of smoking as an analogy in Callahan’s paper is mentioned by Saguy and Riley as a common tactic of those ideologically committed to the health risks of obesity. See Saguy and Riley, “Weighing Both Sides,” 886.

¹⁰² Callahan, “Obesity,” 39.

that will not foster cooperation with those groups who stand opposed to addressing the obesity problem from a realist perspective.¹⁰³ Most practically and importantly, it is hard to imagine a healthy and helpful provider-patient relationship emerging if shaming, stigmatization, and “social pressure” are the dominant public discourses of the day.¹⁰⁴ Or, as Saguy and Riley point out, “the obesity case suggests that medical models blaming individuals for their ill health are likely to be rejected.”¹⁰⁵

Callahan also relies on a view of the moral community as largely overwhelming any claims to autonomy, a view with which many would likely disagree. This view may provide a number of justifications and proposed interventions that are only acceptable to those already in agreement with Callahan that problems like obesity are in need of public management. While his argument that responsibility to the collective may require curtailing freedom and choice seems relatively straightforward, we are left to ask what impact this has on the model of human agency that is central to bioethics. This model values the protection of voluntariness, choice, and autonomy to the greatest extent possible.¹⁰⁶ While Callahan proffers some convincing arguments in favor of limiting autonomy in certain circumstances, he does so by weighing autonomy against existential threats to the community. In so doing, he assumes that the community values particular modes of life, particular levels of health, and particular durations of existence more than those attributes of autonomous action that make us human in the first place. This is a controversial stance to take and one that Donald Cameron Ainslie has directly rebuffed in his work as untenable given the pluralism that inheres in contemporary democratic societies.¹⁰⁷

¹⁰³ Beauchamp and Childress, *Principles of Biomedical Ethics*, 103.

¹⁰⁴ Callahan, “Obesity,” 36.

¹⁰⁵ Saguy and Riley, “Weighing Both Sides,” 914.

¹⁰⁶ Beauchamp and Childress, *Principles of Biomedical Ethics*, 103-105.

¹⁰⁷ Ainslie, “Redefining Bioethics in the Age of AIDS,” 1-37.

Unfortunately, Callahan's answer to the question of moral agency and moral community is to make assumptions about what is best for all by glossing over or otherwise rejecting pluralism. While I am not in favor of abandoning any and all public health approaches to obesity, I remain skeptical of arguments like those made by Callahan because they mask complexity and undermine adequate deliberation about the appropriate balance to strike between individuals and their communities.¹⁰⁸ There is no debating that we have to work together to craft environments that best promote our ability to be autonomous agents, but the *attitude* with which we approach this process and the degree to which we are willing to give up on voluntariness and self-cultivation as values in a pluralist context will determine whether we have a community we are happy to call home over the long-term.¹⁰⁹

In contradistinction to Callahan, Turolto provides a nuanced analysis of the role of responsibility in the cultivation of public health that avoids the simplistic resolution Callahan offers to the problems of moral agency and moral community.¹¹⁰ He also avoids the rhetorical *attitude* of Callahan's piece by side-stepping many of the arguments Callahan makes regarding the false consciousness or wrong-headedness of obese individuals who fail to take action regarding their health. In so doing, he attempts to build a perspective that cultivates a "middle path between collectivism and libertarianism," thus addressing my concerns about Callahan's rejection of pluralism.¹¹¹ Turolto's starting point is to suggest that bioethics, and in particular, the principles I have detailed earlier in this chapter (i.e., autonomy and beneficence), are inadequate to the task of addressing large-scale, population-wide threats to health. He thus

¹⁰⁸ Ainslie, "Redefining Bioethics in the Age of AIDS," 1-37.

¹⁰⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 103.

¹¹⁰ Turolto, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1202.

¹¹¹ Turolto, "Responsibility as an Ethical Framework for Public Health Interventions," 1202; These are, as I suggest above, also the concerns of Ainslie in his "Redefining Bioethics in the Age of AIDS," 1-37.

articulates a shift from bioethics to a version of public health ethics that grounds its arguments in responsibility. He writes,

Bioethics, in fact, suffers from an individual-centered approach because its attention is mainly directed toward medicine and medical research, which are concerned with the individual level. Public health, however, focuses on the population level and is concerned with the lives of the whole population or of large subgroups of the population. Here I try to show that the ethos of medicine and medical research cannot be transported as such into the realm of public health measures, because that would make public health measures very difficult to implement. Next, I establish the significance of responsibility rather than autonomy as central to public health ethics.¹¹²

This articulation of the problems with bioethical analysis when approaching population-based health problems is commonplace in the public health ethics literature.¹¹³ It is also not controversial to suggest that shifting one's perspective from the individual patient to the larger population will require a renegotiation of the principles one applies in the effort to promote health.¹¹⁴ He later suggests, "The responsibility-centered ethical framework I propose stands between the libertarian perspective, which gives priority to the individual and allows only a minimal state, and the collectivist point of view, which aims to promote the greatest aggregate benefit and considers individual rights dependent on the shared will of the community."¹¹⁵ Thus, placing some value on the needs of the community is inherent in any discussion of public health; however, unlike Callahan, Turoldo works assiduously to avoid an exclusionary vision of the moral community as primarily communitarian.¹¹⁶ In fact, many of his arguments work in the direction of balancing collective and individual beliefs and desires (see below).

¹¹² Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1197.

¹¹³ See FN 5.

¹¹⁴ Even bioethicists accept this as an acceptable stance. As Beauchamp and Childress argue, when one takes the view of the larger population, there may be times when autonomy needs to be curtailed. Beauchamp and Childress, *Principles of Biomedical Ethics*, 105.

¹¹⁵ Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1201.

¹¹⁶ Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1201-1202.

In realizing his argument, Turolto identifies two forms of responsibility that largely align with Baier’s “backward” and “forward-looking” perspectives: “consequent” and “prospective” responsibility.¹¹⁷ He ultimately defends a “prospective” model that places most of the responsibility for action in the hands of those with the power to change the current states of affairs that lead to poor health (what he terms “noncoercive” or “soft coercive interventions”).¹¹⁸ In this regard, he argues that those approaches which focus on the “prospective” capacity of government or other institutions to aid individuals by providing them information or transforming their environment to promote healthier activities may actual assist obese individuals (or any others suffering from lifestyle-related illnesses) in “implementing their autonomy.”¹¹⁹ While he does at one point argue in favor of a limited role for “highly coercive interventions” the thrust of his paper is to balance the larger socio-cultural, political, and economic responsibilities of those in power with the responsibilities of individuals to care for themselves when this is the only way to promote their health and achieve their healthcare goals.¹²⁰ In this view, he is not alone. As Kelly D. Brownell, Rogan Kersh, David S. Ludwig, Robert C. Post, Marlene B. Schwartz, and Walter C. Willett argue,

Creating conditions that support personal responsibility is central to public health. Default conditions now contribute to obesity, a reality that no amount of education or imploring of individuals can reverse. Government has a wide variety of options at it command to address the obesity problem. Judicious use of this authority can increase responsibility, help individuals meet personal goals, and reduce the nation’s health care costs.¹²¹

¹¹⁷ Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197 (and throughout).

¹¹⁸ Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1199-1201.

¹¹⁹ Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1200. Puhl and Heuer make a similar argument regarding the need to improve the overall conditions for healthy living. Puhl and Heuer, “Obesity Stigma: Important Considerations for Public Health,” 1024-1025.

¹²⁰ Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1201.

¹²¹ Kelly D. Brownell, Rogan Kersh, David S. Ludwig, Robert C. Post, Rebecca M. Puhl, Marlene B. Schwartz, and Walter C. Willett, “Personal Responsibility And Obesity: A Constructive Approach,” *Health Affairs* 29, no. 3 (2010): 379-387.

In fact, this commonplace way of speaking about responsibility suffuses the literature regarding the obesity epidemic. It is, of course, in keeping with the notion that individuals are not islands. Their environments affect them in a myriad ways that may energize or enervate their capacity to exercise their autonomous choice-making capacities and act in responsible ways. It is difficult to imagine an effective strategy for addressing the obesity problem that does not somehow engage the structural problems that undermine the cultivation of healthy practices.

Turoldo's view, shared by others, that regulation of corporations (and a host of other approaches) may assist individuals in making the choices they ultimately want to make is fine from a public health perspective and likely central to addressing the obesity problem from a policy-making point of view. However, due to his focus on public health, he does not develop an approach to understanding how his model of responsibility might play out in a clinical encounter (the lacunae in the literature I have been identifying since chapter 1). It is for this reason that I turn from public health ethics to bioethics to consider a different way of putting the story of responsibility together. Crucially, the rudiments of this turn exist in Turoldo's work, especially when he articulates "noncoercive" and "prospective" approaches to changing health activities.¹²² They also exist in Kurt Baier's articulation of "forward-looking" and "capacity"-based accounts of responsibility.¹²³ In retaining a robust conception of autonomy and valuing the important role of beneficence in the provider-patient relationship, we do need to stretch our conception of autonomy to include the capability—and thus the enhancement of the capability—to act on one's own behalf. On this view, responsibility is figured as something that is cultivated by individuals through political organization, socio-cultural norms, and pedagogical approaches within the

¹²² Turoldo, "Responsibility as and Ethical Framework for Public Health Interventions," 1199-1200.

¹²³ Baier, "Moral and Legal Responsibility," 104.

clinic that enhance their capability to act in certain ways.¹²⁴ Thus, the notion that responsibility is tied to capability may play out both on the larger stage of public health and in the narrower confines of the clinical relationship.

The capability to take action can be inherent, conferred, attributed, or created by the state of things—particularly in this case by the state of public health discourse or by the clinical encounter. Individuals might have the capability to act conferred upon them due to their social status, their access to power, their strength, their privilege, and the like. For example, according to some theories of social justice, individuals that have access to vast sums of money (or other forms of material wealth) have the capability and, therefore, the responsibility, to help those who are less fortunate.¹²⁵ They might also be granted certain capabilities through education and cultivation of various habits and ways of thinking.¹²⁶ In addition, one could imagine placing responsibility with larger institutions or governments when these have the capability to act in ways that an individual or even group of individuals could not.¹²⁷ As Ignaas Devisch and Myriam Deveugele argue,

Although we make our own choices, lifestyle is far more than the personal expression of who we are and more than what society says we should be: sometimes it is a survival strategy, a way to deal with stress and anxieties—in short, a method of living your life. It is a matter of chances and opportunities, education, and environment. This is also a question of why some people succeed in managing certain opportunities whereas others do not. Above all, lifestyle is never simply the result of a conscious and rational choice; it is also the result of personal habits and desires, a great many of which play their role at an

¹²⁴ On the notion of cultivation, especially in the context of education, see Martha Nussbaum, *Cultivating Humanity*.

¹²⁵ For a recent analysis of this version of social justice in terms of global poverty, see Thomas Pogge, “World Poverty and Human Rights,” *Ethics & International Affairs* 19 (March 2005): 1-7.

¹²⁶ Nussbaum, *Cultivating Humanity*.

¹²⁷ This is Turolto’s argument, especially when highlighting “noncoercive” and “soft coercive” interventions. Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” 1199-1201.

unintentional level. And, finally, it is partly the result of cultural or societal habits, patterns, or evolutions far beyond our individual reach.¹²⁸

In short, the cultivation of lifestyle is achieved through the interplay of various layers of the individual's social setting and her choices. What remains is for us to determine how individuals may develop responsibility over their lifestyles (that is, develop the capability to care for themselves) given the variety of elements that may intervene or otherwise impede this process.

Taking this back to the context of the clinical setting, physicians (as opposed to their patients) have the capability to act (in some cases) given that their knowledge far exceeds that of their patients in the treatment of disease and illness (beneficence). Because they have this capability, they must act to help their patients. This is a fundamental aspect of the professional obligations of physicians.¹²⁹ However, physicians are constrained when it comes to obesity and other chronic conditions. Their knowledge can be shared, and some therapeutic actions can be taken in the clinical setting; however, if they are to avoid the negative consequences of the unhealthy behaviors that are at least associated with their weight, obese patients will need to take action to care for themselves by engaging in lifestyle change therapy. In this sense, primarily because obesity requires self-care if it is to be addressed and resolved, obese patients could be said to have the responsibility to act because it is their action that is required. Patients are uniquely capable of acting in regard to their health activities, and it is this unique capability that provides grounding for a bioethical approach to the question of responsibility. In this sense, we might say that physicians and patients both must cultivate skills in care giving, although they will draw on very different sites, contexts, and modes of understanding in the attempt.¹³⁰

¹²⁸ Ignaas Devisch and Myriam Deveugele, "Lifestyle: Bioethics at a Critical Juncture," *Cambridge Quarterly of Healthcare Ethics* 19 (2010): 557.

¹²⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 197-239.

¹³⁰ Tronto, "An Ethic of Care," 60-68.

However, how I have elucidated what I have been calling a “capability” may not achieve the full meaning of the term. Much as traditional accounts of responsibility rely on a base-line capacity to act in response to harm caused or potential future harm, capability includes a rudimentary conception of capacity to act.¹³¹ This highlights the ability to take action as opposed to the quality or extent of the ability. Thus, the above paragraph uses the term capability in its most minimal sense without imagining a developmental telos that is at the heart of improving and realizing capabilities that might cultivate robust forms of responsibility. Therefore, it is important to note that capabilities can be developed over time through various practices and access to certain goods. In this regard, Nussbaum argues for a “capabilities approach,” using the term capabilities to foreground the notion that individuals can be granted the right circumstances through which to internalize new capabilities and transform their daily actions: “My idea is that all citizens should have a basic threshold level of each of these capabilities, the level to be set by internal political processes in each nation, often with the contribution of a process of judicial review.”¹³² Under this view, capabilities are seen as “entitlements” and “opportunities for functioning,” and include such items as “life,” “bodily health,” “bodily integrity,” “senses, imagination, and thought,” “emotions,” “practical reason,” “affiliation,” “play,” and “control over one’s environment.”¹³³ Nussbaum sees these basic capabilities as “central areas of human life that are likely to prove important for whatever else the person pursues.”¹³⁴ Nussbaum’s capabilities approach highlights the fact that individuals may find themselves in situations with the right tools or holding the right cards to act in response to a problem, or they may lack these

¹³¹ Baier, “Moral and Legal Responsibility,” 104.

