

AN ETHICAL EXAMINATION OF PUBLIC HEALTH COMMUNICATION

by

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Abstract

Public health agencies engage in the public discourse through the creation and promulgation of various health-related campaigns. Using anti-obesity messages for context, I analyse the ethics of the communicative actions that public health engages in, finding that the ethical standards of truth-telling and respect for agents are frequently sacrificed in favour of quick, catchy, and manipulative messages. This is morally problematic. For example, in the case of anti-obesity communications, manipulative messages utilise and contribute to the on-going discrimination, marginalisation, and imperialisation of the fat body, which contributes to and reproduces oppression. This oppression is observable in the lives of fat people, with research showing negative impacts upon important aspects of social identity, and upon self-regarding attitudes. An impact of manipulative campaigns upon attitudes that contribute to the capacity for self-governance and self-authorisation may be that individuals become less able and less likely to undertake the behavioural changes that public health encourages. Further, a central aim of public health activity is the achievement of greater equity in society. I argue, in sum, that public health defeats its own behaviour-change efforts, while also undermining its central equity-focussed aim, in engaging in manipulative campaigns in the public discourse.

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Introduction

From 2010 to 2014, I was employed as a researcher and policy analyst in the health promotion unit of the public affairs department of the Ontario Medical Association (OMA). I worked with people who had years of experience in political and policy arenas, as well as in public communications and campaign design and execution. The OMA's involvement in the public and political discourse in Ontario, Canada, around health-related issues like tobacco control and the use of cell phones while driving a motor vehicle had been instrumental in having provincial and federal legislation passed to protect the health of (as it was always framed) 'patients.' My work involved researching and writing reports and policy documents on various health issues of interest to the OMA, which could be used to lobby the government to implement health-protecting or promoting legislation. These topics included antimicrobial resistance, cycling injuries and deaths, and insecure housing.

The OMA had long-standing policy and ongoing public communications on childhood obesity prevention when I joined the organisation. In 2012, the OMA published a paper entitled, "Applying lessons learned from anti-tobacco campaigns to the prevention of obesity" (2012a). This paper was commissioned by the OMA's director of health promotion from the director of the Ontario Coalition for Action on Tobacco (OCAT), an advocacy group of which the OMA is a founding member. The paper was subsequently adopted by the OMA board of directors as internal policy, which meant that it became available for staff to use in public communication, campaigns, and governmental lobbying efforts. Through conversations with the director of health promotion – my direct supervisor – I learned that commissioning this paper was

motivated by a number of factors: first, the OMA enjoyed much success with its efforts in lobbying the government on issues relating to tobacco control. The government gained popular support for many of these initiatives, and the OMA's role in proposing to the government policy options backed by medical evidence and authority, and in selling these ideas to the public, helped the organisation gain leverage for other lobbying and negotiation efforts. Second, the OMA saw a rise in public opinion polls around the time of its involvement in lobbying for tobacco controls, and the executives read this as a sign that this kind of intervention in governmental affairs was considered welcome and appropriate by the general public. Third, smoking was considered by my supervisor and many of my colleagues to be a similar issue to obesity, which was fast becoming the next big topic in public health, and, some thought, presented media and policy opportunities to gain public support for the OMA. Thus, the 'obesity crisis' presented a major opportunity for the OMA to reassert its relevance as a medical authority in the public discourse, and thereby regain some lobbying power.

Improving health outcomes for the people of the province of Ontario, or even for all Canadians when national efforts were organised, was ostensibly the motivation for the OMA's health promotion efforts. Indeed, proposed research or campaign initiatives would not be approved if they did not feature a strong enough 'doctorly' angle: the issues had to be defensibly within the reasonable scope of expertise of physicians, and to relate in some obvious way to patient wellbeing. However, the OMA's central purpose is to represent doctors and promote their interests to the government. Except when contract negotiations were going poorly (when we would take an adversarial stance with the government), OMA staff worked on our various files with an eye to government appetite,

party platforms, and ‘win-win’ public relations outcomes for the OMA and for the government.

The OCAT/OMA paper on applying lessons from anti-tobacco campaigns to obesity presented seven recommendations, encompassing a range of options that included restricting advertising to children, improving school food programs, and raising taxes on ‘unhealthy’ foods. The OMA focussed on the third recommendation, to require nutritional information and warnings about the consumption of unhealthy food items on food packaging, for the publicity materials accompanying the public release of the OCAT paper. So, the primary outcome of the paper was a poster campaign, introduced at a media event and via news releases. At the time of writing this, in spring of 2017, the OMA website has been remodelled, and the news release and four of the posters that were created for the campaign have been removed (which featured a chocolate milk carton, a box of French fries shaped like a cigarette pack, a grape juice drinking box, and a pizza box). Only the policy document and one campaign poster, of an orange soda can, remain publicly available (OMA 2012b). Two of the posters, the soda can and the pizza box, are described in detail in Chapter 1.

I tell this story as an introduction to this dissertation because it was this campaign, and the posters that were created as a part of it, that lead to the ideas and the subsequent research that ultimately became the body of work that follows. I felt morally perplexed by the planned campaign, and was vehemently against the posters. In my view, they used ‘shame and blame’ tactics – we were purposely making people who were fat feel ashamed and placing the blame for obesity on them – which were inappropriate for the OMA to use. In my view at the time, the OMA was supposed to engage at the policy

level with the provincial government, not tilt our lance against members of the public, or ‘patients’ as it were. My supervisor disagreed with me, and did not see the posters as instances of shame and blame techniques; he saw them as identical to the techniques used on smoking packages, and thus simply acceptable. He also thought that they targeted the contents of the food, rather than the person who ate them. At the time, I was unable to defend my position and respond to my supervisor’s arguments as well as I would have liked. I began thereafter to create a proposal for research into whether there was a moral problem with these campaigns, and if so, what it might be.

The ethical challenges presented by obesity campaigns extends beyond my own past working life at the OMA. Various governments around the world continue to search for ways to address obesity in their populations, and the creation of anti-obesity campaigns is an active and developing area. This dissertation joins the discourse around these issues in the context of recent recommendations that public health undertake anti-obesity campaigns. Lately, as I will outline in Chapter 2, policymakers and ethicists have argued that campaigns showing the harms of being fat are necessary for addressing the ‘obesity crisis’ (Callahan 2013; Bayer & Fairchild 2016; Standing Senate Committee on Social Affairs, Science and Technology [Standing Committee] 2016). This is despite the broad agreement among experts and body of evidence showing that obesity is a multi-dimensional issue with wide-ranging contributors not limited to individual food choices or physical activity levels (though certainly these both matter in some way) (Standing Committee 2016).

The view that anti-obesity campaigns similar to those employed against smoking are, if not morally appropriate, then at least a necessary evil, for effectively addressing

population rates of obesity is widespread. To illustrate, on an unpublished draft of an early version of the first chapter of this dissertation, an anonymous reviewer wrote,

The campaigns you mention are based on evidence of the associations between obesity, the determinants of obesity (high kilojoule low nutrient foods and drinks, low levels of physical activity and high levels of sedentary behaviour) and the health outcomes – chronic diseases especially diabetes. These chronic diseases are linked to adverse outcomes at an individual and societal level and need to be addressed as a matter of urgency. That public health effort mirror those of the anti-smoking body are quite deliberate as they have been shown to be effective and the food and beverage industry act very much like the tobacco industry. [*Sic*]

This reviewer perhaps did not recognise at the time the varied and diverse factors that evidence shows contribute to obesity, such as low socio-economic status and low educational attainment (which I will present in the following chapters), and their comments are revealing. The reviewer takes as granted many of the things that I attempted to call into question in my paper; almost without exception, the statements they made are ideas that I think need to be interrogated, morally and empirically. The reviewer is not alone, and expresses what I have found is the dominant view of obesity within public discourse, policy discourse, and, indeed, spheres of academic discourse. This dissertation undertakes a moral analysis of these campaigns. Since obesity is of interest to so many people, there is a wealth of research from various disciplines, both empirical and theoretical. I will draw on both kinds of work in what follows, and, ultimately, argue that many of the anti-obesity campaigns that have been created by public health agencies are morally unacceptable for the tactics they use, and the impacts they have on some groups.

Definitional Notes

A few clarifications will be helpful to the reader at the outset. First, I would like to acknowledge that my examination of campaigns in this dissertation is narrowly focussed on the visual materials – posters and videos – that are created as a part of broader

campaigns. Public health campaigns often include a multi-pronged approach, involving different kinds of initiatives. In this dissertation, I am examining the visual materials for their ethical content, and will use ‘campaign’ as a short-hand for these components. It should be remembered, however, that complete public health campaigns may include any combination of visual materials, informational websites or printed material (pamphlets, leaflets, etc.), social media and traditional media engagement, radio announcements, messaging to physicians, nurses, pharmacists, and other health-care providers, lobbying efforts for legislative changes at various levels of government, front-line engagement by public health physicians and nurses, and other tactics. Of these components, I have singled out the poster and video materials for analysis because they are visible and powerful ways of communicating ideas, and because they impact a wide and nonspecific audience. More is said about this in Chapters 1 and 2. For the moment, it suffices to say that while I will often refer to anti-obesity campaigns in this dissertation, I am speaking of the visual components of what may be (and usually is) a larger effort on the part of the public health organisation in question.

It is also important to explain my choice of terminology when discussing fatness and obesity. Feminists and fat studies scholars have written about the fraught status of these words, and the various pressures on and social readings of body states (Cooper 2010; B. 2017; Murray 2005). My own body is read as slim, and I acknowledge that the social privileging of thinness has afforded and continues to afford me numerous visible and invisible advantages in daily life, in relationships, in my profession, and in the crafting of my personal and social identities. In this dissertation, I hope to speak with fat individuals and scholars, and not for them. Throughout this dissertation, when using the term

“obesity,” I will be referring specifically to the pathologised, or medicalised, notion of body fat as indicative of a disease state, and with reference to the way that public health and medicine conceive of an illness characterised by an excess of body fat. When discussing people, however, I will use the term “fat” as a straightforward and nonjudgmental descriptor. Toward a positive understanding of ‘fat,’ Charlotte Cooper writes that “fat is a fluid subject position relative to social norms, it relates to shared experience, is ambiguous, has roots in identity politics and is thus generally self-defined” (2010). Cooper is interested in reclaiming the word ‘fat’ from its derogatory use, and establishing its significance as a term of pride and identity. I hope to support, or at least not undermine, this effort.

Additionally, I have a complementary interest in divorcing the notions of body weight from notions of healthiness. It is obvious to me that just as only some slim bodies are healthy bodies, only some fat bodies are unhealthy bodies, and that fat is an essential part of every body. The crucial distinction between a body’s outward appearance and internal health state is frequently lost in public health messages and the public discourse, and it must be reinforced whenever possible. Therefore, when I use the term ‘fat’ in referring to people in posters or videos, I aim to do so without judgment, allowing the space for complex personal identities, self-confidence, pride, health, and fitness regardless of body size or shape.

A final short note on language in this dissertation regards the use of pronouns ‘they/them’ instead of ‘he/she.’ As part of my commitment to recognising a spectrum of gender identities rather than a binary, I use the third-person plural pronoun, they, (also known as the ‘singular they’ (Merriam-Webster 2017)) throughout this dissertation

instead of the third-person singular. This may result in awkward sentence constructions for some readers, such as sentences that read ‘a person... they’. However, this practice is becoming increasingly widespread, with certain academic journals, style guides and newspapers adopting it as standard (e.g. the Chicago Manual of Style, and Washington Post). I endeavour to write as clearly as possible, and hope that the reader will forgive any awkwardness this practice causes in favour of greater acceptance of gender-diversity.

Overview of Chapters

In the argument I present here, public health anti-obesity campaigns provide the context for a moral analysis of the way that public health organisations communicate with the agents who make up their audience, grounded in feminist theory and social justice. The first chapter of my dissertation presents nine different anti-obesity campaigns from various English-speaking nations. For some of these campaigns, more than one example of a poster or video is presented. These are described in detail, and a preliminary ethical analysis is presented for each. The posters and videos are described, rather than giving the images here, for two practical reasons. The first is that some of the campaigns have, during the writing of this dissertation, been discontinued. Campaigns are constantly changing and being reinvented, so some of these are now only available on archived websites. However, that they are still available means that they are still relevant, and given that they were recently active campaigns, I believe they are still useful examples for providing context for this discussion. The second practical reason is that only the posters would have been able to be included here, as the videos could not be embedded. So, because some poster campaigns were discontinued and no videos would be included, it seemed best to give each campaign the same treatment and provide a detailed description.

Following this presentation of campaigns, the second chapter outlines three recent arguments that have been presented in support of using stigmatising or fear-based anti-obesity campaigns to achieve behaviour change at the population level. These come from Daniel Callahan, the Canadian Senate Standing Committee on Social Affairs, Science, and Technology, and from Ronald Bayer and Amy Fairchild. Callahan (2013) was among the first ethicists to call for the use of stigmatising techniques for obesity that are similar to those used to confront smoking rates, and Bayer and Fairchild are the most recent, relying on meta-analyses of fear-based campaigns to argue for their effectiveness and their appropriateness. I use the arguments and recommendations presented in each of these papers to motivate the ethical concerns driving my research. I am interested in investigating these campaigns because 1) their effectiveness may be overstated, 2) even if they do work, they may be immoral, and 3) they may not be coherent with the stated aims of and the responsibilities delegated to public health agencies. The first chapter introduces some of the ethical issues involved in the poster and video components of anti-obesity campaigns, the most pressing of which is the way that images (and sounds, in videos) are used to send extra-textual messages to the audience.

This issue is taken up in the third chapter, in which I analyse the modes of communication described by the terms ‘information,’ ‘persuasion,’ ‘manipulation,’ and ‘coercion.’ Drawing on Neil Manson and Onora O’Neill (2007), I adopt the agency-model of communication, which says that in order for a communicative transaction to successfully occur, both parties must share a number of background commitments and assumptions, including shared knowledge, values, language, social contexts and understandings, and a variety of other things. On this understanding, communication is

inherently a normative undertaking that relies on the agency of both speaker and audience. I provide an overview of some of the dominant definitions of persuasion, manipulation, and coercion in the literature, and defend my own definition of these. I also briefly discuss propaganda, as it has been defined and described in recent work by Jason Stanley (2015).

In applying these definitions to the anti-obesity campaigns outlined in Chapter 1, I find that many public health agencies employ communication that can be characterised as manipulative in their visual materials. While persuasion, I argue, is a communicative act that takes place between agents or groups in a context of mutual respect, manipulation happens when a communicator fails to respect the agency of the audience, and attempts to bypass their reasoning faculties to influence them. As a result, public health agencies often sacrifice ethical standards of truth-telling and respect for agents. I argue that public health agencies, as authoritative and power-holding, ought to be held to a higher standard of communicative practice: epistemic responsibility (Manson & O'Neill 2007). This chapter gives some primary reasons to think that manipulation is impermissible, but some authors have defended its use by public health, and so these must be examined.

The fourth chapter of my dissertation, therefore, analyses the potential defences of manipulation and its potential harms. First, I address the concerns that manipulative messages utilise stereotype and stigma. As mentioned, some researchers and ethicists have advocated for the use of fear-based or, as I describe them, manipulative campaigns. They do this based upon the view that such campaigns are stigmatising, and that if this is bad, its badness is outweighed by the potential or real benefits that may be produced by putting negative social pressure on undesirable health behaviours. I argue that this point

of view is mistaken, and that stigma and stereotype have concrete harms for some people in the audience of public health campaigns that cannot be outweighed by a potential population-level achievement of behaviour change. Via the mechanisms of stigmatisation and stereotyping, as theorised by Bruce Link and Jo Phelan (2001), manipulative public health campaigns contribute to the oppression of, in this case, fat people.

While I acknowledge that people who identify as fat may not also identify as a group in the political sense that Iris Marion Young (1990) describes in her work on oppression (though, I also note, this may be changing), I utilise Young's theory to describe how public health's messages create or contribute to the marginalisation and cultural imperialism of fat people. I introduce Paul Benson's (2000) description of the distortion of responsibility in oppression to underline the powerlessness in the public discourse that 'out-groups' experience. The results of this oppression are observable in the lives of fat people. Research from the social sciences provides evidence of negative impacts upon the career prospects, personal lives, mental and physical well-being and self-regarding attitudes of fat people, resulting from the stereotypical beliefs held about them and the material harms that result from these dominant social assumptions and meanings.

Finally, I address the defence (or sometimes criticism, depending upon one's point of view) that manipulation is paternalistic. However, in the context of this dissertation, and perhaps in public health in general, paternalism is a red herring. In taking action to protect the health of the population (i.e. a collective), public health does not override an individual's autonomy to promote that same individual's welfare; public health overrides their autonomy to promote everyone's welfare, regardless of whether that specific person

will benefit or not. It is often difficult to show where and to whom, at which time, public health benefits accrue. Thus, paternalism is not a strong defence or criticism of manipulative public health campaigns, nor perhaps of any public health intervention.

In the fifth chapter, I examine the impact that manipulative campaigns, and stigmatizing and stereotyping messages have upon important self-regarding attitudes that contribute to autonomy. I employ Catriona Mackenzie's recent (2014) analysis of autonomy as being composed of three axes: self-governance, self-authorisation, and self-determination. I argue that manipulative public health campaigns damage important skills, feelings, or abilities on each axis (self-regarding attitudes on some, social recognition on others, for example). This ultimately means that the target audiences of manipulative public health campaigns become less able and less likely to undertake the behavioural changes that public health encourages.

These findings, taken together, provide good reason to think that the use of manipulation in public health campaigns is never permissible. In sum, campaigns that take the form of those examined in my project are unethical, and would have to change significantly to be ethically produced. Public health undermines people's self-efficacy, and may worsen the health of some groups, in taking the approach to public campaigns that has characterised anti-obesity work in the past ten or so years.

The final chapter of my dissertation argues that public health's role and responsibilities are grounded in social justice and the reduction of inequities. Achieving health equity is often taken to be a central goal of public health, including by the professionals involved in it. Explicitly making social justice the aim of public health may warrant regulatory interventions with greater impacts on individual liberty to address

chronic diseases. I argue that the supposed difference between what some people have termed the ‘old’ or ‘traditional’ public health, with a focus on infectious diseases, and the ‘new’ public health, with a focus on chronic diseases, is not morally relevant. This distinction is sometimes made to claim that ‘new’ public health activities are less legitimate than ‘traditional’ public health activities, and that public health is overstepping the limits of appropriate intervention in the former, by getting involved in people’s choices in unjustified ways. However, the problems that public health addressed in the past, like sanitation, and the problems it is addressing in the present, like obesity, have in common that they unequally impact the worst-off in society. Low socio-economic status is as key an indicator for chronic disease (or so-called ‘lifestyle disease’) as it is for infectious disease.

This chapter also highlights the ethical problems with framing population rates of obesity as an individual-level problem with individual solutions; while individuals have roles to play in their health, evidence indicates that obesity is a multi-factorial issue, with collective, systems-level sources (in the food provision and distribution systems, economic systems, education systems, et cetera). Thus, predominantly collective, systems-level solutions are most appropriate, and may be more effective at addressing rates of obesity in a population. Given public health’s responsibility for introducing collective interventions that individuals cannot achieve on their own, public health must address failures of health systems and the distribution of important health-related goods at the systems level.

By focusing on promoting equity, public health could improve population rates of health on various indicators by addressing the needs of the worst-off. This would,

undoubtedly, still benefit the best- and well-off in a given society. It is important to note that individuals cannot choose to not be affected by public health problems with systems-level sources. Whether the example is sanitation or obesity, at the level of systems (the sanitation system, the food provision system) no one is able to choose not to be affected. If certain environments are glutted with sugary beverages and soda advertising, like sporting venues or food stands, everyone in those environments will be affected by this, regardless of discreet individual choices about what to drink. Thus, I conclude, it is in everyone's interest to correct poorly functioning systems through public health interventions.

Chapter 1

This chapter presents a descriptive analysis of nine poster- and video-based anti-obesity campaigns. To find these campaigns, an internet-based keyword search was performed. A number of criteria were used to narrow the scope of examination. In order to be included in this set of examples, a campaign or significant part of it had to: a) have a focus on food or eating behaviours, b) use the English language, c) have a broad population impact, being directed at a national or regional level, d) be provided by a governmental agency or a policy-influencing body, and e) have a developed website to accompany the visual (poster or video) materials. Many campaigns did not meet all five of these criteria. The campaigns presented below were pragmatically selected to illustrate the types of campaigns available and the types of groups (governmental and non-governmental) who have produced such campaigns. As they are being presented here to provide some context for the ethical analysis in this dissertation, they are not intended to provide either an exhaustive account or a complete list of all existing anti-obesity campaigns.

Campaigns that were not in English were excluded from this set of examples because of the potential to misinterpret messages when translated into English. This limited the campaigns to nations that are primarily English-speaking: the United Kingdom (UK), Canada, the United States of America (US), New Zealand, and Australia. The examples here were produced by governments or policy influencers, as this dissertation primarily investigates the communications of these organisations. A presumption was made that bodies of this nature would endeavour to provide information to the public with some degree of evidential or medical accuracy. Small, local or private initiatives were excluded

because they have a shorter reach and have fewer obligations to the public to provide a certain quality or type of information.

The first of the four poster campaigns is the ‘Cut your portions, cut your risk’ campaign from the New York City Department of Health (Department of Health, New York City [DH NYC] 2012). This organisation was included because The New York Metropolitan Area is the largest city in the United States, and one of the largest purchasers of food in the United States, and therefore enjoys a considerable level of influence over policy change (Public Health Ontario 2012). The Department of Health has been active in setting new targets for sodium reduction in municipal food suppliers, and has introduced a number of obesity-related laws and campaigns.

The second poster campaign is from Children’s Healthcare of Atlanta (CHoA), Georgia (CHoA 2011). Though CHoA is a hospital, examples from their Strong4Life ‘Stop childhood obesity’ campaign were included because this was a state-wide initiative, and the inaugural poster campaign discussed in this examination sparked a flurry of debate around anti-obesity campaigns that reached the international news cycle, and raised a number of ethical issues in the public mind (Dailey 2012).

The third campaign is the ‘Warning labels’ campaign from the Ontario Medical Association (OMA) (OMA 2012b). In the Canadian context, each province and territory has a body that represents the interests of physicians. The OMA represents the largest number of physicians in Canada, and is tasked with representing their interests to the government through negotiating fees and payments as well as lobbying the government for health-related legislative change. This organisation has been influential in having laws

dealing with tobacco use, seatbelts, and the use of cell phones while driving introduced and passed in the provincial legislature in the last few years. Their efforts on obesity are both long-standing and controversial.

The final poster example is the ‘Breakfast eaters’ campaign from the Government of New Zealand (Government of New Zealand 2014). As the only federal campaign in the set of poster examples, this initiative was included because it takes a different approach than the others, and so provides an alternative perspective.

In the presentation of video campaign examples, the ‘Pouring on the Pounds’ campaign by the New York City Department of Health, and the ‘Who cares?’ and ‘the Talk’ videos from the Strong4Life campaign by Children’s Healthcare of Atlanta, which shows the change in tactic from the poster series mentioned above, have both been included (CHoA 2012, 2013; DH NYC 2011). The third example is the ‘Grocery store’ video from Health Canada, the fourth is the ‘Me sized meals’ and ‘Be food smart’ videos from the National Health Service (NHS)’s Change 4 Life campaign in the United Kingdom, and the fifth is the ‘Measure up’ campaign from the Australian Government Department of Health (Department of Health, Australian Government 2010; Health Canada 2013; NHS 2009, 2013). These last four video examples are from federal agencies, and thus represent, at least to some extent, the government’s official position and efforts with regard to obesity in their respective nations. In what follows, these four poster-based campaigns and five video-based campaigns are described. A brief analysis of some of the ethical themes in each is presented.

Poster-based campaigns

1. *Growing Burger and Fries*

New York City Department of Health: Cut your Portions, Cut your Risk Campaign (DH NYC 2012)

A series of posters was created for the ‘Cut your portions, cut your risk’ campaign. They share certain characteristics, while using different images. Two of these posters will be described here. In the first poster, three cheeseburgers sit on a bright red horizontal bar of colour in the foreground. On the viewer’s left is the smallest cheeseburger, with one patty and a slice of processed American cheese, dressed with ketchup and some pickles. In the middle is a slightly larger burger, with a sesame seed bun, a thicker patty, lettuce, sliced tomato, and a melted slice of American cheese. On the viewer’s right there is a large cheeseburger, with two patties, lettuce, American cheese slices, tomato slices, pickle, and what might be bacon, on a sesame seed bun. About an inch above the top bun of the cheeseburgers, a black line slants upwards from left, entitled ‘then,’ to right, entitled ‘now.’ Above this, there is a black and white image of a fat woman who is crossing the street on a mobility scooter. The woman appears only from the nose down. She wears a t-shirt and jeans.

In the second poster, three packets of French fries are imposed over a bright red horizontal bar in the foreground. On the viewer’s left is the smallest packet of fries, in a soft-looking white paper pocket. In the middle is a slightly larger packet of fries in a white cardboard box with an arched bottom and a high backing. On the viewer’s right, a packet of fries that looks to be about three-times as big as the smallest packet appears in a large white cardboard box. All three white containers have a yellow and red zigzag across the front. About an inch above the French fries, there is a white line rising diagonally from left to right. Above this is a black and white image of a fat woman mounting a

staircase. Her hair is pulled back, she's wearing a white sweater and black bottoms, and she is carrying a purse on one shoulder and a black bag in one hand. Her free hand grips the railing, and her elbow is bent. Her head and left leg are also bent as she takes a new stair. She appears to be taking the stairs two-at-a-time.

In both posters, to the right of the women portrayed in the photos, there is a transparent-red text box, and inside in large all-capital black letters the text reads "Portions have grown," and in white letters below this, "so has obesity, which can lead to many health problems." Under the food shown in the posters, large white all-capital text on a black background says, "Cut your portions. Cut your risk."

Both posters use a red and black colour scheme that might be taken to indicate danger or warning (Chapanis 1994; Crozier 1996). There is an implication that eating portions that are too large caused these people to become fat, and by extension, caused every fat person to become that way as well. 'Then' on the presented timeline may represent some moment in the past when fast food portion sizes were good for us, or appropriate, whereas 'now' indicates the inappropriateness of the portions. Importantly, though the sizes have clearly been changed by industry – the examples look like approximations of McDonald's or other chain restaurant food – the responsibility for change is assigned to individuals. The message, "cut your portions, cut your risk," does not seem to be aimed at restaurants, who determine the portions, but at the customers.

Features of these posters show us the assumptions made by their designers. For example, in both of these posters, the individuals' faces are obscured. The person on the scooter is portrayed from the nose down, and the person on the stairs has her face turned

away from the camera. This kind of portrayal of fat people, along with people with stigmatised illnesses, has been described as the visualisation of shame (Heuer, McClure, & Puhl 2011). If one thinks that to be fat is a shameful state, then to portray the person's face so that everyone can see them would be like betraying a terrible secret. In the French fry poster, the pictured woman's pose could make her appear to be labouring to climb the staircase, with bent elbow and head, hauling her body upwards, and it seems from the context of the poster that this is what the creators either saw themselves or intended others to see. However, one can see that she is taking the stairs two-at-a-time, with her forward foot two stairs ahead of her back foot. The pose instead looks like one of speed: the woman has her head down and elbows bent, running up the stairs. The creators of the poster seem to have assumed she was struggling, but she may simply be hurrying. This betrays the assumption that fat people are not fit, and therefore are unable to run up flights of stairs. The fact that this woman is taking the stairs two-at-a-time is a reminder that health status is not determined by outward appearance, and that weight does not tell us everything about a person's fitness level.

2. *Little Girl and Little Boy*

Children's Healthcare of Atlanta: Strong 4 Life campaign (CHoA 2011)

This series of posters focuses on having children present messages about problems associated with obesity. The first example shows a black and white image of a young girl with her arms crossed, looking out at the viewer with a serious expression. She looks to be eight or nine years old. She is chubby, and is wearing a tight striped collared t-shirt over a long-sleeved white shirt and jeans. The background is blurred out. Across her mid-section, under her crossed arms, large red all-capital text says "WARNING" and underneath in smaller black all-capitals, "It's hard to be a little girl if you're not." Under

this, in white lettering on a black background, text reads “Stop childhood obesity” followed by the website address Strong4Life.com.

In another example, a black and white image of a little boy with his hands in his pockets is presented. He looks at the camera with a serious expression. He is also chubby, and he’s wearing a tight dark polo shirt, unbuttoned at the neck, and jeans. Across his mid-section, large red all-capital text says “WARNING” and underneath in smaller black all-capitals, “Fat prevention begins at home. And the buffet line.” Under this, in white lettering on a black background, text reads “Stop childhood obesity.” followed by the website address Strong4Life.com. This poster series is inflammatory, and garnered a lot of negative attention when it was released. Despite changing tactics with their next anti-obesity campaign (as discussed in the video section below), Strong4Life’s original posters are still easily accessible online.

The messages in this series do not present any fact-based health information. Instead, they communicate stereotypes about fat people. In the poster of the girl, one is told that she is not little, leaving the viewer to deduce that she must be big, and that this is bad. Being big, in the bodily sense, is made to sound undesirable and negative, and the serious attitude of the girl along with the message implies that she cannot have fun or enjoy childhood. In the poster of the boy, the use of the word ‘fat’ with a negative valence labels him immediately, and the message “prevention begins. . . in the buffet line” uses the stereotype that fat people have no self-control. It conjures an image of this boy and his family going to all-you-can-eat buffets and over-eating. These posters seem to call upon well-known stereotypes of fat people – being lonely, feeling unhappy, having no

self-control, and over-eating (Harris, Walters, & Waschull 1991) – to deliver a message about being fat, instead of communicating any health- or nutrition-related information.

Besides being stigmatizing in their messaging, these posters blame individuals, both the children and their parents, for their being fat. The poster of the girl puts blame on her parents: she cannot enjoy her childhood because she is “not a little girl,” so her parents have ruined her childhood by allowing her (or causing her) to become fat. In the poster of the boy, this blame is more explicit. Stating “fat prevention begins at home” is a clear assignment of responsibility to his parents for allowing him (or causing him) to become fat. However, the second half of that message, “and the buffet line,” places blame on the boy for ‘pigging out’ at all-you-can-eat restaurants and his parents for allowing him. The Little Girl and Little Boy poster series is a clear example of the typical allocation of blame for fat at this time.

3. Warning Labels

Ontario Medical Association: Obesity Prevention (OMA 2012b)

This poster series focused on applying a warning-label method of informing people about health risks of being fat, taken from anti-tobacco efforts of the past (OMA, 2012a). In this example, a pizza box floats on a royal blue background. The box is white. A green check pattern along the topmost edge, and the word ‘Pizza’ in red italics, covers the top two-thirds of the box lid. The bottom-third of the lid is covered with a large black-outlined box. There is an image of a diseased liver on the viewer’s left-hand side of the box; the liver is spotted all over with yellow, so that the usual dark red is almost completely obscured. To the right of this is a small red-lettered “Warning,” and below this, in black,

the text says, "Excess consumption of this product contributes to obesity and resulting Non-Alcoholic Fatty Liver Disease."

In a second example, an orange pop can floats on a royal blue background, lit from behind. The section of the can facing the viewer is entirely covered by a large black-outlined box. Inside this box, at the top, is an image of a foot seen from below. The big toe points upwards toward the top of the pop can, and the second toe is missing. In the sole of the foot, below the big toe, there is a large diabetic ulcer. This shows a deep red circle of bleeding flesh where the upper layers of foot skin are missing, and around the edges of the circle the thick upper layers of skin are white and dying. Below this image is a small red-lettered "Warning," followed by the text, in black, "Excess consumption of sugary drinks contributes to obesity, Type 2 Diabetes and related complications."

Similar to cigarette-package warning labels, which show images of gum disease and lung cancer, these posters use jarring and grotesque imagery to invoke disgust about fat, in an emotional, scare-tactic communication style. The messages in the posters rely on the prior effectiveness of stigmatizing smoking to convince people to quit and change social perceptions about that habit (Callahan 2013; OMA 2012b).