¹³² Nussbaum, *Upheavals of Thought*, 418. For an application of capabilities theory to professional practice in healthcare, see David B. Brushwood, “Professional Capabilities and Legal Responsibilities of Pharmacists: Should ‘Can’ Imply ‘Ought,’” *Drake Law Review* 44 (1995/1996): 439-462.

¹³³ Nussbaum, *Upheavals of Thought*, 416-418.

¹³⁴ Nussbaum, *Upheavals of Thought*, 416.

resources and thus the capability. Nussbaum's view suggests that individuals may be more or less capable depending on their context, on how their social, cultural, and familial networks are organized, and the like. When institutions (among them, the profession of medicine) are powerful, they have the responsibility to provide a socio-cultural, economic, and political environment in which individuals can flourish by developing their own capabilities. Nussbaum's view comports in part with the public health focus on enhancing the ability of individuals to act autonomously by intervening to change environmental conditions that undermine choice.¹³⁵ Thus, her notion of capabilities is largely rooted in the project of providing adequate starting points for development. This approach leaves space for ongoing cultivation. It is at the level of ongoing cultivation that my bioethical approach to responsibility begins to take shape.

Accordingly, when viewed in terms of self-care, the capability approach suggests that obese patients who achieve the basic bioethical condition of autonomy in virtue of wanting to lose weight or improve their health conditions have the responsibility to take on the caregiver role through participation in various therapeutic interventions (or through the development of capabilities that will enhance their efforts to achieve their health-related goals). They hold this responsibility regardless of the social conditions in which they find themselves largely because lifestyle change requires individual agents to act on their own behalf (the basic capacity view). Only the individual can choose to change her daily practices in accordance with reconfigured health-related or overall life goals (the developmental/capability view).

It is important to note here that a bioethical framing requires the autonomous non-coerced acceptance of this responsibility. This is where it stands in direct tension with the public health views described earlier. Individuals should not be blamed for refusing to engage in lifestyle

¹³⁵ Turoldo, "Responsibility as an Ethical Framework for Public Health Interventions," 1199-1201.

change therapies, nor should they be coerced or unduly pressured. Engaging with them should be an autonomous activity on their part, one that emerges as much from their own health goals and plans as from the beneficence-based persuasion of their healthcare providers, health institutions, or governments. In this way, a capability approach affirms an appropriate *attitude* toward the specific kind of responsibility held by obese and overweight individuals.¹³⁶ It is difficult to imagine the sort of shaming that Callahan endorses in terms of such beneficence-based persuasion, as it explicitly fails to evidence an appropriate attitude toward obese individuals. In contrast, appropriate, beneficent persuasion does not imagine them to be wrong-headed or incapable of voluntary choice, and it does not wrest decision making powers from them. At the same time, and despite my skepticism and that of the nominalists presented in chapter 2, other intervening factors (e.g., elements of their environment and social situatedness) may block the autonomy individuals have, thus requiring that institutions and expert individuals may need to take beneficently motivated action on their behalf. However, such paternalistic actions must be taken with all due caution. Here, Turolto gets it right:

Even responsibility belongs to the same family as *phronesis*, or moral judgment reached in a particular situation, of reflective judgment, and so on. Acting in a responsible way is similar to acting in a wise way and as a mature person, which resembles neither a mechanical application of abstract rules nor a trial-and-error application of rules that proceeds blindly without the guiding light of any universal principle whatsoever. Whoever acts in this way knows the rules or ethics and applies them while learning from their own experience, utilizing their own discernment, and letting themselves be guided by their habits of acting well.¹³⁷

In this way, viewing responsibility as dually shared between obese individuals and groups allows both to take action in the most appropriate ways, with a view toward enabling individuals to craft healthy lives for themselves. The capabilities approach—whether viewed at the population level

¹³⁶ Beauhamp and Childress, *Principles of Biomedical Ethics*, 103.

¹³⁷ Turolto, “Responsibility as and Ethical Framework for Public Health Interventions,” 1199.

as Turoldo and Nussbaum suggest, or at the clinical level as a shared responsibility to achieve the goals of the patient—draws on a “forward-looking” ethos of responsibility that is not concerned with determining cause except insofar as we are looking for those who can bring about positive change.¹³⁸ It thus avoids the stigmatization inherent in more “backward-looking” approaches when applied to individual obese agents.¹³⁹

This cashing out of the capabilities approach affirms the need for ongoing deliberation about the roles that different individuals should adopt as well as the means through which they might be made capable of such action. Nussbaum’s conception of judicial review provides a nice analogy here. As individual obese patients take up responsibility for their obesity, they do so in the context of ongoing deliberation about the extent to which they can take this action and the various factors that will improve their possibility for success. Instead of placing blame on obese patients, this model instead allows for their creative and inventive participation in the ongoing socio-political and cultural debates about obesity. Other models of responsibility, especially those that imply judgment and blame, curtail this possibility for such deliberation. One benefit of the capabilities approach is that it implies the need for ongoing dialogue or what Kenneth Burke calls the “unending conversation” of human life.¹⁴⁰ Individuals choose to act in this world because they have been given the opportunity to act autonomously and to constantly revise their actions. There may never be a final answer as to who is *actually* responsible for the obesity problem or who has the most responsibility. Instead, the focus, under this version of responsibility, is to allow individuals to take on the responsibility for deliberating about how best

¹³⁸ Baier, “Moral and Legal Responsibility,” 104.

¹³⁹ Baier, “Moral and Legal Responsibility,” 104.

¹⁴⁰ Burke, “The Philosophy of Literary Form,” 110.

to address the problem faced and how best to engage in productive action through the correct configuration of individual, social, political, cultural, and economic supports.

3.4 (RE)ARTICULATING RESPONSIBILITY

The table below summarizes the various layers of responsibility described in the previous sections. In doing so, it also indicates a linear progression (downward) toward the most apposite mode of responsibility in the context of bioethics and the clinical relationship. While I have accepted a certain amount of balancing between bioethics and public health approaches in this chapter, largely in agreement with Turolto (e.g., the notion that the environment in which we live may need some revision in order to promote health), I retain my skepticism toward large-scale public health efforts, especially those that undermine the voluntariness and choice-making capacities of individual agents. I am also invested in retaining the principle of beneficence; however, as the preceding pages have indicated, beneficence must be tempered by respect for the autonomy of patients, as evidenced by inviting and awaiting their coming to a provider and asking for help. This to some extent pushes back against Turolto's claim, largely due to his focus on public health, that beneficence largely overwhelms autonomy when considering responsibility in the promotion of population health.¹⁴¹ In addition, the capability approach to responsibility affords the correct rhetorical *attitude* needed to maintain human agency while stretching autonomy to fit a more pedagogically oriented clinical encounter that is essential to the potential effectiveness of caring for obese persons. Tempering the public health approach in this

¹⁴¹ Turolto, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1198.

way and remaining skeptical of the negative consequences of responsibility discourse marshaled at the larger socio-cultural and political layers of a community provide a safety valve that may provide needed correctives to stigmatization and oppression of those who do not fit societal norms.¹⁴²

Table 1. Summary of Types of Responsibility

Type of Responsibility	Description
1) Past-Oriented Responsibility	An approach that seeks to define responsibility based on past actions—that either cause the relevant consequence or breach a social norm relevant to it. ¹⁴³ Baier’s category of “backward-looking” responsibility is a direct analogue to this category. ¹⁴⁴ It also captures Oshana’s notion of responsibility as “accountability.” ¹⁴⁵ This form of responsibility would include models that utilize shame, stigma, or other symbolic and material consequences to incentivize change in individuals. ¹⁴⁶ Institutions and corporations might face similar kinds of sanctions or new legal and policy frameworks to change their actions based on the problematic activities they have undertaken that contribute to the obesity problem. ¹⁴⁷
2) Future-Oriented	An approach that seeks to reduce the possibility of future harm by identifying either those that might cause such harm and somehow stopping them, or those who have the capability of preventing or ameliorating the harm. ¹⁴⁸ Baier’s category of “forward-looking” responsibility is a direct analogue to this category. ¹⁴⁹

¹⁴² Rich and Evans, “Fat Ethics,” 341-358.

¹⁴³ Baier, “Moral and Legal Responsibility,” 101-130; Oshana, “Ascriptions of Responsibility,” 71-83.

¹⁴⁴ Baier, “Moral and Legal Responsibility,” 101-130. Turolido’s notion of “retrospective” responsibility would fit here as well. Turolido, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197 (and throughout).

¹⁴⁵ Oshana, “Ascriptions of Responsibility,” 71-83.

¹⁴⁶ Callahan, “Obesity,” 34-40.

¹⁴⁷ Turolido, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202; Just and Wansink, “Do Not Support Regulation of Sugar-Sweetened Beverages,” 1465-1466.

¹⁴⁸ Baier, “Moral and Legal Responsibility,” 101-130.

¹⁴⁹ Baier, “Moral and Legal Responsibility,” 101-130. Turolido’s notion of “prospective” responsibility would fit her as well. Turolido, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197 (and throughout).

Table 1 (continued).

<p>3) Responsibility as “Capability”¹⁵⁰</p>	<p>A nascent but not fully developed category of responsibility that draws directly from the principle of respect for autonomy. It may come in the form of creating opportunities for individuals to more fully realize their autonomy.¹⁵¹ Alternatively, it may involve the cultivation of therapeutic pathways (such as lifestyle change therapy) that provide opportunities for individuals to develop a more robust sort of responsibility for their own lives.¹⁵²</p>
---	--

The first two categories in the table indicate basic elements of the definition of responsibility (“past-oriented” and “future-oriented”) that largely align with the views of Oshana, Baier, and Turolido.¹⁵³ As we have seen these orientations can have positive and negative consequences. Tempering them with a “capability”-approach, rooted in the works of Baier, Turolido, and Nussbaum, provides a way around the problem of establishing objective or clear-cut understandings of causation, except when these are focused on figuring out who the best actor to achieve a goal might be. Rhetorically framing responsibility in this way sets up a turn to the pedagogical encounter between providers and patients, one that requires further consideration and development of the principles of beneficence and autonomy (see the next chapter).

These arguments bring me to the last pivot point of this thesis – a turn to the empowerment of the patient as a sort of expert in her own care, one who brings a sense of health and wellbeing to the table that must be valued by her provider. This does not mean that patients

¹⁵⁰ Nussbaum, *Upheavals of Thought*; Nussbaum, *Women and Human Development*; Turolido, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202.

¹⁵¹ Nussbaum, *Upheavals of Thought*; Nussbaum, *Women and Human Development*; Turolido, “Responsibility as an Ethical Framework for Public Health Interventions,” 1197-1202.

¹⁵² Nussbaum, *Cultivating Humanity*.

¹⁵³ Also, Turolido’s views largely conform with those espoused by the public health literature cited throughout this chapter.

should not work in relationship with expert medical professionals. Instead, what I seek is an account of the patient as capable of (and thus responsible for) achieving her own goals in terms of her lifestyle-related illnesses. Turning to the patient seems apt in this regard as it is the patient who must enact lifestyle changes, who must find a way to fit such changes into their overall framework of goals, life plans, and daily activities. I am not the first to suggest that the relationship between patients and their providers should be a mutually empowering one; however, I believe that more work needs to be done to understand this relationship and protect it from incursions of paternalism.¹⁵⁴

¹⁵⁴ A great deal of work has been done to develop a conception of the empowered patient who works with providers in a context of shared responsibility. In this regard, see D. Badcott, "The expert patient: Valid recognition or false hope?" *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 173-178; A. Edgar, "The expert patient: Illness as practice," *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 165-171; P.G. Gibson, H. Powell, A. Wilson, M.J. Abramson, P. Haywood, A. Bauman, M.J. Hensley, E.H. Walters, and J.J.L. Roberts, "Self-management education and regular practitioner review for adults with asthma," *Cochrane Database of Systematic Reviews* Issue 3 (CD001117), <http://thecochranelibrary.com> (Accessed April 22, 2011); S.L. Norris, M.M. Engelau, and K.M. Narayan, "Effectiveness of self-management training in type 2 diabetes: A systematic review of randomized controlled trials," *Diabetes Care* 24, no. 3, (2001): 561-587; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient self-management of chronic disease in primary care," *Journal of the American Medical Association*, 288 no. 19 (2002): 2469-2475; Edward H. Wagner, "Chronic disease management: What will it take to improve care for chronic illness?" *Effective Clinical Practice*, 1, no. 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving chronic illness care: Translating evidence into action," *Health Affairs (Millwood)*, 20, no. 6 (2001): 64-78; Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 79-86.

4.0 LIFESTYLE CHANGE AS ETHICAL CLINICAL PRACTICE¹

4.1 INTRODUCTION

As discussed in previous chapters, addressing the obesity problem requires cutting edge forms of lifestyle intervention.² Whether surgical interventions, pharmaceutical possibilities, or other approaches to obesity and its associated co-morbid conditions take center stage in research and care, lifestyle change appears to be an essential ingredient in achieving or maintaining better health outcomes (chapter 1). Of course, obesity may require larger public health efforts to inspire such changes; however, these seem to drive controversy and contestation rather than assisting in the construction of effective and ethical clinical care for obesity (chapters 2 and 3). Thus, the approach of this thesis has been skeptical, especially when evaluating the most coercive and potentially stigmatizing approaches currently advocated in the domain of public health policy (especially chapter 3). Given that I am currently positioned as a health care researcher and bioethicist, the complete rejection of effective means to address potentially life-saving forms of care is untenable (whether in the domain of public health or clinical care) but so too is the move

¹ This chapter includes substantially revised portions of a paper previously presented at conference. John Rief, "Lifestyle Coaching in the Context of Obesity: A Practical Pedagogical Approach," paper presented at the *Nineteenth Annual Meeting of the Association for Practical and Professional Ethics*, Cincinnati, OH, 4-7 March, 2010.