Additionally, the posters that use images of foods like pizza (another uses French fries) present food in a way that does not appeal to nutrition science or health research. Though the warnings, like those on cigarette packages, attempt to present a balanced message by saying that "excess consumption" is harmful, indicating that moderate or infrequent consumption of these foods is acceptable, the message conveyed by the images are not similarly careful. Foods like pizza and French fries have nutritional

content, and do have a place in a healthy diet, where moderation, treats, and variety are valued. Over-consumption of soft drinks has a clearer link to negative health outcomes (Malik, Schulze, & Hu 2006), and yet the use of an image of a person's foot that has wounds and amputations does not convey a measured and reasonable message. This theme will recur when discussing the videos below, but drawing a connection between a food and an illness through pictures uses fear to scare people away from food at the same time as it stigmatises and simplifies certain illnesses. Cancer and type-2 diabetes are common boogeymen in anti-obesity campaigns.

4. *Breakfast Eaters*

Government of New Zealand: Breakfast eaters have it better (Government of New Zealand 2014)

The Government of New Zealand has developed food-related campaigns that focus on encouraging healthy eating behaviours. As an example, they have created a poster series that focuses on the importance of eating breakfast. In one poster, two girls sit side-by-side. The frame is close, so not much of the surroundings are visible, but the girls are seated at a table and appear to be in a classroom. The girl closest to the viewer appears to be alert and focused on work, and is holding a pencil over paper as if she is writing something. Above her head, the words "Breakfast-eater" appear in white bubbly writing, with an arrow pointed to her. The girl beside her sits with her chin resting in both of her hands, with her shoulders slightly stooped, and her eyes closed in a position that implies sleepiness. In the bottom right-hand corner, in an orange arc, the poster tells us "Eating breakfast gives kids energy to learn better." Under this appears the slogan "Breakfast-eaters have it better."

In another version of this poster, a group of boys runs toward the viewer, and the leading boy is holding a rugby ball. The boys are wearing either royal and navy blue striped shirts, or red and yellow striped shirts, indicating different teams at play. The leading boy has an arrow above his head, with the words “Breakfast-eater” in white writing. In the bottom right-hand corner, the poster says “Eating breakfast gives kids energy to play better.” A separate section of these posters, either the reverse or a right-hand attachment, tells the viewer that they can “Give your kids a real head start” by giving them breakfast, and provides four “fast, low-cost” suggestions, including banana and bread, porridge, or left-overs or fruit if there is nothing in the cupboard.

New Zealand’s government does not have a campaign specific to obesity, instead focusing on the health impacts of eating habits. The Government of New Zealand states that they are focusing on breakfast in this particular campaign because it has been shown to have a positive impact on educational performance, physical activity, and weight maintenance (Government of New Zealand 2014). Though weight maintenance is mentioned as a concern, it is notable that in the campaign materials there is no allusion to it, and the word ‘obesity’ does not appear on the accompanying website.

Video-based campaigns

1. *Sugar Packets: ‘Do You Drink 93 Sugar Packets a Day’*
New York City Department of Health: Pouring on the Pounds campaign (DH NYC 2011)¹

A series of videos were created for the ‘Pouring on the Pounds’ campaign. In this selection from the series, entitled ‘Do you drink 93 sugar packets a day,’ the video opens with a close over-the-shoulder view of a person opening a cooler full of soft drink bottles,

¹ Last viewed on YouTube on 08 May 2017, with 363,245 views at this date.

as a voice-over begins, “Does this sound familiar?” The only background sound is the ticking of a clock. “You grab a mid-morning soda. . .” the voice-over says, as the person grabs a green drink from the cooler, and sugar packets appear in the top-right corner of the screen saying ‘20oz Soda: 16 packets of sugar.’ The scene changes to another rear-view of a person sitting at a table with a cafeteria tray in front of them, holding a burger and French fries, as the voice-over continues “. . . a sweetened tea at lunch. . .” (sweetened tea, in the US context, is sweet-tasting iced tea, rather than a hot tea with sugar in it) and the sugar packets appear again saying ‘23oz Tea: 18 packets of sugar.’ The person takes a drink of the sweet tea. The scene changes again, to a close over-the-shoulder shot of (presumably) the same person, with a computer screen in front of them. The voice over says, “. . . a frozen coffee drink in the afternoon. . .” accompanied by slurping sounds, and the sugar packs in the corner tell us ‘Medium frozen vanilla coffee: 32 packets of sugar.’ The scene changes again, to focus on a glass sitting on a coffee table, with a take-out container of spaghetti to the right and a remote control to the left, as a hand pours liquid from a two-litre bottle. The voice-over says, “. . . and a couple of sodas at dinner.” The sugar packs say ‘2 glasses of soda: 27 packets of sugar.’ The voice-over continues, “Seems harmless enough,” as the scene changes to a shot of all of the beverages this person has consumed in the video lined up against a black background. The voice-over says, “but that many sugary drinks a day can add up to a lot of extra sugar.” Above the beverages, capitalised white text appears with a bright pink rolling-style ticker of numbers in the middle, which stops to say ‘One day total: 93 packets of sugar.’ The beverages fade out over a rear-view shot of two fat people walking down a sidewalk. The voice-over says “And all that sugar can bring on serious health problems

including obesity. . .” One person, who is only visible from the armpit downwards, wears black pants and a purple shirt. The other wears an orange shirt and brown pants while riding in a motorised wheelchair. The sound of a heartbeat begins where the ticking of a clock had been audible, and gets louder throughout the remainder of the video. The voice-over says, “. . . which causes type-2 diabetes. . .” as the scene abruptly changes to a shot of the tip of a foot, with swollen, red skin, multiple yellow ulcerations on the toes, and blackened flesh covering most of the big toe, half of the second toe, and the tip of the third toe. The scene changes abruptly again to picture a fat person lying prone holding their side with their left hand. Their face is mostly obscured, and a paramedic’s arms reach over the person’s torso with defibrillator paddles. The paddles appear to discharge as the person twitches, and the sound of an ECG machine accompanies the voice-over in saying, “. . . heart disease. . .” The scene changes again to a man in a hospital gown, looking downwards in an attitude of solemnity, as the voice-over finishes, “. . . and even some cancers.” The scene changes to a shot of a variety of beverages, including sweet tea, energy drinks, and soda, on a black background, and above them in pink and white capitals, text tells us ‘Don’t drink yourself sick,’ as the voice-over repeats the message, “so don’t drink yourself sick.” These beverages are replaced by a different set of beverages, including a glass of water, a cup of tea, and milk, on a white background. Text in the top-right corner and the voice-over both say “Go with water, seltzer, fat free milk, or unsweetened teas instead.” The video finishes with a shot of the slogan, “Are you pouring on the pounds?” accompanied by the sound of fizzy soda being poured into a glass.

The first half of this video is compelling and conveys nutritionally accurate information. The emphasis on how much sugar is in beverages that many people frequently consume with little thought is impactful. However, the second half of the video disposes with this kind of fact-based communication in favour of scare tactics and stereotypes. The extensive use of face-obscuring shots of fat people communicates their shame to the viewer (Heuer et al. 2011), while implying that if one is not fat, then the preceding health warnings may not apply.

Similarly to some of the posters above, the visual connection this video draws between type-2 diabetes and a damaged foot is offensive, and also misinforming. People who do not have a good understanding of what type-2 diabetes is could end up thinking that it is some kind of flesh-eating disease. Type-2 diabetes has a multitude of contributors, and fat can increase a person's chance of becoming diabetic. However, people who have successfully managed their diabetes for decades would have good reason to be outraged by this kind of portrayal of the disease. This topic, as well as the general use of chronic diseases as a threat, deserves more attention (McNaughton 2013). It is important to ask why the creators of this video and visual materials like it tend to choose a sick foot to represent type-2 diabetes, instead of an insulin metre or some other image that would portray the chronic and on-going nature of diabetes.

2. *Family View: 'The talk: Mom and Dad,' and 'Who Cares'*
Children's Healthcare of Atlanta: Strong4Life campaign²

In the first video, entitled 'The talk: Mom and Dad' (CHoA, 2012), a woman walks into the kitchen with her purse and keys in her hands, and takes a shopping list off the fridge

² Viewed on YouTube Nov. 2014, with 1,182 views at this date. On 08 May 2017, video was no longer available.

door. She looks at it and reads “Orange soda, cookies, ice cream.” She sighs and says, “What are we doing to our kids.” She looks over her shoulder at snacks on the counter, which include a canister of ‘cheese balls’ (which appear to be cheesies or cheese puffs) and a dish of something that looks like candy packages. She sighs again, shakes her head, and says, “This has got to change.” She leaves the kitchen, and the camera cuts to a close-up of the fridge door with word-magnets, as a voice-over tells us “Today parents say the most difficult conversation with their kids is not about sex or drugs.” The camera zooms in on two photos of kids – one a girl holding a dog, and the other a boy. Both are smiling and appear to be happy in the photos. While the camera pans right, the voice-over continues, “It’s about weight.” The screen fades to black and reopens with the woman coming into the kitchen with a paper bag of groceries, with bananas, broccoli, carrots, and other vegetables poking out of the top. A look of dismay crosses her face as a man comes into the kitchen from a different entrance with two large pizza boxes. He sets these on the counter and opens his hands in a kind of shrug, and says “Hey hon, no cooking tonight.” As the woman looks at her vegetables with dismay, the man yells “Hey kids, we got pizza!” The screen fades to black again, and white text appears saying “Time for the Talk?”

The Strong4Life campaign changed tactics significantly after the uproar caused by the *Little Girl* and *Little Boy* posters, discussed above, and this certainly seems like a less troubling example than the original posters were. This video emphasises eating habits, calling attention to the power of convenience foods with pizza for dinner versus the vegetables in the shopping bag. However, the primary message of the video is that parents have to talk with their children about their weight. The kids in the photos on the

fridge look happy and healthy; there is an implication that their weight is a problem, but there is no explanation for why this would be so.

Further, the parents in this video are shown to have choice about what they eat. They are able to go to the grocery store and buy a variety of foods, indicating a certain income level, and implying that they know how to cook them as well. This, in the American context, is at odds with the lives of many people who are fat, as income is a barrier to healthy eating and food literacy (Treuhaft & Karpyn 2010). There is also an interesting gender dynamic at play in this video. On one hand, the video is telling the viewer that parents need to be a team to help their families eat healthier; on the other hand, the video shows dad to be the junk-food lover, and mom is the health-conscious worrier. This crops up again in the next video.

A second video in this campaign, entitled “Who cares,” (CHoA 2013)³ opens with the camera panning across a floor, where homework, pencil crayons, games, playing cards, and newspapers are strewn. A person’s legs and feet are visible. In bold white writing, the words “Who Cares?” pop into the frame for three seconds. The camera shot changes to pan across a counter top, where an empty container with chicken wing bones and sauce, almost-finished pizza in boxes, an opened bottle of a soft drink, a glass with juice in it and a can of soda all crowd together. People can be seen in the background on a couch with a T.V. on. The words “Who Cares?” pop into the frame again, as music and the ticking of a stopwatch become audible. The shot changes again to the people in the living room. There is a boy napping on a couch, who rubs his eyes and looks toward the

³ Watched on YouTube Nov. 2014, with 2,161 views at the time. This video was also shown as a television ad, so YouTube does not account for the entire viewership. On 08 May, 2017, this video was no longer available online.

television, a girl reclining with her feet up and a laptop open, and a man holding the remote control looking at the T.V. The man reaches over to a bowl of cheese puffs beside him and eats one. There is a glass of a pink beverage on the table, along with papers, books, pencils and more playing cards. Pillows are on the floor. As the man eats a cheese puff, the words “Who Cares?” pop into the frame for a third time, but with a voice-over this time, and as the man looks toward the girl with the laptop, the shot fades and enormous white words with accompanying voice-over say, “You Do.” Upbeat music begins as the shot changes to a search bar on a computer screen. The address ‘Strong4Life.com’ appears as the voice-over says “And we do, too. That’s why our experts at Children’s Healthcare of Atlanta have created Strong4Life.com, the place where busy parents can go when they’re ready to start living healthier.”

There are a number of unusual features about this video. First, the children in this ad are not fat, but the father may be (his seated position and the fact that we only see any of the characters briefly makes it difficult to discern). They appear to be having a relaxing Sunday afternoon together in the living room, but that itself is not a health issue. This video could be seen as an improvement over the others for possibly not portraying people who are fat, but addressing inactivity among everyone (potentially) instead. Second, the room is clearly designed to make the viewer see the people in the video as slovenly. The mess on the counter reflects the mess on the floor, and the video seems to be implying that the food itself is ‘messy.’ The words ‘who cares’ repeated on the screen over the messy scenes implies that the people lack motivation and are lazy. There is a connection being drawn between healthy, active people and ‘clean living,’ clean spaces, and clean

food, in contrast to the unhealthy, inactive people and ‘messy,’ unclean junk food being depicted in the video.

Like the last video in the Strong4Life series, this video shows a subtle gender bias. Dad is depicted as the junk-food lover again, as well as a couch potato. There is no mother in this ad, which seems to imply that when Mum is away everyone will just hang around and let the house become filthy. This message is as disparaging to men and fathers in presenting them as lazy bums as it is to women and mothers in implicitly contrasting them as nannies and housemaids.

3. *Grocery Store: the ‘Grocery Cart’*

Health Canada: Healthy Canadians campaign (Health Canada 2013)⁴

In this video, an adult woman and young boy are standing at a self-serve checkout lane in a grocery store. The boy is scanning items as the woman hands them to him, and he is putting them in the bag beside him. The first item is unclear, but the second item the boy scans is a bag of apples, followed by a two-litre beverage carton, and then a dozen eggs. The woman and boy are working quickly, and the scanner makes a regular ‘beep, beep, beep’ sound. The woman hands the boy a box of something to scan, and the scanner makes a long, sustained beep, causing the woman to look up and quickly take the box back. Over the sustained beep, a voice-over begins, “Be careful to choose foods that are lower in fat, sugar, and sodium for you and your family,” as the woman examines the side of the box. We see that she is looking at the ‘nutrition facts’ panel, with her finger below the number indicating that one serving of the food contains 21% of the recommended daily amount of sodium. The voice-over says, “Read the nutrition facts

⁴ Last viewed on YouTube on 08 May 2017, with 2,736 views at this date.

table to pick healthier food products.” The woman makes an expression that seems to say ‘I’m too clever to be tricked by this food,’ and puts the box to the side. The camera shot changes to a birds-eye-view, and the woman hands the boy a bag of two items that might be onions. He scans this item with an accompanying beep. The screen changes to blank white, with the words “Learn more at healthy.canadians.gc.ca/EatWell” and the government of Canada’s logo, while a regular beeping continues.

This and videos like it comprise the Government of Canada’s efforts to encourage healthy food choices and eating behaviours. Though fairly innocuous, there are a couple of interesting points to discuss. The first is the nutrition panel, which is Canada’s version of the UK traffic light system, but not nearly as customer-friendly. Canada has been attempting to teach calorie literacy to people so that they can use the panel properly (Government of Canada 2014), while the food industry thwarts attempts to introduce a more accessible system of nutrition information provision (Bureau of Nutritional Sciences Food Directorate, Health Products and Food Branch, Health Canada 2009).

The second and more interesting observation about this video is the beeping that accompanies the scanning of food items. The regularity of the short beeps followed by the one long beep sounds suspiciously similar to an electrocardiogram machine indicating heart beats and the flat-line of cardiac arrest. This is a subtle but loaded auditory device; it implies that something in that boxed food was dangerous or lethal, and that the woman in this video avoided great danger by putting the food aside and not feeding it to her family. While much subtler, this is similar to the food-cancer and food-fear messages used in some of the other videos.

Placed in the grocery store context, the food-danger message underscores the blame placed on individuals for being fat or having weight-related health concerns. The government considers itself delivered of its obligation to protect the health of citizens through providing the nutrition facts panel and telling people how to use it. The government could place regulations on industry to change the ingredients in boxed and pre-packaged foods. Instead, the government requires industry to disclose ingredients in a manner that has shown to be difficult for consumers to understand, and then instructs individuals to decipher the meaning.

4. *What Are You Eating? 'Be Food Smart,' and 'Me Sized Meals'*
National Health Service, United Kingdom: Change4Life

This video from the NHS challenges people to examine what is in their food. In the video, entitled “Be food smart,” (NHS 2013)⁵ three clay figures sit on a couch. They are noisily eating things: the orange figure is eating French fries, the green one is eating pizza, and the pink one is drinking a soft drink. As the camera zooms in to the green figure, a voice-over says, “Honestly, you lot! What are you putting into your bodies?” A real human hand reaches into the frame and taps the orange figure on the shoulder, as the voice-over says, “Let me show you. Come on, hold tight!” The hand then lifts the couch with the three figures out of their living room and onto a life-sized counter. A wine glass is set in front of the figures, and the voice-over says, “This is the amount of fat in that whole pizza,” as lumpy white semi-solid is poured into the glass, filling it two-thirds of the way. The voice-over continues, “Yuck!” as the figures all gasp. The hand puts a ramekin of sugar cubes in front of the pink figure saying “There’s 17 cubes of sugar in that fizzy drink,” causing the figure to gasp again and throw the cup over its shoulder,

⁵ Last viewed on YouTube on 08 May 2017, with 170,656 views at the time.

followed by the orange and green figures throwing their pizza and fries away. The voice-over says, “Too many hidden nasties can create dangerous levels of fat in your body, that could lead to heart disease, stroke, type-2 diabetes, cancer.” The figures huddle together in fear and become pale to the waist at these words. The hand takes hold of the couch again and drops it back into the figures’ living room, while saying, “Come on, let’s get food smart. Here’s our free meal mixer,” handing the figures a tiny flip book, all of them giving the hand a thumbs-up. The voice says, “It’s packed with cheap and tasty everyday ideas.” The scene cuts to the three figures sitting around a table with water in their glasses and plates holding chicken legs, carrots, and peas. The hand tries to steal a chicken leg, but drops it when the orange figure stabs the thumb with a fork. The voice-over finishes, “Be food smart. Join Change4Life for your free meal mixer and special offers.”

In the series created by Change4Life, this is one of the least troubling commercials. That said, the language used to describe fat and sugar is “hidden nasties,” and this is problematic. Calling these food components ‘nasty’ is unscientific, imprecise, and misleading. The attractive visual components and plain language in the video indicate that the NHS is attempting to reach a wide audience. However, there must be a way to use plain, accessible language without having to use words like ‘nasty’ to describe food. Fat and sugar are legitimate, even necessary, parts of the human diet. While the voice-over says ‘too many’ of these can cause problems, indicating that it is acceptable to eat them sometimes, the strength of the word ‘nasties’ instead of just ‘ingredients’ or even ‘foods’ undermines the message of moderation. This has the potential to undermine healthy eating by making people think that they should not eat fats or sugars at all. This

video also uses food-fear messaging, employing the same threats as the other videos and posters described here. In addition to stating that fat causes diabetes and cancer, the food-fear message is underlined by the concept of ‘hidden nasties’ in food. This seems especially frightening because the video tells the viewer that these are hard to detect, by being hidden, and one may not know that the harmless-seeming food they eat is actually going to kill them.

In a second NHS video, entitled “Me sized meals,” the focus changes to ask the viewer about how much food they are eating (NHS 2009)⁶. A blue clay figure sits at a table, sighs, and puts its head in its hand. “Mum loves me,” it says in a child’s voice, as a green figure driving a front-loader piled high with bangers and mash pulls up to the table and dumps it in front of the blue figure. The blue figure continues, “. . . and thinks lots of food will make me big and strong. But she gives me enough to feed a horse!” The green figure pats the blue one on the head as a thought bubble forms showing a horse at the table of bangers and mash. The bubble pops, and we see the blue figure eating a sausage and wiping drops of sweat from its forehead. “Whew. Good job we have Ben,” it says, as it tips the leftover food on its plate into the open mouth of a pink dog on the floor. The blue figure walks slowly into the living room holding its stomach, and says, “She forgets that I don’t need grown-up portions,” and sits down in between the green figure and an orange figure on the couch. The dog flops onto the floor as the blue figure rolls up its stomach to reveal a hole and says, “. . . and the teacher said if we eat too much and do too little, food gets stored as fat in our bodies.” The camera zooms in on the hole in the blue figure’s stomach and shows mining carts full of white gelatinous blobs rolling on tracks

⁶ Last viewed on YouTube on 08 May 2017, with 255,843 views at this time.

with squelchy sounds in the background. The carts join a line as the figure continues, “Which means we could grow up to have heart disease, cancer, or type-2 diabetes,” as the carts stop at a centre space and start tossing the white stuff, which comes together in the space to form the word FAT, which increases in size with the name of each disease. The camera zooms out of the stomach hole in the blue figure and the green and orange figures look concerned. The blue figure rolls its stomach down and says, “Nasty.” The scene changes to a dinner table, where the three figures have different sizes of bangers and mash servings on their plates. The blue figure says “So, I told mum not to fill me ‘til I burst. I eat me-sized meals, just the right amount for my tum.” The dog waiting at the end of the table does not get any leftovers, and the blue figure says, “Sorry, Ben.” A voice-over says, “Me Sized Meals, just one of the many ways to make a Change4Life.”

This ad raises many concerns, especially because it is aimed toward children and their parents, with a child doing the voicing. The creators of the video made a questionable choice in having the video open with ‘mum loves me.’ This is an example of a food-love message that also appears in other NHS videos. This love comes with a caveat, however, as the video implies that mothers are harming their children by overfeeding them. The video tells children that they should tell their parents how much to feed them. Reading the YouTube comments section below the video reveals the worries and concerns from parents about this specific issue. Some say that their young children are refusing food, or wanting smaller portions even if they were already getting the right size for their age.

The comments also reveal the impact of scare-tactic messaging when directed at children. Parents write that their children are afraid to eat because they think that they will get cancer from eating food. The use of the word FAT in large white letters

accompanied by squelchy sounds while disease-words are voiced-over is problematic. There are obvious negative connections being made between being fat and being sick, blaming diseases on food, and underscoring that fat is bad and undesirable. Like the previous NHS video, this video uses the word ‘nasty,’ however in this video it is used as a judgment for being fat or having certain diseases, rather than for food ingredients. As bad as using ‘nasty’ to describe ingredients was, the use of it to describe bodily states is much worse. It is clearly normative, placing negative judgments on fatness and diseases such as diabetes or cancer, and it is harmful to the people who have those conditions.

5. *The Measuring Tape: ‘What Measures Will You Take’*

Department of Health, Australian Government: Healthy Active Australia campaign (Department of Health, Australian Government 2010)⁷

The ‘Measure Up’ campaign is one of many undertaken by the Australian Government. It opens with a man walking toward the viewer on a large white measuring tape, which is placed on the ground. He starts walking from number 82, wearing only white boxer shorts. He looks to be in his late 20s or early 30s, is fairly fit-looking, and has brown hair. Speaking to the viewer, the man says, “You know how it is, you settle down, put on a few kilos . . .” as his midsection becomes slightly larger and he pats his stomach. He appears to age a bit, with his hair thinning as he walks over number 92, “. . . but I’m not worried,” he finishes. The scene cuts to a black screen with white measurement marks along the top and bottom, with white words in the middle of the screen and a voice-over saying, “1 in 2 Australian adults is overweight.” The scene cuts back to the man walking toward the viewer. As he says, “Then you have kids,” a girl and a woman wearing white shorts and

⁷ First watched on YouTube in December 2014, with 17,059 views at this time. This video was also a television ad, so YouTube views do not accurately represent total viewership. As of May 2017, the video is no longer posted by the Australian government. However, the video was reposted by a different organisation in November 2016, and can be found at this address: <https://www.youtube.com/watch?v=c-SGdV12F8>

t-shirt come onto the screen. The man picks up the child and swings her around as both laugh, and sets her down again. He says, “life gets busier,” as the child and woman run off-screen together smiling and looking back at the man. The man gets visibly older again, and more weight is added to his frame, as he says, “you let yourself go a bit. I’m not worried.” In this sequence, the measuring tape the man is walking on has gradually become yellow, and then orange, as he walks over the numbers 94 to 104. The screen cuts to black with white measuring marks and text as a voice-over begins again, saying, “Unhealthy eating and drinking and not enough physical activity can seriously affect your health.” The scene changes back to the man on the measuring tape, which is now red, and a slightly older girl comes into the shot from the side and touches the man on the shoulder saying, “tip, you’re it, Dad.” She runs toward the viewer as the man growls and starts to run after her.

After a few paces, the man visibly ages again with grey hair and more weight being added to his appearance. He slows down, breathing heavily, as the girl giggles and runs out of the frame. He leans over with his hands on his knees and breathes heavily, looking up at the viewer with a dismayed look on his face. The screen changes to black as a voice over says, “for most people, waistlines of over 94 centimetres for men and 80 centimetres for women increase the risk of some cancers, heart disease, and type-2 diabetes.” As the voice makes these statements, measuring tapes unroll from left to right. After the numbers 94 on the men’s tape and 80 on the women’s tape, the white measuring tapes become yellow and grade into orange and then red at the end. The scene returns to the man, who is now standing on a red measuring tape over the number 112. He turns to the side and says, “And when I first realised it was affecting my health. . .” and looks back at

the measuring tape he has been walking along toward the yellow and distant white sections of it, as the girl comes back into the frame with her back to the viewer. The man continues to breath heavily and looks toward the girl. The shot changes so that the viewer can see the girl's smile fade, before changing again to a close-up of the man's face. He has all-white hair now. He looks at the viewer with an expression of worry or fear, and says in voice-over, ". . . yeah, I got worried." The screen changes to black with white measuring lines again, with text and a voice-over that say, "The more you gain, the more you have to lose." The video cuts to a white screen with text saying, "how do you measure up?" A measuring tape unrolls to form the question mark. The voice-over advises, "To find out how you measure up, go to Australia.gov.au/MeasureUp."

This video focuses on general weight gain, emphasizing neither unhealthy eating nor insufficient physical activity, while mentioning both. It uses the now-familiar scare-tactic cancer message, however it also has a focus on abdominal girth, which has not been seen in the other campaign examples. Rather than a general anti-obesity or fat message, this campaign's focus is specifically on waist circumference. While waist circumference is particularly associated with diseases of the heart and arteries, the first illness mentioned in this video is cancer.

There is a clear linking of appearance and health in this video, and even of aging and health. The character ages significantly over the span of the ad, rather than simply gaining weight. This draws a link between getting older and being fat for no apparent reason, and plays into stereotypes about 'healthy youth' versus old age and sickness. Presumably, the character did not have to age so much for his body type to change, but the creators of the video chose to emphasise lifespan and aging.

The video does not indicate at what point on the measuring tape the man's weight started to impact his health. Though the viewer has been watching the man gain body mass, there is no obvious cue that the man's weight has gone from 'healthy' to 'unhealthy.' The trick of using the colour of the measuring tape to indicate that the man is leaving the white 'safe' zone of waist circumference and travelling into the red 'danger' zone is so subtle that it required several close watches of the video in the process of making this transcription to become aware of it. With the frequent and gradual changes in the man's appearance, the viewer is not left with a distinct impression of the range of body sizes (as depicted in this video) that represent health. This is particularly interesting since the man is well into the red zone before the viewer discovers that the man's health is allegedly being impacted by his weight. He implies that it started somewhere back down the measuring tape, by looking backward. It appears on close watching that the man enters the yellow 'warning' zone on the measuring tape while still appearing to have a fairly fit and entirely average body size. It would be understandable if fat people watching this ad became disheartened and did not find it to be motivating. Also problematic is that as people age they tend to put on a normal amount of weight, so that someone at 70 will likely have a different body shape than they did at 30, even while being healthy and fit. The video ties age and weight gain, but does not explain this relationship or highlight that the man depicted ought not to have the same frame at the end of the video as he has at the beginning, even if he is healthy, given the amount of years he has aged.

Chapter 2

Introducing the Ethical Analysis of Anti-Obesity Campaigns

Critical evaluations of popular media in current Anglo-Western culture suggest that a lingering dualistic notion of the psychological and moral subject and the physical body permeates typical representations of the self. Susan Bordo (2003) has argued that by today's measure, the body is often considered to be impure and full of wanton and animalistic desires that must be ruled by a pure and rational mind. Obesity, as a social and medical interpretation of body fat, has come to represent the lack of a strong will, a failure to control base drives, and as an extension, evidence of moral impurity (Bordo 2003; Guttman & Salmon 2004; Jutel 2001; Lupton 2015). This view has deep roots in the history of Greco-Roman and Judeo-Christian thinking. The image of the mind and body in a contest of power has special significance now, in an age of heightened consumerism. As Bordo observes, in a historical era where consuming is not only common but necessary by current definitions of national economic health, "we find ourselves continually besieged by temptation while socially condemned for overindulgence" (2003, p 199). Fat people may come to represent this overindulgence, consumption without restraint, and capitulation to the desires of the body.

As I will argue in full in Chapter 6, governmental bodies such as ministries of health and Canada's Standing Committee delegate certain health-related duties to public health organisations. Along with prominent researchers and ethicists, governments have given public health the task of communicating to fat people that they have transgressed upon social and medical mores. In this dissertation, I am specifically interested in the visual media components – posters and videos – of campaigns created by public health agencies

and governments to send messages to the public about obesity. Visual media form important parts of broader campaigns, being used to draw attention to an issue, deliver short bursts of information, and motivate people to learn more. While often cloaked in the language of concern for a person's health status and future welfare, the visual imagery and text used to deliver public health messages often invoke particular moral judgments. It is common for these to make use of non-rational communication pathways. As Messaris and Abraham say in their examination of the role of images of African-American men in framing news stories, "images are capable of conveying un verbalised meanings . . . [though] awareness of those meanings may be elusive" (2001, p 225). The visual aspects of anti-obesity campaigns provide context, nuance, and additional messages about social cues, expectations, or acceptability that cannot always be captured in text. Images have the ability to convey controversial messages "with impunity that is not afforded to textual messages" (Messaris & Abraham 2001, p 225). As a result, images in visual media, as well as sounds in videos, are used to convey extra-textual messages to the viewer.

Numerous analyses of anti-obesity campaigns have now been conducted by ethicists and sociologists (Carter, Entwistle, & Little 2015; Heuer, McClure, & Puhl 2011; Lupton 2013, 2014; Puhl, Peterson, & Luedicke 2013; Rossi & Yudell 2012). Chapter 1 provided my own descriptive analysis of nine examples of poster and video campaigns from English-speaking, liberal, democratic nations. It is important to note that this work is not intended as a survey of all available anti-obesity campaigns. As is evident from the recent advice from the Standing Committee, the creation of these campaigns is an active area at the moment, and there is a multitude of campaigns that could be provided as examples.

The campaigns in Chapter 1 have been chosen as a sample that gives an indication of the range of campaigns that are produced by public health bodies, in order to provide a reference for the ethical discussion in the following chapters.

While some campaigns use text-based messages that are relatively neutral, the accompanying images reveal biases or utilise stereotypes, thereby providing more information than given by text. The effect of imagery is that it enhances or undermines the intended meaning of words with immediate visual cues, carrying important implications for how messages are likely to be received. Images evoking fear, disgust, shame and other affective reactions bypass the audience's rational thought-processes. Such emotional appeals have been promoted and defended for their shock-value, with proponents arguing that it is precisely the shocking nature of the images that makes them effective (Bayer & Fairchild 2016; Bordo 2003; Callahan 2013; Ruiters, Abraham & Kok 2001). However, as Bayer and Fairchild (2016) point out, the effectiveness of emotive campaigns depends upon there being some way to avoid the threat, which may not be the case for body fat.

Aside from empirical questions regarding efficacy, there remains an ethical question about whether or not it is morally permissible for public health organisations, imbued with medical authority and exercising power over their audience, to use non-rational communication techniques in obesity-related campaigns. This is where my analysis of anti-obesity campaigns will start, because the manner in which these messages are communicated is a fundamental ethical question in determining the morality of this kind of governmental and public health intervention. One of the important commonalities among the anti-obesity campaigns in Chapter 1 is that posters or videos that may seem to

use different methods or approaches actually rely on similar tactics to communicate their messages to their intended audiences. Some campaigns use startling messages or imagery in a transparent attempt to shock the viewer, as Callahan suggested they ought, while others are more restrained and use subtler messaging. However, both use certain techniques to influence the audience in an attempt to convince people that being fat is a bad thing.

Many public health bodies use various influencing tactics in place of providing health information messages. For example, almost all of the campaigns in Chapter 1 use explicit or implicit appeals to fear (of the examples analysed, New Zealand's 'Breakfast eaters' is the only one that does not). They frequently use fear of diseases, often cancer and type-2 diabetes, to reinforce messages about healthy eating (if present). Some of the fear-cues are subtle, as in the 'Grocery cart' video from Health Canada (see Chapter 1). While tactfully avoiding stereotypes or explicitly scary imagery, the video features a prominent beeping sound from a grocery scanner that sounds like the steady beeping and sudden flat-lining of an electrocardiogram machine, linking the visual images of food products with auditory (medical) danger cues. There is a tendency to make food threatening in many examples of anti-obesity messages, and to create a food-fear connection through these (Lupton 2015). This is evident in some campaigns (for an example, see 'Me sized meals' in Chapter 1), where the message that food causes cancer overwhelms the encouragement of healthy eating. The use of jarring visual images juxtaposing food with disgust, and language reflecting the same (by employing words like 'nasty,' or 'gross'), are powerful communicative techniques in these campaigns.

In a further example of how non-rational cues are used in anti-obesity campaigns, where children are in the materials or when a child does the voicing (such as in ‘Me sized meals,’ Chapter 1), the intended audience seems to be parents, as the purchasers and preparers of food, rather than children. There is a troubling tendency to draw a connection between providing food and love of one’s children or family where parents are being addressed, which introduces guilt to the armoury of affective messages in these campaigns. In Chapter 3, I shall investigate the nature of the influential communicative techniques used in anti-obesity campaigns, including the use of fear or threats of certain diseases, to motivate the audience. Ultimately, I will argue that these campaigns employ manipulation, and so we must consider whether manipulation can be ethically justified when used in this way and for this purpose.

These campaigns may also cause various kinds of harm to the audience, individually and in groups, such as stigma, low-self-esteem, and shame. Bayer and Fairchild (2016) and Callahan (2013) suggest that this may be justified provided the campaigns are effective. For example, there is a tendency in anti-obesity campaigns to present fat as a problem on its own, even in the absence of any indication of negative health effects. The health effects are implied to be impending, and therefore the fat itself is presented as problematic. However, fat is not the same as a disease, so this visual connection serves to stigmatise fat people by suggesting that certain acute or chronic diseases follow inevitably from having a fat body. To paraphrase Messaris and Abraham (2001, p 225), the combination of images of food, diseases, and stereotypes results in the visual realisation of the aesthetic dimension of ‘being fat’ as a pathology. That is, these posters and videos are the concrete presentation of the sociocultural belief that the *appearance* of

being fat *equals* a poor health status. This is demonstrated when a fat person with no obvious health issues is used as a representation of illnesses like diabetes or cancer (McNaughton 2013). This tendency also stigmatises people who live with certain chronic diseases by implicitly claiming that these are caused by being fat when, in fact, they have myriad causes (McNaughton 2013). A similar effect is achieved when fat people are shown to be messy or unclean, or when a messy home is used as a sign of unhealthiness (for an example, see the ‘Who cares?’ video in Chapter 1). Combined with the absence of claims that are clearly backed by research (through such means as providing references or quotations from credible sources), this exploitation of common cultural tropes leads to the overall impression that the campaigns are not grounded in best evidence about the relationships between body fat and various diseases, but are relying on stereotype and potentially fostering stigma.

Many of these campaigns show similar visual depictions of fat people. These depictions can demonstrate disrespect to the individuals being shown by removing or disregarding their agency. This is accomplished through obscuring or removing the faces of fat people in the images or depicting stereotypical behaviour or appearance in the videos and posters. Campaign materials deploy stereotypes about fat people in place of providing nutrition or health information. Materials showing fat people sitting in front of computer screens or on mobility scooters use imagery that functions as attitudinal-behavioural cues, which communicate stereotypes about fat people, such as illness, laziness, sloppiness, and lack of individual drive, to the audience (McNaughton 2013; Messaris & Abraham 2001). As Messaris and Abraham put it, “the myth is implicitly manifest in the visual rendition of the story” (2001, p 224). The campaign materials

utilise the assumed stereotypes of the audience to deliver their health-focussed messages, instead of directly presenting information.

Three Arguments for Anti-Obesity Campaigns

i. Daniel Callahan

Daniel Callahan was one of the earlier ethicists to discuss addressing rising rates of obesity. Though various public health documents have recommended the creation of anti-obesity campaigns, Callahan (2013) was the first ethicist to specifically call for the use of stigmatizing messages. In his argument, he writes that in order to address increasing population rates of obesity we need to change almost everything about the way we live. He presents Gallup poll findings that suggest that American men and women may not realise that they are collectively and individually gaining weight, and that they are poor judges of their children's weight as well (p 35). Though he argues that entire systems in which we live must change, Callahan's conclusion is that in order for any regulatory change to succeed we must undertake public messaging to drive home the idea that being fat is not acceptable or desirable. To address the apparent error in the public's perception of their own and their children's body size, and to prevent people from becoming obese, Callahan says three strategies are required.

The first strategy calls for strong public health measures by government (p 36). Callahan mentions taxation of some foods, subsidies of other food, and posting calorie amounts on menu boards as three examples of the kind of government regulation he is envisioning (p 36). Though these would be introduced via regulatory change, taxation of foods or posting calorie amounts, for example, place the burden of change upon individuals (MacKay 2015). Callahan does not mention regulations in which the food processing and restaurant industries would hold responsibility for change, such as altering

the content of food, or the food procurement and distribution system as a whole, though he would likely support these measures.

Callahan says that only powerful regulations to curb industry behaviour could be truly effective, but is concerned that lobby groups and libertarian-minded folks who oppose government intervention would overpower new regulations, as happened in the case of New York City's soda size limit (p 36). In this case, as I will come back to in Chapter 6, New York City's mayor introduced a bylaw restricting the sizes of cups permitted for use at soda fountains in various fast-food-style venues (Bateman-House 2017). The beverage industry reacted by framing this bylaw in 'nanny state' terms, alleging that this was an example of how the government oversteps the decisions of grown adults, who have the ability and right to make their own choices. Despite the fact that a person could still drink the same amount of soda (by refilling the smaller cup, for example), limiting the very large cup sizes proved to be extremely unpopular. The bylaw was eventually struck down by the courts, and rescinded.

Callahan therefore thinks that other measures will be required, because regulation is slow, difficult, and cannot be depended upon. Thus, his second suggestion is to target children with obesity prevention techniques (p 36). These techniques could include increasing access to healthy foods at school and at home, and finding ways to increase physical activity among children. Callahan also suggests restricting children's exposure to food marketing on television (p 37). This measure has been taken in jurisdictions in Scandinavia and in Quebec, Canada, with evidence of effectiveness (Dhar & Baylis 2011; Galbraith-Emami & Lobstein 2013). However, Callahan is wary of the ability of government to introduce this measure in the political context of the United States, and

suggests that the food industry will be left to self-regulate its marketing strategies.

Callahan thinks, and I agree, that we may reasonably have grave doubts about industry's willingness to do this.

Callahan's final strategy, and the one most relevant to the first three chapters in this dissertation, is "to find ways to bring strong social pressure to bear on individuals, going beyond anodyne education and low-key extortion" (p 37). He argues that stigmatizing being fat, the way that smoking became stigmatised in previous decades, is the way forward. Callahan remarks on his own experience as a smoker, and thinks that just as smoking was made to be unpopular, we should put pressure on people's feelings of identity to make them realise that they do not want to become fat, or stay fat. He says this even after acknowledging the extreme difficulty of losing more than 5-10% of body weight and the multi-billion-dollar industry that thrives on people's (usually ill-fated) attempts to do so. Callahan acknowledges some of the main objections to his proposal to stigmatise fatness: "it is wrong to stigmatise people because of their health conditions; wrong to think it will work well, or at all, with obesity; and counterproductive with the obese because of evidence that it worsens rather than improves their condition" (p 38). While, arguably, stigmatizing smoking focuses on a behaviour and not on smokers as persons, stigmatizing obesity attacks the identity of the person instead, and there is evidence of material harm to fat people caused by stigma (p 38).

However, Callahan does not respond to these objections. He also does not consider that though public health utilised stigmatisation against smoking, it may not have been morally right to do so. Rather, he argues that stigmatisation is necessary to make people serious enough about wanting to avoid being fat to accept government interventions,

which is the role he sees stigma playing. He considers this to be a method of ‘empowering the victims’ of being fat because it may motivate them into action (p 40). This depends upon the effectiveness of the strategy, however, and the assumption that stigma can lead to greater benefits than harms. If we are left with having to change everything about the way we live, Callahan says, then progress seems unlikely. In order to achieve such vast amounts of change, we must make sure that people have a strong aversion to be(com)ing obese: “it is hard to imagine that much progress can occur toward solutions for obesity unless we bring some form of social pressure to bear against it” (p 38). Thus, even to achieve appropriate and effective government regulation, Callahan argues that we must stigmatise fatness.

ii. The Standing Committee

In early 2016, Canada’s Standing Senate Committee on Social Affairs, Science, and Technology (henceforth the Standing Committee) published a report entitled ‘Obesity in Canada.’ This report is a comprehensive exploration of the issues surrounding obesity rates in the Canadian population, and the Standing Committee heard testimony from a wide range of experts in the sciences and policy fields. The Standing Committee reports that witnesses told them about the changes in Canada’s food environment, and that these experts “stressed that climbing obesity rates have not been the fault of individuals but rather a direct consequence of the multitude of environmental changes” (Standing Senate Committee 2016, p 8). Experts highlighted that sugar in the form of sucrose and/or high-fructose corn syrup is added to almost 80% of food products (p 6), and that certain social determinants of health, especially socio-economic status and education, are strongly correlated with obesity, eating behaviour, food insecurity, and physical activity (p 9). After listening to the expert testimony, the Standing Committee concluded that:

Although there may be a tendency to declare that people who are overweight are personally responsible and society is not to blame, an analysis of the issues presents a different perspective. Rather, it is virtually impossible to conclude that quite suddenly within the past few decades a large proportion of the population has collectively lost its willpower. As such, pursuing healthy weights should involve the supportive environment of a whole-of-society approach rather than be dismissed as a purely individual responsibility (p 10).

The Standing Committee's conclusion is a reasoned and measured response to the overwhelming evidence that exists on the topic of obesity rates.

However, the Standing Committee's perspective seems to narrow when it comes to recommending a course of action to the government, showing evidence of what the Marmot Review Working Committee calls 'lifestyle drift.' This is the tendency "for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors" (Hunter 2009, p 3). Though the Standing Committee's recommendations are broad, those that deal with food and food ingredients are focussed on changing Canada's national food guide and the nutrition facts panel – a table of nutrient values that the Government of Canada requires all pre-packaged food to include, and which consumers find difficult to interpret (pp 25-33). Another section of the recommendations deals with funding for infrastructure and physical activity programs. The first and last recommendations in the document call upon the government to implement national campaigns combatting obesity, and promoting healthy eating and active lifestyles (pp 21, 38). The Standing Committee reports that, like Callahan, many of their witnesses drew comparisons with the anti-smoking push of the past few decades, and suggested that similar approaches should be used regarding body fat.

The techniques of the anti-smoking movement focussed to a large extent upon changing individual behaviours via taxation and stigmatising campaigns, alongside laws that addressed public environments by limiting the places in which smoking was permitted (among other things). While these measures were successful in reducing the smoking rate by a great deal, approximately one quarter of the population in Canada (and other Western nations where similar tactics were employed, like the UK, Australia, and US) still smokes. For many of these people, smoking is not addressed via such measures. There is a distinction between interventions that directly place responsibility in the hands of the individual (such as raising taxes and education campaigns) and interventions that attempt to influence behaviours by changing environments to support healthier decisions, though ultimately, many interventions of the latter sort end up relying on individual uptake to succeed anyway.

To illustrate, the remaining smokers tend to smoke in response to certain systemic features of their lives: poverty, deprivation, drug addiction or mental health issues unaddressed by health systems, among other things (Voigt 2010). The creation of healthier environments, by banning smoking in restaurants, for example, can encourage better individual choices, but only if these environments are accessible to the person in the first place and if the rest of their lives are such that they experience a range of choices for behaviour. While banning smoking in restaurants is an excellent health measure for reducing second-hand smoke in particular, it is not a measure that would reach certain groups of long-term smokers. Since 30% of working class and 90% of homeless people smoke (Voigt 2010), banning smoking in restaurants is a measure that is less likely to influence their behaviour if they rarely or never go out to eat, than it is to influence the

16% of professional-class smokers. This raises both efficacy and equity concerns.

The recommendations of the Standing Committee threaten to fall prey to similar issues, and this is problematic. Rates of obesity have been linked to socio-economic status (Bayer & Fairchild 2016; Chaufan et al. 2015), and this has a clear impact on people's ability to decide what, where, and when to eat. Calorie labels on restaurant menus may reach people who go to restaurants, but not those who cannot or only rarely can afford to go to them. It also places the responsibility for change in the hands of the individual for making a food choice, and not upon the restaurants or food production companies to reformulate food recipes (MacKay 2015). The overwhelming tendency of the recommendations made by the Standing Committee is to focus on soft regulation around certain components of the food and built environments, in ways that ultimately leave it up to individuals to change their behaviour. This focus on education and lifestyle leaves the responsibility for improving population trends in obesity with the individual, which means that success hinges upon individuals having the psychological, economic, and physical resources to change.

It is relevant to note here that the Standing Committee's recommendations may support the government's pre-existing policies or programs focussed on individuals, or encourage the government to create more of these as part of a responsible and evidence-based reaction to the report. On the Canadian government's obesity web page, under the heading 'Government of Canada's Role,' a list of interventions are presented. The government is executing its responsibilities toward citizens by "helping Canadians improve their health and well-being by promoting and supporting regular physical activity and healthy eating" (Government of Canada 2006). 'Enabling' or 'empowering'

citizens, often through information or education (through Public Health Agency of Canada and the Centre for Health Promotion), along with nutrition-focused policies, the Canada Food Guide, and food safety regulations (through the Office of Nutrition Policy and Promotion, the Food Directorate, and the Centre for Chronic Disease Prevention and Control) compose the entirety of the government's role, by its own assessment (Government of Canada 2006). As I will argue in later chapters, these sorts of interventions are downstream techniques that rely on individual uptake for change, and are thus more vulnerable to failures of individual behaviour change and potentially less effective than regulatory changes at the level of food systems, or educational or housing systems.

The Standing Committee's recent recommendations support the individual approach, though they appear to be mismatched with the evidence presented to and recorded by the Committee: that the social determinants of health limit the range of options and behaviours from which individuals have to choose. The Standing Committee stops short of making strong recommendations (even in an aspirational way) to the government, such as requiring the food industry to stop adding (so much) sugar and salt to foods. Recommendations like this may be unpopular with industry and challenging for the government, as Callahan said, but may also be more appropriate levels of intervention for public health. Even if such a recommendation were cast aside by government at a later time, the Standing Committee should perhaps be expected to provide recommendations that represent the range of available options. They are, after all, charged with listening to experts and producing advice based on their testimony. The Standing Committee's obligations lie with the Canadian public and not industry, nor, indeed, the government of

the day.

iii. Ronald Bayer and Amy Fairchild

Most recently, Ronald Bayer and Amy Fairchild (2016) have argued that fear-based campaigns ought to be employed by public health agencies to ‘educate’ and ‘empower’ the public in the face of obesity and other health issues. Bayer and Fairchild begin by arguing that the claims that fear does not work, or does work but comes with undesirable consequences, are overblown. In their ethical review of a selection of studies and meta-analyses on the effectiveness of fear, they state that “all [studies] concluded that fear work[ed] provided that individuals perceived that there were effective interventions and that the stronger the threat the better” (p 392). They argue that as the utilitarian ethic of public health developed, the duty to intervene in matters of public health and the duty to warn either alongside interventions or when interventions were not possible became of central concern. Thus, telling people about the various dangers surrounding them has become a moral duty at the same time as it can pose a moral problem for public health.

Bayer and Fairchild support the use of fear in public health campaigns. They consider that there is reason to think that they are effective and that on a utilitarian view of public health, negative stigma outcomes for some do not outweigh the benefits of education and empowerment for many. But, they also argue that “a commitment to the value of solidarity on the part of public health ethics demands careful attention to the ways in which fear-based campaigns could generate experiences of shame, guilt and marginalisation in the near term” (p 394). Thus, public health has to balance these proximal harms against promoting the potential longer-term well-being of the public at large. This, they say, may come at the expense of the few ‘left behind’ individuals, who

either cannot or will not change. They also recognise that these campaigns could “rightfully be viewed as a pretext for failing to address the very patterns of morbidity and mortality that justify such efforts” (p 395; MacKay 2015). This is observable in the Standing Committee’s acknowledgement of the social determinants affecting obesity rates in Canada and their simultaneous focus on individual-level factors in their suite of recommendations. So, Bayer and Fairchild essentially admit that this strategy could widen health inequalities, in opposition to one of the central philosophies of public health practice.

Bayer and Fairchild are likewise still focused on the individual as the locus of change. They point out that in order for appeals using fear to be effective, the audience has to see options open to them for taking action. In the case of obesity rates, if one argues that fear appeals are a legitimate tool to use, then one must think that there are individual-level actions that are effective against it. However, as the Standing Committee says, it is not true that obesity is simply caused by and to be fixed by individuals, or that people have developed a mass-problem of will-power; a high rate of obesity in a population is closely tied to socio-economics, education, and food systems, and requires correspondingly systemic solutions. As I argue in Chapter 5, this means that it is primarily up to governments to address obesity rates via regulatory tools. In addition, stigma- or fear-based campaigns, which put singular focus on individual responsibility, are morally unacceptable for public health agencies. I shall explain why this is so in the following chapters.

The Standing Committee, Bayer and Fairchild, and Callahan, among others, think that the use (or creation, perhaps) of stereotypes and the use or deepening of stigma can be

justified using a utilitarian ethic, where potential benefits in terms of a population-level reduction of obesity may be weighed against harms resulting from stereotype and stigma. However, as I will argue in Chapter 6, promoting equity is a stated aim of many public health agencies and practitioners. Improvement or worsening in equity among groups may not always be captured by a utilitarian calculus. When considered from a moral perspective emphasising equity, certain methods or outcomes in public health may be unethical even if they help to achieve a desirable goal (and they may be unethical even if they do not cause harm). Thus, I will argue in Chapters 4 and 5 that the use of stereotype and stigma is unethical, and thus impermissible, even if anti-obesity campaigns using them happened to produce positive population-level results.

This argument is closely related to my view that there are certain responsibilities unique to public health organisations and governments, which act as limits to the means that they may use to achieve certain health-related goals. It is remarkable that despite the fact that some of the anti-obesity campaigns included in Chapter 1 are from non-governmental policy-influencing bodies, the focus of these campaigns is also on individual responsibility rather than raising awareness of systemic problems. This is perhaps unsurprising when one considers the current individual-responsibility and behaviourally-focused policy trend in Western liberal democracies (MacKay & Quigley in progress; MacKay 2015). However, policy-influencers can use public perception to motivate government action. Organisations like the New York City Department of Health, the OMA, or, indeed, the Standing Committee have influenced regional and/or federal government policy on a variety of issues in the past, and have the opportunity to create campaigns that focus on raising public awareness of the systemic contributors to

obesity in the food or eating environments. That said, in Chapter 4 I will briefly argue that such campaigns are not a very efficient use of an organisation's resources. Inefficiency notwithstanding, these groups have created campaigns that place blame on individuals and/or parents, as have government campaigns. The question of individual versus systemic blame-casting will recur throughout this dissertation, leading to my final argument in Chapter 6, that it is an important role of public health to work towards justice, and that this requires systems-level problem-solving.

Conclusion

This chapter has set the stage for the argument that follows throughout the dissertation, that the recommendations to use anti-obesity campaigns to motivate people to not be fat are unethical. Though they are rife with moral issues, stigmatising, individual-focussed anti-obesity campaigns are widely promoted by academics and policymakers as essential components of a public health response to obesity in Western societies. A number of ethical problems have been raised here, specifically of manipulation, of stigmatisation, and of public health's focus on individual behaviour change. These three topics will be considered in turn in the remainder of this dissertation. In the next chapter, I argue that anti-obesity campaigns often utilise a style of communication that I characterise as manipulation to play upon people's fears and social stereotypes about being fat. This kind of communication will be contrasted with two other styles, which I call informing and persuading, and the moral character of each will be examined.

Chapter 3

*Words can be relied on only if one is sure
that their function is to reveal and not to conceal.*

– Hannah Arendt, *On Violence*

Communication in Anti-Obesity Campaigns⁸

Important ethical insight may be gained by analysing the methods that public health anti-obesity campaigns generally employ to deliver information to an audience. Most campaigns seem to fall into one of two overlapping groups, which are distinctive in many ways for the communicative techniques employed in each. In one group, the campaign posters or videos seek to provide evidence-based health information to the public. The reason this information is given may be to attract the viewers' attention in order to alert them to a certain state of affairs, or to raise awareness in the audience, or to provide individuals with knowledge that will benefit them in some way. In this group, the messages sometimes include a recommendation for action of some kind, indicating that the messages are aiming to impact the behaviour of the audience. These, I will argue, are messages that operate via persuasion.

In the second group, the campaigns also aim to achieve behaviour change, but not through the presentation of scientific evidence or fact-based claims. In order to find such information, the audience will need to go to a source other than, but probably related to, the campaign material. In these cases, a public health organisation aims to engender an immediate reaction in its audience, through the use of a sensational message in posters or

⁸ A shortened version of some arguments in this chapter, specifically the sections on information, persuasion, and manipulation, have been accepted for publication in MacKay, K.L. (forthcoming). A feminist analysis of anti-obesity campaigns: Manipulation, oppression, and autonomy. *International Journal of Feminist Approaches to Bioethics*.

videos, and to cause behaviour change as a result of this reaction. These, I will argue, are messages that operate via manipulation.

In the following discussion, I will focus on distinguishing persuasive campaigns from manipulative campaigns, assuming that at least some campaigns are attempts at providing evidence-based information to the audience. This will require a discussion about what it means to inform, to persuade, to manipulate, and to coerce an audience via campaign messages. There are modes of communication that present information in a way that enables another person to come to their own understanding, such as mere informing, and modes of communication that seek to alter another person's understanding of the world in a particular way in order to achieve a pre-determined result, which includes both persuasion and manipulation. Both of these modes use information to influence others' decisions, but one does this overtly in a way that is open to reasoning and argumentative challenge, while the other does this covertly, in a way that is more difficult to address. I suggest that persuasion and manipulation are the two primary modes of communication operating in this influential manner in public health campaigns.

In the previous chapter, I indicated that many public health anti-obesity campaigns employ influential communication techniques to send a message to their audience. In this chapter, I will present a number of definitions for the kinds of influence involved before adopting modified views of each. Though I do not presume to reach a definitive conclusion about each concept here, I will do a considerable amount of philosophical work in attempting to untangle these notions. Using the definitions that I adopt, I will argue that many anti-obesity campaigns use manipulation to influence the audience. Further, I will argue in favour of particular understandings of 'persuasion' and

‘manipulation,’ upon which persuasion is something that may be used in morally permissible and impermissible ways, while manipulation may always be impermissible because it entails a lack of respect for the agency of its audience. I will also discuss recent work on the nature of propaganda, as some descriptions of it are relevant to and compatible with my description of campaigns as manipulative. However, I will not adopt this terminology. As will become clear, ‘propaganda’ does not always refer to false or undermining public messages. However, because the word carries an established negative valence, I will refrain from using it to refer to public health campaigns. Finally, the analysis in this chapter will conclude with a brief consideration of coercion and whether it is relevant to a discussion of campaigns.

Information

To begin, a charitable view of the problematic public health anti-obesity campaigns outlined in Chapter 1 is that they are genuine attempts to inform the population about issues that affect peoples’ health. However, the concept of ‘information’ and what it means to merely inform an audience are complex. Delivering information requires both speaker and audience to call upon a rich set of culturally-specific assumptions. In the case of obesity campaigns, at least some of these assumptions may be problematic.

In the simplest sense, ‘information’ is the true content that makes up knowledge about the world (Manson 2010; Walker 2012). This content could be about any number of things and come from any number of sources, such as books, documentaries, pictures, or experience, and this information may make no difference to how a person acts (Manson 2010). One may gain a large amount of information about cats in ancient Egypt purely out of curiosity, and not for any practical need or purpose. Humans are curious creatures,

and we may come to know many bits of information that are practically irrelevant to our daily life and work.

We may also seek out information for a particular purpose or as a means to another goal. We amass large amounts of information specific to our professions, for example, and there may be little or no overlap between two individuals' work-related knowledge. However, as Neil Manson and Onora O'Neill point out in their work on informed consent, information is fecund, and can be used in many different rational and practical projects, so a person's work-related knowledge may be put to use when pursuing some non-work-related goal (Manson & O'Neill 2007; Manson 2010). Information can be presented in propositional claims, which may be evaluated for their truth by others, and it can be practical or action-guiding, as in a recommendation (Manson & O'Neill 2007). Information in the form of propositional content is central to reasoning (this will be touched upon again in the discussion of propaganda, below).

The word 'information' can denote that which is conveyed (the ideas, knowledge, or content of thoughts) or an action of conveyance (Manson & O'Neill 2007). For the current discussion, my interest lies in 'mere informing:' the communicative action that involves delivering information-as-content to another person in a manner that does not primarily seek to achieve a particular outcome through altering their understanding of the world (though an altered understanding may be a secondary effect). A person can search for information on their own, but sometimes others decide that a person ought to know about something that they have reason to believe the person does not already know, and they may have reason to believe that they want to know or that the information would be relevant to them. For example, a newspaper editor may decide that readers should know

about recent crimes, traffic accidents, or restaurant openings, without aiming to change the readers' behaviour (even though this is a possible result). The act of informing does not have to have a specific goal beyond providing knowledge to others.

Throughout my discussion of communication, I will adopt the agency model of communication as developed by Manson and O'Neill. They describe the communicative process as a type of action and interaction. As opposed to the conduit metaphor of communication, which supposes communication to be the transfer of meaning, ideas, or content in chunks (like bytes) from one person to another, the agency model views information as the content of communicative transactions — speech acts, behavioural cues, gestures, etc. — which succeed only where participants acknowledge one another as agents with cognitive and practical commitments, and assume one another's adherence to a range of communicative, epistemic, and ethical norms (2007, p 66). On this view, communication is a normatively rich affair.

The agency model has important implications for public health campaigns, as communication is heavily norm-bound and context-dependent. As Manson and O'Neill argue, acts of communication require a rich practical and normative framework to succeed. The meaning of what is communicated will depend on a shared understanding between the participants in the act — the communicator and the audience — about what the context is, including actions, beliefs, and expectations. For example, if an audience is mistrusting of the communicator or assumes that they have violated certain norms, the audience may not accept the speaker's intended meaning; an act of mere informing may fail because a communicator cannot inform a fundamentally mistrusting audience.

The norms involved in communication are many. For one, people interact on the assumption that communication is undertaken for reasons relevant to the audience; that there is a purpose behind giving another person information (2007, p 47). Certainly, in the case of public health agencies or other organisations, we assume that public-focused communication is done for relevant public-focused reasons, and it is important that this belief is respected and upheld. Otherwise, the public may simply begin to ignore the information being delivered. The transparency of these reasons is also important to the act of communicating.

As Manson points out, having and providing reasons for communicating specific things demonstrates respect for persons through a kind of recognition-respect—recognizing the person as an agent, with her own interests and capacity to live her life as she sees fit (2010; also Benson 2000). The notion of respect and what this means is central here, and will be important in later sections of this dissertation. Respect is a kind of acknowledgement of another person, that they are worthy of being called ‘a person,’ and that they have an inner life composed of thoughts, beliefs, commitments, reasons, and so forth, that I do not have immediate knowledge of. Further, this notion of respect takes the inner life of another to be a source of agency and value. Recognition-respect is, thus, the process of acknowledging these aspects of another when we meet them, and is important to communication, normative authority for the choices one makes, and for moral accountability.

The failure to have (and provide, if asked) reasons relevant to the audience that could justify the communication can indicate a lack of respect. This is the purposefulness norm of communication, and is underpinned by another norm: that information-as-content is

rationally assessable and submitted to an audience as true (Manson & O'Neill 2007, pp 44-45). In the everyday sense, information is bound to claims and proposals, which an audience must judge and react to (inwardly or outwardly). The audience assumes that communicators provide them with true information, which they can evaluate and determine to be relevant or put aside.

Relatedly, and crucial to discussing public health campaigns, mere informing is inferentially fertile; communication enables people to make a variety of inferences, and successful communication essentially depends upon the use of inference by the audience to complete the transaction (pp 46-47). Manson and O'Neill elaborate that communicative acts are made feasible thanks to the communicator's and the audience's rich stocks of shared cognitive commitments, and each assumes or knows that the other has and uses this stock, too. This interactive process explains how implicit messages can be utilised with some reliability in obesity-related and other campaigns. The communicator assumes that they and the audience share background knowledge about the world, and linguistic and social conventions that permit the use of such communicative tactics as plays-on-words, messages that hold multiple meanings, and stereotypes (2007). To deliver the intended messages, these strategies rely on an audience's ability to infer meaning from images and statements.

Given that many norms must be observed for communication to succeed, Manson and O'Neill state that the information-as-content presented by a communicator must be 'epistemically responsible.' Epistemic responsibility means that a message follows the norms outlined above: there are relevant reasons for making claims, which can be shared, and the audience can adequately and accurately assess the message (2007, pp 59-60). In

addition, epistemic responsibility requires that speakers do not engage in certain communicative acts when audiences are likely to be misled. Acts of informing are typically achieved by a type of speech which Manson and O'Neill call 'representatives,' a class that includes acts of asserting, telling, and stating. One way to mislead an audience is to make what seems to be an assertion of information, when really it is something else, such as an order or a warning. Manson and O'Neill view epistemic responsibility as a stringent requirement in part because it stipulates to communicators that it is irresponsible to state as true that which one has incomplete grounds for taking to be true. Accordingly, this requirement entails that the message does not aim to deceive the audience, or mislead in other ways (2007, pp 60-62).

In public health anti-obesity campaigns, the requirement to be epistemically responsible would mean that many current campaigns need a drastic rewrite. For example, many claims made in these campaigns—both those claims made overtly and those that are implied—may mislead the audience by presenting likelihoods, risks, or correlations as if they were certainties. For example, Cancer Research UK's latest campaign includes large-format animated signs on video boards that appear as fill-in-the-blank messages. When all the letters are filled in, the signs say "OBESITY causes cancer" (Cancer Research UK 2016). While it is known with certainty that obesity is a generic cause of some kinds of cancer in the same sense that smoking is of lung cancer, or sun exposure of skin cancer, the problem with messages that make risk sound like certainty is that some people without a solid grasp of causation in epidemiology will read this as saying that in every case obesity causes cancer, which is of course false. Some messages, such as this example and others in public health and advertising campaigns,

will be misinterpreted by an audience in predictable ways (Stanley 2015). Public health organisations are able to foresee that such assertions about risks will be misinterpreted as assertions about certainties. This is problematic for a variety of reasons.

It would be worrisome if misinterpretations of this kind were a foreseen and desired outcome of public health campaigns, such as in a case where public health relies on the audience to form an incorrect interpretation of their message for communication to succeed. If this were true, it might also mean that this kind of misinterpretation was the mechanism used to achieve behaviour change. Should it succeed in changing behaviour, some might find this to be an acceptable means. I would argue, however, that public health is not permitted to rely on or foster misinterpretation (or misinformation) to achieve change. Whether the misinterpretation of a public health message is merely foreseen, intended, or ‘counted upon,’ we may have good reason to worry about the use of such messages. This is in part because it would be a failure to discharge certain responsibilities that public health holds to the public. As an expert body and authority, public health holds a great degree of responsibility and accountability for the claims it makes. The use of messages in public health campaigns that are likely to be misinterpreted, whether the misinterpretation is intended or not, is problematic because it undermines the epistemic responsibility of the messages coming from an agency that holds particular responsibilities toward the public.

Epistemic responsibility could, thus, place a limit on the kinds of claims that are permissible for public health to communicate to the public. However, it is not obvious that this high standard ought to be followed, instead of perhaps undertaking pre-emptive or precautionary communications where likelihoods are involved. For example, some

may argue that where we know that an illness, such as type-2 diabetes, is closely related to high levels of fat in the body, warning people about the risk of developing diabetes if one is or becomes obese may be warranted. In the health professions, the concept of causation may be understood in several complex ways. However, the everyday understanding of causation is that one state of affairs leads with certainty to some set of effects. For example, when one says that the moon causes the tides, that migraine causes pain, or that traffic causes air pollution, the use of ‘cause’ is interpreted as indicating a direct, inevitable, and sometimes unique, link. If public health campaigns claim that one thing ‘causes’ another, intending something like ‘contributes to,’ ‘is a generic cause of,’ or ‘is one of a number of factors causing,’ they may fail to communicate with (and mislead) the audience, even if unintentionally.