² On this, see especially chapter 1. For the most comprehensive account, see Kathleen M. McTigue, Russell Harris, Brian Hemphill, Linda Lux, Sonya Sutton, Audrina J. Bunton, and Kathleen N. Lohr, "Screening and Interventions for Obesity in Adults: Summary of the Evidence for the U.S. Preventive Services Task Force," *Annals of Internal Medicine* 139, no. 11 (2003): 933-949.

to undercut the autonomy of patients and undermine the core values underlying provider beneficence, which are expressed chiefly through the provision of *ethical and effective* care to those who are in need.³ Thus, my skepticism of public health approaches to obesity is not so much driven by a lack of evidence in terms of their potential consequences for the health of larger populations but rather by the consequences they have for the morality of our community (as noted by the nominalist position detailed in chapter 2) and the extent to which we protect and maintain those things most important to our cultivation as human beings (chapter 3).⁴

This, of course, stands in opposition to efforts to redefine the principles of bioethics to accord with a “communitarian” perspective regarding the responsibilities of individuals.⁵ While I am at pains to leave some room for public health approaches, given that I agree with the realist view that obesity represents a potential threat to the health of millions of people, I am also cognizant of the need to protect the individual and thus defend a view of responsibility that highlights its role in the cultivation of the capability for self-care.⁶ I am also aware that my discussion in chapter 3 is highly schematic and theoretical, leaving unanswered questions regarding how this model of responsibility, with its attention to the protection of autonomy and beneficence, might function when rolled out in a clinical setting. Beginning to describe how it would function requires attention to grounded practices, particularly clinical and self-care practices, and the development of tools for the cultivation of lifestyle change, as opposed to the

³ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009), 99-148, 197-239.

⁴ Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997).

⁵ Fabrizio Turolto, “Responsibility as an Ethical Framework for Public Health Interventions,” *American Journal of Public Health* 99, no. 7 (2009): 1197-1202; Daniel Callahan, “Bioethics: Private Choice and Common Good,” 24, no. 3 (1994): 28-31; Ezekiel Emmanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge: Harvard University Press, 1991).

⁶ Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2001); Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2000).

public health efforts described in chapter 3 and their focus on the persuasion of populations to take particular actions regarding their health (or otherwise construct constraints to decision making that would improve such actions).⁷

In order to fill this gap in my account, this concluding chapter takes on the question of responsibility as capability (with all its attendant problems) in the context of a recently completed pilot study at the University of Pittsburgh: the Online Lifestyle Support System.⁸ While the pilot project is completed at this point, this OLSS program is still being developed. It offers online lifestyle training and planning with lifestyle counselors for individuals meeting certain criteria including risk factors for diabetes and other obesity related conditions. The primary purpose of this study was to determine whether online coaching buttresses the efforts of primary care physicians as they work with patients who want to lose weight.⁹ As part of this pilot study, professional coaches interacted with patients. As the study progressed, the investigators

⁷ Turolfo, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1202; David Callahan and Bruce Jennings, "Ethics and Public Health: Forging a Strong Relationship," *American Journal of Public Health* 92, no. 2 (2002): 169-176; Betty Wolder Levin and Alan R. Fleischman, "Public Health and Bioethics: The Benefits of Collaboration," *American Journal of Public Health* 92, no. 2 (2002): 165-167; James F. Childress, Ruth R. Faden, Ruth D. Gaare, Lawrence O. Gostin, Jeffrey Kahn, Richard J. Bonnie, Nancy E. Kass, Anna C. Mastroianni, Jonathon D. Moreno, and Phillip Nieburg, "Public Health Ethics: Mapping the Terrain," *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 170-178; Onora O'Neill, "Public Health or Clinical Ethics: Thinking Beyond Borders," *Ethics & International Affairs* 16, no. 2 (2002): 35-45; R.E.G. Upshur, "Principles for the Justification of Public Health Intervention," *Canadian Journal of Public Health* (March/April, 2002): 101-103.

⁸ For a complete description of the OLSS study and initial findings indicating its effectiveness in the treatment of obesity, see Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey R. Simkin-Silverman, "Using the Internet to translate an evidence-based lifestyle intervention into practice," *Telemedicine & eHealth*, 15, no. 9 (2009): 851-858; Kathleen M. McTigue, Tina Bhargava, Cindy L. Bryce, Molly Conroy, Gary S. Fischer, Rachel Hess, Laurey R. Simkin-Silverman, and Susan Zickmund, "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care," *Patient Education and Counseling* 83 (2011): 261-264. The OLSS study, along with the classical Greek concepts discussed in this chapter, are also the focus of my dissertation project and a published article. See John J. Rief, "Searching for the Good Life: Rhetoric, Medicine, and the Shaping of Lifestyle," (PhD diss, University of Pittsburgh, 2012); John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue, "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care," *Health Education & Behavior*, forthcoming.

⁹ McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Miloas, and Simkin-Silverman, "Using the Internet to Translate an Evidence-Based Lifestyle Intervention into Practice," 851-858; McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care," 261-264.

and coaches learned that communicating with patients is a difficult and highly nuanced activity requiring pedagogical resources.¹⁰ For this reason, coaching materials were developed by the study organizers in order to enhance coaching effectiveness and maintain the primary goals of the program. Later in this chapter, I analyze these coaching materials, focusing primarily on the protocol developed for the Online Lifestyle Support System (OLSS) in order to develop an account of lifestyle change as an ethical clinical practice that enhances patient decision-making, involves a robust conception of autonomy, and utilizes a notion of responsibility that features the capability of patients to care for themselves (chapter3). In my analysis, I draw on pedagogical concepts elucidated in the ancient Greek tradition in order to elucidate some of the ethical and practical dimensions of communicative encounters between patients and lifestyle counselors.¹¹

¹⁰ Rief, “Searching for the Good Life.”

¹¹ There are many efforts that criticize or otherwise remain skeptical of the ways in which pedagogy is deployed to manage individual bodies. One example that should be familiar to a scholarly audience is the approach taken by Michel Foucault in his *History of Sexuality* in which he shows how efforts to manage lifestyle are in many instances modes of domination. See his *The Care of the Self*, vol. 3 of *The History of Sexuality*, trans. Robert Hurley (New York: Vintage Books, 1988); Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège De France 1981-1982*, ed. Frédéric Gros, trans. Graham Burchell (New York: Picador, 2005). Valerie Harwood translates Foucault’s historical concerns directly into the context of the obesity problem. She suggests that lifestyle change therapy may be viewed as a form of “biopedagogy” that enforces modes of self-discipline in the service of the larger community: “This focus on life needs to be understood not as the heralding of some new caring and kinder age; but in terms of the aims of the state to solidify itself via the control of life (and hence strength, economic viability) of its population.” Valerie Harwood, “Theorizing Biopedagogies,” in *Biopolitics and the ‘Obesity Epidemic’: Governing Bodies*, ed. Jan Wright and Valerie Harwood (New York: Routledge, 2009): 16. On this argument, also see Joanna Zylińska, *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009). Other theorists outside the Foucauldian frame make similar arguments. For example, Saguy and Riley are highly critical of “lifestyle theory” given the fact that it may be deployed to judge and stigmatize obese individuals. Abigail C. Saguy and Kevin W. Riley, “Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity,” *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 18-22. They cite earlier work by Tesh as a critical interlocutor in the development of their views. See Sylvia N. Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick, NJ: Rutgers University Press, 1988). In response to these fears, and directly confronting Foucault’s work in particular, Nussbaum claims that, “the pursuit of logical validity, intellectual coherence, and truth delivers freedom from the tyranny of custom and convention, creating a community of beings who can take charge of their own life story and their own thought.” Nussbaum doubts “whether Foucault can even admit the possibility of such a community of freedom, given his view that knowledge and argument are themselves tools of power.” It is this disconnect between postmodern/post-structural theories of discourse and power, and those of the humanistic tradition that Nussbaum defends that informs my own understanding of lifestyle management. I view the humanistic tradition as far more promising. See Martha Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994), 5.

4.2 *EUDAIMONIA, PAIDEIA AND PHRONESIS: THREE FOCAL POINTS FOR LIFESTYLE CHANGE THERAPY*¹²

While developing lifestyle change as an ethical and effective therapy, it is critical to deal with the problem of maintaining the autonomy of patients (i.e., respecting their personal choices). Thus, in re-envisioning the role of bioethics in the management of obesity as primarily a problem of lifestyle, it is helpful to employ the notion of *the good life*, a concept central to the ancient Greeks in their quest to achieve happiness and virtue, which might allow us to wish for health and prosperity, even plan for them, while sustaining individual autonomy and the richness of human experience. As Joan Tronto declares, we are in need of

. . . a more complicated account of ethics, one that tries to restore to the word *ethics* its original meaning – knowledge about how to live *a good life*. This perspective requires not only a broader interpretation of the nature of ethics, but a more complete account of the nature of care. In making daily and thoughtful judgments about caring, people every day engage in a high moral calling. Our moral sensibilities will be greatly enhanced if we learn to think more thoughtfully about the morality of everyday life embodied in an ethics of care.¹³

I whole heartedly agree with Tronto's view that ethics must account for the good life. Previous chapters have engaged in criticism of those views that take the good life to be one thing or to have only one goal, for instance, health.¹⁴ What's more, Tronto's call for more attention to the good life brings us to the central problem undergirding the development of lifestyle change therapies: the maintenance of the goals and aspirations of the individual while intervening into her daily life practices and revising them. These tasks would seem to work in opposite directions, but only if we imagine that individuals are being forced to revise their behaviors (as in the public

¹² This section draws directly from my work in "Searching for the Good Life."

¹³ Joan C. Tronto, "An Ethic of Care," in *Ethics in Community-Based Elder Care*, ed. Matha B. Holstein and Phyllis B. Mitzen (New York: Springer Publishing Company, 2001), 61. Emphasis added.

¹⁴ Jonathon M. Metz and Anna Kirkland, eds., *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

health model discussed in chapter 3). If we instead adopt the view that individuals should undertake lifestyle change as a matter of exercising their own autonomy (the bioethical view I advocate), then lifestyle change is itself bound up in the process of achieving the good life that Tronto mentions here.¹⁵

Accordingly, we must work hard to understand the nature of the good life and how it can be achieved, a topic that dominates early Greek philosophy. Martha Nussbaum refers to the goal-oriented and aspirational conception of *the good life* defended by Tronto as *eudaimonia* (the Greek term) and suggests that it can be applied to contemporary life as long as we understand that goals, values, virtues, and appropriate habits for achieving these are redefined and re-conceptualized in every cultural milieu.¹⁶ She bases this view on a close reading of Aristotle's conception of the good life that leaves room for its re-articulation in the context of contemporary America:

Aristotle saw people not as striving to maximize a state of satisfaction, and also not as striving to perform a list of duties. He saw them, instead, as striving to achieve a life that included all of the activities to which, on reflection, they decided to attach intrinsic value. He thought of the problem of life-planning as one that fundamentally involved deliberation about a rich plurality of rather general ends, in which the deliberator asked what concrete form of "moderation" or "courage" made most sense for his own life. Put in these terms, Aristotle's ethical enterprise is not unreachably "other" or impossibly foreign. Indeed, it might well be argued that it fits what real people do when they think about their lives – even in present-day America – better than do the abstractions of utilitarian moral theory.¹⁷

¹⁵ It is also in keeping with Donald Cameron Ainslie's account of "the bioethics of everyday life." See Donald Cameron Ainslie, "Redefining Bioethics in the Age of AIDS," (MA thesis, Center for Bioethics and Health Law, University of Pittsburgh, 1996), 21-30.

¹⁶ *Eudaimonia* is a term used throughout Martha Nussbaum's work to indicate an overall perspective of human emotional, physical, and ethical wellbeing. See Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, up. ed. (Cambridge: Cambridge University Press, 2007); Nussbaum, *Upheavals of Thought*.

¹⁷ Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997), 119-120. On this, see also Nussbaum, *Upheavals of Thought*, 31-33. Moving beyond Nussbaum's work, *eudaimonia* has been the subject of major debates in philosophy, particularly those centered on the unity versus plurality of goods or whether happiness and fulfillment have singular or diverse

That is, in coming to understand how we might achieve the good life, Nussbaum, following Aristotle's account, suggests that it allows for a plurality of approaches and values.¹⁸ Nussbaum further clarifies this view when she argues that "as Aristotle reminds us, something can be an end in itself and at the same time be a valued constituent in a larger or more inclusive end. The question whether something is or is not to count as part of *eudaimonia* is just the question, whether something is a valuable component in the best human life."¹⁹ Thus, *eudaimonia* is a term open to deliberation, reflection, revision, and critique.

Nussbaum's view of the pluralism of Aristotle's approach to ethics is in keeping with Donald Cameron Ainslie's critical take on contemporary bioethics.²⁰ As previously described, Ainslie's approach to bioethics is rooted in the liberal tradition which presumes that "since pluralism is a fundamental feature of our contemporary societies, political arrangements must be justified without reliance on the particular features of any one group's idiosyncratic moral outlook."²¹ Ainslie applies this view to bioethics, suggesting that answering moral questions in the provision of healthcare requires attention to disagreement and a constant effort to avoid what he describes as a paternalistic form of "managerialism."²² As Ainslie observes, "The managerial questions arise because the patient and the medical manager approach each other as relative

meanings. On this debate see Thomas Nagel, "Aristotle on *Eudaimonia*," in *Essays on Aristotle's Ethics* ed. Amélie O. Rorty (Berkeley: University of California Press, 1980), 7-14; J. L. Akrill, "Aristotle on *Eudaimonia*," in *Essays on Aristotle's Ethics*, 15-34.

¹⁸ See Nussbaum's note on the history of the term that includes various definitions such as "human flourishing" and "activity according to excellence(s)." Nussbaum, *The Fragility of Goodness*, 6. On *eudaimonia* as "human flourishing," also see (cited by Nussbaum) John M. Cooper, *Reason and Human Good in Aristotle* (Cambridge, MA: Harvard University Press, 1975).

¹⁹ Nussbaum, *The Fragility of Goodness*, 297.

²⁰ Ainslie, "Redefining Bioethics in the Age of AIDS."

²¹ Ainslie, "Redefining Bioethics in the Age of AIDS," 13.

²² Ainslie, "Redefining Bioethics in the Age of AIDS" (throughout).

strangers and make the assumption that they will not share a comprehensive moral outlook.”²³ Thus, working out appropriate decisions in the provider-patient relationship requires attention to such disagreements and a careful application of various moral points of view so as to avoid overwhelming the goals, beliefs, and commitments of the individual. This view of *eudaimonia* is in keeping with my efforts in chapter 2 to evaluate the various viewpoints of realists and nominalists when defining and addressing the obesity problem. Recall that my proposed resolution to the controversy is open-ended and rests on the insight provided by Saguy and Riley that an “integrative perspective” may be needed.²⁴ Therefore, I do not declare one side the victor but instead call for reflection about how we might bring multiple viewpoints together to inform our approaches to the obesity problem. However, Saguy and Riley do not provide a roadmap for how this perspective might be achieved.