To illustrate, Chapter 1 describes a campaign, ‘Sugar Packets,’ that focusses on excess consumption of sugary beverages. In it, the New York City Department of Health states, “...all that sugar can bring on serious health problems including obesity, which causes type-2 diabetes...” and accompanies this statement with an image of a foot with amputated toes and blackened flesh (Department of Health, New York City 2011). Including the (possibly dry) technical and scientific explanation of the relationship between sugar, diabetes and its complications, and obesity could blunt the impact of the story that the video is trying to convey about people’s sugar consumption and the impact that this behaviour may have on their health. Thus, defenders of such campaigns may argue that a compromise must be made between making the sort of statements from which people will draw only true inferences, and a message about behaviour that gets the

point across effectively. This appears to be a guiding principle of many public health campaigns.

However, there are at least three reasons for preferring epistemic responsibility in public health campaigns to a precautionary or pre-emptive stance on health communication. These are the empirical validity of the reasons for communicating, preserving the trustworthiness of the communicator, and the value of truth-telling:

1. Empirically valid reasons: The reasons provided for undertaking communications on body fat may not be empirically robust. Presumably, one reason for informing in ‘Sugar Packets’ is that the New York City Department of Health does not think that people know enough about the negative health effects of sugary drinks and/or fatness, and must be told about these in order to convince them that they do not want to become obese. Likewise, Cancer Research UK has written that most people do not understand that obesity may be a contributing factor in the development of some kinds of cancer, and thus they must be told (Hooper 2016). We could dispute the claim that the public lacks any knowledge of the potential health effects of obesity on empirical grounds, and thus question the strength of the reasons for communicating on this topic.
2. Trust in communicators: If the audience believes that the claim being made in New York City’s ‘Sugar Packets’ about fatness and diabetes is not true, perhaps because they know fat people who do not have diabetes, or they know people with diabetes who are not fat, or for some other reason, then the message undermines the communicator’s trustworthiness. This has important implications for future

communications from the public health agency in question, and may lead to a loss of credibility in the public mind.

3. Truth-telling: As I will explain below, the audience of public health anti-obesity campaigns may not be able to evaluate the claims being made. An audience with little or no medical or scientific knowledge related to obesity or diabetes, or to relative risk, will not be equipped to evaluate the claims being made, and it may be the case that the public health agency is counting on this lack of background knowledge for the success of delivering their message. They can assume that if an audience does not have knowledge to evaluate a claim then they will rely on other cues to determine its value, such as the trustworthiness of the source (which could be problematic, as mentioned in 2, above). If these cues lead the audience to adopt this information as presented, then it is possible that they will have been misled to believe something about the relationship between fat and diabetes, or what diabetes is, which is inaccurate. A number of negative consequences can result from this, including stigmatisation of fat people and/or diabetic people, and the spreading of false information. Further, if we value truth-telling in general we may have a *prima facie* reason to question the use of foreseeably misleading claims.

Public health communications that tell people potentially misleading things that are ‘close enough’ to the truth to motivate them to adopt health-protective behaviours are morally problematic if we value certain things, such as trust or truth-telling as much as or more than we value health. Analysing the epistemic responsibility of the information being provided in ‘Sugar Packets’ and other examples included in Chapter 1 reveals that

many claims made in obesity campaigns are predictably misleading. Presenting misleading claims to an audience and desiring that they will accept these as given is a use of influence over other people. It may be that public health agencies are attempting to influence others because they have determined that the audience ought to believe or do a particular thing in the interest of their own welfare. Rather than merely informing, campaigns created for this purpose utilise persuasion or manipulation to sway the audience.

Kim Witte (1994), argues that public health communication is always persuading and manipulating, and never informing, because public health always has particular motives in its campaigns (i.e. behaviour change). Witte is thus highly sceptical of public health's ability to present information in an unbiased way, even if they were to attempt or claim to do so. Witte broadly defines persuasion and manipulation together as a process of influencing people to do what someone or some organisation wants them to do, either through direct or indirect strategies. While some might think that such public health undertakings as 'awareness campaigns' are informative, aiming to raise the visibility of some issue, Witte considers them to be persuasive/manipulative, always aiming to have people adopt different behaviours in light of the messages delivered. In this way, Witte is calling attention to the idea that public health may not engage in acts of 'neutral' communication, because they always have health-related behaviour change as a goal. However, while persuasion and manipulation share the aim of getting a person to do something that another thinks they ought, the method of influencing that person seems to differ in each, such that separating these concepts is useful.

Persuasion

While information is the content of communicative transactions, informing, persuading and manipulating are modes of communicating. In this section, I will examine persuasion, considering a number of definitions before finally adopting Beauchamp and Childress's (2001) version. This states that one is persuaded when one comes to believe something based on the merit of reasons presented by another person. Using this definition, I will argue that persuasion as such does not undermine an agency-based conception of communication; rather, the paradigmatic case of persuasion is a conversation between agents, where reasons for coming to believe a certain thing can be debated and evaluated before the agents involved reach a conclusion. The moral permissibility of the action of persuasion, we shall see, is independent of the truth of the reasons one presents another. On this understanding, the act of persuasion is morally permissible even when we may dispute the content of the ideas contained therein.

In their discussion of the principles of biomedical ethics, Tom Beauchamp and James Childress state that persuasion describes a scenario in which a person comes to believe in something "through the merit of reasons another person advances" (Beauchamp & Childress 2001, p 94). Sound deductive reasoning would therefore be persuasive; communication that takes the form 'given that x and y, you ought to do z' is an instance of persuasion if x and y have merit as reasons as judged by the agents involved in the communicative act. This definition of persuasion seems to map everyday forms of practical communication. The 'ought' contained in the final clause of the persuasive argument need not be a moral 'ought,' and could just as easily be a prudential recommendation.

Similar to Beauchamp and Childress' definition, John Rossi and Michael Yudell define persuasion as "influence that is achieved by giving reasons for the adoption of a position and/or influence that is noncoercive and nonmanipulative" (2012, p 193). On their account, persuasion is moral-value-heavy, at least as it is used by public health agencies. In this context, Rossi and Yudell argue, value judgments about which actions are in the interests of individuals, in the interests of society, and preferable amongst other courses of action are incorporated into the persuasive message. Persuasive messages convey information about responsibility, benefits and harms, and the moral status of various actions. Therefore, they say that persuasion implicitly or explicitly contains a normative claim, and "prescribes that the audience should think or act in a certain way" (2012, p 196).

On the account that I have adopted from Manson and O'Neill, all communicative acts are normative by nature. As was discussed above, communication requires a rich stock of shared norms to succeed. On this understanding of communicative acts, Rossi and Yudell's observation that persuasion entails normativity is unsurprising and not concerning. However, it is worth noticing that some of the information provided in communicative acts can signal commitments to the status of certain moral values. For example, public health communications often contain very strong assumptions about the relative worth of health as a value. The worth of health as assessed and communicated by public health agencies may be very different from the worth of health as assessed by any given individual. Disparities between these evaluations may lead to communication failure, when a speaker values something highly and the audience not highly at all. It may also be that a speaker accurately gauges the worth of some value to a population and is

able to appeal to their concern in the process of persuading them to adopt a new behaviour.

For this analysis, Beauchamp and Childress' (2001) definition of persuasion, which states that it is the process by which someone comes to believe something based on their judgment of the merit of reasons presented by another person, is most defensible. On this understanding, a persuasive message is an attempt to influence someone by drawing their attention to a combination of relevant pieces of information (for example, "x: it's raining and y: you'd like to keep your feet dry, so z: you ought to wear Wellingtons if you go outside"). The inclusion of a recommendation in a persuasive message indicates a forthright attempt to influence another's behaviour by suggesting a course of action. This sets persuasion apart from mere informing, because there is a particular and transparent intent behind the persuasive act.

Furthermore, drawing upon the agential model of communication presented above, persuasion is a two-directional communicative action between mutually-respectful agents. While Beauchamp and Childress stipulate that persuasion involves a person coming to believe something through the 'merit of reasons' advanced by another person, on their account this does not entail that the reasons need to stand in a certain truthful relation to the world. It only means that the reasons submitted for motivating action address and can be assessed by the audience's faculties of reason. Thus, it is not essential to the definition of persuasion that the reasons presented be true. An agent may have a false belief about something and try to persuade others to adopt a conclusion based partially upon this false belief. If an agent presents their false belief as one of the reasons for adopting a view, such that other agents may debate and evaluate this belief on their

own, this will yet be an instance of persuasion. The merit of a reason is to be judged by the agents involved in the persuasive act, and the objective falseness of a particular belief held by the communicator does not mean this is not an instance of persuasion. So, and importantly, the quality of the information presented to other agents as reasons for adopting a conclusion may be something that can be considered separately from the communicative act of persuasion. We may object to the content of a persuasive message, finding fault with the beliefs or claims presented by another person, or the values contained therein, while still accepting the process of persuasion itself.

It is important at this stage to disentangle two conditions under which persuasion can happen. As I have presented it, persuasion involves a conditional claim that takes the form, ‘if x and y, then z’ to an audience, and using the reasons x and y to convince them that z is true or should be adopted. In the context of public health campaigns, this raises an important question about who is selecting the health-related goals that appear in position z, and motivate the persuasive endeavour. If the goal of a message is a behaviour change of some kind, and the audience of a public health campaign has set this goal themselves (let us suppose that we can know this through opinion polling or the like), then the use of persuasive influence to help the audience adopt behaviours conducive to achieving the goal may be justified. However, if the goal of behaviour change has been selected by public health (or the government) either without consulting the public or expressly against their values or goals, then using persuasive influence to convince them to adopt different behaviours may seem unjustified. Richard Thaler and Cass Sunstein (2008) present an argument similar to this when defending their ‘libertarian paternalistic’ suggestion of nudging people into making the choices those people would like to make

for themselves. If public health campaigns are not only considered normative, but paternalistic, insofar as they influence people towards the adoption of values or goals that are in their best interests as determined by public health, then it may be important to determine whether the intended audiences of public health campaigns agree with these values and endorse these interests.

However, unlike nudges, persuasion is a conversational act. If the audience does not value the goal being promoted by a persuasive message, or if they believe some of the reasons to be misguided or factually incorrect, they are under no obligation to heed the reasons presented to them or to adopt the conclusion. Persuasion may fail, and often does in everyday life. In the two-directional process of persuading, the agent who examines reasons submitted to them and remains unpersuaded is able to carry on as they did before, unhindered, or offer counter-reasons to the persuader. As this model calls upon the agent-based notion of communication, it presumes the roughly equal respect and reasonably good intentions of participants. If this respect is not present, then I would claim that we are no longer considering an act of persuasion⁹. Further, as I will explain in Chapter 3, the ability on the part of the audience of the persuasive act to carry on as they did prior to receiving the message means that communicative acts of persuasion, and manipulation as well, do not count as instances of paternalism.

As Claudia Mills (1995) writes, at its most innocent, persuasion is something that we employ regularly to teach each other about the current state of the world and the consequences of action: ‘You ought to do your homework, otherwise you will fail your

⁹ One may wonder how an audience member could offer counter-reasons to a poster. While obviously a person could not engage media components in a conversation, a public health agency engaged in persuasion would be (must be) open to public feedback on a campaign, and also be willing to adapt their campaign if audience-submitted reasons are meritorious. Thus, a public health agency must be open to being persuaded, in turn, if they engage with their audience in a mutually-respectful manner.

course.’ There are meritorious reasons, or stronger yet, logical reasons, for doing or not doing certain things, and we use persuasion to convince each other that these reasons should govern action. Persuasion is fundamentally social, and requires recognition and engagement between agents. In many cases of persuasion, such as examples about homework or Wellingtons, the foremost reasons are prudential. In other cases, the foremost reasons may be moral, and in others still, moral and pragmatic reasons may be inextricably linked¹⁰.

However, when it comes to public health messages, where communication takes place in the context of a power differential between an expert-level body and the general public as lay-audience, the expectations for the quality of the reasons being delivered must be higher than that proposed by Beauchamp and Childress. As argued previously, and incorporating Manson and O’Neill’s norms of communication, epistemic responsibility should be the minimum requirement for reasons in persuasive public health messages. Linked to maintaining trust in communicators and the value of truth-telling, an additional motivation is grounded in the authority held by public health. Epistemic responsibility may be an inappropriate standard when we are considering persuasion between two roughly equal agents. This is in part because in roughly equal person-to-person instances of persuasion, the merit of reasons may be markedly easier for an agent to evaluate. However, because the role and the positioning of public health organisations

¹⁰ On this and some other definitions of persuasion, education in its many forms is a persuasive endeavour. Jason Stanley (2015) thus includes education as a kind of propaganda. Nurit Guttman (1997) argues that public health faces a dilemma due to education’s use of persuasion. This dilemma is caused by the tension Guttman finds between individual freedom and the normative ends of education. However, if persuasion is not impermissible simply by virtue of its normativity, as I argue, it may be the case that we can acknowledge the persuasive nature of education and accept this as an unavoidable part of the project of teaching people. In fact, we might only think that education-as-persuasion is a problem when we find the content – rather than the process – to be objectionable. It would take me too far afield to delve into this question here, however it is worth acknowledging that education may sometimes be persuasive.

as experts lends power and authority to these agencies, it is appropriate to call for greater stringency in considering their communications with non-expert audiences. In authority-to-person encounters, such as with public health or educational institutions, or even certain professionals (such as doctors or lawyers), it may be much more difficult for the non-expert audience to evaluate the reasons being put to them. The authority-holder may submit reasons for adopting certain actions or beliefs, but to be an instance of epistemically responsible persuasion given this power and knowledge differential (and not another form of influence) these must clearly be evaluable by reason and not knowingly mislead the audience.

An example of persuasion included in Chapter 1 is ‘Breakfast Eaters’ from the Government of New Zealand (2014). This campaign presents a series of claims about the benefits to children of eating breakfast. The claims in the campaign include that eating breakfast leads to better school performance, providing kids with more energy for physical activity, that low-cost breakfast foods are available, and that it assists with weight management. A number of different kinds of values are tangled together in these claims. However, the claims being made are forthright, and the audience can take the role of agents and interlocutors to grapple with these reasons, in order to come to a decision about their merit. Some individuals may find the claims convincing, and on the merit of these reasons they may even change their families’ breakfast habits. Others may find the claims to be lacking or to assume things that do not fit with their lives (such as, that parents are present at breakfast time) and continue with their regular routine as constrained by the various factors in their lives, including income and work schedule. Based on the definition I have adopted, this campaign can be characterised as persuasive.

Manipulation

Whereas persuasion is an appeal to reason, Beauchamp and Childress' account of manipulation includes non-rational, emotional, or what they call 'forceful' attempts at influencing another person. 'Forceful' attempts to influence, they clarify, involve the use of non-rational tactics, such as persistent badgering or the use of misleading language, which changes the nature of influence one wields over another person. Beauchamp and Childress further state that manipulation occupies the area of influence between persuasion based on reason, and coercion, which involves the use of a "credible and severe threat of harm or force to control another" (2001, p 95). Rossi and Yudell adopt the definition of manipulation as presented by Jennifer Blumenthal-Barby and Hadley Burroughs, which states that manipulation happens when a person "influences another by bypassing their capacity for reason, either by exploiting non-rational elements of psychological make-up or by influencing choices in a way that is not obvious to the subject" (Blumenthal-Barby & Burroughs 2012, p 5). This definition of manipulation is consistent with the broad range given by Beauchamp and Childress, while providing additional specificity. Rossi and Yudell and Mills expand on this definition, adding that manipulation also involves providing reasons for action that are "known by the message source to be in some sense bad or defective" (Rossi & Yudell 2012, p 194; Mills 1995). Rossi and Yudell take two components to be the key ingredients of manipulation: that the communication tactics bypass a person's ability to reason, and that these tactics are intentionally used to achieve this bypassing effect.

Blumenthal-Barby and Burroughs' unmodified formulation of manipulation captures the relevant aspects of manipulative influence without over-complicating the concept. While manipulation can be characterised as an attempt to usurp control (Walker 2013),

Mills, Rossi and Yudell stipulate that intentional delivery of a message that bypasses rational decision-making is a requirement for manipulation. However, intentionality is not a necessary feature. While it is the case that people have justified the use of jarring imagery or text by claiming that other approaches are not effective (people need to be ‘shocked’ into action), this justification does not necessarily correlate with a communicator’s conscious awareness that they are misleading or bypassing reason in their audience.

When a person’s persuasive reasons are not strong enough to convince another to adopt a recommended course of action (such as ‘if it’s raining and you want to keep your feet dry, then you should wear Wellingtons’), the communicator may resort to offering a different kind of motivation that triggers emotions, or otherwise undermines the reasoning process (for example, perhaps something like, ‘if it’s raining, then you should wear Wellingtons or else people will think you’re silly’). On this view, attempts at persuasion may become manipulative when appeals to reason seem to fail to achieve the desired effect and are abandoned in favour of other kinds of influence, whether the person providing the message realises they are making this switch or not. The people creating public health messages are most likely working in good faith, doing what they deem to be the right or necessary thing to help other people to improve their welfare; they may not purposely or consciously be attempting to mislead or bypass reason as such, and would not likely recognise motivations they present to the audience as undermining reason. These characteristics of public health messages can be evaluated externally, and so whether or not these are cases of manipulation need not rest on whether the campaign creators intended to bypass the audience’s faculties of reason.

The distinction between persuasion and manipulation is not stark. When reasons for taking an action or decision fail to be epistemically responsible or when they begin to address something other than the faculty of reason, the line between persuasion and manipulation will have been crossed, perhaps unwittingly. It may even be the case that a persuasive campaign for one is a manipulative campaign for another, if, for example, these agents hold very different levels of knowledge about an issue. However, we may use Manson and O'Neill's account of the norms of communication to highlight an important distinction between these two communicative acts. Compared to persuasion, manipulation is not a mutually respectful social act. Manipulation is a one-directional mode of communication that does not respect the agency of the audience and does not encourage discussion, but engenders a reaction. So for example, the claims made in 'Sugar packets' may not be rationally assessable by an agent who did not complete high school, and the claims about diseases may trigger fear in this agent. So, the campaign disrespects their agency, and closes off deliberative discussion of the claims. Together, these factors cause the campaign to be manipulative of this agent, and others in their position.

On this understanding of manipulation, most of the examples of public health anti-obesity campaigns examined in Chapter 1 are manipulative. For example, in the 'Little Boy' poster, an image of an unsmiling, chubby boy with his arms crossed appears with the text "fat prevention begins at home. And the buffet line" written across his stomach (Children's Healthcare of Atlanta 2011). The directive contained in this poster appears below this text: "Stop childhood obesity." There is no presentation of epistemically responsible reasons for action that could qualify as persuasion in this example. Rather,

the poster communicates by using stereotypes about fat people, as the poster strongly implies that fat individuals lack the self-control to stop themselves from over-eating or frequenting all-you-can-eat restaurants, and therefore others must police their behaviour. As an example of the inferential fertility of information, the lack of persuasive reasons and health-specific information in this poster do not prevent it from conveying a powerful message: that parents are doing something wrong and irresponsible if their children are fat. In fact, the success of evoking guilt, anxiety about parental and personal failure, and shame, relies on the inferences made by the audience through the visual imagery of an unsmiling boy and implications in the text. The specific remedy to be undertaken by parents is open-ended, but the place of responsibility is clear. When such tactics are employed, it seems that the person who is trying to influence another is not appealing solely to reason to convey their message. Thus, we could not characterise materials like this poster and many public health campaign materials like it as persuasive, but as manipulative.

i. A defence of manipulation

As the utilisation of non-rational motivation for behaviour-change, the permissibility of manipulative communication requires close examination. Manipulation in public health campaigns, like persuasion, attempts to guide the audience toward a specific behaviour chosen by another based on their evaluation of that audience's best interests, welfare, or health status. This may come at the possible expense of some individual freedom. Marcel Verweij and Mariette van den Hoven (2012) point out that public health campaigns are not attempting to influence individual choices, though this seems like an obvious requirement for success, as much as they are aiming to create group benefits. Achieving a

group benefit, they say, will often come at the cost of some individual preferences. In some cases, it could be that we are quite willing to sacrifice a few instances of autonomous decision-making for overall group gains. It could be that in cases where people will be influenced to make healthier choices more often, we may accept manipulation as a permissible – and effective – mode of influence.

The justification for using manipulative tactics in public health campaigns has focussed on the potential effectiveness of manipulation, especially when persuasive or mere informational tactics appear to be ineffective. Following what Bayer and Fairchild (2016) describe as the utilitarian ethics of public health, this position holds that as long as the results are positive, meaning the public health campaign or policy creates better health outcomes, then the means by which this is achieved are justifiable. Take the ‘Little Boy’ example, which utilises messages that manipulate parents of fat children into action through conveying blame, and may even make them feel irresponsible and culpable. If the use of blame in these campaigns motivates large numbers of individual parents to change certain behaviours in their children’s lives, resulting in significant drops in childhood obesity rates at the population level, then public health agencies might consider this a success, which may in turn justify such manipulative tactics. Proponents may claim success even if opponents consider the public health agency to be failing to meet standards of epistemic responsibility, or judge the use of blame to be unethical on non-consequentialist grounds. A proponent of this tactic could judge the campaign messages “not by their quality but by their efficacy” (Mills 1995, p 100). In this spirit, Blumenthal-Barby and Burroughs suggest that instances of manipulation, such as attempting to motivate parents via blame, can be justified “if a careful consideration

shows that the benefits outweigh the risks,” (2012, p 7) and if an explanation can be given for why manipulation was used rather than persuasion.

Policy documents discussing public health campaign materials are often rife with advocacy for the use of “‘shock tactics’ or ‘distressing’, ‘threatening’, ‘disturbing’ or ‘graphic imagery’ in mass media campaigns” in order to create the motivation for behaviour change (Lupton 2015, p 6). The apparent justification for such techniques is the assumption that members of the intended audience are apathetic or resistant to the health messages being conveyed to them or that public health has a duty to counter the messages that come from commercial advertising (Bayer & Fairchild 2016; Hooper 2016; Lupton 2015). Using the example of emotionally impactful smoking-cessation videos that show family members suffering heart attacks, for example, Blumenthal-Barby and Burroughs argue that “such manipulation is defensible on the grounds that it is not practical or effective to engage smokers in rational argument” (2012, p 5). They assume that the audience of smokers is addicted or resistant enough that no argument could be sufficiently persuasive to overpower the desire to smoke. They further assume that there is no rational reason to smoke, and that smokers *must* be convinced to stop. So, there is a moral and practical requirement that public health continue its efforts to convince this group to change their behaviour. Thus, they argue that an emotionally gripping and non-rational motivator is needed to create the conditions that are required for change.

Blumenthal-Barby and Burroughs suggest that manipulation can use emotion and salience to create the powerful motivation that is required for change where persuasion fails. In discussing the challenge of communicating complex research findings, Baruch Fischhoff (2007) notes that some people abandon an approach based on reasoned

argumentation because they think that it will not achieve the desired change; the audience will not be sufficiently motivated, or they may not understand the complexities and implications of the information they are given. To achieve meaningful change, the audience needs to understand the message being directed at them, and also find it meaningful enough to act upon. The ability of communicators to take advantage of an audience's psychological quirks through the effects of salience or framing has been well-established. Employing research from the behavioural sciences makes it possible to sway people in certain directions. The key to the effectiveness of these influences is that “the things that are made salient motivate people emotionally (e.g., fear of death or disability) or are things that the person cares about (e.g., money, avoiding losses generally)” (Blumenthal-Barby & Burroughs 2012, p 4). In the smoking-cessation videos, the desire to avoid the loss of one's own life is combined with the emotional salience of the suffering or death of a loved one, in order to motivate a person to change their smoking behaviours. Blumenthal-Barby and Burroughs erroneously state that the risks of using such effects to manipulate someone to stop smoking are “nonexistent to minimal, whereas the health benefits are enormous” (2012, p 5).

Thus, on this view, if manipulative techniques in public health campaigns cause harms to a few people, but result in overall positive outcomes, then we ought to consider using them. It is difficult to retroactively separate the effects of different actions on population-level behaviour, but if some of the manipulative public health actions undertaken in Canada, the United States, Britain, and the European Union, for example, were effective in helping to lower rates of smoking (as opposed to regulatory actions, like laws and taxes), then some argue that we ought to replicate them for other public health

concerns, such as obesity (Bayer & Fairchild 2016; Callahan 2013; OMA 2012a). The harms, such as overriding personal autonomy, undermining social justice, or increasing stigmatisation, may not be considered significant enough in frequency or magnitude to outweigh the gains in population health.

ii. A response to the defence of manipulation

Like the authors mentioned above, we may find that there are cases in which the use of manipulation may be justified. In cases of smoking cessation, if we strongly believe that smoking has no (or unimportant) benefits and many harms, we might agree with Blumenthal-Barby and Burroughs in thinking that the benefits outweigh any harm that may result in using manipulation. However, besides being false, since evidence suggests that smoking has important mental health benefits to some individuals, for example, and harm reduction benefits by replacing other, more dangerous addictions for others, suggesting that manipulation is justifiable because of apparent success in one area does not justify the use of manipulation on the whole.

The first response to the above defence is that manipulative campaigns may not be as effective at improving health as is commonly assumed. People have complex reactions to risk and to fear. These public health campaigns may cause their target audiences to avoid the messages “by responding with perceptual and cognitive defense mechanisms – in effect engaging in avoidance or denial that the risk affects them or a fatalistic acceptance of risk” (Lupton 2015, p 7). The result is that an audience that appears resistant to persuasive health messages and is bombarded with provocative and emotional manipulative messaging may end up feeling estranged from health professionals on the whole, and avoid the source of the messages. As discussed in the previous chapter, Bayer

and Fairchild's (2016) recent paper on fear in health promotion reports the findings of meta-analyses that fear has some small positive impact on behaviour change in the short-term, provided there is a clear action that the audience can take to avoid the fearful thing. Considering the long-term changes required for weight management and the vagueness of recommendations for action in anti-obesity campaigns, it seems that at least on this example the success conditions for fear-based campaigns seldom obtain. The messages thus may not have the intended impact.

A related second response is that research suggests that images and texts evoking strong emotional reactions in viewers, in the way that many of the anti-obesity campaigns analysed in Chapter 1 do, may have counterproductive effects (Hastings et al. 2004).

There has been considerable study on the impact of public health campaigns that purposely or accidentally contribute to the stigmatisation of certain groups. These studies have found that stigma and the feelings associated with it – blame, shame, guilt, and isolation – are counterproductive to improving health and overall welfare (Becker 1993; Herek et al. 2003; Lupton 2015; Puhl & Brownell 2003; Puhl et al. 2013). Some gains in lowering population obesity rates may come at the expense of other health indicators in some groups, such as good mental health and freedom from shame.

It is important for public health organisations to recognise the accumulating empirical evidence that manipulative modes of achieving behaviour change may come at a higher health cost than using other methods of communication. Additionally, certain harms such as undermining social justice or contributing to stigmatisation of some groups may never be ethically justifiable. There may be some kinds of anti-obesity campaign messages that are impermissible based on the importance of values other than health. More will be said

about the unintended side effects of anti-obesity campaigns, such as stigmatisation, shame, and the apparent prioritisation of weight-related health over other kinds of health in later chapters.

When it comes to overriding personal autonomy, it may be the case that we are comfortable with some trespasses upon individual freedom and uncomfortable with others. Public health initiatives always involve a judgment about what is in the interests of other people's welfare (if I am granted the assumption that public health agencies do not maliciously use manipulation). In some cases, the public may select or endorse certain health-related interests for themselves, and public health agencies may come to know this through surveys or other means. Some may argue that manipulative campaigns that influence people to protect these interests are permissible. In contrast, if public health organisations select goals in the interest of the public's health, which the public did not choose or which the public expressly does not support, manipulating them toward these goals could be impermissible. Manipulative communication may share certain qualities with other public health interventions deemed paternalistic. As mentioned, this will be explored in the next chapter.

For current purposes, it is important to observe that, unlike persuasion, manipulation does not respect participants in a communicative act as would be required by the agency-based model of communication. Informing and persuading are both communicative modes that respect the audience of a particular message by recognizing the audience's agency. Manipulation is a form of communication that disregards the conversational, deliberative agency of the audience, and purposely undermines it, in order to take advantage of reactionary agency. It may be the case that we are comfortable with some

instances of having agency undermined. However, the fundamental lack of respect for the agency of the audience is morally problematic on my feminist non-consequentialist account (for one), and indicates that there are deeper moral issues involved in manipulative communication. On these grounds, I think manipulative campaigns are unacceptable, and justifications for using them would need to provide very good reasons, beyond the assumption that persuasion might not work, for not conferring recognition-respect on the audience. More will be said about this in the following chapter.

Propaganda

Jason Stanley's recent work on propaganda is relevant to my argument in a number of ways, and so merits comment. On his account, propaganda is "a kind of speech that fundamentally involves political, economic, aesthetic, or rational ideals, mobilized for a political purpose," which either supports or undermines those same ideals (2015, p 52). Stanley's remarks about how propaganda works in liberal democracies reflects a number of my foregoing comments on communication in public health campaigns, and may be enlightening.

As in my description of persuasion, Stanley says that propaganda can consist of true or false claims. Propaganda that includes false claims may yet be delivered sincerely (p 41). This may be due to a person holding a flawed ideology, which may further "lead one to sincerely hold a belief that is false and that, because of its falsity, [disrupt] the rational evaluation of a policy proposal" (p 46). In some cases of propaganda, "someone is being misleading, rather than stating something false, or even implicating something false. One expresses a truth, and relies on the audience's false beliefs to communicate goals that are worthwhile" (pp 42-43). This idea, that one may express a truth while anticipating and counting on an audience to misinterpret it, is very similar to my argument regarding

manipulation. It is possible to foresee or even predict that an audience will misinterpret one's message, and to utilise that misinterpretation to achieve one's aims.

Stanley is interested in how political ideologies may lead to the acceptance of propagandistic messages. Like manipulative messages as I have defined them, he says that flawed ideologies may be used to cut off rational deliberation and discussion. In characteristic cases, "they do so by using the flawed ideologies to overwhelm affective states" (p 47). However, he clarifies that "propaganda is not simply closing off rational debate by appeal to emotion; often, emotions are rational and track reasons. It rather involves closing off debate by 'emotions detached from their ideas'" (p 48). In order for propaganda to work, emotions must become unmoored from the idea that previously anchored them, and become attached to a new word, image, or idea.

Stanley does not discuss the process of stigmatisation in his work, but it is relevant and enlightening to his position. In particular, the way that groups are newly labelled with negatively-valenced terms may be key. I discuss this process, as described by Bruce Link and Jo Phelan, in Chapter 4. Deborah Lupton has also described how anti-obesity campaigns, and other messages focused on communicating health risks, undertake to attach the emotions of disgust and fear to images or words related to undesirable health behaviours. The result of such attachments, she argues, is a complex concept she terms an 'emotion-risk assemblage' (2013, p 640). In employing this term, Lupton emphasises "that both emotion and risk interact with each other and in the process, configure each other. ... They are each produced through other material and non-material phenomena: individual and collective memories and experiences, discourses, practices, objects, space and place, flesh" (pp 640-641). In other words, public discourse and public context

influence the meanings and experiences of emotions and risks. Controlling the way that public discourse guides meanings is therefore a powerful method of influencing people.

I have described public health as standing in an unequal relation of authority to the agents it communicates with, and this results in a requirement that public health present epistemically responsible messages. Stanley does not use this term, but I believe he would agree with me. He argues, as I do in the section on persuasion, that certain kinds of communication may only take place between roughly equal agents. He says, for example, that evaluating “a proposal is something one does with an equal” (p 145). A proposal, which is the suggestion that a particular claim be entered into the realm of public discourse as true, involves a process of debate and evaluation; were the claim to be deemed meritorious, it would be accepted by the various parties to the debate. However, “when there are asymmetrical authority relations, a proposal may become a command” (p 145). That is to say, the merit of the claim that has been offered is no longer up for debate; the authority of one of the parties places the claim above the level of public debate and evaluation by other agents.

In my description, I allowed that this may be the result of unequal levels of expertise. Such inequality is in itself not problematic, because it may sometimes result from the natural inclinations of different people to pursue various disciplines or endeavours, and expertise seems in many ways desirable. However, sometimes certain groups will purposely or unavoidably make command-type claims, and some groups will purposely be prevented from gaining the authority to make them. Once a person, group, or organisation has gained the position of ‘expert’ in a society and the authority (including

legitimate, democratically-gained authority) to make commands, all claims coming from the group may appear as commands, and thus not be up for public debate¹¹.

Persuasive and manipulative public health campaigns may be included as sub-types of propagandistic messages in the public domain. Stanley appears to include these campaigns as a type of common propaganda. On my definitions, propaganda may be more akin to manipulation (or may perhaps be taken as another term for ‘manipulation in public discourse’) than it is to persuasion. This is evident when Stanley writes that propaganda “is a method to bypass the rational will of others in the service of some goal” (p 57). Insofar as this is true, he says that “the Kantian would regard propaganda in either [the ideology-supporting or -undermining] sense as a moral violation” (p 57). This is because “insofar as a form of propaganda is a kind of manipulation of rational beings toward an end without engaging their rational will, it is a kind of deception” (p 58). While propaganda seems, thus, to match my description of manipulation, it is not clear whether manipulative public health campaigns would be ideology -supporting or -undermining propaganda on Stanley’s account. Supporting propaganda works to uphold certain political, health, aesthetic, or other ideals. Undermining propaganda makes a contribution to public discourse that is presented as an embodiment of certain ideals, yet tends to erode those same ideals (p 53). In providing examples of supporting propaganda, Stanley writes that one example “is delivering a very frightening public health warning to raise excessive fears about (for example) smoking, with the goal of increasing public health by the use of exaggerated fear” (p 58). This would be supporting propaganda if the public ideal of health was supported by the use of this message. While the Kantian and I

¹¹ For a description of the process of exclusivity and creation of expertise, the reader is referred to chapter 2 of Jason Stanley’s book, *Propaganda* (2015), or to my discussion in Chapter 3.

might still think there is a problem with using manipulative messages in this way, Stanley argues that this is democratically legitimate, because “we task the ministry of health with giving us warnings that will convey a message that will have the effect of doing all the work of informing us about the relevant health issue” (p 59).

While I have acknowledged the democratic legitimacy of various public health undertakings, I think there is reason, related to trust in authorities, to suspect that campaigns of this kind may in fact be undermining propaganda, rather than supporting. In describing Samuel Huntington’s position, Stanley makes some comments to this effect as well. Huntington, Stanley writes, recommended that governments

...reinstall some measure of obedience to authority by making various central domains in life, ones that should be governed democratically, the domain of experts, who are employed to make the masses feel unqualified to weigh in on central decisions about their lives... to employ the vocabulary of scientific expertise in a political way, in effect using epistemic ideals as forms of coercion. Such mixtures of epistemic and practical authority, where epistemic authority is used to gain practical authority over the domain of democratically autonomous decision, tend to undermine the epistemic ideals. It leads to distrust of those who self-present as “scientific experts,” even when they want to warn us about the importance of vaccines or climate change. (p 40)

In making his pitch for the politically strategic use of the language of objective science, Huntington was “calling for people to claim expertise over matters of value, with the result that citizens defer their autonomous judgment to these so-called experts. This is to use an attractive and admirable ideal, the ideal of objectivity, in a nonobjective way, a way that tends to undermine trust in objectivity” (p 40). This passage from Stanley’s argument is important because it highlights that the credibility of a ministry of health, or a public health agency, can be damaged when it engages in certain kinds of communication. In our current political context, the undermining of public trust in health and scientific experts is well underway, as evidenced by a growing skepticism about

vaccinations and scientific evidence in general. It seems as though the loss of trust is not merely hypothetical, and that it is not an issue-specific problem; losing trust in health experts because of their (real or perceived) abuse of objectivity on a particular topic may well leech away one's trust in these same experts on matters of other health behaviours. Thus, insofar as public health campaigns may contribute to the erosion of public trust in scientific objectivity (for not adhering to the requirements of epistemic responsibility), we might well regard manipulative public health campaigns as a kind of undermining propaganda, rather than supporting propaganda. This could be another reason to prefer epistemic responsibility to precautionary communications.

Finally, Stanley makes some remarks that seem particularly relevant to anti-obesity campaigns about the impact that propaganda has on empathy for certain groups. Stanley says that "one characteristic form of propaganda in a liberal democracy takes the form of claims that rely on flawed ideology to decrease empathy for a minority group" (p 124). Such a claim would work by undermining reasonableness in public discourse. Stanley says that a proposal is reasonable if it appears so from the perspective of each citizen in a particular society. He further says that reasonableness presupposes the capacity for empathy for other people. Thus, he says, "we should expect paradigm cases of propaganda to have as part of their communicative content that a group in society is not worthy of our respect. So one characteristic way to convey that a target is not worthy of respect is to cause one's audience to lose empathy for them" (pp 126-7). I will make use of Paul Benson's arguments about respect and self-worth to highlight the ways in which public health anti-obesity campaigns perform exactly this manoeuvre in public dialogue in the following chapters. In a nutshell, I will argue that by stereotyping and stigmatizing

fat people, public health anti-obesity campaigns send messages that undermine their status as moral agents and equals in society. This is intricately tied to the dominant group's ability to empathise with them, and to the creation and reproduction of their exclusion from social spaces and oppression.

Coercion

Before quitting the question of how to characterise public health campaign communication, it is important to consider whether communicative acts can be coercive. When considering coercion in the context of this dissertation, it seems important at the outset to differentiate between possibly coercive communications and coercive actions. On several accounts considering autonomy and free action, coercion involves harm or credible threats of harm directed against a person in such a way that it is extremely or unreasonably difficult for them to resist the influence of the coercer (Beauchamp & Childress 2001; Rossi & Yudell 2012; Walker 2013). Being mugged at gunpoint is often used as a paradigm example of a coercive scenario; though the victim chooses to give the mugger their wallet and watch, we can say that it is not a freely chosen action because it is motivated by the presence of a gun and the threat of its use.

Tom Walker (2013) states that coercion is not being able (due to a present and credible threat) or not knowing that one is able to refuse to do a particular action. On this definition, coercive actions and manipulative actions could seem to overlap. We could also consider many regulations to be coercive, though justifiably so. Certain kinds of laws dictate action, and though these laws can be broken, this comes at the credible risk of costs, some of which are extremely high. Regulations that come close to being conventions, such as which side of the road to drive on, are essentially coercive, but in an unproblematic sense. Our freedom to drive any which way is curtailed for the sake of

order and safety, and people, if they reflect on it at all, seem to accept this as a reasonable trade-off for an impingement upon their autonomy.

However, regulations are not the only way that coercion appears in the public realm. Public health initiatives that make certain things unreasonably difficult to do or to obtain can also be considered instances of coercion. We may find such limits appropriate for a variety of reasons, but, for example, some anti-smoking by-laws, raising cigarette prices, or restricting locations in which it is permissible to smoke can all be considered coercive. This is because the act of smoking becomes difficult or impossible to do for some people, while still being technically available. For the person who lives on an extremely limited budget, and for whom smoking is their only pleasurable indulgence, increases in cigarette prices cause real and immediate crises of choice. Cigarettes may be costly enough that they can only be purchased in the place of other necessities. In this case, the government is coercing an individual into not smoking through pricing cigarettes outside of their budget. As mentioned above, that smoking must be made difficult is a judgment that we could contest, given its potential harm reduction qualities and other unconsidered benefits.

In the current analysis, it is important to ask whether the visual materials in public health campaigns can be considered coercive. In order for campaign messages to be coercive, they would need to carry a credible and immediate threat of harm to the audience. I do not think that there is a sense in which the poster or video materials exert the magnitude of force upon a person that is required to consider them coercive, though some may be very emotionally impactful. Some public health campaigns use emotions such as fear of the risk of disease to try to motivate people to adopt different behaviours,

but this does not appear to be a threat, per se. In coercive cases, the threats involved typically must be extremely serious and immediate, such as bodily harm (from a gun) or police arrest (when breaking laws), or in coercive policies, the action involved must become very difficult to do and/or punishable (such as smoking in restaurants). Even when public health campaigns utilise the risk of lung cancer or diabetes to try to frighten people into behaviour change, these negative health outcomes are abstract, probabilistic, and temporally removed – not immediate – which may be key to why they are not always powerful enough to motivate behaviour change. Contrasted with the mugging victim who must either give up their wallet or be shot, the audience of a public health campaign does not face a similar dilemma.

Given the lack of immediacy, it is not clear that public health campaign material can actually be coercive. Obesity-focused public health interventions that might be considered coercive could include placing bans or taxes on certain kinds of food or ingredients, such as the sugar tax being introduced in the UK or the now-repealed tax on fat content in Denmark (Nestle 2011; Nestle 2012). Coercion seems to be a property of situations and actions rather than communications. On this understanding coercion will be set aside as the analysis of these campaigns continues.

Conclusion

In this chapter, I have examined information, persuasion, manipulation, propaganda, and coercion as they apply to public health campaigns. On the agency-based model of communication, information occurs between agents who rely on a rich background of shared knowledge, including ethical, social and context-specific norms. Communication succeeds when participants share this background knowledge and correctly assume that each will utilise it. Communication can fail when norms are violated or assumptions

about background knowledge are incorrect; for example, a public health body can fail to communicate with the general public if that body has lost credibility through presenting messages that violate norms of trust or truth-telling. Persuasion is a communicative act that involves influence, but in a transparent dialectic way. A conversation is a paradigmatic example of persuasion; one agent attempts to influence the decisions of another by providing reasons for doing or believing something and discussing these with that other. Manipulative communication is a non-rational use of influence, involving appeals to emotions such as blame or fear, or bypassing reason in other ways, to elicit a response to the message being provided.

While the act of persuasion is morally permissible by virtue of being a conversational endeavour between agents, the act of manipulation is morally problematic. However, the content of an act of persuasion may be objectionable, even while the act of persuading someone is acceptable. In cases of manipulation, the moral evaluation is intricately tied to interests and to agency. The content of a manipulative message may also be objectionable, but this is a secondary question to the lack of respect afforded to an audience of manipulation. In the following chapter, I will examine whether there are any exceptions to the impermissibility of manipulation, shedding light on the moral status of influential communication techniques in public health campaigns.

Chapter 4

The Impermissibility of Manipulation may be Absolute¹²

This chapter will present two considerations that provide reasons to conclude that the impermissibility of manipulation should be taken very seriously. The first consideration focuses on the use of stigma to encourage behaviour change. This has been promoted by various agencies and ethicists, and their arguments provide a defense of the use of manipulation in public health campaigns insofar as stigmatizing messages are thought to lead to health-protective behaviour change. Stigma may lead to greater harm than good, however, and it may not be appropriate for public health to ever utilise it in an attempt to alter behaviours. The second consideration will focus on oppression, specifically marginalisation, cultural imperialism, and the distortion of responsibility. On a particular understanding of these terms, public health anti-obesity campaigns contribute to or aid in the creation of the oppression of fat people. In this case, public health's intervention may constitute a significant negative impact on the welfare of fat people, rather than a contribution toward its improvement.

These arguments will be followed by the presentation of and response to a potential objection to my position. Some may argue that paternalism can justify manipulative campaigns. Paternalism is a common feature of public health initiatives. Though its appropriateness is debated and contested in the ethics literature, generally speaking, the public is willing to accept many of public health's paternalistic interventions. However, it does not seem to be the case that a campaign counts as the kind of public health initiative

¹² A shortened version of some arguments in this chapter, particularly the section on oppression, has been accepted for publication in MacKay, K.L. (forthcoming). A feminist analysis of anti-obesity campaigns: Manipulation, oppression, and autonomy. *International Journal of Feminist Approaches to Bioethics*.

that can be paternalistic. It may be confused with paternalistic initiatives because it shares one feature with them: that a campaign, like other initiatives, demonstrates a commitment to a particular set of values on the part of public health and/or the government. This is a distraction, though, and like coercion in the previous chapter, I will argue that paternalism is a red herring in the discussion of the ethics of campaigns.

Why Stigma is Impermissible

Recently, some authors and organisations have promoted stigma as a useful and appropriate tool for achieving behaviour change (Callahan 2013; OMA 2012a). These authors have acknowledged that stigma has harmful effects besides those effects that are desired, but consider this to be an acceptable trade-off for potentially beneficial health outcomes. Based on the work of Bruce Link and Jo Phelan, and Erving Goffman, I will argue in this section that stigmatisation is an unacceptable public health tool because it is harmful, and disrespectful by its nature.

i. Stigmatisation – The Concept and Process

To begin, Bruce Link and Jo Phelan (2001) described stigmatisation in terms of a social process with five distinct components. Briefly, this process involves the following:

- 1) Distinguishing between and labelling human differences;
- 2) Applying dominant cultural beliefs to these labels, linking people to undesirable characteristics and negative stereotypes;
- 3) Placing labelled people in categories, which separates ‘us’ from ‘them’;
- 4) For labelled people, experiencing status loss, discrimination, and other negative social repercussions, leading to unequal outcomes; and
- 5) That stigmatisation is contingent upon access to social, economic, and political

power that allows the processes described in 1-4, above, and the full execution of disapproval, ejection, exclusion, and discrimination.

In her paper on public health's use of the process of stigmatisation, Desiree Abu-Odeh (2014) argues that public health is able to use stigma by deepening or creating absent components of Link and Phelan's five-part process. Link and Phelan's conceptualisation of stigma concludes that it is a matter of degree; they argue that, for example, distinguishing between traits, or the separation of categories of people based on these traits, can be more or less complete, and thus stigmatisation can be greater or lesser depending on the group being considered. Abu-Odeh charges that as long as one has the power described in Link and Phelan's fifth component, one can count on (exploit) or produce (augment or create) the other four components of stigma to evoke the emotional responses of disapproval, ejection, and exclusion in an audience. This, Abu-Odeh suggests, is something that public health does in messages targeting obesity. Further, this seems consistent with Jason Stanley's description (presented in Chapter 3) of one of the ways in which propaganda may be used to undermine empathy for certain groups.

As mentioned above, part of the process of stigmatisation involves creating a distinction between the categories, 'us' and 'them,' through identifying an attribute and marking it as undesirable. Interestingly, almost all of the anti-obesity campaigns included in Chapter 1 draw heavily on the use of disgust to deliver a message about fatness.

Deborah Lupton has done considerable work on analysing the use of disgust in public campaigns, and has found that it is used overtly or covertly in a wide range of advertising and public service messages. Lupton's analysis finds that stigma is closely associated with "the emotions of fear and hatred incorporated into such responses as racism, sexism,

homophobia and discrimination against fat people, those with disabilities and the elderly” (Lupton 2015, 10). Jason Stanley has also argued that reducing or destroying empathy for certain groups is one vehicle by which propaganda undermines reasonableness in public discourse (2015). Thus, when fat people are portrayed in the news media and in public health anti-obesity campaigns as “repellent and grotesque,” as well as faceless, disembodied, or sick (Lupton 2015, 10) the result is an increase in the distance between ‘us’ and ‘them,’ and a reduction of empathy for the out-group. Research has found that people who already feel disempowered, psychologically distressed or who are socioeconomically disadvantaged feel powerless after exposure to manipulative campaigns using disgust as a motivator (Hastings, Stead, & Webb 2004; Hunger et al. 2015). I will argue in Chapter 5 that messages that foster feelings of powerlessness cannot have the desired outcome of creating behaviour change, or improving people’s health and well-being.

Abu-Odeh does not elaborate on whether creating and exploiting components of stigma are morally equivalent. However, while exploiting existing stigma is bad, for a public health organisation to create or augment missing or minimal stigmatising social components is worse. Because stigmatisation is a social process, in some cases the labels or categories may exist prior to any public health interest in them. If one understands Link and Phelan’s conceptualisation to be descriptively accurate, then one can see that to reverse the stigmatisation process is extremely difficult. The best we could hope for, perhaps, would be to not make stigma worse (rather than hoping to eradicate stigma altogether). So, if partial stigma based on a particular human difference exists prior to public health becoming interested in an issue that overlaps with that difference, then

public health may be obligated to try to avoid exploiting the stigma or unintentionally making it worse. To actively foster stigma by augmenting social processes, like making categories concrete or providing labels for human difference through the power that public health has to shape public opinion and wield medico-scientific authority, seems potentially harmful, and thereby inappropriate for an agency focussed on promoting welfare.

It is morally important that the utilisation of stigma and disgust in public health anti-obesity campaigns introduces deep cultural and moral assumptions about the rightness or wrongness of having certain bodies. For example, in ‘Be food smart’ (National Health Service, United Kingdom 2013), included in Chapter 1, fat as a food ingredient is presented as a chunky white semi-solid glopping into a glass, and is later referred to as a “hidden nasty” that can cause cancer, while in the ‘Tobacco Method’ poster series (OMA 2012b), a fatty liver and a foot ulcer are presented as the results of eating pizza and drinking sugary beverages. These words and images are chosen to evoke disgust and fear of diseases, and, by extension, fatness. As mentioned previously, Lupton (2015) writes that when disgust and fear are combined this way, a new set of meanings is introduced through the association between disgust, repulsion, and ideas of dirtiness, contamination, and decay (as represented by a foot with amputated toes and an open wound, for example). Fearsome things, such as cancer or diabetes, may be viewed as powerful, Lupton writes,

But when they are also presented as disgusting they become degraded and contemptible. More so than in the case of fear alone, the meanings of disgust involve notions of ‘proper’ comportment, containment of the body and ideas related to deviance and moral judgments that inspire anger and contempt for individuals or social groups (2015, p 12).

So, the reaction inspired by disgust and contempt is repulsion; the audience pushes the images away and draws a distinction between themselves and the source of the disgust. That this process is involved in the audience's reaction to anti-obesity campaigns is problematic, as it undermines feelings of sympathy, solidarity, and community, and inspires instead the creation of categories, out-groups, and stigma. Again, this process of creating 'others' who are less deserving, less proper, or even less human than the in-group has important negative outcomes for public health. Furthermore, while these campaigns might be effective in promoting health in one group, they may undermine wellbeing in another group who might already be disadvantaged, thereby widening health inequalities. This is strongly against the general public health ethos. In the next chapter, I argue that the use of stigmatisation (and the related processes) destroys the conditions for promoting health, including self-respect and freedom from shame.

ii. Stigma, Smoking, and Obesity

As mentioned in the second chapter of this dissertation, some researchers have recommended that campaigns targeting obesity utilise stigmatisation techniques, since, in their opinion, such techniques were successful in reducing the smoking rate (Callahan 2013; Ontario Medical Association 2012a). Whether or not this is true is yet up for debate; separating the effectiveness of stigma from the multitude of other anti-smoking interventions made at the same time, like raising taxes, outlawing smoking inside workplaces, restaurants, and bars, and changing the visibility of cigarettes in stores, is extremely difficult (Sutton 2009; Voigt 2010).

However, smoking and fatness are very different things, and it is not at all clear that the two could be compared in such a way that would make policy techniques that worked

for one obvious candidates for application to the other. Yet, this is just the sort of comparison that happens in arguments such as those offered by Callahan (2013) and the OMA (2012a) in support of stigmatisation. Though the World Health Organisation (2015) and others consider both smoking and dietary choices to be modifiable contributors to chronic disease, there are important differences between smoking and behaviours related to fatness, and to fatness itself. First, smoking is not an essential behaviour for life, while eating is. Second, though low-income individuals are more likely to smoke, not every low-income person will smoke; in food procurement, however, low income is predictive of low-quality eating options and curtailed choice (Chaufan 2015; Voigt 2010; Warin 2015). Third, body fat is an essential component of the physiological make-up of humans, and the badness of fat for a given individual is a complicated combination of the amount, kind, and placement of fat in the body, as well as the individual's genes and physical activity levels. This is different from smoking, which, though it may have important mental health or addictions benefits for some individuals, is typically bad in similar ways for everyone who engages in this behaviour (Sutton 2009; Voigt 2010).

Fourth, while smoking is a behaviour, fat is a feature or trait of a person; while a smoker engages in smoking as an activity, a fat person simply *is*. A smoker does not have a cigarette permanently stuck to their face to identify them, but a fat person is identifiable as fat in every context. If public health focussed on stigmatising eating behaviours (though this is a terrible idea – eating should never be the target of stigmatising campaigns), then using slim people in campaigns would be equally effective for messaging. Smoking campaigns feature a wide variety of people, implying that smoking

is the target behaviour and the individual characteristics of the bodies of smokers are irrelevant. However, public health uses fat bodies to represent the kind of threat involved, or as motivation to avoid certain behaviours. In fact, if a slim person were featured in a campaign, it may not send the message they wish; slim people are given social permission to eat as they like, even if the food is considered less healthy, whereas fat people are not (MacKay 2015; Puhl & Heuer 2010). Public health campaigns aim to change behaviours that have been connected to fatness, and what they target through visual imagery and campaign messages (and thus, what ends up being stigmatised) is the state of being fat.

This brings me to a fifth and especially salient way in which smoking and being fat are different. In his work on stigma and spoiled identity, Erving Goffman (1963) argues that some stigmatizing attributes are discreditable, while others are discrediting. The smoker is discreditable; in social interactions with new people, a person who smokes is accorded the respect and regard that their outward social identity has led others to anticipate extending to them, until, that is, the moment of smoking. Once revealed as a smoker, this respect and regard may be removed based on stigma associated with smoking. However, smoking can also be hidden from others, and social appearances may be maintained. Fatness, on the other hand, is an immediately discrediting attribute. A fat person is immediately revealed to the other as fat; they are visually detected. Unlike smoking, a behaviour that can be secreted away by a person, being fat is an immediate and obvious characteristic that offers no opportunity to “pass” as “uncontaminated” (Goffman 1963). The ability to hide one’s stigmatising attribute is diminished, and the impact of stigma and the frequency of encountering it are heightened. This difference has

important implications for suggestions that stigma ought to be used against obesity the way it was used against smoking; fat people have no safe harbour away from stigmatisation once it is established, while smokers have the opportunity to hide their stigmatised behaviour.

An argument that is often used to support the use of stigma in public health is that it can motivate people to change. Certainly, Callahan and the OMA take the position that stigmatisation is or can be a positive social influence – a motivator – on people’s behaviours. By clearly communicating that a particular attribute is undesirable, people will be motivated to not be considered to have the attribute. So, people will change or limit behaviours associated with the attribute, leading in these cases to an improvement in health. This part of stigmatisation seems to be true: once some people understand an attribute to be undesirable they are motivated to avoid it, and are caused to feel repulsion and rejection of it (Lupton 2015).

However, not all people may be motivated to avoid the undesirable attribute being stigmatised. Those who have it already or feel their identity connected to it in some way may not be so motivated; stigmatisation can have the opposite effect of demoralizing this group, even though this is likely the group public health would wish to target (Guttman & Salmon 2004; Hunger et al. 2015; Puhl, Peterson, & Luedicke 2013). For these people, stigmatising messages may create or deepen feelings of shame, guilt, lack of self-worth, or failure, which can in turn cause or contribute to ill physical and mental health (Becker 1993; Guttman & Salmon 2004; Hunger et al. 2015; Puhl et al. 2013). This may lead to a number of negative results for the people who do have the attribute.

The justifications for using stigma seem to be closely tied to a sense of personal responsibility. Smokers, for example, are considered to be responsible for their health outcomes and behaviours, because smoking is often considered to be a voluntary and non-necessary action. Fat is sometimes characterised this way, too; fatness is perhaps not considered voluntary, but engaging in things that may contribute to it are, such as eating unhealthy foods or not engaging in physical activity. As I discussed in Chapter 3, in manipulative public health campaigns, a message is delivered to the audience that appeals to emotions or psychological responses. The examples presented in Chapter 1 appeal to a variety of emotions, but something that they have in common is the tendency to blame individuals for becoming fat. This is not entirely surprising, given the individualistic cultures in which these are being presented. Stigma seems to imply a degree of blame when deployed purposely in public health campaigns. Communicating that a group must change something about their behaviours or appearance implies that this change is within their control. In obesity (and perhaps other cases), this is not entirely true. As mentioned above, social factors and economic status is closely connected to rates of obesity in a population, and genetic backgrounds and individual health states have significant impacts upon the amount and kind of fat that people carry on their bodies (Chaufan 2015; Warin 2015).

Rather than working to reduce social disadvantage and inequities, stigma positions people as inferior. To date, sociological and medical research has discovered a long and varied list of negative effects of stigma, including social exclusion, shame, guilt, fear, belief that one is unworthy, damages to one's identity, and limits to one's agency (Abu-Odeh 2014; Goffman 1963; Hunger et al. 2015; Link & Phelan 2001; Lupton 2015; Puhl

et al. 2013). These affective results of stigmatisation are directly at odds with the goals of public health. Furthermore, such outcomes lead to diminished self-regard and social standing, and lessened ability to make behaviour changes, such as those often encouraged by public health campaigns. Even if a person is interested in making lifestyle changes, the effects of stigma may be so damaging to their selfhood as to undermine the agency required to change. Scott Burris (2002) and Martha Nussbaum (2004) have separately argued that stigma is barbarous and unacceptable, and should be seen as repugnant for the many ways in which it diminishes a person in society. In seeking to promote wellbeing, the employment of stigma is antithetical. I will discuss this, and the implications of it, in greater detail in the following section and the next chapter.

Oppression

Though public health activity is often focused on equity issues, unintended (though foreseeable) consequences of manipulative campaigns can include stigma, which I have argued is harmful, and can lead to deepening inequities and injustices through fostering or reproducing oppression. This happens through at least two of Iris Marion Young's (1990) processes - marginalisation and cultural imperialism - and the distortion of responsibility as described by Paul Benson (2000). In the introduction to Young's chapter, the Five Faces of Oppression, Young employs a quote by Simone Weil that reads, "oppression is the second horror of human existence. It is a terrible caricature of obedience" (1990, 39). Oppression is insidious, systemic, and embedded in everyday life. Oppression designates what Young terms a family of concepts and conditions, which may entail or cause distributive injustice at the group level, but which all involve issues of justice in addition to distribution. Many groups suffer from oppression of one form or

another, or many forms at once, and because of the systemic nature of oppression, there need not be an ‘oppressor’ group. Rather,

Oppression refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media, and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms – in short, the normal processes of everyday life (1990, 41).

Throughout this section, I will argue that public attitudes toward fatness clearly meet the criteria of oppression described in Young’s discussion of marginalisation and cultural imperialism, and in Benson’s discussion of distortion of responsibility. In addition, while public health anti-obesity campaigns may not intend to oppress fat people, one result of engaging in manipulative public health campaigns is the reproduction of oppression. The oppression of fat people is a real, rather than merely theoretical, concern, with important and damaging impacts on people’s lives. This will mean that public health cannot ethically or effectively use manipulation to achieve behaviour change because it is contradictory to the aims of public health and its focus on equity. I will briefly argue at the end of this section that this means that it is especially counter-productive and harmful as a “counter-manipulation” attempt.

i. Marginalisation

Young describes marginalisation largely in terms of labour relations. ‘Marginals,’ she says, are people the labour system either cannot or will not use. This, Young thinks, is perhaps the most dangerous form of oppression, because an entire group of people – elderly people, disabled people, certain racial groups, and, as I argue below, fat people – are excluded from useful and fulfilling social participation in the form of paid work. This means that they are potentially the victims of material deprivation, social exclusion, isolation, and the affective repercussions of these, such as low self-worth.

Young thinks that there are two primary injustices, beyond distribution, of marginalisation in advanced capitalist societies: that provision of welfare creates further injustices by depriving beneficiaries of freedoms and rights, and that it blocks the opportunity for exercising capacities in socially defined and recognised ways. For the current discussion, I will focus on the second kind of injustice of marginalisation. Young says that even if, through the provisions of a welfare state, marginal people were materially comfortable, injustices would remain “in the form of uselessness, boredom, and lack of self-respect” (p 55). Most of society’s productive and recognised activities take place in contexts of organised social cooperation, such as employment and education, and to be excluded from these involves unjust deprivation of cultural and practical opportunities for exercising capacities, being recognised as a person, and interacting with others.

Many social scientists have been reporting on the effects of bias and discrimination against fat people in the workplace. Researchers have found that fat people are less likely to be hired, less likely to be promoted, more likely to be paid less than their colleagues, more likely to be terminated without cause, and are subject to stereotypes and discriminatory assumptions: that they are less intelligent, less motivated, less ambitious, and less effective employees (Puhl & Heuer 2009; Puhl & Heuer 2010). Through the covert workings of stereotype and bias, fat people are more likely to lose their jobs, and less likely to get hired for new positions. The process of marginalisation has even translated into voyeuristic newspaper stories and reality television shows focusing on people who are “too fat to work.”¹³ Fat people are becoming increasingly marginalised in

¹³ There are a number of examples of stories of this kind. A television show in the UK, entitled *Benefits Britain*, provides a particularly good illustration of the kinds of harmful effects of marginalisation,

western capitalist societies, and this has a real and measurable impact on their health and well-being.

Public health anti-obesity campaigns feed into the stereotypes in play in employment decisions. Through the complex relationship in which we connect outward appearance and behaviour to internal states, campaigns use visual cues to indicate dispositional attitudes and health status (Messaris & Abraham 2001). So, for example, the outwardly normal-weight family in the ‘Who Cares’ video included in Chapter 1 is interpreted as obese by the viewer, because they are eating unhealthy food, living in an unclean house, and being physically inactive (Children's Healthcare of Atlanta 2013). The public health body that created this video calls upon – or counts on, as Abu-Odeh says – the audience’s previously-held stereotypes to activate negative judgments and feelings. The audience interprets the family to be lazy, unmotivated, and unhealthy. Likewise, in Sugar Packets (Department of Health, New York City 2011), presented in Chapter 1 and discussed in Chapter 2, an employee is seen at various points in their workday drinking large sugary beverages, and then at home eating a meal of take-out food and soda. The message of the video is that drinking these beverages is unhealthy, but also that the employee who drinks them is a loafer – the depiction of their lifestyle communicates lack of energy, ambition, and care. The messages that public health agencies communicate in these campaigns, and the stereotypes they call upon to deliver the messages, transpose erstwhile health matters into the other parts of people’s lives. This meets Young’s conditions for marginalisation because weight-related biases have affected, for example, employment opportunities for fat people.

including scrutiny by others and humiliation (<http://www.channel5.com/show/benefits-britain-life-on-the-dole>).

ii. Cultural Imperialism

Cultural imperialism involves the establishment of a ‘normal’ set of experiences, goals, and culture, through the universalisation of the dominant group’s views. To experience cultural imperialism, Young says, is to “experience how the dominant meanings of a society render the particular perspective of one’s own group invisible at the same time as they stereotype one’s group and mark it out as the Other” (pp 58-59). I hesitate to suggest that fat people identify as a group in the sense that this definition might imply, but both the processes of invisibility and Othering are at work in cultural attitudes towards being fat. Fat people’s perspectives on themselves and their lives are made invisible insofar as they are subjected to the meanings of dominant culture – of illness, inability, unattractiveness, etc. At the same time, fat people are Othered and stereotyped, and are even presented to us in popular media as threats or enemies. Young’s further explication of cultural imperialism certainly seems applicable to fat people: she says that the culturally imperialised become “remarkable, deviant beings,” who are stamped with an essence. This “[confines] them to a nature which is often attached in some way to their bodies, and which thus cannot easily be denied” (p 59).

Like Goffman’s explanation of discrediting attributes in stigma, Young locates the oppression of cultural imperialism in aspects of one’s body; the culturally imperialised are obvious and visually detected outsiders, their social interactions foregrounded by stereotype. So, as Young says, one’s identity is created for one by the dominant group’s meanings of them; “everyone knows... that Indians are alcoholics, that women are good with children,” and that fat people lack self-control (p 59). Through the creation of ‘ugly bodies,’ marking out the culturally imperialised as “dirty, defiled, impure, contaminated, or sick,” the dominant group exercises its powers of Othering and standardisation (p

123). The dominant view stands as normal, rational, and objective, and the dominant group can harness science to enforce and reinforce the categories created in cultural imperialism. As the privileged groups lose their peculiarity, assuming the position of a universal, scientific view, the oppressed become “locked in their objectified bodies, blind, dumb, and passive” (p 127). While the culturally imperialised are denied the opportunity to define themselves, and are marked as degenerate, flawed, and undesirable, the dominant group is allowed to individuate, and takes the position of superiority, both corporeal and moral.