Here, with the conception of *eudaimonia* as understood by Tronto and Nussbaum, we may begin to chart a course through the thicket of problems plaguing lifestyle change. First, the view of *eudaimonia* described here provides a context for further developing my view of responsibility as capability. As I suggest in chapter 3, we are all responsible for crafting our own good lives even in the face of various environmental, socio-cultural, political, and other factors that may stand in the way. This is not a negative form of responsibility but rather an acknowledgement that we are the primary agents of change when it comes to our own lives. Thus, our lives do not emerge from the ether nor are they fully determined. Rather, we craft a way of life through, as Tronto argues, “knowledge and judgment” and “[making] such judgments as well as possible.”²⁵ Such “knowledge and judgment” is rooted in the dual action of provider

²³ Ainslie, “Redefining Bioethics in the Age of AIDS,” 15-16.

²⁴ Saguy and Riley, “Weighing Both Sides,” 874.

²⁵ Tronto, “An Ethic of Care,” 64.

and patient in coming to recognize what is needed to adequately address the goals and aspirations that the patient hopes to realize. As Tronto points out,

Caring should take place in an environment in which all of those engaged in caring – caregivers and care receivers as well as other responsible parties – can contribute to the ongoing discussion of caring needs and how to meet them. No single actors in a care process can assert their own authoritative knowledge in the process. Within the activity of caring itself, actors must continue to be attentive, responsible, competent, and responsive to the others in the caring process.²⁶

Thus, the good life is achieved not by one individual but by a relational network, a group of individuals working together to achieve a desired outcome. The good life is pluralistic in orientation, if one follows Nussbaum’s take, but also grounded in the effort to achieve some level of interaction and acknowledgement between various parties (including the patient) working to realize the goals of the patient.

Beyond this conception of *eudaimonia* as the good life (or perhaps, more appropriately, *a good life*), there is another sense in which this chapter both draws on the Greek tradition and attempts to articulate a new or at least wider arena for bioethical work. In order to achieve *eudaimonia*, at least according to many Greek philosophers, one needs to have a relationship with and access to *paideia* (commonly translated as “cultural education”).²⁷ According to this view, the community advances its ethos, its history, its thinking, its commonplaces, and its achievements through immersion, proper education, and practice. As Werner Jaeger points out when describing the general notion of *paideia* in the Greek tradition, “Education (*paideia*) is the process by which a community preserves and transmits its physical and intellectual character.

²⁶ Tronto, “An Ethic of Care,” 65.

²⁷ The most robust contemporary discussion of Greek *paideia* can be found in the works of Werner Jaeger. See Werner Jaeger, *Paideia: The Ideals of Greek Culture, Volumes I, II, and III* (New York: Oxford University Press, 1945). See also, Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994).

For the individual passes away, but the type remains.”²⁸ One can find this view of *paideia* in the works of Plato for whom popular understanding and belief (for example, those promulgated by the nominalists about obesity detailed in chapter 2) are dangerous and must be rejected in favor of the truth as established by those who are actually *in the know* (*Protagoras*).²⁹ Thus, according to Plato’s view, the popular beliefs or individual accounts of *eudaimonia* cannot be valuable because they are not based on the proper method for finding and embodying truth.

However, one can immediately grasp the problem with this initial description of the Greek conception of *paideia*: it is rooted primarily in the cultivation of an overarching cultural viewpoint rather than the pluralism defended above in my discussion of the meaning of *eudaimonia*. Plato’s views accord largely with the most coercive elements of public health ethics when responding to obesity. For example, Daniel Callahan’s notion of “social pressure” is based, at least in part, on the notion that those who know better should bring the misguided flock into accord with the truth about obesity.³⁰ Thus, Callahan, and others who advocate for coercion as a means to inspire lifestyle changes, largely adopt the Platonic conception of *paideia*.

Opposed to this view, Aristotle offers a more pluralistic analysis of *paideia* through the lens of *phronesis* or experiential learning.³¹ According to Martha Nussbaum’s reading of

²⁸ Jaeger, *Paideia, Volume I*, xiii.

²⁹ Nussbaum has done substantial work to criticize Plato’s stance in the *Protagoras*. See Nussbaum, *The Fragility of Goodness*, 89-121.

³⁰ Daniel Callahan, “Obesity: Chasing an Elusive Epidemic,” *The Hastings Center Report* 43, no. 1 (2013): 34-40.

³¹ The notion of *phronesis* as a developmental and experiential approach to ethics and everyday life, originally developed in Aristotle’s *Nicomachean Ethics*, has been the subject of substantial scholarly discussion. See e.g., Nussbaum., *The Fragility of Goodness*, Joseph Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame: University of Notre Dame Press, 2009); Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame: University of Notre Dame Press, 1984); Lois S. Self, “Rhetoric and *Phronesis*: The Aristotelian Ideal,” *Philosophy and Rhetoric* 12, no. 2 (1979): 130-145; Steve Schwarze, “Performing *Phronesis*: The Case of Isocrates’ *Helen*,” *Philosophy and Rhetoric* 32, no. 1 (1999): 78-95; Robert Hariman, “Prudence/Performance,” *Rhetoric Society Quarterly* 21, no. 2 (1991): 26-35. In addition, I have elsewhere commented on the role of *phronesis* in understanding the development of patient skills in self-care. See Rief, “Searching for the Good Life”; Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simin-

Aristotle, because life is complex and never experienced in exactly the same way, the cultivation of *eudaimonia* requires an ongoing process of development and renegotiation of one's values and capabilities.³² As Nussbaum, and a variety of others have pointed out, Aristotle's *phronimos* or person of practical wisdom, detailed in his *Nicomachean Ethics*, embodies this process. She dwells in the realm of contingency, revising her practices based on her experiences, her goals, and her sense of what it means to lead a good life.³³ In other words, the *phronimos* must take the general background knowledge she has and apply it to the specific circumstances in which she finds herself.³⁴ She must see herself from the perspective of a particular situation and develop practical tools for engaging in decision-making in the realm of contingency.³⁵

Therefore, and following Tronto yet again, achieving *eudaimonia* "requires not an abstraction from the concrete case to a universal principle, but an explication of the 'full story.'"³⁶ This "full story" is to be found in what Ludwig Wittgenstein and Joseph Dunne call the "rough ground" which includes the complex and ever-changing understandings and experiences (*phronesis*) of all those involved in the caring process and thus provides content for deliberations

Silverman, and McTigue, "Promoting Patient *Phronesis*." In addition, I am not the first to investigate the link between *phronesis* and *eudaimonia* in the context of patient decision-making and self-care. See Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 307-311. My account overlaps significantly with theirs. For a more extended discussion of the relationship between our accounts, see chapter 3 of "Searching for the Good Life." Finally, *phronesis* is most commonly understood in bioethics through the lens of "clinical judgment" and is thus seen as part of the provider's approach to the delivery of care. On this, see F. Daniel Davis, "Phronesis, Clinical Reasoning, and Pellegrino's Philosophy of Medicine," *Theoretical Medicine* 18 (1997): 173-195; Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993); Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006).

³² Nussbaum, *Fragility of Goodness*, 372.

³³ Chapter 3 of "Searching for the Good Life"; Rubinelli, Schulz, and Nakamoto, "Health Literacy Beyond Knowledge and Behaviour," 309.

³⁴ Self, "Rhetoric and *Phronesis*," 130-145; Schwarze "Performing *Phronesis*," 78-95; Hariman, "Prudence/Performance," 26-35.

³⁵ On this, see Aristotle, *Nicomachean Ethics*, Book VI.

³⁶ Tronto, "An Ethic of Care," 64-65.

about the meaning of *eudaimonia* in the first place.³⁷ Furthermore, utilizing the term *phronesis* here brings to mind the more complicated notion of autonomy I have been attempting to develop throughout this thesis. In accordance with Tronto’s locating of care in such “rough ground,” the autonomy of the patient may be seen as a critical component but one that must be balanced with the insights of others involved in the caring process. This is, at its heart, what I argue lifestyle change therapy is all about: the autonomous choice to seek care for weight-related or lifestyle-related health problems and to revise one’s daily life in cooperation with a trusted healthcare provider so as to achieve the goal of better health and wellbeing.

4.3 THE ONLINE LIFESTYLE SUPPORT SYSTEM (OLSS)³⁸

In this section, I shift from theory building to analyze an example of lifestyle change therapy. As I analyze this example, I bring forward the concepts developed in the previous section (e.g., *eudaimonia*, *paideia*, and *phronesis*) and refer to arguments that have been made in previous chapters. My goal is to provide some evidence that lifestyle change therapy can be designed in such a way as to incorporate the values and principles I have defended throughout this thesis, especially responsibility as capability, autonomy, and beneficence.³⁹ Thus, this section brings the entire work of this thesis together in a short discussion of how best to proceed with the

³⁷ On the role of deliberation in *phronesis*, see especially Self, “Rhetoric and *Phronesis*,” 130-145. The “rough ground” is a metaphor used by the philosopher, Ludwig Wittgenstein, to describe the complexity and the contingency of lived experience, especially actual language use. See Ludwig Wittgenstein, *Philosophical Investigations*, rev. 4th ed., ed. P. M. S. Hacker and Joachim Schulte, trans. G. E. M. Anscombe and P. M. S. Hacker (Malden, MA, Wiley-Blackwell, 2009), S107. Dunne borrows this language to talk about *phronesis* as an orientation to pedagogy that has been lost due to an increasing commitment by some to a “technist” and bureaucratic view of education. See Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique*.

³⁸ This section summarizes key findings already detailed in my dissertation. Rief, “Searching for the Good Life,” especially chapters 3, 4, and 5.

³⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*.

cultivation of lifestyle change therapy in the years to come. It also shows how a return to a bioethics frame, rather than embracing a thoroughgoing public health frame, brings different understandings of responsibility, autonomy, and beneficence to the table in our effort to address the obesity problem (chapter 3). Thus, this section counter-balances the effort, primarily undertaken by Fabrizio Turoldo, to craft a “framework” for responsibility that focuses mostly on whole populations or larger institutions.⁴⁰

The Online Lifestyle Support System (OLSS) is a pedagogical program (*paideia*) that has been designed to enhance the capabilities of lifestyle coaches and physicians in their efforts to help patients lose weight by providing training in healthy eating and physical activity.⁴¹ Because the program involves active online interaction between lifestyle counselors (i.e., healthcare practitioners with training in, for example, physical activity and nutrition) and participants, the original researchers involved in the pilot study developed training materials for both.⁴² While I am invested in shifting the focus of discussion about the obesity problem into the realm of the patient as an “expert” in his or her own care, the analysis in this section focuses on the provider

⁴⁰ Turoldo, “Responsibility as and Ethical Framework for Public Health Interventions,” 1197-1202.

⁴¹ McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Miloas, and Simkin-Silverman, “Using the Internet to Translate an Evidence-Based Lifestyle Intervention into Practice,” 851-858; McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, “Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care,” 261-264.

⁴² This protocol was made available to the author by the OLSS working group at the University of Pittsburgh. Its working title is, “Lifestyle Coach Training,” Copyright University of Pittsburgh, 2008. It is a modified version of the Diabetes Prevention Program’s (DPP) principles. See <http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/index.htm>. It should also be noted here that the investigators involved in developing the OLSS have assigned copyright for all materials associated with the program to the University of Pittsburgh and have licensed its sale to an outside party. Thus, none of the investigators receive proceeds for the sale or distribution of any elements of the OLSS. See McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Miloas, and Simkin-Silverman, “Using the Internet to Translate an Evidence-Based Lifestyle Intervention into Practice,” 851-858; McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, “Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care,” 261-264.

training materials developed for the study.⁴³ It does so because these materials display the extent to which, at least in this study, lifestyle coaches were trained to interact with participants in a way that enhances their cultivation of responsibility as capability (i.e., their expertise) while simultaneously valuing the role of provider beneficence in achieving quality care. Thus, my argument in this section is that the best way to determine whether lifestyle change therapy can in fact assist patients' self-cultivation of responsibility as capability is to investigate how providers are trained to make this happen in a real world setting.

Thus, the underlying practical condition for the OLSS exhibits one of its key ethical commitments: all participants in this study chose to participate. Thus, their autonomy is an element implicitly respected and promoted in all of the steps of the protocol following their initial choice. My argument specifically illuminates the points at which the protocol provides substantive content for the view of autonomy that I endorse, a view that is compatible with assuming responsibility as capability. The rest of this section discusses the content of the protocol, focusing on the "tips" section that provides a set of basic principles for action for lifestyle coaches.

⁴³ D. Badcott, "The expert patient: Valid recognition or false hope?" *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 173-178; A. Edgar, "The expert patient: Illness as practice," *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 165-171; P.G. Gibson, H. Powell, A. Wilson, M.J. Abramson, P. Haywood, A. Bauman, M.J. Hensley, E.H. Walters, and J.J.L. Roberts, "Self-management education and regular practitioner review for adults with asthma," *Cochrane Database of Systematic Reviews* Issue 3 (CD001117), <http://thecochranelibrary.com> (Accessed April 22, 2011); S.L. Norris, M.M. Engelau, and K.M. Narayan, "Effectiveness of self-management training in type 2 diabetes: A systematic review of randomized controlled trials" *Diabetes Care* 24, no. 3, (2001): 561-587; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient self-management of chronic disease in primary care," *Journal of the American Medical Association*, 288 no. 19 (2002): 2469-2475; Edward H. Wagner, "Chronic disease management: What will it take to improve care for chronic illness?" *Effective Clinical Practice*, 1, no. 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving chronic illness care: Translating evidence into action," *Health Affairs (Millwood)*, 20, no. 6 (2001): 64-78; Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 79-86.

The counselor training protocol for the OLSS (“Lifestyle Coach Training”) emerged out of an earlier version developed for the Diabetes Prevention Program.⁴⁴ OLSS is the online or virtual form of this program designed to work for a variety of different clinical domains by transitioning counseling into an online setting.⁴⁵ According to the coaching protocol, OLSS “is designed for delivery in coordination with outpatient medical care, and teaches patients about healthy eating and physical activity patterns, along with tips as to how best fit them into their lives.”⁴⁶ This part of the protocol immediately marks the overall strategy of the OLSS as a pedagogical endeavor. It is an effort to achieve some form of *paideia* that will aid in the overall efforts of participants to lose weight. What kind of *paideia* is involved becomes clear upon examination of various portions of the protocol, particularly the “tips” section which provides specific clues regarding how lifestyle coaches are meant to interact with the participants in the study while assisting them in the cultivation of new lifestyle practices.

The protocol opens by addressing a critical element of the overall OLSS: the role of persuasion in achieving lifestyle change. It discusses how the expert, technical information of health professionals is to be adequately translated to a lay public.⁴⁷ For instance, the protocol discusses the two ways in which messages exchanged between lifestyle counselors and participants through an email system designed for the study (“notes”) are delivered to

⁴⁴ William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan, “Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin,” *New England Journal of Medicine* 346, no. 6 (2002): 393-403.

⁴⁵ See McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Miloas, and Simkin-Silverman, “Using the Internet to Translate an Evidence-Based Lifestyle Intervention into Practice,” 851-858; McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, “Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care,” 261-264.

⁴⁶ “Lifestyle Coach Training,” 1.

⁴⁷ This is a central insight of Ainslie’s work in “Redefining Bioethics in the Age of AIDS.” The notion that there are different kinds of arguments that might be utilized in personal, professional, and public environments has been the subject of substantial scholarly development in the field of argumentation studies. For an excellent exemplar that tends in the direction of my analysis here, see G. Thomas Goodnight, “The personal, technical, and public spheres of argument,” *Journal of the American Forensics Association* 18 (1982): 214-227.

participants: “scheduled” and “as needed.”⁴⁸ In both instances, the coach is trained to “ask the participant questions if you feel you need more information on a topic. He or she can write back with the information, and you can address their response in a new message.”⁴⁹ Here, the communication between counselor and participant is figured as ongoing and essential to the success of the OLSS program. Information alone is not sufficient; particularizing it to the needs of the patient is crucial to the successful implementation of the OLSS.

This part of the protocol follows the basic but important ethical point that persuasion between provider and patient should happen openly and honestly and should value both sides of the dyad. For example, Ruth R. Faden and Tom L. Beauchamp note that “persuasion is always a non-clandestine form of interpersonal influence; the persuader openly puts forward reasons for accepting or adopting what is advocated. All choices made and acts performed on the basis of persuasion are non-controlled.”⁵⁰ In other words, persuasion is autonomy-respecting conversation in which alternatives are presented and then discussed.⁵¹ It should also involve input from both the provider, in this case the lifestyle coach, and the participant without allowing either to have superior power. As David H. Smith and Loyd S. Pettegrew (notably drawing on the ancient Greek rhetorical tradition in their account) declare,

We cannot recommend the patient sovereignty model. It would sacrifice, in the name of avoiding manipulation, the opportunity for what could really be called a relationship between physician and patient. Reducing the physician to the role of an expert reporting data would rob that profession of part of its richest tradition and would rob the patients of reassurance and caring. Interdependence demands responsible interaction, not separation. Viewing the doctor-patient relationship as

⁴⁸ “Lifestyle Coach Training,” 2.

⁴⁹ “Lifestyle Coach Training,” 6.

⁵⁰ Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986), 262.

⁵¹ David H. Smith and Loyd S. Pettegrew. “Mutual Persuasion as a Mode for Doctor-Patient Communication,” *Theoretical Medicine and Bioethics* 7 (1986): 127-146. I discuss the relationship between their work and my own most directly in chapter 4 of “Searching for the Good Life.”

mutual persuasion not as information and consent, can offer us a useful alternative to the directives and orders of paternalism.⁵²

In short, these passages drawn from the bioethical literature indicate the extent to which persuasion is an essential element of the provider-patient relationship. Thus, the idea that lifestyle change therapy as a sort of persuasion would not violate the autonomy of the individual or render them somehow subject to rather than participants in the caring relationship.

Accordingly, what I have in mind is a view of autonomy not merely as autonomous chooser or as self-determination, but autonomy as a capacity that increases with the increase of one's capability to assume responsibility for self-care. This stands in contrast with the public health view described in chapter 3. While public health advocates see their efforts to address the obesity problem as largely rooted in the same concern for beneficence and the same practice of persuasion described in this section, there are critical differences between the two approaches that now may be made clear.⁵³ Public health efforts may be considered problematic insofar as they do not allow for the negotiation between provider and patient that is the hallmark of the clinical environment. One would not refer to large scale public health campaigns as examples of "mutual persuasion" as Smith and Pettegrew use the term above. It is for this reason that I remain skeptical of these strategies in response to the obesity problem. Instead, and in line with the theorists briefly mentioned here and the OLSS protocol, I believe that the *eudaimonia* of obese patients is best served when it is crafted through an ongoing and open communicative relationship. Furthermore, the most coercive undertakings of public health in the domain of the obesity problem, e.g., Callahan's "stigmatization lite," not only violate this communicative relationship but also have material consequences for the individuals marked as obese and in need

⁵² Smith and Pettegrew, "Mutual Persuasion as a Mode for Doctor-Patient Communication," 144.

⁵³ In fact, this is Turolto's argument in a nutshell. Turolto, "Responsibility as an Ethical Framework for Public Health Interventions," 1197-1202.

correction.⁵⁴ Thus, the public health frame occludes and potentially justifies the violation of the clinical frame in which the cultivation of a relationship between provider and patient is seen as paramount. This relationship includes both the notion that patients cannot simply advance their own understanding of *eudaimonia* without being engaged and potentially challenged by their provider (*paideia*).

Second, the OLSS protocol directly addresses the problem of particularizing the various elements of the program to the specific needs of individual participants (thus continuing the development of a dyadic strategy that values patient input and needs). This insight is articulated throughout the protocol and expressed most clearly on the first page:

Each participant makes personal choices about how to achieve the goals [of the OLSS program]. This allows for flexibility and reinforces the ability of the participants to shape and evaluate their own progress by self-monitoring, developing personal goals and action plans, and problem solving. Your role [as a lifestyle coach] is to guide and support the participants in self-management.⁵⁵

This passage shows a concern for the needs, life goals, and plans of the participants in the program (*eudaimonia*), something I have figured as crucial to contemporary conceptions of respect for patient autonomy and the development of new capabilities rooted in the experiences and needs of the individual (*phronesis*).⁵⁶ In this way, the overall protocol is designed to counteract any of the tendencies that have been criticized by those I have referred to as nominalists. The protocol explicitly rejects the idea that individuals must fully accept the goals of medicine in achieving their goals. This does not mean that the OLSS is not grounded in medical science or aimed at achieving improvements in health. Rather, it means that individual

⁵⁴ Callahan, "Obesity," 39.

⁵⁵ "Lifestyle Coach Training," 1.

⁵⁶ See, e.g. Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision-Making* (Cambridge: Cambridge University Press, 1989); Beauchamp and Childress, *Principles of Biomedical Ethics*.

autonomy and the cultivation of responsibility as capability are highlighted as primary constraints on the provision of care. This, in tandem with the protocol's concern that the best medical evidence available be provided to participants and used in designing various approaches to achieving individual goals, shows how autonomy and beneficence are both at play in the effort to achieve lifestyle change in this program.⁵⁷

With these initial insights in mind, I now move on to a discussion of the 7 “Practical Tips for Lifestyle Counseling” that give an even more detailed account of the view of rhetorical practices and pedagogy in the counseling protocol:

Tip 1 – “Express support & acceptance for the participant regardless of their progress toward their lifestyle goals.”⁵⁸ This tip indicates the importance of building rapport with the patient.⁵⁹ By not blaming patients and by showing an awareness of their current condition without judging them, the counselor shows kindness, builds credibility, and solidifies their relationship with the patient. Thus, this tip shifts attention away from the health frames and negative provider attitudes that tend toward stigmatization detailed in previous chapters.

Tip 2 – “Look for success & build on it, no matter how small or gradual.” This tip largely reaffirms the first. It indicates that recognition of even small successes for the patient can yield positive dividends in the long run.⁶⁰ Such recognition builds on the notions of support and

⁵⁷ “Lifestyle Coach Training,” 1.

⁵⁸ “Lifestyle Coach Training, 4.” All of the quotes in the remainder of this section are taken from page 4 of the document.

⁵⁹ This has been a central insight of clinical care since the time of Hippocrates. See the Hippocratic writer, *Tradition in Medicine*, in *The Medical Works of Hippocrates*, trans. by John Chadwick and W.N. Mann (Oxford: Blackwell Scientific Publications), 13. I more fully develop this argument in chapter 2 of “Searching for the Good Life.”

⁶⁰ This is a controversial aspect of lifestyle change therapy as there is disagreement over the effectiveness of minor changes that would somehow have a cumulative effect on weight loss. See Krista Casazza, Kevin Fontaine, Arne Astrup, Leann L. Birch, Andres W. Brown, Michelle M. Bohan Borwn, Negertiti Durant, Gareth Dutton, E. Michael Foster, Steven B. Heymsfield, Kerry McIver, Tapan Mehta, Nir Menachemi, P. K. Newby, Russell Pate, Barbara J. Rolls, Bisakha Sen, Daniel L. Smith, Jr., Diana M. Thomas, and David B. Allison, “Myths, Presumptions, and Facts about Obesity,” *New England Journal of Medicine* 268, no. 5 (January 31, 2013): 446-454.

autonomy developed in the first tip. It does so by indicating that lifestyle coaches should not be in the business of judging the participant or making them feel as if his or her activities are not adequate. This again challenges the most coercive elements of the public health frame by indicating an *attitude* of support and acceptance for the patient, something obviously needed given the ongoing problems of stigmatization both in and out of the clinical setting.⁶¹

Tip 3 – “Maintain the highest standards and expectations.” This is a crucial tip because it shows a concern with provider beneficence. Edmund D. Pellegrino suggests that the primary goal of modern medicine is improving the quality of life of the patient: “The medical good aims at the return of physiological function of mind and body, the relief of pain and suffering by medication, surgical interventions, psychotherapy, etc.”⁶² On this interpretation, the goal of medicine is to provide a higher quality of life for the patient. Giving up, reducing our expectations, and remaining rooted only in the status quo of the patient’s life and choices would fundamentally undermine this goal of medicine. The coaching protocol continues its discussion of this tip by suggesting that “expectations are often self-fulfilling. If expected to do poorly, participants are more likely to do poorly; if expected to do well, many will rise to the occasion.” There is a powerful ethical point being made here: if medicine completely conforms with the current beliefs and expectations of the individual and pays no attention to potential transformations in medical knowledge, then patient care may be seriously degraded.⁶³ This tip indicates the degree to which the “integrative perspective” defended by Saguy and Riley may be

⁶¹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 103.

⁶² Edmund D. Pellegrino, “The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions,” *Journal of Medicine and Philosophy* 26, no. 6 (2001): 569. Pellegrino limits his analysis to the clinical encounter rather than also including such circumstances as co-clinical or extra-clinical communication; however, for my purposes, the definition is applied to the broader context.

⁶³ Smith and Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” 127-146.

needed in addressing controversies surrounding obesity research and care.⁶⁴ Instead of falling into the trap of constantly questioning and rejecting new medical discoveries, we may be better served by constantly revising our understanding of medicine and its role in our lives based on the best evidence available. This does not mean blind acceptance of medical knowledge and expertise but it does mean that accepting the findings of medical research, no matter how provisional, must be part of the project of improving health and searching for the good life (*eudaimonia*) for everyone.⁶⁵

Tip 4 – “Do not assume that a barrier to the study goals exists until it is evident (for example) that a participant who has a lower level of education will be unable to calculate fat grams when self-monitoring). Such assumptions are often based on hidden biases that may prove false.” This tip brings up another set of concerns. First, it indicates that when we craft messages for the individual patient, we may sometimes assume things about them that are false. Healthcare professionals should work assiduously to avoid such false assumptions, as they distract the professional from attending to what is true, and frequently express disrespectful attitudes toward the patient (either by employing disrespectful stereotypes or by failing to attend to the patient as an individual in her own right). A lifestyle counselor’s remaining open to the possibility that she has incorrectly understood the capabilities of a patient shows concern for the changing dynamics of human communication. Second, it addresses the ethical problems of first impressions and of assuming too much about what the patient may actually want. Such assumptions may affect the quality of care that is delivered and undermine autonomy. Third, it promotes the pedagogical goal of training educators to believe in the power of education to transform and empower the

⁶⁴ Saguy and Riley, “Weighing Both Sides,” 874.

⁶⁵ Rief, “Searching for the Good Life.”

student.⁶⁶ The OLSS program was designed to challenge barriers to weight loss, improved physical activity, and nutrition, not reify them. This tip generates important insights for counselors in this regard as it invites them to continue the process of engaging the participant, thereby revising what is possible for her to achieve. This is precisely how autonomy is both maintained and enhanced through the provider-patient relationship.⁶⁷

Tip 5 – “Involve the participant as much as possible.” This tip largely reaffirms the last and emphasizes the role of the patient in his or her own care. It also indicates that experimentation on a daily basis is a necessary component of pedagogy: “evidence of a barrier is not a sign of failure on the part of the counselor or the participant but rather is a valuable piece of information to be used to design and test a better experiment together.” This advice also reaffirms the need for ongoing revision of the counselor-participant interaction and of the methods of care being applied in the participant’s everyday experience of obesity and weight management.⁶⁸

Tip 6 – “Be the expert.” This is an important caveat to the patient-centered approach being described. It indicates that while there needs to be give-and-take between the counselor and the patient, there is still a power imbalance in terms of different domains of knowledge. The OLSS is not designed to turn obese patients into scientific or clinical experts but rather to activate them in their own care. Health professionals still have important knowledge that must remain part of the give-and-take communication they engage in with their patients.⁶⁹ As Tronto points out, “the caregiver has some kind of ability, knowledge, or resource that the care receiver

⁶⁶ Roter, Stashefsky-Margalit, and Rudd, “Current Perspectives on Patient Education in the U.S.,” 79-86; (cited by Roter et al.) Paolo Friere, *Pedagogy of the Oppressed: 30th Anniversary Edition* (New York: Continuum, 2006).

⁶⁷ Smith and Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” 127-146.

⁶⁸ Tronto, “An Ethic of Care,” 60-68.