Culturally imperialised people internalise the dominant group’s views, says Young, at least to the extent to which they are forced to react to them. Young argues that this creates what W.E.B. Du Bois called ‘double consciousness:’ “the sense of always looking at one’s self through the eyes of others, of measuring one’s soul by the tape of a world that looks on in amused contempt and pity” (Du Bois 1969, as quoted in Young 1990, p 60). While the subject sees themselves as a person capable of achieving their goals and living a life of hope and possibility, the dominant culture tells them that they are flawed, inferior, and incapable. Du Bois’ double consciousness is faithfully rendered by the video, ‘Measuring Tape,’ described in Chapter 1 (Department of Health, Australian Government 2010). In this campaign, viewers are actually encouraged to find out how they ‘measure up,’ in comparison to an idealised (slender, but also young and white) body, with imagery of measuring tapes providing a constant visual theme.

Through exercising their claims on scientific objectivity, public health organisations can culturally imperialise groups of people under the auspices of promoting health. The decision that health in general or the particular notion of ‘health-as-thinness’ should be

promoted is one that prioritises a particular view of what constitutes health over other views, and prioritises the value of health over other possible values central to people's lives. Decisions to transform human differences into medical problems (the process of medicalisation), and about how much and what kind of health risk should be tolerated, display a similar prioritisation of a particular vision of health and living well over other, possibly equally legitimate, visions. The values providing the basis for these decisions are those held by the dominant group, and processes like medicalisation help the dominant group to mark out the Other and reinforce categories of difference. All of this happens on a structural level; I do not wish to suggest that any practitioner sets out to oppress others through marking them as different. I do suggest, however, that this process of oppression is at play in public health campaigns, and that health and scientific concerns surrounding obesity are not entirely free from biases based in cultural imperialism.

iii. Distortion of Responsibility

The final form of oppression that I will discuss here is the distortion of responsibility as described by Paul Benson. The systematic distortion of responsibility is a feature of most resilient forms of social oppression, Benson, referencing Hoagland, explains that people harmed under oppression are held responsible for everything that happens to them, their own choices as well as the situation itself, or alternatively they are perceived as complete victims, as if they are not doing their best to survive and carry on (Hoagland 1988, as referenced in Benson 2000, p 73).

Holding people and being held responsible is an important part of social interaction. As Benson sees it, responsibility is “a matter of calling forth a moral relationship with the person being blamed,” and the person being blamed is supposed to recognise the legitimacy of the demand placed upon them by such a calling forth (p 79). However, in

cases where an oppressed person is called upon (blamed) by a member of a dominant group, this interaction happens within a power imbalance. The oppressed person is not able to account for themselves in a way that makes sense to the dominant point of view. Benson explains that the “efforts an oppressed person might make to answer for their actions may be transgressive and simply not count, morally” (p 80). Rather than being granted worthiness, they may be considered “infantile, bestial, impure and incapable of [the] moral sensitivity and self-control” that would warrant recognition as an accountable agent (2000, p 80; Bordo 2003). Being held responsible for one’s actions or beliefs implies that one is considered equal and that one’s reasons for performing actions or holding beliefs could be accepted as reasons, even if they were disputed. In order to dispute, one must recognise one’s opponent to be worthy.

This idea evokes my foregoing definition of persuasion, where agents are addressed in a mutually respectful conversational format, as two parties to an exchange of ideas. A similar context is implied in holding and being held responsible; thus, if one party is not considered fit to account for oneself, there can be no exchange of ideas, and therefore no position of responsibility for one’s actions or beliefs. So, a person who realises that they are not afforded the same standing as others may feel a lack of worth, and this could gain expression through this person’s self-regarding attitude that their values are not worthy of disclosure, or their commitments are not the correct ones to act upon. For people who have internalised the prevailing norms of such a society, an attitude of low self-worth “will be one element of the broader lack of moral self-respect, the failure to recognise their fundamentally equal moral worth as persons” (80). This may lead people to have

grave doubts about their own competence as moral agents and self-authorizing actors, and this will be discussed in detail in Chapter 5.

Furthermore, it seems that even if one thinks that one could account for oneself, if others do not afford one the recognition required for responsibility, one's justifications for one's beliefs or actions may not be considered justifications at all. If one is held by the broader society to be unequal, as fat people are held, then the sorts of reasons one could provide for one's actions may simply be disregarded as wrong or misguided, and thus not stand as acceptable reasons. While the oppressed should not be held personally responsible for things out of their control, they also should not be looked upon as powerless. This, I take it, is the distortion of responsibility in both directions that Benson wants to acknowledge. Hoagland, Benson, and Lupton provide connecting accounts of the discounting of fat people, as people who count as moral agents, as autonomous, as full persons, and as citizens (Benson 2000; Hoagland 1988; Lupton 2015). For Benson, being morally responsible is a matter of occupying a certain social position; one must be an eligible participant in a community of moral dialogue in order to be responsible and accountable. Fatness is taken to be blame-worthy, because it is seen as largely the result of choices under individual control. Though often blamed for being fat, it is not clear that fat people hold the social position that would allow them to account for their fatness in a way that would be deemed acceptable to the dominant group. Rather, it seems that most attempts to account for oneself as being fat are interpreted as excuses or confusions, both of which require remedy through motivation or education.

In framing fat as blameworthy, or buying into the idea that fatness is blameworthy, public health reinforces the distortion of responsibility. Many campaigns in Chapter 1

imply that their target audiences suffer from ignorance or laziness, or both. Blaming individuals for being fat is problematic because, as mentioned, there is a significant amount of evidence that high levels of body fat can be caused by a complex interaction of our economic, social, and educational systems, as well as genetic predispositions and self-selected lifestyle factors (Guttman & Salmon 2004; Lupton 2015). This makes blaming some groups inherently unfair because they are not blameworthy (Rossi & Yudell 2012). There is a pervasive cultural belief that obesity is a blameworthy condition and that fat people have a responsibility to change their ways. However, given that public health authorities know about the many overlapping causes and contributors to obesity, which includes powerful mechanisms outside of the individual's control, they should not condone or promote that belief.

Public Health Manipulation as Counter-Manipulation

That public health should use manipulative means to counter the powerful advertising of food companies has been argued by Bayer (2003; Bayer & Fairchild 2016) and Wilkinson (2016). The foregoing two chapters ought to make my objection to this tactic unsurprising, however, I will briefly address this here. These authors have argued that public health should wield advertising's own tools against it. This is misguided for two principal reasons. The first is that public health organisations using money from public coffers (so, governmental agencies and certain non-governmental organisations) cannot and should not attempt to meet the hundred-million-pound advertising budgets of commercial firms. Those resources would be more responsibly and effectively spent in other kinds of public health activities. Privately-funded non-governmental agencies, such as the OMA, may attempt to counter-advertise, but even they will not be able to achieve the same reach or impact as industry. With an advertising budget of \$1 million

(Canadian) per month for some of their campaigns, the OMA barely reaches outside of the province of Ontario, Canada, with their messages. Thus, the feasibility of counter-manipulation and such a use of public money is extremely suspect.

However, and more importantly to this discussion, public health's use of manipulation to counter-act manipulative advertising does not bring the public forum to a net-zero-manipulation state. The idea, in some sense, seems to be that public health can use manipulation to neutralise industry advertising. It may be that manipulation is cumulative, so adding manipulative messages to a space already occupied by manipulative messages would not neutralise the public discourse, but make the truth ever-more difficult to detect. Without presenting straightforward information in either an informative or persuasive way, public health cannot clarify an issue or question for the public. Furthermore, engaging in counter-manipulation may erode the public's trust, which is problematic for reasons outlined in Chapter 3. If public health is interested in combatting advertising from industry, then they ought to use a cost-effective and powerful tool at their disposal: regulation. I will say more about the role and responsibility of public health in Chapter 6, and so will not pursue this line of argument further here.

Paternalism in Public Health

i. In General

Paternalism has been defined in a wide variety of ways (for example, Buchanan 2008; Carter 2015; Childress 2007; Dworkin 2016). The key points of similarity in the various definitions that have been proposed are that (1) in a particular situation a person's autonomy is curtailed, and (2) this is done in the interest of that same person's welfare. Different authors have framed these conditions in different ways, or added other

conditions. For example, Gerald Dworkin (2016) also thinks that the limiting of one's autonomy must be done without one's prior consent for it to count as paternalism, and that the person's autonomy must be overridden to achieve a goal that is counter to what the person wishes, or thinks is in their own interest. The language of such definitions is normative; words like 'curtailed' and 'overridden' both have a negative valence. It is difficult to find a definition of paternalism that does not contain within it an assumption of wrong-doing, even though there is nothing about paternalism *per se* that is negative or wrong. It is crucial to the definition that the reason that a person experiences a limit on what they may do (in action or omission) is that their welfare is served by being limited in that context. Yet, in much of the ethics literature, autonomy is given so much importance that paternalistic interventions are considered to be *prima facie* problematic, and to require strong justifications.

This has resulted in a kind of obsession in the ethics of public health. As Ronald Bayer (2008) has said, paternalism can be seen as "part of the warp and woof of public health," because public health bears the unique responsibility of providing collective interventions (which I will return to in Chapter 6). Who demands change and for what purpose are important questions when considering the appropriateness of public health interventions. Paternalism in public health is, arguably, a different creature from other cases of medical paternalism. First, rather than an instance of one-to-one paternalism, such as one might find in bioethics cases featuring physician-patient relationships, the intervention group in public health is often an entire population. In most cases in advanced democracies, public health initiatives are subject to some kind of democratic process – public deliberations, focus groups, consultations on drafts, or the legislative

process. All of the societies who are an audience for the anti-obesity campaigns discussed in this dissertation, for example, operate in accordance with democratic systems, which means that people in those countries have effectively delegated the portion of their autonomous decision-making power related to the functions of state, region, and municipality to other people at these various levels of government. We happily delegate this power; we do not typically wish to be involved in every decision at municipal, regional, and state-level politics. Public health interventions may gain legitimacy through democratic, representational group decisions. This would mean that definitions of paternalism that require a lack of consent or action contrary to interests, such as those proposed by Dworkin, would not clearly apply. That individuals had not given prior consent to a public health activity may not be relevant; the individuals in question invested elected representatives with their own decision-making power to run the various parts of government and make various policy decisions. So public health, as a branch of government activity, would be acting within the remit of that vested power. In the case of some collective goods, like clean air, clean water, or control of infectious diseases, government-level activity is the most effective way to ensure everyone's compliance and to achieve the desired goal (Dawson 2011; Kass 2001).

Additionally, public health is interested in achieving collective goods (Dawson 2011). Jonny Anomaly (2011) has argued that because public health works in the interest of an entire population to achieve certain non-rival, non-excludable public goods (which are one kind of Dawson's collective goods), it is not paternalistic. Anomaly identifies something important here. However, we must appeal to the individual's welfare for something to be, by definition, paternalistic (Wilson 2011). On this understanding, public

health initiatives are not paternalistic. This is because, in cases of collective goods, it is not just the individual's welfare but actually every person's welfare that is being promoted. This is due to the non-excludability of the good. As such, we are not required to use the individual's good to justify the initiative. By definition, this means that public health is not behaving paternalistically; it is not the promotion of one's own welfare that justifies overriding one's autonomy, it is the promotion of everyone's welfare at once. So, just as initiatives that prevent one from doing something that would cause harm to another are not paternalistic, neither are initiatives that prevent one from doing something that would undermine collective welfare, though that includes one's own welfare, too.

James Wilson writes that on accounts of paternalism that appeal to psychological justifications for policies (that is, the intentions behind the policy), it may be very difficult to find any that are paternalistic (2011). There are two psychological-justification positions that one can take. The first, Wilson writes, is that in order for a policy to be paternalistic, *all* of its motivations must be paternalistic in nature, and none be non-paternalistic (such as the reduction of harm to others). This is an especially challenging position to hold because most policies will be introduced for a variety of reasons, some of which may be paternalistic and some of which may be non-paternalistic. The second position is that a policy is paternalistic if *any* of its motivations are paternalistic. Wilson writes that this stance is inadequate, because it would mean that a policy is paternalistic even if paternalistic motivations were only a very small part of the reasons for introducing it, or if they were not (or far from) the primary aim for introducing it. My suggestion, that public health policy need not ever be paternalistically motivated, may be another response to this position. This is because we may justify

overriding A's autonomy by reference to B and C's good, and overriding B's autonomy by reference to A and D's good, or overriding A and B's autonomy by reference to the good of C, D, E..., Z. Therefore, when public goods are at stake and can only be achieved via collective initiatives, in which no one may opt-out, paternalism is not involved. I think this perspective provides insight into why we may be willing to accept different kinds of interventions in public health, and why, whilst paternalism seems such a troublesome notion in relation to public health activities, it is in fact not an issue.

ii. In Campaigns

While I think the foregoing paragraphs address some of the concerns about paternalism in public health in general (though certainly it does not resolve the debate, nor even attempt to), it seems important to focus on public health campaigns specifically, as a different sort of intervention from examples like water treatment or food safety. In joining a debate that reaches back to the 1970s, Nancy Kass (2001) has argued that all 'health education' campaigns are paternalistic. This is because they imply that specific ways of being ought to be universally valued. So, an anti-obesity campaign could contain a background assumption of the universal value of maximum longevity, thinness, or a variety of other things. On this interpretation, endorsing a specific set of values is considered to be a paternalistic move because this is one way of promoting a particular understanding of another's welfare, and of the nature of the Good.

While I am sympathetic to Kass's worry about the promotion of a specific set of values or a specific notion of the Good, I do not think this is where the real problem of paternalism in public health campaigns lies. It seems, rather, that in order for a campaign to be paternalistic, it is not enough that it promotes specific values; it would somehow need to place a limit on what kinds of choices the audience could make. It does appear to

be the case that manipulation in public health anti-obesity campaigns could make it more difficult for people to make decisions, and in Chapter 5 I will argue that they undermine autonomy in specific ways. Techniques that circumvent a person's reasoning abilities, as manipulation was argued to do in Chapter 3, make it difficult for a person to form a choice that reflects their own preferences. Manipulative techniques are used in communications to influence people in non-rational ways (for example, through affective appeals). The power of manipulation seems to be that a person has greater difficulty rationally evaluating their options in light of their own values. Certainly, manipulative communications impact a person's decision-making ability.

However, a relevant feature specific to campaigns is that one can resist their messages, or, even if impacted by the messages in various ways, not do what the campaign is advising one to do. In Chapter 3, I argued that coercion is not a relevant concern about public health campaigns, because it seems that the nature of communication is such that it cannot be coercive; a communicative act would need to be accompanied by a credible threat of immediate and serious harm to be coercive, and a poster or video campaign does not meet this condition. Likewise, it seems that manipulative campaigns are not paternalistic, insofar as a person can choose to do other than what the campaign is recommending or promoting. I acknowledge that manipulation can be a difficult force to resist, and likely some people will be better able to resist its influence than others. However, rather than characterizing manipulation based on its force or irresistible influence, I characterised it based on its lack of respect for the audience, on an agent-based model of communication. Thus, a campaign can be manipulative on my definition without it being irresistible. Furthermore, paternalism

seems to require that the person who is having their autonomy curtailed is not able to do otherwise than the paternalistic intervention dictates; this is what the curtailing of autonomy consists in. If it were the case that a person was able to do what they wanted to do even with the intervention in place, then their autonomy would not be curtailed, and thus the intervention would not be paternalistic. Based upon the failure of manipulative campaigns to meet this aspect of the autonomy condition, I do not think that they could be defended as paternalistic, and nor could they be criticised as such.

Conclusion

There can be no exceptions to the impermissibility of manipulative public health campaigns on the foregoing account. Paternalism cannot be used to justify manipulative campaigns because paternalism is not relevant to the discussion. Not only is the claim that public health measures are paternalistic disputed in the literature, but on most definitions of paternalism, campaigns are not the sort of initiative that could qualify as paternalistic. Furthermore, those who have argued that manipulative public health campaigns ought to be used to stigmatise behaviours and therefore motivate behaviour change are mistaken about the acceptability of stigma as a tool. These arguments rest largely on the comparison between smoking and obesity, which I have argued is dubious, and upon the notion that stigma is effective at motivating change. Not only is stigma harmful, but it widens health inequalities and works counter to motivating people to change.

I have argued here that even in circumstances in which public buy-in is strong and a manipulative public health campaign seems to be accurately tracking people's values, the impact on certain members or groups who are in the minority of a population may be harmful, and welfare-undermining. By analysing the contribution that manipulative

public health campaigns make towards deepening the oppression of fat people, I have begun the explanation of how these campaigns actually undermine people's abilities to make the sorts of changes to their behaviours that public health is interested in having them make. The following chapter will explore this in detail, outlining the way that manipulation undermines the development and exercise of autonomy. This will be followed by a discussion of public health's role and responsibilities.

Chapter 5

The Impact of Manipulation on Autonomy¹⁴

In addition to the foregoing arguments in Chapter 4, manipulative communication in anti-obesity campaigns may be wrong because it diminishes autonomy. There is an assumption in the literature that manipulation is by its very nature morally impermissible because it impinges upon autonomy through undermining things like reasoning and decision-making. In this chapter, I will draw upon a capability-based relational view of autonomy as drawn from Catriona Mackenzie's (2014) tripartite definition: self-determination, self-governance, and self-authorisation. Though I will agree with her distinctions, with these three terms in hand, 'autonomy' as a stand-alone concept is unhelpful because it is practically inert, and should be left aside.

Employing Mackenzie's distinctions, I will first argue that the term 'autonomy' should be set aside in favour of using terms that allow us to talk about manipulation's (and oppression's) effects on people with greater specificity. In this, I will build upon Mackenzie's view and use her terminology to explain the various ways in which manipulation impacts people's abilities and attitudes for self-direction. Using Mackenzie's concepts of self-governance, and self-authorisation, I will draw upon Carolyn McLeod's work on self-trust, and Paul Benson's work on self-worth to argue that using manipulative means of delivering health messages may undermine the development or exercise of related skills. Capabilities for self-governance and self-authorisation could be undermined by these messages if they undercut or circumvent the

¹⁴ A short version of some of the material in this chapter has been accepted for publication in MacKay, K.L. (forthcoming). A feminist analysis of anti-obesity campaigns: Manipulation, oppression, and autonomy. *International Journal of Feminist Approaches to Bioethics*.

reasoning process because of presumed authority or by using non-rational motivational forces.

I have argued in the previous chapter that manipulative public health obesity campaigns reinforce an oppressive system in which fat people are discriminated against, and here I will argue that anti-obesity campaigns undermine people's abilities to develop the skills and attitudes necessary for self-determination, self-governance and self-authorisation. These appear to be strong moral arguments against manipulative public health campaigns as they are currently realised.

Defining Autonomy

Conceptualizing autonomy has been a decades-long philosophical project. In the various theories of autonomy, it is largely agreed that autonomy is a defining constituent element in human well-being and, importantly, a fundamental precondition for moral agency (Buchanan 2008). In the works of both Immanuel Kant and John Rawls, each person's state of autonomy provides the critical link between principles of justice and the idea of free and equal human beings. As David Buchanan says, "autonomy is the *sine qua non* that enables moral agents to give free and rational assent to any proposed public principles of justice" (2008, p 17). Additionally, autonomy has become important in medical, legal, and political theory because the presumption of autonomy confers normative authority over one's own life (Mackenzie 2008), such that one's decisions cannot be tampered with in ways that seem to disregard this authority. Accordingly, Buchanan (2008) says, philosophers have typically located personal autonomy in an agent's capacity to engage in a process of independent deliberation and decision-making about the course of one's life.

However, explicating exactly what it is to be autonomous, and thus who would ‘count’ as autonomous and what this would mean for them and those who do not ‘count,’ has been extremely difficult. In an effort to faithfully render a portrait of the self-directed person, many things have been packed into the concept of ‘autonomy;’ things like reasoned self-reflection, second-order desires, freedom from coercive influence, and considered value preferences. Feminist and critical theorists pointed out that the standard portrait of the autonomous person as these theories formed it actually depicted an individual with significant privileges of race, gender, and independence; thus, this was not a depiction of ‘the autonomous person,’ but of ‘one kind of autonomous person’ which was neither complete nor universal. Traditional theories of autonomy failed to recognise long-standing oppressive systems, and the insidious ways in which social structures can inhibit or promote the skills required for self-direction. Feminist and critical race theorists urged recognition of the fact that no self-directed person grows up alone in a social vacuum; if one is to become an ‘autonomous’ adult, one must learn how to do this through relationships with other people and within social systems as one matures. This view considers self-directed, self-willed decision-making to be a sum of capacities and attitudes, related to a set of skills that have developed over time, with assistance from other people in a supportive environment.

Because autonomy has been framed as pivotal to respect, civic participation, and the justification of interference from others in the liberal tradition, philosophers are eager to find a definition that is comprehensive, and are reluctant to stop relying on it in favour of other concepts that could prove more useful. As MacKenzie says, “to respect autonomy is to respect each person’s interests in living her life in accordance with her own conception

of the good” (2008, p 512). This is important, and though I am critical of ‘autonomy’s position of importance, components of the concept have been guided by useful moral intuitions about people being able to live their lives as they see fit, without unwarranted interference or restriction. Though we may question people on their choices of the Good Life, ultimately we must recognise that there are numerous ways for people to live meaningful and good lives, and that these should be free from arbitrary or undue interference from others.

Throughout debates and discussions about autonomy, the principal areas of inquiry focus on freedom, competence, and authenticity. Many philosophers worry about questions of authenticity, such as how we can know that someone is making a choice that is *their own* and unhindered by coercion, oppression, false consciousness, or any other state of mind or body that may ‘interfere’ with the willing and the accomplishment of a choice. This question is not about liberty, though freedoms of certain kinds will promote self-directed action. This question is mostly about whether a person can make decisions and carry out actions that outside observers can interpret as demonstrating important parts of that person’s personal identity, value set, or belief system.

Lumping questions of freedom and authenticity together under one heading, ‘autonomy,’ obscures important issues, and doesn’t help us think clearly about what is important about these concepts. Through her recent redefinition of autonomy, Mackenzie (2014) eliminates the need to use the term ‘autonomy’ and provides a new and much more useful vocabulary with which to discuss aspects of authentic self-directed agency. Her account will be discussed in the following sections.

Mackenzie's Three-Part Theory of Autonomy

Rather than discarding the concept 'autonomy,' that has been stretched and warped over time through overuse by many competing theories, Mackenzie (2013, 2014) says that feminist theorists have wanted to keep the idea of autonomy (specifically, relational autonomy) because of the importance of self-determination for women and for members of any group subject to social domination and oppression. In agreement with her non-relational-theorist counterparts, she says that exercising the capacity for self-determination is crucial for leading a flourishing life.

While in earlier writing Mackenzie considered self-determination to be the core of autonomy (e.g. 2013), in her recent book chapter, entitled 'Three Dimensions of Autonomy' (2014), she says that self-determination is but one of three conceptual axes of autonomy, the other two being self-authorisation and self-governance. Mackenzie goes to great lengths to expand upon traditional notions of autonomy, to build in new ideas that would make the concept useful and robust. In this section, I will describe each axis of Mackenzie's recent reconceptualisation of autonomy, which I think provides enough substance and vocabulary to replace 'autonomy' completely. I will argue that Mackenzie's three-part distinction, between self-determination, self-governance, and self-authorisation frees us from reliance upon the concept of 'autonomy,' which, in turn, frees us from the term, and permits us to focus on important contributors or inhibitors with greater specificity in each of the three areas.

i. Self-Determination

In 'Three Dimensions of Autonomy' (2014), Mackenzie shifts her view that self-determination is at the heart of the concept of autonomy, and argues that traditional conceptions of autonomy are most closely associated with *self-governance*, conditions

internal to a person, while *self-determination* is a matter concerning conditions external to the agent, and therefore relates to social structures and to justice. Self-determination means “having the freedom and opportunity to make and enact choices of practical import to one’s life, that is, choices about what to value, who to be, and what to do” (2014, p 18). Structural conditions – social and political – have the potential to impair or to enable individual self-determination and self-governance. The external conditions important to achieving self-determination, Mackenzie says, can be separately considered as freedom conditions and opportunity conditions. Freedom conditions specify certain negative political and personal freedoms, such as freedom of thought, expression, religious exercise, and movement, and freedom from arbitrary arrest, violence, manipulation, exploitation, and assault, as some examples.

Opportunity conditions emphasise positive freedoms that represent access to capabilities in the personal, social, and political realms of a person’s life. Mackenzie argues that capability approach as developed by Amartya Sen, Martha Nussbaum, and others, provides a useful vocabulary for thinking about opportunity conditions.¹⁵ The exact list of capabilities that are identified as central to living a good life is the topic of some debate, though the ‘basic’ capabilities are widely agreed upon. These include education, political participation, physical and mental health, freedom from violence, and gender equality. Mackenzie does not express her views on which should be included in a list of central capabilities; however, she agrees with Elizabeth Anderson (2010) and Ingrid Robeyns (2003) that safety, physical health, nutrition, mobility, education, the ability to interact with others without stigma, mental well-being, political empowerment,

¹⁵ See Amartya Sen, ‘Development as Freedom’ (1999), and Martha Nussbaum, ‘Women and Human Development,’ (2000), for early expositions of capabilities theory.

domestic and paid work, and freedom of religion, among other things, are important opportunity conditions for self-determination. However the list of capabilities is defined, Mackenzie says, “the idea that a just society is one that ensures access, above a certain minimum threshold, to the valuable capabilities...shows why ensuring the opportunity conditions for self-determination is a matter of social justice” (2014, pp 30-31). So, if one considers questions of justice to be concerned with providing access to key capabilities, then one must also see it as concerning the conditions favourable to living a self-determining life. An environment that enables self-determination is incompatible with unjust situations caused by oppression, deprivation, and race- or gender-based discrimination. Social, legal, political, or economic systems that offer in a just manner the opportunities to develop the capabilities to live a good life, will not have the depriving or violent features of oppressive systems.

Mackenzie points out that both capabilities theorists and relational autonomy theorists are concerned with the phenomenon of adaptive preference formation, whereby people who are subjugated by systems of oppression or deprivation adapt their preferences to fit into the realm of options available to them. This means that such people may fail to create preferences for things that they know cannot be satisfied, or fail to conceive how their preferences or goals could be different in other situations. This is a feature of the internalisation of oppression or deprivation, because the constraints upon people are both external, the actually limited range of options, and internal, the limited sense of what a person can be and do in their lives. Mackenzie says that this process demonstrates the causal interdependence of the opportunity conditions for self-determination and the conditions required for self-governance and self-authorisation. A person’s entire range of

self-determining capabilities, and their ability to conceive of and shape plans for a particular kind of life that they could live, may be impaired to some degree by the societal failure to create social and political systems that provide the opportunities and freedoms in which to develop and enact these capabilities.

ii. Self-Governance

Mackenzie argues that *self-governance* involves a certain set of skills or capacities required to make and act upon choices that “express or cohere with one’s reflectively constituted diachronic practical identity”¹⁶ (2014, p 18). As such, self-governance identifies conditions of competence and authenticity. As noted above, Mackenzie considers traditional theories of autonomy to be focused on questions of self-governance, that is, upon authenticity concerns, or upon competence concerns. I will return to this idea in the next section, in which I will expand upon my view that most debates about autonomy really are concerns about authenticity. Here, I will limit myself to explicating Mackenzie’s argument.

Competence conditions, on Mackenzie’s view, refer to the capabilities a person needs to be self-governing, including a range of cognitive skills, from understanding information to critical reflection, and volitional skills like self-control and the ability to make decisions. Developing or exercising these kinds of skills can be impeded by a variety of psychological influences, which range from weakness of will and failures at self-control, to phobias, addictions, and other serious mental illnesses. Mackenzie highlights that relational theorists have identified skills such as imaginative skills, emotional skills, and social/dialogical skills, which are important to self-understanding, self-transformation, and relationships with others, that were not typically included in a

¹⁶ From here onward, ‘reflectively constituted diachronic practical identity’ will be shortened to ‘personal identity.’

list of competencies for being autonomous on traditional definitions, but which should be understood as equally important as critical self-reflection, or self-control. For relational theorists, Mackenzie says, the solution to impediments of the skills for self-governance is not to attempt to free a person from social influence, but “to promote social relationships that foster self-governance” (p 34). Like self-determination, in many cases failures at self-governance can be traced to the workings of social institutions that undermine a person’s development or exercise of these skills.

Mackenzie says that authenticity conditions constituting the balance of what is required for self-governance refer to one’s motivational structure; “what it means for a choice, value, commitment, or reason to be one’s own” (p 32). Mackenzie thinks that there is value in the concept of authenticity because it identifies the *self* that is supposed to be governing itself (p 33). The concept of self-governance (or self-determination) cannot be uncoupled from the ‘self’ who is allegedly in charge. However, the concept of authenticity has been as difficult to define as autonomy, and Mackenzie promotes a specific understanding of it.

Relational theorists have been sceptical of definitions of authenticity that rely on ‘hierarchical endorsement’ theories or coherentist accounts, such as Harry Frankfurt’s (1988). Frankfurt discussed the source of a person’s motivation as being *one’s own* when the subject could ‘wholeheartedly endorse’ their will to do a certain thing. Though Frankfurt never used the term ‘authenticity’ explicitly, his description of ‘wholeheartedness’ has been understood as an account of authentic willing. Critics have pointed out that conditions like Frankfurt’s ‘wholehearted endorsement’ seem not to consider the internalised effects of oppression or deprivation, as discussed above, and put

too stringent a requirement on people by disallowing attitudes of ambivalence or acceptance towards one's values or beliefs in a concept of authentic willing.

Rather than understand authenticity in such a way, Mackenzie recommends adopting John Christman's definition, which focuses on "non-alienation upon (historically sensitive, adequate) self-reflection... or reflective self-acceptance" (2009, pp 155-156; Mackenzie 2014). Under this definition, rather than requiring a person to entirely endorse the beliefs or values they find themselves to be holding, a person must simply not feel alienated from them. People do not, after all, get to choose which values and beliefs they hold from a blank-slate position; there is an element of Heideggerian 'thrownness' involved, insofar as one becomes aware that one holds certain views particular to their personal history, upbringing, and culture *after* one has already been operating with these views and within these contexts. If a feeling of alienation is experienced upon realizing that one holds certain views (one who believes oneself to be non-racist realises that one holds racist assumptions, for example), we would expect one to reject the values or beliefs one previously held, in favour of others that are non-alienating, though this process may be long and difficult.

Thus, we can understand people who live in oppressive social circumstances but who can look inside themselves and recognise who they are and what matters to them in an experience of reflective self-acceptance as people capable of making decisions that are *their own*, in terms of expressing important things about their lives and values, whether this is in line with the roles set out for them by the oppressive situation, or roles that push against such oppression, or something in between. This formulation of authenticity is an important feature of Mackenzie's conceptualisation of self-governance, because

questioning the source of a person's values or desires has typically been considered a way of challenging their ability to be self-directed, autonomous agents, and Mackenzie and Christman provide a defense against this.

iii. Self-Authorisation

Finally, *self-authorisation* is the third axis of Mackenzie's tripartite theory. Self-authorisation, on Mackenzie's (2014) account, means viewing oneself as having normative authority to decide and act, and to see oneself as accountable, and able to hold others to account. Though 'agency' is not explicitly mentioned, the description of self-authorisation seems similar to it. Self-authorisation has three conditions: accountability, self-evaluative attitudes, and social recognition. The accountability condition requires that a person regard themselves as responsible and answerable to others. One must be prepared to take responsibility for one's beliefs, values, and commitments, but also regard oneself as authorised to hold other people accountable. This condition, Mackenzie argues, is "fundamentally social and dialogical, not only because its structure is dyadic or second-personal but also because our reasons, values and commitments, indeed our sense of ourselves, emerge only through this kind of dialogical interaction" (p 37).