⁶⁹ Smith and Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” 127-146.

does not have.”⁷⁰ What is most important is the recognition in “Lifestyle Coach Training” that “information and behavioral strategies are included in the intervention because of their likelihood of enhancing achievement and maintenance of the goals, not as ends in themselves.” This is a crucial acknowledgement of the limits of information and of expert knowledge but a simultaneous acknowledgement of the importance of these things in the counselor-participant relationship.⁷¹ In many ways, this tip acknowledges that expertise should be valued but not as a means to override the broader concerns of the public it is meant to serve. Instead, expertise must be translated and fitted to the needs of specific audiences and patients.⁷² Thus, caring for others, as Tronto argues, involves responsibility: “The moral dimension of caring for is to assume, and to take seriously, responsibility.”⁷³

Tip 7 – “Tailor the intervention to participant lifestyle, learning style, and culture.” This tip largely recapitulates the point I made earlier about *phronesis* in the protocol. It indicates a concern for the specification of medical advice (to situation and patient), the need for patient autonomy, and the need to deal with different learning styles as part of any robust pedagogical encounter.⁷⁴

⁷⁰ Tronto, “An Ethic of Care,” 64.

⁷¹ On the problems associated with “information” models of communication in clinical care, see e.g., Edward H. Wagner, “Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?” *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, “Improving Chronic Illness Care: Translating Evidence into Action,” *Health Affairs* 20, no. 6 (2001): 64-78. Rubinelli, Schulz, and Nakamoto, “Health Literacy Beyond Knowledge and Behaviour,” 307-311; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach. “Patient Self-management of Chronic Disease in Primary Care.” *Journal of the American Medical Association* 288 (2002): 2469-2475.

⁷² Goodnight, “The personal, technical, and public spheres of argument,” 214-227; Smith and Pettegrew, “Mutual Persuasion as a Mode for Doctor-Patient Communication,” 127-146.

⁷³ Tronto, “An Ethic of Care,” 63.

⁷⁴ Roter, Stashefsky-Margalit, and Rudd, “Current Perspectives on Patient Education in the U.S.,” 79-86; Beauhamp and Childress, *Principles of Biomedical Ethics*.

4.4 CONCLUSION

By going back to the context of the ancient Greek tradition and deploying its concepts in the domain of contemporary clinical practice, I have provided a way to think about lifestyle change therapy as a process of *paideia* (education) in the pursuit of *eudaimonia* (the good life), through the appreciation of the needs, strengths, life experiences, and goals of the particular patient (*phronesis*).⁷⁵ Such concerns can and should animate additional research into the pedagogical approaches of health care workers who hope to engage in lifestyle change therapy as well as ethicists hoping to influence clinical practices. As I have briefly shown in the previous section, lifestyle change therapy need not be a Platonic (and public health) effort to radically rework the individual's goals, aspirations, or beliefs through the imposition of *true* knowledge. Instead, as the OLSS coaching documents suggests, lifestyle change therapy is animated first and foremost by the needs and concerns of patients. Thus, its *paideia* is focused on the cultivation of their aspirations and is rooted in their experiences of the world (*phronesis*). For this reason, returning to the clinical domain and bringing a bioethical point of view to lifestyle change saves it from the withering critique of nominalists and tempers the most radical realist views about its necessity. In adopting this viewpoint, we have also seen how patients might be given the tools to develop their own responsibility for their care rather than having it imposed on them by larger public health efforts. The OLSS protocol, and I wager many other approaches to lifestyle change therapy, are grounded not in forcing individuals to change but in assisting them to achieve the changes they already want to make. While a bit of paternalistic persuasion may creep into provider-patient interactions, it is likely to be minor in comparison to the pressures that are

⁷⁵ Rubinelli, Schulz, and Nakamoto, "Health Literacy Beyond Knowledge and Behaviour," 307-311

marshaled in larger socio-political efforts to address the obesity problem. This matter of degree is ethically important, because lifestyle change therapy may then be found compatible with patients' autonomy as self-determining individuals, with their moral equality with those delivering the health-related messages, and with respect for them as individuals capable of assuming responsibilities of self-care.

It is now possible to see how the many pieces of this thesis work in tandem. Chapter 1 provides an initial account of the obesity problem and the frequently conflicting evidence regarding it. The chapter also establishes that, as far as the best evidence we have right now is concerned, lifestyle change therapy is a necessary and effective component of any clinical approach to the treatment of obesity and its related co-morbidities. Chapter 2 charts the contested elements of the obesity problem and suggests that there is good reason for the nominalists and realists to work together in framing the care that individuals should receive.⁷⁶ Such cooperation, I have argued, may be readily found in the domain of clinical care where respect for patient autonomy is a primary value. Chapter 3 shows that responsibility, one of the most contested terms in larger terrain of the obesity problem, can be productively rearticulated if it is shifted from the public health domain and reconceptualized for productive use within the domain of bioethics and the provider-patient clinical relationship. There, the notion of responsibility as capability emerges as an alternative to public health efforts that largely seek to hold individuals or larger institutions responsible in a backward focused moral or causal sense. Of course, as I point out, there is no reason to argue against some of the approaches suggested by public health, especially those that would create better and healthier environments for our communities; however, remaining skeptical of larger public efforts—especially those that either seek or result

⁷⁶ Saguy and Riley, "Weighing Both Sides," 869-921.

in stigmatizing the obese—while remaining committed to the ethics of clinical care may be the best way to bring more individuals on board with the largely health-focused efforts to tackle obesity and lifestyle-related illness generally.

Finally, this chapter analyzes a model for thinking about this clinical relationship that shows how autonomy, beneficence, and responsibility may work in tandem to craft an ethical and acceptable approach to lifestyle change therapy. It does so by reversing the trend, notable in the work of Turolto, to shift our attention away from the clinical domain and into the world of public health.⁷⁷ While I am in agreement with many of his arguments and I draw on the same principles, I do so in the service of a return to the clinical environment. Finally, when viewing the chapters in tandem, we can now see why bioethics must move beyond the strictly clinical domain to comment on problematic aspects of the public health discourse and to seek answers to the vexing problems associated with the obesity problem. Understanding how public discourses function to shame and stigmatize, how approaches to the question of responsibility may do the same, and how various groups feel about the problem of obesity in the first place, may inform a more nuanced analysis of the traditional principles of bioethics in response to the obesity problem. By achieving and implementing this understanding, we may chart a way to a more ethical and effective approach to the care of individuals who seek weight loss, a more active lifestyle, or a better diet in the service of realizing their conception of *eudaimonia*.

⁷⁷ Turolto, “Responsibility as and Ethical Framework for Public Health Interventions,” 1197-1202.

BIBLIOGRAPHY

- Abdel-Halim, R. E. "Obesity: 1000 Years Ago." *Lancet* 366, no. 9481 (2005): 366-204.
- Ainslie, Donald Cameron. *Redefining Bioethics in the Age of AIDS*. Masters Thesis. Center for Bioethics and Health Law, University of Pittsburgh, 1996.
- Arendt, Hannah. *The Human Condition*. Chicago: The University of Chicago Press, 1958.
- Aristotle, *Art of Rhetoric*, Loeb Classical Library 193, trans. John H. Freese (Cambridge: Harvard University Press, 1926/2000).
- , *The Nicomachean Ethics*. Edited by Jeffrey Henderson. Translated by H. Rackham. Loeb Classical Library 73. Cambridge, MA: Harvard University Press, 1926.
- Badcott, D. "The expert patient: Valid recognition or false hope?" *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 173-178.
- Baier, Kurt. "Moral and Legal Responsibility." In *Medical Innovation and Bad Outcomes: Legal, Social and Ethical Responses*, edited by Mark Siegler, Stephen Toulmin, Frank E. Zimring, and Kenneth F. Schaffner, 101-130. Ann Arbor: Health Administration Press, 1987.
- Bayer, Ronal. "Stigma and the Ethics of Public Health: Not Can We But Should We." *Social Science and Medicine* 67 (2008): 463-472.
- Beauchamp, Tom L. and James F. Childress. *Principles of Biomedical Ethics*. 6th edition. Oxford: Oxford University Press, 2009.
- Black, Leeora D. "Corporate Social Responsibility as Capability: The Case of BHP Billiton." *Journal of Corporate Citizenship* (Autumn, 2006): 25-38.
- Blass, Elliot M., editor. *Obesity: Mechanisms, Prevention, Treatment*. Sunderland, MA: Sinauer Associates, Inc., 2008.
- Bodenheimer, Thomas, Kate Lorig, Halsted Holman, and Kevin Grumbach. "Patient self management of chronic disease in primary care." *Journal of the American Medical Association*, 288 no. 19 (2002): 2469-2475.

- Bordo, Susan. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: University of California Press, 1993.
- Boren, Jeremy. "Researchers to Study Impact of New Grocery on Pittsburgh's Hill District Residents." *TribLive:News*. November 21, 2012. <http://triblive.com/news/alleggheny/2963727-74/hill-grocery-homewood-health-residents-shop-store-district-eating-shopping#axzz2D6rpEoak>. Accessed March 5, 2013.
- Brockriede, Wayne and Douglas Ehninger, "Toulmin on Argument: An Interpretation and Application," *Quarterly Journal of Speech* 48, no. 1 (1960): 44-54.
- Brownell, Kelly D. "The Chronicling of Obesity: Growing Awareness of Its Social, Economic, and Political Contexts." *Journal of Health Politics, Policy and Law* 30. No. 5 (2005): 955-964.
- Brownell, Kelly D., Rogan Kersh, David S. Ludwig, Robert C. Post, Rebecca M. Puhl, Marlene B. Schwartz, and Walter C. Willett. "Personal Responsibility And Obesity: A Constructive Approach." *Health Affairs* 29, no. 3 (2010): 379-387.
- Brushwood, David B. "Professional Capabilities and Legal Responsibilities of Pharmacists: Should 'Can' Imply 'Ought.'" *Drake Law Review* 44 (1995/1996): 439-462.
- Buchanan, Allen E., and Dan W. Brock. *Deciding for Others: The Ethics of Surrogate Decision Making*. New York: Cambridge University Press, 1990.
- Buchwald, Henry, Yoav Avidor, Eugene Braunwald, Michael D. Jensen, Walter Pories, Kyle Farhbach, and Karen Schoelles. "Bariatric Surgery: A Systematic Review and Meta analysis." *Journal of the American Medical Association* 292, no. 14 (October, 13 2004): 1724-1728.
- Burke, Kenneth. *Attitudes Toward History*. 3rd Edition. Berkeley: University of California Press, 1937/1984.
- . *Counter-Statement*. Berkeley/Los Angeles/London: University of California Press, 1968.
- . *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952).
- . *Permanence and Change: An Anatomy of Purpose*, 3rd Edition. Berkeley/Los Angeles: University of California Press, 1984.
- . *The Philosophy of Literary Form: Studies in Symbolic Action*. 3rd Edition. Berkeley: University of California Press, 1973.
- . *A Rhetoric of Motives*. Berkeley: The University of California Press, 1969.

- Cahnman, Werner J. "The Stigma of Obesity." *The Sociological Quarterly* 9, no. 3 (1968): 283-299.
- Callahan, Daniel. "Private Choice and Common Good." *The Hastings Center Report* 24, no. 3 (1994): 28-31.
- , "Obesity: Chasing an Elusive Epidemic." *The Hastings Center Report* 43, no. 1 (2013): 34-40.
- Callahan, Daniel and Bruce Jennings. "Ethics and Public Health: Forging a Strong Relationship." *American Journal of Public Health* 92, no. 2 (2002): 169-176
- Campos, Paul, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser. "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic." *International Journal of Epidemiology* 35 (2006): 55-60.
- Casazza, Krista, Kevin Fontaine, Arne Astrup, Leann L. Birch, Andres W. Brown, Michelle M. Bohan Borwn, Negertiti Durant, Gareth Dutton, E. Michael Foster, Steven B. Heymsfield, Kerry McIver, Tapan Mehta, Nir Menachemi, P. K. Newby, Russell Pate, Barbara J. Rolls, Bisakha Sen, Daniel L. Smith, Jr., Diana M. Thomas, and David B. Allison. "Myths, Presumptions, and Facts about Obesity." *New England Journal of Medicine* 268, no. 5 (January 31, 2013): 446-454.
- Centers for Disease Control. "BMI Definition." September 13, 2011.
<http://www.cdc.gov/healthyweight/assessing/bmi/index.html> (Accessed March 8, 2013).
- Centers for Disease Control. "Defining Overweight and Obese." April 27, 2012.
<http://www.cdc.gov/obesity/defining.html> (Accessed March 8, 2013).
- Charon, Rita. *Narrative Medicine: honoring the Stories of Illness*. Oxford: Oxford University Press, 2006.
- Childress, James F., Ruth R. Faden, Ruth D. Gaare, Lawrence O. Gostin, Jeffrey Kahn, Richard J. Bonnie, Nancy E. Kass, Anna C. Mastroianni, Jonathon D. Moreno, and Phillip Nieburg. "Public Health Ethics: Mapping the Terrain." *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 170-178.
- Ciao, A. C. J. D. Latner, L. E. Durso. "Treatment Seeking and Barriers to Weight Loss Treatments of Different Intensity Levels Among Obese and Overweight Individuals." *Eating and Weight Disorders* 17, no. 1 (2012): e9-16.
- Cloud, Dana L. *Control and Consolation in American Culture and Politics: Rhetorics of Therapy*. Thousand Oaks: Sage Publications, 1998.

- Cohen, Deborah A. "Obesity and the Built Environment: Changes in Environmental Cues Cause Energy Imbalances." *International Journal of Obesity* 32, supplement 7 (2008): S137-142.
- Cohen, Deborah A., Roland Sturm, Molly Scott, Thomas A. Farley, and Ricky Blumenthal. "Not Enough Fruit and Vegetables or Too Many Cookies, Candies, Salty Snacks, and Soft Drinks." *Public Health Reports* 125 (January-February, 2010): 88-95.
- Cohen, Stanley. *Folk Devils and Moral Panics*. New York: Routledge, 1972.
- Cooper, John M. *Reason and Human Good in Aristotle*. Cambridge, MA: Harvard University Press, 1975.
- Daniels, Norman. "Health-Care Needs and Distributive Justice." *Philosophy & Public Affairs*, 10, no. 2 (1981): 146-179.
- Davis, F. Daniel. "Phronesis, Clinical Reasoning, and Pellegrino's Philosophy of Medicine." *Theoretical Medicine* 18 (1997): 173-195.
- DeJong, William. "The Stigma of Obesity: The Consequences of Naïve Assumptions Concerning the Causes of Physical Deviance." *Journal of Health and Social Behavior* 21 (1980): 75-87.
- Deurenberg, P., M. Yap, and W. A. Staveren. "Body Mass Index and Percent Body Fat: A Meta analysis Among Different Ethnic Groups." *International Journal of Obesity* 22 (1998): 1164-1171.
- Devisch, Ignaas and Myriam Deveugele. "Lifestyle: Bioethics at a Critical Juncture." *Cambridge Quarterly of Healthcare Ethics* 19 (2010): 550-558.
- Dubowitz, Tamara, Melonie Heron, Chloe E. Bird, Nicole Lurie, Brian K. Finch, Ricardo Basurto-Davila, Lauren Hale, and Jose J. Escarce. "Neighborhood Socioeconomic Status and Fruit and Vegetable Intake Among Whites, Blacks, and Mexican Americans in the United States." *American Journal of Clinical Nutrition* 87 (2008): 1883-1891.
- Dunne, Joseph. *Back to the Rough Ground: Practical Judgment and the Lure of Technique*. Notre Dame: University of Notre Dame Press, 2009.
- Edgar, A. "The expert patient: Illness as practice." *Medicine, Health Care and Philosophy* 8, no. 2 (2005): 165-171.
- Edgar, Timothy, Seth M. Noar, and Vicki S. Freimuth, editors. *Communication Perspectives on HIV/AIDS for the 21st Century*. New York: Lawrence Erlbaum Associates, 2008.
- Emmanuel, Ezekiel. *The Ends of Human Life: Medical Ethics in a Liberal Polity*. Cambridge: Harvard University Press, 1991.

- Faden, Ruth R. and Tom L. Beauchamp. *A History and Theory of Informed Consent*. Oxford: Oxford University Press, 1986.
- Farley, Thomas, David R. Just, and Brian Wansink. "Regulation of Sugar-Sweetened Beverages." *New England Journal of Medicine* 367, no. 15 (2012): 1464-1466.
- Farrell, Thomas B. *Norms of Rhetorical Culture*. New Haven: Yale University Press, 1993.
- Feudtner, Chris. *Bittersweet: Diabetes, Insulin, and the Transformation of Illness*. Chapel Hill: University of North Carolina Press, 2003.
- Finkelstein, Eric A., Chen Zhen, James Nonnemaker, and Jessica E. Todd. "Impact of Targeted Beverage Taxes on Higher- and Lower-Income Households." *Archives of Internal Medicine* 170, no. 22 (2010): 2028-2034.
- Foster, Gary D., Thomas A. Wadden, Angela P. Makris, Duncan Davidson, Rebecca Swain Sanderson, David B. Allison, and Amy Kessler. "Primary Care Physicians' Attitudes About Obesity and Its Treatment." *Obesity Research* 11 (2003): 1168-1177.
- Foucault, Michel. *The Care of the Self: Volume 3 of the History of Sexuality*. New York: Vintage Books, 1988.
- *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan. New York: Vintage Books, 1995.
- *The Hermeneutics of the Subject: Lectures at the College de France 1981-1982*. Edited by Frederic Gros. Translated by Graham Burchell. New York: Picador, 2005.
- "Two Lectures." In *Power/Knowledge: Selected Interviews & Other Writings 1972-1977*, edited by Colin Gordon, pp. 78-108. New York: Pantheon Books, 1980.
- Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: The University of Chicago Press, 1995.
- Friere, Paolo. *Pedagogy of the Oppressed: 30th Anniversary Edition*. New York: Continuum, 2006.
- Freire, Rachel Horta, Mariane Curado Borges, Jacqueline Isaura Alvarez-Leite, and Maria Isabel Toulson Davisson Correia. "Food Quality, Physical Activity, and Nutritional Follow-Up as Determinant of Weight Regain after Roux-en-Y Gastric Bypass." *Nutrition* 28 (2012): 53-58.
- Gaesser, Glen A. *Big Fat Lies: The Truth About Your Weight and Your Health*. New York: Fawcett Columbine, 2002.

- Galuska, Deborah A., Julie C. Will, Mary K. Serdula, and Earl S. Ford. "Are Healthcare Professionals Advising Obese Patients to Lose Weight." *Journal of the American Medical Association* 282, no. 16 (1999): 1576-1578.
- Gard, Michael and Jan Wright. *The Obesity Epidemic: Science Morality and Ideology*. London/New York: Routledge, 2005.
- Gibson, P. G., H. Powell, A. Wilson, M. J. Abramson, P. Haywood, A. Bauman, M. J. Hensley, E. H. Walters, and J. J. L. Roberts, "Self-management education and regular practitioner review for adults with asthma," *Cochrane Database of Systematic Reviews* Issue 3 (CD001117), <http://thecochranelibrary.com>. Accessed April 22, 2011.
- Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster, First Touchstone Edition, 1986.
- Goode, Erich and Nachman Ben-Yehuda. *Moral Panics: The Social Construction of Deviance* (Malden, MA: Blackwell Publishers, 1994).
- Goodnight, G. Thomas. "The personal, technical, and public spheres of argument." *Journal of the American Forensics Association* 18 (1982): 214-227.
- Gordon, Thomas and W. Sterling Edwards. *Making the Patient Your Partner: Communication Skills for Doctors and Other Caregivers*. Westport, CT: Auburn House, 1995.
- Gostin, Lawrence O. "Law as a Tool to Facilitate Healthier Lifestyles and Prevent Obesity." *Journal of the American Medical Association* 297, no. 1 (2007): 87-90.
- Greene, Ronald Walter and Darrin Hicks. "Lost Convictions: Debating Both Sides and the Ethical Self-Fashioning of Liberal Citizens." *Cultural Studies* 19, issue 1 (2005): 100-126.
- Gregg, Edward W., Haiying Chen, Lynne E. Wagenknecht, Jeanne M. Clark, Linda M. Delahanty, John Bantle, Henry J. Pownall, Karen C. Johnson, Monika M. Safford, Abbas E. Kitabchi, F. Xavier Pi-Sunyer, Rena R. Wing, and Alain G. Bertouni (for the Look AHEAD Research Group). "Association of an Intensive Lifestyle Intervention with Remission of Type 2 Diabetes." *Journal of the American Medical Association* 308, no. 23 (2012): 2489-2496.
- Groopman, Jerome. *How Doctors Think*. Boston: Houghton Mifflin Company, 2007.
- Habermas, Jürgen. *The Structural Transformation of the Public Sphere: An Enquiry into a Category of Bourgeois Society*. Translated by Thomas Burger. Cambridge: MIT Press, 1991.
- Hacking, Ian. *The Social Construction of What?* Cambridge: The Harvard University Press, 2001.

- Han, Joan C., Debbie A. Lawlor, and Sue Y.S. Kim. "Childhood Obesity – 2010: Progress and Challenges." *The Lancet* 375, no. 9727 (May 15, 2010): 1737-1748.
- Hariman, Robert. "Prudence/Performance." *Rhetoric Society Quarterly* 21, no. 2 (1991): 26-35.
- Hart, H. L. A. *Punishment and Responsibility*. Oxford: Oxford University Press, 1968.
- Hippocratic Writer. *The Medical Works of Hippocrates*. Translated by John Chadwick and W. N. Mann. Oxford: Blackwell Scientific Publications.
- Huizinga, Mary Margaret, Lisa A. Cooper, Sara N. Bleich, Jeanne M. Clark, Mary Catherine Beach. "Physician Respect for Patients with Obesity." *Journal of General Internal Medicine* 24, no. 11 (November, 2009): 1236-1239.
- Hyde, Michael J. *The Life-Giving Gift of Acknowledgment*. West Lafayette, IN: Purdue University Press, 2006.
- Iglesias, Teresa. "Bedrock truths and the dignity of the individual." *Logos* 4, no. 1 (2001): 114-134.
- Jaeger, Werner. *Paideia: The Ideals of Greek Culture, Volumes I, II, and III*. New York: Oxford University Press, 1945.
- Jay, Melanie, Adina Kalet, Tavinder Ark, Michelle McMacken, Mary Jo Messito, Regina Richter, Sheira Schlair, Scott Sherman, Sondra Zabar, Colleen Gillespie. "Physician Attitudes About Obesity and Their Associations with Competency and Specialty: A Cross-Sectional Survey." *BMC Health Services Research* 9, no. 106 (2009): 10.1186/1472-6963-9-106.
- Jelelian, Elissa. "Survey of Physician Attitudes and Practices Related to Pediatric Obesity." *Clinical Pediatrics* 42, no. 3 (April, 2003): 235-245.
- Jenicek, Milos, and David L. Hitchcock, *Evidence-Based Practice: Logic and Critical Thinking in Medicine*. The American Medical Association Press, 2004.
- Jonsen, Albert R. "Casuistry and Clinical Ethics." *Theoretical Medicine and Bioethics* 7, no. 1 (1986): 65-74.
- Jonsen, Albert R. and Stephen Toulmin. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press, 1990.
- Jung, Carl. *The Practice of Psychotherapy: Essays on the Psychology of the Transference and Other Subjects*. 2nd edition. Translated by Gerhard Adler and R. F. C. Hull. Princeton: Princeton University Press, 1985.

- Kant, Immanuel. *Grounding for the Metaphysics of Morals*. 3rd Edition. Translated by James W. Ellington. Indianapolis/Cambridge: Hackett Publishing Company, Inc., 1993.
- Karnik, Sameera and Amar Kanekar. "Childhood Obesity: A Global Public Health Crisis." *International Journal of Preventive Medicine* 3, no. 1 (January 2012): 1-7.
- Keränen, Lisa. *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research*. Tuscaloosa: The University of Alabama Press, 2010.
- Kersh, Rogan and James A. Morone. "Obesity, Courts, and the New Politics of Public Health." *Journal of Health Politics, Policy and Law* 30. No. 5 (2005): 839-868.
- Kleinman, Arthur. *The Illness Narratives: Suffering, Healing, & The Human Condition*. Basic Books, 1988.
- Klitzman, Robert. *When Doctors Become Patients*. Oxford: Oxford University Press, 2008.
- Knowler, William C., Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan. "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin." *New England Journal of Medicine* 346, no. 6 (2002): 393-403.
- Kontaogianni, Meropi D., Stavros Liatis, Sofia Grammatikou, Desponia Perrea, Nikolas Katsilambros, and Konstantinos Makrilakis. "Changes in Dieting Habits and their Association with Metabolic Markers After a Non-Intensive, Community-Based Lifestyle Intervention to Prevent Type 2 Diabetes, in Greece (the DEPLAN Study)." *Diabetes Research and Clinical Practice* 95 (2012): 207-214.
- Kristeller, J. L. and R. A. Hoerr. "Physician Attitudes Toward Managing Obesity: Differences Among Six Specialty Groups." *Preventive Medicine* 26, no. 4 (1997): 542-549.
- Krug, Etienne G., James A. Mercy, Linda L. Dahlberg, and Anthony B. Zwi. "The World Report on Violence and Health." *The Lancet* 360 (October, 2002): 1083-1088.
- Leach, Joan and Deborah Dysart-Gale, editors. *Rhetorical Questions of Health and Medicine*. Lanham: Lexington Books, 2011.
- LeBesco, Kathleen. *Revolting Bodies? The Struggle to Redefine Fat Identity*. Amherst/Boston: The University of Massachusetts Press, 2004.
- Levin, Betty Wolder and Alan R. Fleischman, "Public Health and Bioethics: The Benefits of Collaboration." *American Journal of Public Health* 92, no. 2 (2002): 165-167.

- Lewis, Cora E., Kathleen M. McTigue, Lora E. Burke, Paul Poirier, Robert H. Eckel, Barbara V. Howard, David B. Allison, Shiriki Kumanyika, and F. Xavier Pi-Sunyer. "Mortality, Health Outcomes, and Body Mass Index in the Overweight Range: A Science Advisory from the American Heart Association." *Circulation* 119 (June 8, 2009): 3263-3271.
- Lynch, John. *What Are Stem Cells? Definitions at the Intersection of Science and Politics*. Tuscaloosa: The University of Alabama Press, 2011.
- Lyne, John. "Contours of Intervention: How Rhetoric Matters to Biomedicine." *Journal of Medical Humanities* 22, no. 1 (2001): 3-13.
- Lyne, John and Henry F. Howe. "'Punctuated Equilibria': Rhetorical Dynamics of a Scientific Controversy." *Quarterly Journal of Speech* 72 (1986): 132-147.
- MacIntyre, Alasdair. *After Virtue: A Study in Moral Theory*. 2nd Edition. Notre Dame: University of Notre Dame Press, 1984.
- McGuire, J.E. and Trevor Melia. "How to Tell the Dancer from the Dance." In *Science, Reason, and Rhetoric*, edited by Henry Krips, J.E. McGuire, and Trevor Melia, 73-93. Pittsburgh: The University of Pittsburgh Press, 1995.
- McKeon, Richard. "Creativity and the Commonplace." *Philosophy and Rhetoric* 6, no. 4 (1973): 199-210.
- "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts." In *The Prospect of Rhetoric: Report of the National Developmental Project*, edited by Lloyd F. Bitzer and Edwin Black, 44-63. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971.
- McTigue, Kathleen M., Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey R. Simkin-Silverman. "Using the Internet to translate an evidence-based lifestyle intervention into practice." *Telemedicine & eHealth*, 15, no. 9 (2009): 851-858.
- McTigue, Kathleen M., Russell Harris, Brian Hemphill, Linda Lux, Sonya Sutton, Audrina J. Bunton, and Kathleen N. Lohr. "Screening and Interventions for Obesity in Adults: Summary of the Evidence for the U.S. Preventive Services Task Force." *Annals of Internal Medicine* 139, no. 11 (2003): 933-949.
- McTigue, Kathleen M., Tina Bhargava, Cindy L. Bryce, Molly Conroy, Gary S. Fischer, Rachel Hess, Laurey R. Simkin-Silverman, and Susan Zickmund. "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care." *Patient Education and Counseling* 83 (2011): 261-264.
- Mello, Michelle M., David H. Studdert, and Troyen A. Brennan. "Obesity – The New Frontier of Public Health Law." *The New England Journal of Medicine* 354, no. 24 (June 15, 2006): 2601-2609.