Seeing oneself as having this kind of authority, to be and hold others accountable, seems to require one to have certain self-evaluative attitudes, which are the second set of conditions for self-authorisation. Mackenzie says that in particular, attitudes of self-respect, self-esteem, and self-trust are important. Carolyn McLeod has emphasised the importance of self-trust for making self-directed decisions (McLeod & Sherwin 2000; McLeod 2002). With Susan Sherwin, McLeod (2000) argues that in oppressive situations, a person's ability to trust themselves is systematically undermined. Not only does the oppressed person fail to see themselves as trustworthy when it comes to making

decisions, but the oppressive systems are arranged such that they do not have the opportunities to practice making decisions in a way that would build such self-trust. In a similar vein, Paul Benson (2000) has argued that self-worth is essential to moral responsibility, which is an important feature of self-authorisation. As discussed in the previous chapter, he argues that oppressive social circumstances can prevent someone, and others around them, from seeing them as the kind of person who can be held responsible. He argues that these people may feel, and have reason to feel, that they do not occupy the appropriate social place to answer for their conduct, and so fail to see themselves with moral self-respect. Benson's and McLeod's accounts are important to my argument that manipulative communications are oppressive and undermine self-directed living, so I will save a detailed explanation of these views for later in this chapter. For now, I will comment that positive attitudes of self-trust, self-esteem and self-worth seem to be required for self-authorisation because they entail that a person sees themselves as worthy, as a person who counts, and as one who can answer to and call upon relations of responsibility between themselves and others.

This last feature of self-authorisation, of being one who has social standing to answer to and call upon responsibilities with others, is what Mackenzie refers to as social recognition. The self-regarding attitudes of self-esteem, self-worth, or self-respect are dependent upon intersubjective relationships. Thus, as Benson similarly points out, Mackenzie claims that one's self-regarding attitudes are vulnerable to refusals by other people to grant recognition that one is "the moral equal of others" (2014, p 38) and that one is the source of views and claims that ought to be taken seriously. Mackenzie states that such recognition failures are "quite typical in social relations involving domination

or inequalities of power, authority, or social and economic status” (p 38). When consistently confronted with sexist or racist attitudes, which undermine one’s position as a legitimate source of opinion, ideas, and claims, one’s sense of oneself as being self-authorizing may suffer. The internalisation of non-recognition, Mackenzie explains, can corrode one’s sense of self-regard.

The conditions Mackenzie outlines here are internal attitudes that make self-directed action possible. Once one has the self-determination and self-governance to make self-directing decisions, it is a sense of self-authorisation that finally enables one to act upon them. Without a sense of oneself as being a recognised source of authority and responsibility, and being the kind of person who can hold others to account as much as one can be held accountable, self-directed action is not possible. If one cannot look inside to find the source of moral and decisional authority, then one will always be acting at the behest of others.

Moving forward with Mackenzie, minus Autonomy

Mackenzie has described three axes of one umbrella term, ‘autonomy.’ These three concepts are self-determination/ *social conditions and justice*, self-governance/ *competence and authenticity*, and self-authorisation/ *agency*. Using these, Mackenzie hopes to pack everything into ‘autonomy’ that is not there in other (liberal or libertarian) accounts. She wants each axis to be understood as important in itself, important in relation to the other two, and part of what makes up the concept ‘autonomy.’ On this account, self-determination and self-governance can be understood as abilities, while self-authorisation is an attitude. Self-determination appeals to external conditions, while self-governance and self-authorisation appeal to internal conditions. Relational theorists have pointed out the important interplay between internal and external conditions, and

attitudes and abilities, and Mackenzie's descriptions of the three axes highlight this.

However, with these descriptions and their interrelated functioning and development laid out, it seems to me that the umbrella term 'autonomy' is made obsolete, and that clinging to this term actually undoes, or permits us to forget about, all the work that Mackenzie has done to develop and articulate the three axis terms.

Mackenzie's account builds on work by relational, capability, and identity theorists to explain how paying attention to social structures reveals that these can develop or inhibit a person's ability to make and carry out the kinds of decisions that are self-directed, by undermining the development or exercise of certain skills and attitudes that are needed for such action. They have also shown us that social structures can impact agency, either positively or negatively, and influence a person's ability to trust themselves, to value themselves, and to see themselves as the kind of person who is authorised to make decisions and be held accountable for them. All of these important insights and understandings can be taken forward, without needing to hold on to 'autonomy.' Thus, I will leave off using the term autonomy in favour of the three distinct areas of self-direction that Mackenzie has identified.

A Note on Authenticity

Before moving on, it is interesting to note here that even if one decided to hang on to the term autonomy, authenticity can provide a critical point of view from which to consider its overall importance. This perspective is afforded because there is good reason to consider authenticity as something greater than merely a component of autonomy.

Though authenticity is important for self-governing action, it also seems possible to lead an authentic yet non-self-determining, or heteronomous, life.

Authenticity has been defined in various ways, but what seems to be agreed upon is that it points out something deep or important about a given individual. In Mackenzie's paper on autonomy and authority (2008) and in her more recent work, as mentioned above, Mackenzie endorses Christman's definition of authenticity, which involves non-alienation upon historically sensitive self-reflection. On this definition, a person can endorse or refuse certain facets of identity, values, or beliefs that have been thrust upon one by society, or accept some of these without endorsing or refusing them, but without feeling alienated from them. Even without complete endorsement, the lack of alienation from the values or beliefs that one finds oneself holding proffers self-acceptance, which is integral to developing a sense of *who one is*.

This view is consistent with a distinction pointed out separately by Natalie Stoljar (2013) and Amy Barnes (2014), which seems to echo Mackenzie's definition of integrity as one's conception of who one is and what matters to one (2008). Starting with the idea of being *one's own* person, which is central to most conceptions of authenticity, and the appeal this conception makes to the idea of a 'core self,' Barnes and Stoljar say that this self can be described as having two components:

- 1) Who I take myself to be, including those things that are most difficult to change about me and who I want to become
- 2) Those things that matter most to me

Rather than being opposed to each other, or alternative understandings, Barnes proposes that these two components are equally parts of one's core self, and that the notion of authenticity can make reference to either or both of them.

If it is the case that authenticity points to the most difficult things to change about who I am, the kind of person I want to become, or the things that matter most to me, then when someone is acting in a way that can be described as authentic we take their action to express important parts of their personal identity including deeply held beliefs, values and commitments. Though it may sometimes seem easier to see one's identity communicated through self-governing actions, communicating one's values and commitments does not seem to be entirely dependent upon the action in question being self-governing. Barnes argues convincingly that ascetics (monks and nuns) do not value, do not display, and do not desire to have a self-directed life. The actions that they perform in any day are determined by their superiors in the monastery hierarchy, and thus do not have features of self-determination. For the nuns in Barnes' monastery interviews, the rejection of self-determination is explicit, and a description of oneself as being 'autonomous' or 'independent' would be met with dismay and discomfort. However, these individuals display authenticity, in the sense that they are living a life and performing actions in accordance with their most deeply held beliefs and values — living a life that is very much *their own* and indicative of their personal identities — even while being heteronomous.

Interestingly, the nuns that Barnes interviewed display self-authorisation, considering themselves and others to be accountable for their actions, and being able to provide reasons for decisions or actions when requested (even interpreting the reasons behind a directive from a superior). While Mackenzie holds self-authorisation to be a separate axis from considerations of authenticity, Barnes describes an authentic person as one who leads a life that “coheres with my sense of who I am and who I wish to be,” and is able to

“provide reasons for why I wish to be this particular kind of person” (p 127). Even while eschewing personal self-determination, the nuns’ feelings of moral and personal agency were alive. Each nun seemed to see themselves as accountable for their own values and decisions, their own concept of a meaningful life, and their own personal system of beliefs within the Catholic tradition.

Once in the monastery, perhaps the only axis of Mackenzie’s account that seems to be paused is self-determination. In entering a life of heteronomy, the nuns in Barnes’ account did not lose the capability nor the motivational structures involved in self-governance, nor many of their self-authorizing attitudes. However, they did enter into a situation where the shape of their lives and careers were determined by others, and where they may not utilise or activate some of these capabilities, motivations, or attitudes. The life the nuns were called to, in dedicating themselves to contemplation or good works, is one in which daily routine, work assignments, and the path of one’s monastic ‘career’ (as in, being put in charge of a new monastery, or being promoted among the hierarchy of nuns, for example) are necessarily decided by others, even the Catholic god.¹⁷ Barnes says that attempts to circumvent this process, or displays of initiative and applying oneself independently, are met with disapproval and conscientiously avoided by the nuns.

Barnes’ work regarding the authenticity of people living monastic lives provides an interesting and refreshing salve to the dominant liberal idea that having ‘autonomy’ is all-important, and is what fills our lives with meaning. The nuns lead authentic lives, even though they are not leading self-determining lives. If this is true, then authenticity is something other than just a component of autonomy, and so even retaining the term

¹⁷ Barnes explains that one cannot actually choose to be a nun; one must be ‘called’ to it. There is a considerable amount of time allocated to newcomers, who may be confused or coming to the monastery for the wrong reasons, to figure out if becoming a nun is really their ‘vocation.’

‘autonomy’ might require a rethinking of authenticity, and the reformulation of answers to philosophical questions. In particular, questions about whether non-autonomous action can demonstrate important parts of who we are and which values we hold deeply may be answered differently if one accepts that authenticity is present and possible inside heteronomous contexts. This does not mean, of course, that environments of oppression and deprivation are not objectionable. The argument is not that having the freedoms and opportunities for self-determination does not matter at all, but that having this may not capture all the important parts of a good life.¹⁸ Living authentically may be of more importance to (some) people, both in terms of providing a sense of meaning and value for our lives, and in communicating to others who we are and what matters to us.

How Manipulation Impacts the Three Axes

As mentioned earlier, manipulation is considered by many theorists to be obviously wrong because “when a person is manipulated, deceived, or tempted their autonomy is being threatened” (Dworkin 1989, 60). Gerald Dworkin thinks manipulation, among other things, can interfere with free will. Being able to make seemingly free choices because of a lack of impediments to action is only a part of freedom; being uninfluenced in ways that alter a person’s will is just as crucial. Philosophers seem to largely agree that the use of manipulative tactics, by definition, infringes upon a person’s self-determination, self-governance, and self-authorisation because manipulation removes the voluntariness of decisions, thereby removing the freedom of will (Blumenthal-Barby & Burroughs 2012; Dworkin 1989; Guttman 1997; Wertheimer 1997).

¹⁸ Barnes argues that the nuns’ disavowal of ‘autonomy’ is not at odds with valuing it and promoting it from a human rights-based perspective, and says that, in fact, the nuns support widespread self-determination even though they give this up themselves.

Adopting Mackenzie's formulation of self-determination, self-governance, and self-authorisation can allow us to perceive the subtle and obvious ways in which manipulation impacts people on a deeper level than a discussion of free will permits. I have argued that we should leave the term 'autonomy' to the side, in favour of thinking with greater specificity about these challenges, and so I will provide arguments here about how manipulation negatively impacts people in each of Mackenzie's three axes. Rather than simply claim that manipulation is a kind of trampling of self-directed willing, however, I will continue to conceptualise manipulation as a contributor to oppression, and from this point of view manipulation raises different sorts of concerns with regard to key features of self-authorisation, self-governance, and self-determination. I have indicated already that I think the biggest problem with manipulation is related to self-authorisation. However, features of self-authorisation, self-governance, and self-determination have significant interplay, and manipulation leaves none of them untouched. As I think that manipulation has the greatest impact on self-authorisation, I will begin here.

Manipulation and Self-Authorisation

In the previous chapter, I argued that manipulative obesity campaigns contribute to the oppression of fat people. In thinking about self-authorisation I will extend this argument, focussing on the impact that manipulation has on important components of self-regard. In contributing to the oppression experienced by fat people, manipulative health messages undermine the development or exercise of self-trust and self-worth required for self-authorisation; oppression makes people feel like they are less worthy, and less competent (McLeod & Sherwin 2000). I will discuss self-trust, self-worth, and body image separately, as self-regarding attitudes that are important to self-authorisation.

i. Self-Trust

In her analysis of trust and self-trust, McLeod says that two components of trust are important to both interpersonal and reflexive attitudes: optimism regarding competence, and moral integrity (2002, p 36). One's ability to trust oneself hinges upon one's self-regarding attitudes of competence and moral integrity, and McLeod argues that self-trust and distrust are socially constituted; they are moulded to a significant degree by the responses of others towards us, and by societal norms (p 37). One has to think, and feel internally, that one is competent to make certain kinds of choices in order for one to trust oneself to do so. To gain the *attitude* that one is competent at something, rather than just the skill-set, one must have some amount of positive (or at least, not an abundance of negative) reinforcement from others. In cases of oppression, this may be missing from one's milieu. For example, public health messages that inform a fat person that most of the time they choose wrongly when eating will undermine this person's attitude that they are competent to make food choices. This may lead them to doubt themselves in this area of choice, or cause the development of self-distrust.

Moral integrity is likewise vulnerable to the beliefs and opinions of others. Being a person with moral integrity means in part that one takes responsibility for one's values, beliefs, and actions. Taking responsibility and being held responsible are essentially social and interpersonal phenomena (Benson 2000; McLeod 2002). So, McLeod argues that the reflexivity of self-trust means that people who are self-trusting must take responsibility for meeting relevant commitments, which puts self-trust in a different light than trust of others; whereas we must simply be optimistic about another person's moral integrity in interpersonal trust, self-trust requires actively taking responsibility.

McLeod argues that rather than requiring a list of necessary and sufficient conditions to determine what trust is or who is trust-worthy, people utilise prototypical concepts. A ‘prototype’ is an idea from cognitive science, and is a “kind of artificial exemplar that combines the statistically most salient features of exemplars of the same class to which the subject has been exposed” (p 13). This approach to trust, and to other philosophical concepts, is appealing insofar as in day-to-day life one rarely reasons from a list of necessary and sufficient conditions; rather, we expand our existing concepts to meet experience. However, the source of our prototypes is a political question, as socially dominant groups will likely create and represent prototypes of many virtues – trustworthiness, beauty, success, intelligence, responsibility, achievement, etc. – as part of their privilege.

Thus, McLeod argues that one barrier to knowing oneself and to trusting oneself well is the distortion of one’s prototype for trust by oppressive stereotypes (p 75). For example, if the prototype of a trustworthy individual is depicted as being slim, self-controlled, and professional, among other aspects (which might include maleness, whiteness, heterosexuality, and other things) then the ways in which one differs from this prototype will challenge one’s sense that one is trustworthy. One’s prototype will stretch to fit new cases where important similarities exist — some features of a prototype will be more salient than others — so one may have some differences from the prototype and still see oneself as trustworthy. But, sometimes people will be told that they are different in significant ways from the prototype, and thus do not fit the description. In manipulative anti-obesity campaigns for example, people are depicted in ways that suggest that they ought not trust themselves, because they differ significantly from the

prototype of trustworthiness. In these campaigns, fat people are rarely depicted as self-controlled or professional; rather, fat people tend to be stereotypically portrayed as falling prey to cravings or inattentive consumption, and are never portrayed in professional roles or attire. These messages tell fat people that they do not match with the prototype of trustworthiness, and so undermine feelings of self-trust.

So, McLeod says, “oppressive trust prototypes often encourage people who are oppressed to distrust themselves where self-trust is warranted, and to trust others who neither have their best interests at heart nor the knowledge to be able to say with authority what their best interests are” (p 76). Public health anti-obesity campaigns provide an interesting case for this claim, because we could admit that public health agencies do see themselves as acting in ways that have the public-qua-individuals’ best interests at heart, and they do operate as if they have the knowledge of what those interests are. We could also recognise, however, that public health agencies may misinterpret the best interests of some groups some of the time, or choose means for meeting these interests that perpetuate oppression, albeit unintentionally. Manipulative anti-obesity campaigns are one such case of misapplied public health interventions, though they may have been conceived with the best intentions.

ii. Self-Worth

The idea that a certain sense of worthiness is important for self-authorisation has been noted above, as a worthiness of being trusted. A sense of worth is also required for moral integrity, or responsibility. As I introduced in Chapter 4, according to Paul Benson, moral integrity concerns one’s worthiness to give account of one’s actions to others (2000, p 81). An attitude of moral responsibility supposes that one is worthy of a certain social standing (p 79), and is a kind of social recognition. Being responsible is a reciprocal

position; one can be responsible and be held responsible, and can hold others responsible in turn (p 78). To hold or be held responsible is a position among people of equal worthiness to account for their actions; if one is at a higher or lower social position than another, one will either feel no responsibility to account for oneself, or a lack of ability to do so, respectively.

Since we know that not everyone in a society is considered equal, or is afforded equal recognition and social standing, Benson says that a person's sense that they have lost (or perhaps never had) full standing in the moral community "will bring a change in their attitude toward their worthiness to disclose values and commitments to others through actions" (p 78). Benson postulates that one may not feel self-worth sufficient for responsibility partly because "any efforts [a person] might make to speak for their own actions would be perceived as transgressing established demarcations of social status, and so would simply not count morally" (p 80). Being held responsible for one's actions or beliefs implies that one is considered equal and that one's reasons for doing or holding these actions and beliefs could be accepted as reasons, even if they were disputed. However, one must recognise one's opponent to be worthy to dispute their reasons.

As explained in the previous chapter, a mutually respectful context is implied in holding and being held responsible; thus, if one party is not considered fit to account for themselves, there can be no exchange of ideas, and therefore no position of responsibility for one's actions or beliefs. So, a person who realises that they are not afforded the same standing as others may feel a lack of worth, and this could gain expression through that person's self-regarding attitude that their values are not worthy of disclosure, or their commitments not the correct ones to act upon.

Not only can one's internalisation of oppressive social norms undermine one's sense of worthiness to be held responsible, it may also impede one's sense of worthiness to behave authentically, for reasons and upon values that are *one's own*. Fat people (among others) may be considered by privileged social groups to be "incapable of the kinds of moral sensitivity, reasoning, and self-control that would warrant their recognition as fully accountable agents" (p 80). For people who have internalised the prevailing norms of such a society, an attitude of low self-worth "will be one element of the broader lack of moral self-respect, the failure to recognise their fundamentally equal moral worth as persons" (p 80). This, Benson and McLeod agree, may lead people to have grave doubts about their own competence as moral agents, and, I would add, self-authorizing actors.

iii. Body Image

Manipulative messages from public health contribute to these doubts in a variety of ways. Campaign posters or videos that attack certain kinds of bodies by displaying them as undesirable or ill may undercut feelings of self-esteem based on body image. As I have argued, our sense of self-worth, self-trust, and other kinds of self-appreciation are shaped socially, by what others think and say about us (McLeod & Sherwin 2000). We perceive how others see us through the way we are treated, and through how others that we think are like us are treated or depicted in various media. Women's value is especially tied to appearance, which has oppressive results for all women (McLeod & Sherwin 2000, p 269). Depictions of people who we perceive to be like us in flattering or unflattering ways will inform our self-conception and our sense of the social positions we occupy. Thus, public health anti-obesity campaigns that show fat people in stereotypical or stigmatizing contexts may lead fat people to perceive their own worth and status as less

than people who ‘accurately’ express certain prototypical concepts, whether that is ‘healthy,’ ‘trustworthy,’ ‘responsible,’ ‘successful,’ or other such ideas.

Many of the campaigns in Chapter 1 seem to use stereotype or stigma to make people feel bad about their bodies or behaviours, to encourage change. One of the by-products of these efforts, I have argued, is shame. In the philosophy of emotions, feelings of guilt are associated with actions, while feelings of shame are associated with our nature; something discloses a flaw in who we are when we feel shame (McLeod 2002, p 43). This shame could be related to those deep conceptions of ourselves that are important to authenticity: those things that matter most to me, or those things about myself which are most difficult to change. In some situations, those parts of ourselves may not match well with social understandings of what people ought to be like or care about, even when we have internalised these understandings. As Stoljar points out, shame is the result of a sense of failing to live up to the norms that a person takes as applicable to them (2000, p 109). Feelings of shame could not be compatible with self-authorisation in a long-term sense. Self-authorisation, including self-regarding attitudes of trust and worth, could perhaps withstand momentary feelings of shame, but when shame becomes an everyday position because of a deluge of messages from the broader society that one is somehow deeply lacking in one’s very nature, the self-regarding feelings that make self-authorisation possible may be impeded and undermined.

Manipulation and Self-Governance

My discussion of self-authorisation has foreshadowed some of the ways in which manipulation impacts self-governance. Many philosophers have objected to manipulation as it interferes with self-governance (though they often use the term ‘autonomy’ to express this). I argued in Chapters 3 and 4 that manipulation is normative insofar as a

person is attempting to change another's behaviour based on a particular view of that person's best interests or welfare. Such an action may be an obstruction of self-governance, in that it blocks the expression of authentic choices by the person subject to manipulation. Mackenzie argues that self-governance involves having a certain set of skills or capacities that make it possible to choose and act in ways that are expressive of one's values, commitments, and identity. Self-governance thus involves conditions of competence and authenticity, which will be treated separately below.

i. Competence

Competence involves the development of certain skills, including cognitive skills, emotional skills, and communicative skills. As mentioned above, a person needs the conditions that foster the development of such skills and the opportunity to practice them to gain competence. In bypassing one's reasoning capacities, manipulation interferes with one's ability to consider all options and threatens one's ability to act in accordance with preferences of one's own (Blumenthal-Barby & Burroughs 2012).

One's ability to choose and choosing for one's own reasons are closely connected in these criticisms of manipulation. In a case of self-governing choice, we may assume that an agent has been presented with options among which to choose, and maybe with some reasons for choosing some options over others, and through the employment of various skills related to the decisional process, the person has made a choice that best fits with their values, beliefs, and commitments, among other reasons that might range from pragmatic to idealistic. This situation describes a persuasive, and ultimately, respectful process. In a case of manipulation, this respect is absent. Manipulation interrupts the choosing process by substituting a decision made by someone else, thus one has not arrived at the choice on one's own. In so doing, one's competence to make certain kinds

of decisions may suffer; one's critical thinking skills may not develop if one is usually manipulated into making selections, or one may not become adept at communicating their values because one has not had the opportunity to practice doing so.

Communications, especially from public health agencies, ought to treat the audience with respect, which manipulation does not do. As I stated in the discussion of self-authorisation, manipulation does not address people as equals within an exchange of ideas, who enter a discussion from a particular perspective and with their own goals, values, and commitments. Rather, it bypasses rational processes to supplant a person's reasoning with a set of ideas determined by others. In treading upon a person's ability to self-govern in this way, manipulation treats people without respect; manipulation disregards the agent and prevents or diminishes their ability to choose for themselves (Rossi & Yudell 2012). Thus, manipulation may disrupt important skills for self-governance from being practiced or developed.

ii. Authenticity

Even if one has managed to develop the skills for self-governance in an environment of frequent manipulation, one may not have the opportunity to make choices for reasons that are *one's own*, either in that they express what matters most to one or in that they express important parts of who one is. Manipulation may prevent one from expressing one's own values by substituting the values of others. A substitution of values or beliefs (e.g. that one's worth is tied to appearance, rather than that one is inherently worthy) is a common trait of oppression, and the internalisation of these values leads philosophers to question the ability for an oppressed person to make authentic decisions. For example, Stoljar (2000) discusses the 'feminist intuition' that because some choices that women make are attributable to the gender oppression under which they live, these choices cannot be

considered authentic to them (and, therefore, not autonomous). The oppression of women interferes with their self-governance to the point that they may not be able to choose paths unsanctioned by the patriarchy, or that doing so would cause significant internal distress, social ostracism, or alienation.

As I am committed both to feminism and pluralism, I struggle with the feminist intuition; it is difficult to acknowledge both that a wide variety of life paths are valuable and can be authentically chosen, and that some choices may be less autonomous because of the influence of internalised oppression. Rather, I hold the position that authentic choices can be made, despite the existence of oppressive messages that may become internalised. Manipulation, as I have conceived it, is only one component of systematic oppression. The worries about authentic choosing within oppressive systems are important, but the observation that people can and do resist oppression demonstrates that oppression is not an automatic cancellation of one's ability to self-govern. Further, I suspect that a person may be able to authentically choose what they would otherwise be manipulated toward, and that in such a case a person would be able to provide self-originating reasons for their choice if they were asked.

The possibility that a person may choose something authentically which they would have been manipulated toward anyway causes a frisson of discomfort for philosophers. One may want to say, like Frankfurt does, that this situation is problematic because this person's will is overdetermined (Stoljar 2013). They could not, really, have chosen otherwise, because part of their desire to choose this way came from something outside of individual control. In my view, this may not alter the authenticity of the choice from the subjective perspective. On Christman's description of authenticity as reflective self-

acceptance, even though parts of one's self — what matters most to one and who one takes oneself to be — are formed by various social factors, including privilege and oppression, it is possible to deeply hold some values as important to one even though they have been engendered in one through upbringing and other social experiences. Without imagining people to be like mushrooms, as Hobbes does, we ought to accept the 'thrownness' of each person, and that one will simply find oneself holding certain values and beliefs. As long as one does not feel alienated upon consideration of the values one finds oneself holding, then we can accept expressions of these values as being markers of authenticity. Therefore, if one can give reasons for a decision that are one's own, in that the reasons express deeply held values or important parts of who one is, then we can acknowledge the authentic source of this decision even if one may have been manipulated toward it as well.

The impact of oppression upon one's self-authorisation may spill over into one's self-governance, and one's self-determination as well. This is because a person may come to doubt the legitimacy of their values and beliefs as sources of action. Some illustrations of this come from a set of cases in the feminist literature. For example, an oppressed person may have a clear sense of what matters to them, but also become convinced that this is wrong or perverse. This kind of case is described by Paul Benson in his example of Charlotte, a woman who knows that she does not like family life and wants to become an artist, but who is convinced that these preferences are signs that she is mentally unwell (2000). Another kind of case is described by Thomas Hill in his example of the deferential wife (1973). In this case, a woman may not develop a sense of what matters to

her and fail to form her own preferences, so she accepts what she thinks ought to matter from other people.

It may be the case that, although some choices can be authentically made and happen to coincide with the choices one would otherwise be manipulated toward, when one feels that the majority of one's commitments are not worthy of being acted upon or when one adopts the majority of one's views from other people, one's sense of authentic selfhood has been drastically interfered with. It is important to stress that being authentic in one's choices does not mean always having to oppose the mainstream; however, it is an important part of authenticity that one feels that one has reasons of one's own for doing what one chooses to do. So, manipulative messages that contribute to oppression and a person's feelings that their beliefs are not sufficient for action, or that these messages should be adopted in place of other beliefs, undermine a person's ability to discover what matters most to them, and thereby form authentic desires.

Manipulation and Self-Determination

According to Mackenzie, self-determination is about having the freedom and opportunity to make choices about one's life – who to be, what to do, etc. Noting that manipulation contributes to oppression in the previous chapter, I have also pointed out how the oppression of fat people limits their opportunities and life chances. Fat individuals have their options limited by others, and may also limit themselves in the development of life goals because of the effects of oppression. These effects include coming to believe that the goals one has for oneself are inappropriate or unachievable, that one is unable to reach one's goals or achieve certain dreams because one is not 'good enough' or is undeserving. The intersection of manipulation's effects on self-authorisation, self-

governance, and self-determination are made clear here, because if one does not see oneself as being worthy of success, one may simply not set goals or try to achieve them.

i. Goals

As was touched upon above, one's decisions to pursue some goals instead of others may be altered by manipulative influence. One may come to see one's goals as being unworthy of pursuing, or one's goals may be completely supplanted by the goals of another when one is manipulated. For example, manipulative anti-obesity public health campaigns communicate to people that there are certain body-related goals that they ought to be pursuing, even if this kind of goal was not something that they had previously worried about. These campaigns encourage people to adopt goals (e.g., body weight goals) that they may not have otherwise had. As some scholars have pointed out, through these messages, public health encourages fat women to disavow their bodies and others with bodies like theirs, and to adopt the dominant view of what an attractive female body looks like (Bordo 2003; Meyers 2000). Because of the manipulative, or propagandistic (Stanley 2015), way in which the goals are presented, not as propositions but as obvious truths not up for debate (e.g. it is simply true that one must be slim to be healthy, or it is simply true that fat causes illness), the option of not adopting these positions is barely live.¹⁹

ii. Freedom to do Otherwise

This leads to an important consideration of how manipulation might limit freedom in a particular way: namely, does manipulation permit people the freedom to do otherwise, not as a function of oppression, but through its own nature? This is a difficult question. I

¹⁹ Clearly public health is not the only sort of agency that promotes body goals to people, but I think that we must question public health's adoption and promotion of such goals. More will be said about this in the following chapter.

have been characterizing manipulative anti-obesity campaigns as contributors to oppression, but it is also true that manipulation happens outside of oppressive systems. Manipulation can happen in interpersonal relationships, and in messages from many different kinds of organisations. Presumably, in cases of manipulation (as contrasted with coercion) one always has a kind of choice to make; manipulation obscures the choice and makes it more difficult to see, but it is there nonetheless.

I argued in Chapter 3 that because coercion typically requires the imminent threat of harm, it was not a property of communication as such. The purpose of the threat of harm in coercive circumstances is to essentially force a person into a particular course of action – a mugger forces their victim to give up their wallet by using the threat of shooting them with a gun, and so we say that the person did not really have a choice in this circumstance. However, it might be the case that in manipulation, even though there is no immediate threat of harm, one is left without a real choice to make. It seems like manipulation may sometimes lead people into a decision without them noticing. When manipulation circumvents reasoning, it takes one by the hand and brings one to a decision that one may not have a recollection of arriving at later. Manipulation does this by appealing to certain powerful feelings, like fear or shame.

Manipulation is not like brainwashing, though, and it would be a drastic overstatement to suggest that everyone who is exposed to a manipulative message becomes a zombie in search of whatever the message was about. Manipulation is subtler and more insidious than this; by plucking upon the strings of cultural beliefs, stereotypes, or fears, manipulation leads one to believe certain things to be true, and to act accordingly, without critically evaluating the messages for truth or bias. An attentive and

critical person, therefore, could do otherwise than follow the suggestion of a manipulative message. It may be the case, however, that people are often uncritical when receiving certain messages, especially when these come from a ‘trusted’ source, such as a public health agency.

Thus, the answer to whether manipulative messages permit the self-determining freedom to do otherwise does not seem clear. While some people may be more critical of messages they are exposed to, it seems to me that the authority of the source of a manipulative message confounds a person’s ability to evaluate it. When a manipulative message is sent by an agency that one is used to trusting and listening to, like a public health body, one may not be on one’s guard against the influence of such a message. This trusted position and its responsibilities must be examined further in the following chapter.

Conclusion

In sum, manipulative public health campaigns undermine the self-efficacy required by members of their audience to enact the behavioural changes that public health desires and promotes. Given the harms of manipulative campaigns outlined in Chapter 4, and the arguments here about the deleterious impact that manipulative campaigns have on the ability of agents to implement the behaviour changes that public health recommends, it seems clear that manipulative campaigns are immoral and self-defeating. I have argued here that manipulative anti-obesity campaigns undermine people’s abilities to develop the skills and attitudes necessary for self-determination, self-governance and self-authorisation. They do this in a variety of systemic ways, undermining people’s self-regarding attitudes, and placing social barriers in the external world as well.

These appear to be strong moral arguments against the use of manipulative public health campaigns. In the next chapter, I will propose that, given the role and

responsibilities of public health, the use of manipulative campaigns is incoherent. This chapter and the preceding one have demonstrated that these campaigns undermine the ability to make choices to improve one's health. In the next chapter, I will argue that they also undermine public health's stated aim, to promote equity. Thus, these campaigns are counter-productive to public health in two ways. I will also point to a constructive direction for public health's endeavours regarding obesity, focussed on regulation.

Chapter 6

The Roles and Responsibilities of Public Health

As recently as the spring of 2016, ethicists and policy-influencing bodies were calling for the creation of anti-obesity public health campaigns as an effective and responsible tactic to address high rates of obesity (Bayer and Fairchild 2016; Standing Senate Committee 2016). In the previous four chapters, I examined such campaigns and highlighted ethical problems within them. In this chapter, I will focus on examining the role and responsibilities of public health, and whether or not the creation of (manipulative) anti-obesity campaigns coheres with these. For much of this argument, I will discuss the public health agencies that operate as part of governments. This is because governmental public health agencies are vested with authority, have access to state powers and democratic mechanisms, and hold related responsibilities, in terms of the kind and range of health-related issues under their remit and moral obligations to the agents that make up the citizenry, that other kinds of public health groups may not have. However, there are many different kinds of public health actors, including international non-governmental agencies, that hold important public roles and influence, sometimes stepping in where state governments are absent, and some of what I argue in the following may apply to them as well.