- Metzl, Jonathon M., and Anna Kirkland, editors. *Against Health: How Health Became the New Morality*. New York: New York University Press, 2010.
- Midei, A. J. and K. A. Matthews. "Interpersonal Violence in Childhood As a Risk Factor for Obesity: A Systematic Review of the Literature and Proposed Pathways." *Obesity Reviews* 12 (2011): e159-e172.
- Miller, Franklin G., and Howard Brody. "The Internal Morality of Medicine: An Evolutionary Perspective." *Journal of Philosophy and Medicine* 26, no. 6 (2001): 581-599.
- Mitchell, Gordon R., and Kathleen M. McTigue. "The U.S. Obesity 'Epidemic': Metaphor, Method, or Madness." *Social Epistemology* 21, no. 4 (2007): 391-423.
- Montgomery, Kathryn. *Doctor's Stories: The Narrative Structure of Medical Knowledge*. Princeton: Princeton University Press, 1991.
- . *How Doctors Think: Clinical Judgment and the Practice of Medicine*. Oxford: Oxford University Press, 2006.
- . "Thinking about Thinking: Implications for Patient Safety." *Healthcare Quarterly* 12, special issue (2009): e191-e194.
- Montgomery, Scott L. *The Scientific Voice*. New York: The Guilford Press, 1996.
- Morland, Kimberly, Steve Wing, Ana Diez Roux, Charles Poole. "Neighborhood Characteristics Associated with the Location of Food Stores and Food Services Places." In *Race, Ethnicity, and Health: A Public Health Reader*, edited by Thomas A LaVeist, pp. 448-462. San Francisco: Jossey-Bass: A Wiley Imprint, 2002.
- Morris, David B. *Illness and Culture in The Postmodern Age*. Berkeley: University of California Press, 1998.
- Morris, David B. *The Culture of Pain*. Berkeley: University of California Press, 1991.
- National Association for the Advancement of Fat Acceptance. "Health At Every Size." 2011. <http://www.naafaonline.com/dev2/education/haes.html>. Accessed March 7, 2013.
- Newberry, Sydne. "Preventing Obesity and Its Consequences: Highlights of RAND Health Research." *Research Highlights*. RAND® Corporation, 2011. http://www.rand.org/pubs/research_briefs/RB9508.html. Accessed February 26, 2013.
- Norris, S. L., M. M. Engelau, and K. M. Narayan. "Effectiveness of self-management training in type 2 diabetes: A systematic review of randomized controlled trials." *Diabetes Care* 24, no. 3, (2001): 561-587.

- Nussbaum, Martha C. *Cultivating Humanity: A Classical Defense of Reform in Liberal Education*. Cambridge: Harvard University Press, 1997.
- . *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*. Updated Edition. Cambridge: Cambridge University Press, 2007.
- . *The Therapy of Desire: Theory and Practice in Hellenistic Ethics*. Princeton: Princeton University Press, 1994.
- . *Women and Human Development: The Capabilities Approach*. Cambridge: Cambridge University Press, 2000.
- . *Upheavals of Thought: The Intelligence of Emotions*. Cambridge: Cambridge University Press, 2001.
- Oliver, J. Eric and Taeku Lee. "Public Opinion and the Politics of Obesity in America." *Journal of Health Politics, Policy and Law* 30, No. 5 (2005): 923-954.
- O'Neill, Onara. "Public Health or Clinical Ethics: Thinking Beyond Borders." *Ethics & International Affairs* 16, no. 2 (2002): 35-45.
- Oshana, Marina A. L. "Ascriptions of Responsibility." *American Philosophical Quarterly* 34, no. 1 (1997): 71-83.
- Pan, L., D.A. Galuska, B. Sherry, A.S. Hunter, G.E. Rutledge, W.H. Dietz, and L.S. Balluz. "Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults United States, 2006 – 2008." *Centers for Disease Control Morbidity and Mortality Weekly Report* 58, no. 27 (July 17, 2009): 740-744.
- Paroske, Marcus. "Deliberating International Science Policy Controversies: Uncertainty and AIDS in South Africa." *Quarterly Journal of Speech* 95, no. 2 (May, 2009): 148-170.
- Parker, Lisa S. "Breast Cancer Genetic Screening and Critical Bioethics' Gaze." *Journal of Medicine and Philosophy* 20 (1995): 313-337.
- Perelman, Chaïm . "The Philosophy of Pluralism and the New Rhetoric." In *The New Rhetoric and the Humanities*, pp. 62-72. Dordrecht, Holland: D. Reidel Publishing Company, 1979.
- Perelman, Chaïm, and Lucie Olbrechts-Tyteca. *The New Rhetoric: A Treatise on Argumentation*. Notre Dame: The University of Notre Dame Press, 2003.
- Pellegrino, Edmund D. "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of Helping and Healing Professions." *Journal of Medicine and Philosophy*, 26, no. 6 (2001): 559-579.

- Pellegrino, Edmund D. and David C. Thomasma. *The Virtues in Medical Practice*. New York: Oxford University Press, 1993.
- Plato. *Phaedrus*. Translated by Christopher Rowe. London: Penguin Books, 2005.
- Plato. *Protagoras and Meno*. Translated by Adam Beresford. London: Penguin Books, 2005.
- Pogge, Thomas. "World Poverty and Human Rights." *Ethics & International Affairs* 19 (March 2005): 1-7.
- Puhl, Rebecca M. and Chelsea A. Heuer. "Obesity Stigma: Important Considerations for Public Health." *American Journal of Public Health* 100, no. 6 (2010): 1019-1028.
- . "The Stigma of Obesity: A Review and update." *Obesity* 17 (2009): 941-964.
- Pulgaron, Elizabeth R. "Childhood Obesity: A Review of Increased Risk for Physical and Psychological Comorbidities." *Clinical Therapeutics* 35, no. 1 (January, 2013): A18-32.
- Reiser, Stanley Joel. *Medicine and the Reign of Technology*. Cambridge: Cambridge University Press, 1978.
- Rich, Emma and John Evans. "'Fat Ethics' – The Obesity Discourse and Body Politics." *Social Theory and Health* 3 (2005): 341-358.
- Rief, John J. "Lifestyle Coaching in the Context of Obesity: A Practical Pedagogical Approach." Presented at the *Nineteenth Annual Meeting of the Association for Practical and Professional Ethics*. Cincinnati, OH. 4-7 March, 2010.
- . "Searching for the Good Life: Rhetoric, Medicine, and the Shaping of Lifestyle." PhD Dissertation. University of Pittsburgh, 2012.
- Rief, John J., Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue. "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care." *Health Education & Behavior* (2012): epub ahead of print.
- Rollnick, Stephen, Pip Mason, and Chris Butler. *Health Behavior Change: A Guide for Practitioners*. New York: Churchill Livingstone, 1999.
- Rollnick, Stephen, William R. Miller, and Christopher C. Butler. *Motivational Interviewing in Health Care: Helping Patients Change Behavior*. New York: The Guilford Press, 2008.
- Rorty, Amélie O., editor. *Essays on Aristotle's Ethics*. Berkeley: University of California Press, 1980.

- Rose, Nikolas. *Inventing Our Selves: Psychology, Power, and Personhood*. New York: Cambridge University Press, 1996.
- Roter, Debra L. and Judith A. Hall. *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*. 2nd edition. Westport, CT: Praeger, 2006.
- Roter, Debra L., Ruth Stashefsky-Margalit, and Rima Rudd. "Current Perspectives on Patient Education in the U.S." *Patient Education and Counseling* 44 (2001): 79-86.
- Rothblum, Esther, and Sondra Solovay, eds. *The Fat Studies Reader*. New York/London: New York University Press, 2009.
- Rubinelli, Sara, Peter J. Schulz, and Kent Nakamoto. "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient." *International Journal of Public Health* 54 (2009): 307-311.
- Ruse, Micheal. "The Theory of Punctuated Equilibria: Taking Apart a Scientific Controversy." In *Scientific Controversies: Philosophical and Historical Perspectives*, edited by Peter Machamer, Marcello Pera, and Aristides Baltas, 230-240. New York: Oxford University Press, 2000.
- Sadler, John Z. and Simon Craddock Lee. "Can Medicalization be Good? Situating Medicalization within Bioethics." *Theoretical Medicine and Bioethics* 30 (2009): 411-425.
- Saguy, Abigail C. and Kevin W. Riley. "Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity." *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 869-921.
- Salinas, Gregory D., Terry A. Glauser, James C. Williamson, Goutham Rao, Maziar Abdolrasulnia. "Primary Care Physicians Attitudes and Practice Patterns in the Management of Obese Adults." *Postgraduate Medicine* 123, no. 5 (2011): 10.3810/pgm.2011.09.2477.
- Schön, Donald A. "Generative metaphor: A perspective on problem-setting in social policy" in *Metaphor and Thought*, edited by A. Ortony, 137-163. 2nd Edition. Cambridge, MA: Cambridge University Press, 1993.
- Schwarze, Steve. "Performing *Phronesis*: The Case of Isocrates' *Helen*." *Philosophy and Rhetoric* 32, no. 1 (1999): 78-95.
- Segal, Judy. *Health and the Rhetoric of Medicine*. Carbondale: Southern Illinois University Press, 2005.

- Self, Lois S. "Rhetoric and *Phronesis*: The Aristotelian Ideal." *Philosophy and Rhetoric* 12, no. 2 (1979): 130-145.
- Sher, George, "Our Preferences, Ourselves." *Philosophy and Public Affairs* 12, no. 1 (1983): 34-50.
- Shultz, Kara. "Every Implanted Child a Star (and Some Other Failures): Guilt and Shame in the Cochlear Implant Debate." *Quarterly Journal of Speech* 86, no. 3 (2000): 251-275.
- Smith, David H. "Ethics in the Doctor-Patient Relationship." *Critical Care Clinics* 12, i. 2 (January, 1996): 179-197.
- Smith, David H. and Loyd S. Pettegrew. "Mutual Persuasion as a Mode for Doctor-Patient Communication." *Theoretical Medicine and Bioethics* 7 (1986): 127-146.
- Sobal, Jeffrey. "The Medicalization and Demedicalization of Obesity." In *Eating Agendas: Food and Nutrition as Social Problems*, edited by Donna Maurer and Jeffrey Sobal, 67-90. New York: Aldine De Gruyter, 1995.
- Sobal, Jeffrey, and Donna Maurer, eds. *Weighty Issues: Fatness and Thinness as Social Problems*. New York: Aldine De Gruyter, 1999.
- Sontag, Susan. *Illness as Metaphor and Aids and Its Metaphors*. New York: Anchor Books, 1990.
- Stearns, Peter N. *Fat History: Bodies and Beauty in the Modern West*. New York: New York University Press, 1997.
- Strong, Carson. "Specified Principlism: What it is, and Does it Really Resolve Cases Better than Casuistry." *Journal of Medicine and Philosophy* 25, no. 3 (2000): 323-341.
- "Critiques of Casuistry and Why They Are Mistaken." *Theoretical Medicine and Bioethics* 20 (1999): 395-411.
- "Justification in Ethics." In *Moral Theory and Moral Judgments in Medical Ethics*, edited by Baruch A. Brody, pp. 193-211. Kluwer Academic Publishers, 1988.
- Sulzberger, A. G. "Bloomberg Says a Soda Tax 'Makes Sense.'" *The New York Times*. March 8, 2010. p. A18.
- Tesh, Sylvia N. *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick, NJ: Rutgers University Press, 1988.
- Toulmin, Stephen. *The Place of Reason in Ethics*. Chicago: The University of Chicago Press, 1986.

- . *The Uses of Argument*. Updated Edition. Cambridge: Cambridge University Press, 2003.
- Tronto, Joan C. "An Ethic of Care." In *Ethics in Community-Based Elder Care*, edited by Martha B. Holstein and Phyllis B. Mitzen, pp. 60-68. New York: Springer Publishing, 2001.
- Turoldo, Fabrizio. "Responsibility as an Ethical Framework for Public Health Interventions." *American Journal of Public Health* 99, no. 7 (2009): 1197-1202.
- Upshur, R. E. G. "Principles for the Justification of Public Health Intervention." *Canadian Journal of Public Health* (March/April, 2002): 101-103.
- U.S. Department of Health and Human Services (Office of Disease Prevention and Health Promotion), "*Healthy People 2020* Framework: The Vision, Mission, and Goals of *Healthy People 2020*." No date. <http://www.healthypeople.gov/2020/Consortium/HP2020Framework.pdf>. Accessed March 5, 2013.
- U.S. Department of Health and Human Services. "Nutrition and Weight Status." September 6, 2012. <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>. Accessed March 5, 2013.
- U.S. Department of Health and Human Services. "Understanding Adult Obesity" (Fact Sheet), National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. November, 2008. <http://win.niddk.nih.gov/publications/PDFs/understandingobesityrev.pdf>. Accessed March 4, 2013.
- Wagner, Edward H. "Chronic disease management: What will it take to improve care for chronic illness?" *Effective Clinical Practice*, 1, no. 1 (1998): 2-4
- Wagner, Edward H., Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi. "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)*, 20, no. 6 (2001): 64-78.
- Wailoo, Keith. *Drawing Blood: Technology and Disease Identity in Twentieth-Century America*. Baltimore: The Johns Hopkins University Press, 1997.
- Weaver, Richard M. *The Ethics of Rhetoric*. Davis, CA: Hermagoras Press, 1985.
- Weber, Samuel. *Institution and Interpretation*. Expanded Edition. Stanford: Stanford University Press, 2002.
- Wittgenstein, Ludwig. *Philosophical Investigations*. Revised 4th Edition. Edited by P. M. S. Hacker and Joachim Schulte. Translated by G. E. M. Anscombe and P. M. S. Hacker. Malden, MA, Wiley-Blackwell, 2009.
- Wolf, Susan. "The Importance of Free Will." *Mind* 90 (1981): 386-405.

World Health Organization. "Global Strategy on Diet, Physical Activity and Health," 2004, p. http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf. Accessed February 26, 2013.

World Health Organization. "Health Topics: Obesity." 2013. <http://www.who.int/topics/obesity/en/> (Accessed March 8, 2013).

Wright, Jan, and Valerie Harwood, editors. *Biopolitics and the 'Obesity Epidemic': Governing Bodies*. New York: Routledge, 2009.

Zylinska, Joanna. *Bioethics in the Age of New Media*. Cambridge/London: The MIT Press, 2009.