Public health agencies, and the practitioners within these agencies, often describe themselves as engaged in equity-focussed endeavours. In Public Health England's (PHE) strategic remit and priorities letter for 2017-18, Member of Parliament Nicola Blackwood states that PHE "fulfils the Secretary of State for Health's statutory duties to protect health and address health inequalities, and executes the Secretary of State's power to

promote the health and wellbeing of the nation” (Blackwood 2017, p 1). Likewise, the Nuffield Council on Bioethics writes that public health involves “the collective efforts of all parts of society..., [and] should contribute to generating and supporting measures that improve the health of all. The role of the government is to provide certain key services that... operate in a way that is compatible with promoting population health and reducing inequalities” (2014, p 8). Even when public health practitioners have philosophically unclear conceptions of health equity, many describe their work as primarily concerned with achieving this (Smith 2015).

The literature around public health ethics suggests that there are certain characteristics of or contributors to disease that make them suitable targets for public health intervention: 1) the disease characteristics or contributors disproportionately affect the worst-off in society, 2) they result from a lack of or failure in health-protective community-based systems, and 3) they cannot be effectively addressed by individuals alone, but require collective interventions (Chaufan et al. 2015; Dawson 2011; Friel et al. 2015; Freeman 2007; Reid 2016; Voigt 2010). On a conceptualisation of public health as being centrally concerned with equity, these characteristics seem plausible, and could be used constructively to delimit the purview of governmental public health endeavours. Furthermore, these characteristics indicate that the aim of public health in its various activities is to mitigate disease factors among the least well-off in order to increase the population’s overall health. Public health’s central responsibility in doing so is to secure certain background social conditions that permit the flourishing of a population, which provide a baseline for the achievement of individual levels of health-related capabilities. In combination, the aim and the responsibility of public health mean that achieving and

promoting social justice is the primary concern for public health activities, though it may seldom be recognised as such.

If the foregoing is true, then there are at least two reasons to think that public health organisations are not acting in a way coherent with their aims, nor delivering on their responsibilities, when they create the kinds of anti-obesity campaigns discussed in this dissertation. The first reason is conceptual: public health's ends can only be achieved through collective action, so initiatives at the systems level, rather than at the individual level, are required to address rates of obesity, or indeed any public health issue. What I mean by 'individual' and 'systems' levels throughout this chapter is the locus of action for an initiative. The primary focus of public health, as stated above, is upon those kinds of interventions that individuals cannot achieve by themselves, perhaps because they require a level of coordination, enforcement, or regulatory intervention not possible by the action of individuals on their own. The achievement of certain collective goods requires these kinds of collective activity. Public health initiatives that target, for example, infectious disease control, or food production and provision, are systems-level interventions, where improvements to the conditions for good health achieved by the intervention will impact the population in a systematic and collective way. Public health interventions that focus, for example, on the provision of information at point-of-sale (like calorie postings on menus), or altering choices at the consumer level through 'nudges' or the like, are individual-level interventions. Reactions to these public health interventions are left to the individual and will happen on a one-person-at-a-time basis, unless a corporate response is triggered.

The second reason to argue against the creation of anti-obesity campaigns is that they are just the type of intervention that falls afoul of public health's responsibility to enact systems-level initiatives. If the foregoing description of public health is correct, then it follows that agencies ought to look past non-regulatory individual approaches, such as campaigns, to instead address failures of health systems and the distribution of important health-related goods across the population. Campaigns are an example of the kind of intervention that operates on a one-person-at-a-time basis, encouraging each person to change how they act or make decisions, without addressing the conditions of the world in which they act. The 'downstream' point of intervention of anti-obesity campaigns is the wrong place for public health to focus on effecting change. Public health interventions at 'upstream' points are the more appropriate level of intervention, by addressing social or environmental conditions that could change the conditions of life for the worst-off in a society, ultimately improving the health of everybody.

To reiterate, first, public health aims can only be achieved collectively, and second, systems-level interventions (rather than individual-level interventions) are coherent with the expressed values of public health and its practitioners. In what follows, I will begin by considering how we should understand the 'publicness' of public health, and will then discuss the first and second reasons to object to the creation of anti-obesity campaigns given the role and responsibility of public health. At the end of the chapter, I will respond to two liberty-based objections to my position.

The 'Public' in Public Health: Collectives, Justice, and Capabilities
Angus Dawson (2011) asks whether we can capture the 'publicness' of public health via accounts of human flourishing and capabilities, and I think we can answer in the

affirmative. This is in part because we can understand members of a community to have collective interests in goods and harms (Dawson 2011), many of which directly and indirectly impact individual well-being, and in part because we can understand public health to be one of a suite of government agencies responsible for providing access to and material requirements for the development of fundamental human capacities and functionings (Kass 2001; Powers & Faden 2006). Dawson (2011) provides examples of a number of different kinds of interests – congruent, convergent, and common – related to health, in which people require certain conditions to be true to achieve their private goals. So, herd immunity through vaccination (convergent), water treatment and sewage systems (congruent), and low rates of HIV in the population (common), are all interests that people share on the basis that these background conditions allow each person to be better able to obtain their own desired goals (Dawson 2011). Public health is charged with securing these background systems-level conditions, among others, that permit the flourishing of the population as a whole, and which provide the basis for individual levels of health-related capabilities (Kass 2001; Powers & Faden 2006).

Though some would disagree (e.g. Epstein 2003), there is wide agreement among academics and public health professionals themselves that one of public health's purposes is to promote equity of health for members of a community. The meaning of 'health equity' and how public health should aim to achieve it has been a topic of some debate (summarised in Smith 2015). Some of the main points of argument focus around the notion that 'equity' is a term relating to the justness of distributions, and achieving equity of health states is complicated due to the variety of heritable and accidental differences in human functioning (Smith 2015).

Public health measures disease rates in populations using epidemiological research, observing the overall rates of disease in groups, rather than observing individual-level instances of illness or other differences in general health states (Verweij & Dawson 2007). Public health uses this data to track the rates of disease, and to identify where and among whom instances of disease are particularly high. Hence, public health is able to measure whether and by how much certain disease factors disproportionately affect the worst-off in society, allowing the redress of inequities resulting from systemic and distributional failures that lead to higher rates of disease among particular groups (Chaufan et al. 2015; Friel et al. 2015; Reid 2016). Public health thus has the ability and the incentive to address disadvantage, by improving capacities and avoiding further inequities, in order to achieve and maintain gains in the health of the entire community.

Due to the unique positioning of public health to identify and address disadvantage in a society, Bruce Jennings (2015) argues that public health is concerned with a ‘sensitivity of place.’ Jennings means by this that public health should enable people to dwell in an environment conducive to health and to justice. Public health plays an important role in setting up conditions conducive to and likely to achieve justice, he argues. This is and ought to be one of the root motivations for public health actions because health is instrumentally valuable insofar as each person requires a certain level of health in order to achieve other goals. As Amartya Sen said, “health is freedom enhancing, by expanding our actual capability to do what we may have reason to do” (as quoted in Womack 2012, p 223). Deeply disadvantaged people, who lack the basic opportunities of health, functional education, gainful employment, or economic and social security experience “varieties of unfreedom” (Sen 1999). Personal freedom is inextricably linked to the

flourishing of others, and so mutuality of concern and respect, or solidarity in matters affecting health, are the kind of common interest best supported by collective interventions (Jennings 2015; Powers & Faden 2006; Sen 1999).

This may be why some accounts of justice place special importance on health, health care or the social determinants of health, indicating that a special moral obligation may exist to prioritise these over other goods (Smith 2015). Lynette Reid (2016) argues that it is a normatively significant fact about our world that deficits in one or more areas of the social determinants of health may lead to deficits in other areas. This creates what Jonathan Wolff and Avner De-Shalit call ‘clusters’ of interconnected sources of disadvantage (2007). When conditions or factors for disease are correlated to states of disadvantage in a society in which some groups suffer directly as a result while others do not, distributive justice would demand that the society take action to remedy these discrepancies, and, as Wolff and De-Shalit say, ‘decluster’ the disadvantage (2007). Rather than level everyone down to a state of equal disadvantage, a society with the means to do so (as are the societies in which the anti-obesity campaigns discussed in this dissertation appear) ought to endeavour to close the gap between social groups by improving conditions for the worst-off, so that disadvantages do not cluster around specific groups but are more evenly shared among groups. Responsibility for doing this lies partly with public health agencies, insofar as they are vested with the democratically-derived authority and power of government, as well as with other government branches, like education and housing. This is especially the case when these conditions would resist individual remediation and in which people are facing deep disadvantage. Understanding how inequalities cluster helps us to identify the disadvantages that public health most

needs to address (Reid 2016). This would have the impact of improving conditions for everyone. Crucially, as I will discuss later in this chapter, disadvantageous conditions for some lead to reductions in flourishing for all. Thus, we have a collective interest in reducing inequities and disadvantage.

The Need for Collective Action

In this section, I will argue that public health's ends can only be achieved through collective action. Systemic interventions, rather than individual-level actions, are necessary to remedy high rates of obesity and, more generally, to improve the health of entire populations. First, though, I will discuss the trend toward individual interventions that public health agencies seem to have joined, even while most practitioners recognise that these do not address the deeper causes of poor health. In the ethics of public health, a distinction between 'narrow' and 'broad' public health, or 'old' and 'new' public health has been gaining attention (Bell et al. 2011; Epstein 2003; Pratt 2014; Rothstein 2002; Verweij & Dawson 2007). In the distinction created by contrasting 'old' and 'new,' or 'narrow' and 'broad' public health, the terms 'broad' and 'new' are often used to label a perceived shift in the aims of public health activity. This shift takes public health away from the 'traditional' work that would typically include things like infectious disease control, sanitation, and a focus on disease-vectors, toward 'non-traditional' public health work, with a focus on personal health risk, lifestyle factors, and their connection to individual behaviours (Bell et al. 2011; Epstein 2003; Pratt 2014). For example, 'new' public health work is characterised as (inappropriately, to some) focussing on the so-called modifiable risk factors for non-communicable diseases (World Health Organisation 2015). As such, a focus on smoking, alcohol, eating habits, and physical

activity — a collection of alleged lifestyle choices — has developed, with increasing focus on individual behaviours and responsibilities.

The shift in public health attention toward matters of individual health behaviours coincides with a similar shift in policy developments. As discussed in Chapter 2, the Marmot Review Working Committee has termed this ‘lifestyle drift,’ which is “the tendency for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors” (Hunter 2009, p 3). In tandem with the shift towards the ‘new’ public health, lifestyle drift has taken place over a number of years. It coincides with the current low-intervention political climate in many of today’s advanced democracies, reflecting long-standing anxieties about personal liberty, where worries about (unjustified) interference with individual choices about self-regarding health behaviours have been paramount (Owens & Cribb 2013; Wilson & Dawson 2010).

Some authors employing the old/new public health distinction take the position that interventions should be restricted to ‘old’ or traditional public health concerns like safe water, sanitation, infectious diseases, and safe food (e.g. Epstein 2003). Some of the arguments against ‘new’ public health activities are motivated by worries about the government overstepping its boundaries, and interfering inappropriately with people’s liberty (Anomaly 2012; Epstein 2003; Moore et al. 2015; Pratt 2014; Wiley et al. 2013). The foundation of these arguments is that ‘old’ public health interventions, and any impact these had on the liberty of individuals, were somehow more appropriate and/or legitimate for addressing communicable diseases, which represent harms to ourselves and

others, or failures of important community systems or infrastructure that can provide protection from such diseases. This is contrasted with ‘new’ public health interventions, which these authors argue address individual choices, which are not communicable nor caused by traditional disease vectors, and therefore less appropriate or legitimate targets of public health intervention.

Mark Rothstein (2002), for example, says that, unlike with ‘old’ public health measures, where public health can exercise its police powers (like quarantine) to protect people with some level of legitimacy, people’s failures to undertake ‘new’ public health measures do not put the health of other people at risk, and so may not justify public health interventions that restrict people’s liberty. This way of viewing public health interventions – should public health, or should it not, interfere with the liberty of community members in order to secure a collective interest – at the least inappropriately prioritises individual liberty over other values (Wilson & Dawson 2010), and leads one to imagine that individuals must be on guard against an increasing amount of interference by public health.

Rothstein’s view, and those like it, assumes that threats to liberty are more important than threats to health that might come from social conditions. Onora O’Neill observes that an obsessive focus on individual liberty may actually result in a negative impact on the health of the public (as referenced in Dawson 2011). Additionally, if we give justice (and possibly other values) as much weight as individual liberty, we can see that the claim that there is a distinction between ‘old’ and ‘new’ public health activities is a false dichotomy. If we set liberty aside for a moment, and consider a ‘traditional’ public health concern, such as sanitation, from the perspective of promoting equity, we may see that it

shares commonalities with ‘new’ public health activities. To illustrate, where disadvantage (poverty) is linked to a disease (cholera) resulting from lack of access to an important resource (clean water), then providing a systems-level solution to address disadvantage (a sewage system and clean water source in poor neighbourhoods) instead of individual interventions (boil-water advisory or cholera-awareness campaign) more effectively achieves collective well-being, though it may represent a greater infringement upon liberty (the introduction of rules and regulations). ‘Traditional’ public health activity is concerned with securing equity of health-related functioning by promoting and protecting collective well-being at some cost to liberty, just like ‘new’ public health interventions. Public health’s involvement in supplying sewage and clean water is not solely dependent upon the communicability or mode of action of a disease. Rather, it is dependent upon the community-based nature of the issue and the impact it has on people; sanitation cannot be achieved by individuals, but the lack of it has devastating impacts on individual and community health, thus it has to be a collective undertaking.

Obesity, and the World Health Organisation’s modifiable risk factors for disease, similarly require collective action, because these cannot be addressed solely by individuals, and the systems failures that give rise to them are damaging to the community as a whole. The framing of modifiable risk factors as ‘lifestyle’ diseases, because of an apparent link to individual choice, is dependent upon viewing something like population rates of obesity as non-systemic, and placing it opposite the ‘old’ public health issues like sanitation. In this vein, Jonny Anomaly (2012) argues that obesity is not necessarily a public health problem, even though reducing obesity may be a public good. He argues that the language of emergency, through the use of terms like ‘epidemic,’ is

misapplied to obesity, in part because fatness is not contagious, and does not spread via typical disease vectors. Obesity, he says, is neither unpredictable nor indiscriminate. The use of the word ‘epidemic’ or ‘public health crisis,’ he argues, are applied hyperbolically “to gain sympathy for politically controversial goals” (2012, p 218). In arguing that we ought to give individual liberty priority, Anomaly positions obesity to be directly the fault of the person who is fat. Thus, public health does not have the responsibility nor the authority to overstep individual liberty and act on obesity, though it may be the case that the public would benefit from such action.

While I also hold reservations about whether obesity should be labeled as an ‘epidemic,’ it is because I think that applying this term is more stigmatizing to fat people than the alternative of not applying it. Furthermore, while ‘obesity’ is the medical language for a disease-state related to fatness, it is commonly applied in public discourse to the simple bodily state of being fat, even when the fat individual is well (and even if they are not technically in the ‘obese’ range of body fat). This, too, leads to misunderstanding, stereotyping, and stigma, which I have dealt with in previous chapters.

More pressingly, however, I disagree with Anomaly that obesity is not a public health problem, because the contributors to obesity are systemic and have roots in unpredictable and indiscriminate inequities that have important impacts on health. Population rates of obesity show a socio-economic gradient, and result from a complex network of economic and educational disadvantages, in combination with the system of food production, transportation, advertising, and provision, as well as changes in the working and built environments, among other things (Chaufan et al. 2015; Farrell et al. 2016; Friel et al. 2015; Green et al. 2015; Standing Senate Committee 2016; Warin et al. 2015). Thus,

obesity is partly the result of systemic and distributional failures like other public health problems. In fact, mounting evidence suggests that obesity cannot be addressed individually nor via individual choices alone, but must be addressed at multiple levels of social systems (Dawson 2011; Standing Senate Committee 2016; Womack 2012). When the causes of behaviours that contribute to a disease are not just the result of an individual's choice, but are constrained by a variety of conditions outside of individual control, then it may not be appropriate to attribute responsibility for the consequences of "choices" to individuals in any meaningful sense (Dawson 2011; Powers & Faden 2006). This is certainly true of obesity, and its myriad contributors.

Additionally, obesity can have real health and social consequences for people, and these people tend to be subject to multiple sources of political and social oppression that remain concealed by the view that obesity results from individual behaviour (Chaufan et al. 2015). As I described in Chapter 5, fat people are subject to marginalisation in the workforce, features of cultural imperialism such as stereotyping and Othering, and to the distortion of responsibility that simultaneously blames them individually for being fat and removes their power to explain or present reasons, values, and goals. Public health anti-obesity campaigns contribute to the distortion of responsibility because they tend to address the public qua separate individuals, rather than as an interconnected group. That is, public health agencies focus on attempting to motivate individuals to change their choices. This places the responsibility for change on the individual themselves, and obscures the constraints upon their choices. Obesity is better understood as a public health responsibility needing a collective response. In the next two sections, I will present some challenges to public health's endeavours in this area to date.

i. Public Health in A Political Climate of Individualism

There may be a tension between the role and goals of public health, and governmental appetite for policy change in the issue of obesity (and others). Public health agencies may be pulled in two incompatible directions by governments asking for quick responses to high rates of obesity. It seems that public health is often asked to achieve two things: a) to put a halt to the increasing population rate of obesity through prevention, and b) to reduce the real number of fat people through encouraging individual weight loss and other mechanisms (see, for example, Standing Senate Committee 2016). While a) is responsive in the long-term to upstream systems-level policy solutions, b) is a downstream, individual (perhaps medical) target. When public health focuses on the individual, it is goal b), to reduce the actual number of fat people in a society, that is taking precedence over goal a), to reduce overall rates of obesity.

The pursuit or achievement of goal a) is compatible with public health's responsibility to secure health-protective conditions within a society, while goal b) may not be. The interest of the government in b) may oppose public health's goals of promoting the community's flourishing and the achievement of a), by refocussing attention and responsibility onto individuals. This is especially so if the techniques employed to try to achieve goal b) result in stigma and the oppression of fat people, as I have argued in Chapter 5. Goal b) may also be extremely difficult to achieve. This is partly because there is growing evidence that body fat is something that is very stubbornly difficult to change, and we now have evidence that the very effort to change it, such as dieting or bariatric surgeries, can lead to many additional health problems (like metabolic issues, digestive troubles, nutrient deficits, or decreases in mental health) (Fothergill et al. 2016). Furthermore, and crucially, goal b) cannot be reliably achieved in

the absence of changes to the deeper, policy-responsive systemic factors that would help to achieve goal a). Public health initiatives that fulfill the responsibility towards securing conditions for collective flourishing, and take a collective approach to addressing the social conditions that contribute to obesity are, thus, essential to the achievement of either goal.

However, government interest in addressing obesity seems to remain centred upon individual responsibility and on achieving goal b), to reduce the real number of fat people, to a greater degree than policy responses and goal a), reducing population rates of obesity. This may be in part due to the lobbying efforts of food and other industries, or because there is little political appetite for upstream solutions in today's political climate (Bateman-House 2017; Owens & Cribb 2013). Governments seem to be sensitive to the kind of public backlash against more regulatory interventions, largely based on arguments about personal liberty, that have been fuelled by food corporations expounding the virtues of freedom of choice (Bateman-House 2017; Wiley et al. 2013). Speaking from an American perspective on the popularity of nudge-style government interventions, though this may reflect the mood in other advanced democracies as well, Eric Carter (2015) suggests that public health is at an impasse in the current political climate. To solve allegedly urgent and demanding problems such as increasing rates of obesity, behavioural change is required, "but if we take the libertarian argument seriously, people must be persuaded, or else unconsciously guided, to change diet, exercise, and lifestyle" (p 380) through the use of tools like public campaigns. At the same time, "at least in the US, addressing underlying 'social determinants' of health is a political non-starter" (p 380). Thus, governments are attracted to non-regulatory low- or no-interference

approaches to public health issues that frame obesity as an individual issue with individual solutions, because governments seem to assume that these have greater levels of public acceptance at the moment than policy actions.

A controversy over the appropriate public health response to obesity seems to be at the heart of this reaction, and this is perhaps because decisions regarding eating behaviours and physical activity are considered among community members to be of a self-regarding nature, rather than a systemic issue of collective interest (Anomaly 2012; Rothstein 2002; Wiley et al. 2013). Public health may unintentionally reinforce and perpetuate an individualistic view through the anti-obesity campaigns they produce. Certainly, public health interventions that appear to encourage individuals to make 'healthier decisions' regarding eating behaviours or physical activity (even if this is merely lobbyist spin) are more vulnerable to 'nanny state' objections. However, a governmental distaste for regulation could help to explain why there seems to be a greater emphasis put on goal b) by public health agencies.

Falling squarely under this template, anti-obesity media campaigns are downstream techniques, and focus on the individual as the locus of change. These campaigns seek out behaviour change at the level of each person, by attempting to convince the audience to think and act differently. Catherine Womack writes that the public has strong but conflicted feelings about the causes of obesity and who is responsible for them, and these are at odds with what public health experts know: "that health behaviours are strongly influenced by the social context in which they occur" (2012, p 223). It is understandable that the public would feel conflicted or confused about the causes of and responsibility for obesity. Even though public health experts know that social determinants and

inequitable distributions are important to health behaviours, the messages public health agencies tell the public in media campaigns are about individual choices and responsibility. Most analyses of obesity conclude by calling for public health policies aimed at individual behavioural changes directly (health education interventions) or indirectly (taxes, etc.) (Chaufan et al. 2015). Even reports that acknowledge the wide-ranging contributors to obesity still conclude with recommendations that suffer from ‘lifestyle drift,’ and many call for campaigns that tell people about their individual behaviours (for example, see the report from the Standing Senate Committee 2016). Thus, the public receives messages from public health bodies that are contradictory to what research shows and experts agree upon.

ii. The Problem with ‘Meeting Fire with Fire’

As I briefly mentioned in Chapter 4, one common justification for the kinds of campaigns that have been discussed in this dissertation is a ‘meet fire with fire’ notion for addressing corporate advertising. While this position holds that public health needs to do something about obesity, it also holds that public health must be as non-interventionist as possible unless they can establish a concern about harm to others. Otherwise, public health is overstepping the boundaries of individual liberty, and being problematically paternalistic. So, one of the things public health can do is address food advertising using the same tools that ad companies use, to level the market playing-field. There is an explicit or latent idea in many arguments of this kind that using ‘educational’ manipulative media campaigns is as effective as sales-focussed manipulative marketing techniques, and that all public health needs to do is tell people some scary things about lacking physical activity or eating particular foods to motivate them to avoid these or make other behavioural changes.

Besides erroneously assuming that countering manipulative advertising with manipulative campaigns could achieve a zero-manipulation state in public discourse (as argued in Chapter 4), this perspective makes two additional errors. The first is that it may underestimate the power that marketing techniques have over consumers in creating desires and ‘needs’ (Moore et al. 2015). The second, more salient error is that this argument partly rests on, and wholly reinforces, the notion that chronic diseases are the result of an individual’s failure to take appropriate precautions against a known risk. Since public health tells the community that eating certain foods causes obesity, then being fat, on this view, must be the result of individual choices to eat these foods even after being warned about them. When liberty and individual responsibility are privileged over other values, public health has a very limited role. Once anti-obesity campaigns are undertaken, public health has discharged its duties to warn the public about the known risk. Even though research demonstrates the limited efficacy of public health campaigns with threatening or warning tones, especially when they call for nonspecific long-term changes in behaviour, the liberal view does not tolerate greater intervention (Bayer & Fairchild 2016; Friel et al. 2015; Ruiter et al. 2001; Tannenbaum et al. 2015). In fact, greater intervention would be an affront to liberty and self-directedness, and an unwarranted interference on the part of the government (Moore et al. 2015; Wiley et al. 2013).

So, public health has been requested and encouraged to utilise campaigns to change perspectives on individuals’ food-related behaviour. As discussed throughout, some authors have even called for the use of stigma to motivate change among fat individuals (Bayer & Fairchild 2016; Callahan 2013; OMA 2012a). To recapitulate the argument in

Chapter 4, the justifications for using stigma are closely tied to holding fat individuals personally responsible for behaviours that impact health; while obesity is perhaps not considered voluntary, engaging in things that may contribute to it are, such as eating unhealthy foods or not engaging in physical activity. However, as I have argued, research shows that stigmatisation can have the opposite effect of demoralizing the intended audience of these campaigns (Guttman & Salmon 2004; Puhl et al. 2013). For some people, stigmatizing messages may create or deepen feelings of shame, guilt, lack of self-worth, or failure, which can in turn cause or contribute to ill health (Becker 1993; Guttman & Salmon 2004; Puhl et al. 2013).

I have also argued elsewhere that the focus on individual responsibility in policy initiatives may lead to judgmental and threatening food environments (MacKay 2015). In a commentary on menu labelling, I argued that one of the potential consequences of this intervention is that people may face public scrutiny and judgment about their food choices (MacKay 2015). The creation of ‘good’ and ‘bad’ food categories and the moralisation of food choices may increase feelings of shame, deviance, and moral transgression. It is plausible that the unintended consequences of such an intervention could be greater surveillance of fat people’s eating behaviours, resultant feelings of shame and guilt, and the creation of hostile food environments that encourage unhealthy and potentially pathological relationships with food. In addition to these unintended consequences, menu labelling as a behaviour-change mechanism is at bottom simply a way of avoiding the introduction of meaningful (and more interventionist) public health policy. Menu labelling, just like anti-obesity campaigns, places the responsibility for changing eating behaviours on individuals, and allows public health agencies (and

governments) to claim action on obesity to those who demand it, while avoiding addressing the underlying systemic and distributional issues (MacKay 2015). This is an inappropriate, and ineffective, public health response to obesity's contributors and causes.

The rationale for such public health interventions as anti-obesity media campaigns is weak at best. In addition to doubtful effectiveness, there are two further problems with focussing on individual-level interventions: on the one hand, it leaves public health open to specific kinds of liberty-based objections (such as 'nanny state' objections, which I will return to at the end of this chapter), while on the other hand, it permits governments and others to appear to be making efforts to address poor health, while simultaneously allowing them to make no or few changes at other levels, such as regulation (MacKay 2015).

While research into obesity has revealed a population pattern with distributional failures at its source, initiatives to address it have, so far, remained inappropriately targeted at individual decision-making. This leads to the second reason to think that public health creation of anti-obesity campaigns is wrong: in utilizing these, public health neglects (or actively undermines) its responsibility to secure the background social and environmental conditions that permit the flourishing of the population as a whole. This requires specific kinds of interventions that do not refocus the problem onto the individual. Because obesity, and a variety of other health-related issues, is the result of an unfair distribution of health opportunities, fulfilling public health's mandate to address it requires specific kinds of collective interventions. Public health must avoid placing responsibility for the problem solely in the hands of the individual.

Public Health's Responsibility Regarding Obesity

In this section, I will present arguments supporting the second reason, based on public health's responsibility to take a systems-level approach, to object to the creation of anti-obesity campaigns. The disagreements over public health's regulatory role in obesity and other 'lifestyle diseases' are linked to the role of the values of liberty and justice in determining public health actions, and the way that these ought to be weighed against each other. So, toward the end of the chapter I will present two liberty-based objections to my view, and respond to each.

As outlined in the introduction to this chapter, it seems clear that public health agencies and practitioners take the achievement and promotion of health equity to be a central goal and responsibility of public health. Governments invest public health with the authority to take necessary policy-related steps to improving health conditions for the entire population. Importantly, in executing its responsibility to improve well-being and promote health, public health has a duty to do more than just warn people about things like consuming particular foods or lacking physical activity. The responsibility for improving the social conditions and environments in which people live is not sufficiently satisfied by the warnings presented in anti-obesity (or other kinds of) campaigns. If public health has a duty to enact (or advocate for) policies that would improve health-related functioning and result in a decrease in the levels of, for example, fast food consumption, then they may share (along with the government) responsibility for the systemic failures that result in people having to rely on fast food for nutrition in the first place. The over-consumption of certain low-quality foods by some people out of necessity, may be framed as a failure of public health to protect the community from a known health threat. Viewing obesity as the systemic problem that it is may motivate

governments and public health to address underlying distributional failures, since campaigns cannot satisfy their obligation to address inequities.

Addressing obesity requires collective participation orchestrated by public health. Obesity is not responsive to individual efforts to change, in part because obesity is closely connected to systems-level issues; as mentioned above, epidemiological research has discovered that poverty and low educational attainment are important indicators, among other things (Dawson 2011; Friel et al. 2015; Standing Senate Committee 2016; Wiley et al. 2013; Womack 2012). This is not only true for those individuals who are already obese; this is true as well for people who are not yet obese but may become so. Individual behaviours that might affect personal body weight, such as food choices in a restaurant, have limited efficacy after these social conditions are accounted for (Standing Senate Committee 2016). Thus, a coordinated effort in society is required to alter social conditions in which people live, work, interact, and make everyday choices. One way to understand public health interventions, as Verweij and Dawson write, is that “the participation of individuals is not just important for those individuals themselves, but it is necessary because their joint participation itself might contribute to public health, in that it will improve the conditions for good health for all” (2007, p 26). This understanding of public health highlights the importance of social conditions for individual change. For example, if fewer people smoke, it may become easier for individuals to stop or to avoid ever starting smoking. The changing of social and other background conditions requires collective effort, and this can be guided by public health initiatives.

Public health has taken some steps toward making systemic changes that would impact rates of obesity, but could do more. As I will return to at the end of this chapter, if

public health agencies and governments were serious about wanting to reduce rates of obesity or improve levels of health in a population, then addressing the foundational contributors would be unavoidable: failures of systems regarding income, educational attainment, housing, food, the environment, transportation and various other factors would require repair. Justice-based obesity-related interventions to improve the health-related functioning of individuals in a community could mean, for example, changes to the food production and provision system, or, more fundamentally, mitigating the deleterious effects of poverty (Chaufan et al. 2015). Perhaps because of lifestyle drift or a perceived lack of public appetite for regulatory change, such ambitious changes have not been introduced.

That said, the ban on trans-fats in foods introduced by numerous jurisdictions is an example of a public health regulatory change that improves the health of everyone, but especially those who are worse-off in society. Trans fats are a food additive that industry has been using for over a century to lengthen the shelf-life, improve palatability, and stabilise for deep-frying a number of processed foods (Brownell & Pomeranz 2014). These fats are also closely associated with increases in the incidence of high levels of ‘bad’ cholesterol (low-density lipoprotein) in the blood, and increased risk of cardiovascular disease (Brownell & Pomeranz 2014; Resnik 2010). To date, a number of European countries have banned or placed mandatory disclosure requirements on trans fats, and the United States Food and Drug Administration introduced regulations in June 2015 requiring the removal of trans fats from the food supply by June 2018 (European Union 2016; Food and Drug Administration 2015). As mentioned above, there is accumulating evidence that people with less money, less education, insecure employment

and poor housing conditions are more likely to experience food insecurity, eat unhealthy diets, and have higher levels of dietary-related diseases than are other groups (Friel et al. 2015). People in the lowest socio-economic range are more likely than people at higher socio-economic levels to have to rely on processed foods for a larger portion of their diet, and thus are more likely to experience the negative effects of trans fats on their health (Brownell & Pomeranz 2014; Resnik 2010; Wilson & Dawson 2010). However, in a paradigmatic example of how failures in the food supply that most affect the worst-off have effects on all of us collectively, everyone who eats processed foods, no matter how rarely, will experience the negative effects to some degree. Thus, removing trans fats from the food supply increases equity by protecting the health of those who must rely on processed foods more often, while promoting the health of everyone, and improving the overall health of the entire community.

In a similar case, Public Health England (PHE) has recently published guidelines for the food industry restricting the amount of sugar added to food in the United Kingdom (PHE 2017). The food categories covered by the guidelines include the likely suspects, which one would expect to contain sugar, like ice cream and cake, but also some possibly surprising candidates, like breakfast cereals and yoghurts (PHE 2017). In North America, the Standing Committee heard testimony that sugar is added to 80% of processed foods (2016; also Jeffery & Cappello 2012). Additionally, there is now some evidence that sugar has negative impact on the body's metabolic functioning (PHE 2017). Given that processed foods covered by a trans fats ban also contain high levels of sugar, and that the social groups more likely to rely on processed foods face the brunt of the corresponding negative health impacts, regulations on sugar similar to those regarding trans fats may be

called for, and may have similar equity-improving effects. The high levels of sodium currently added to processed and restaurant foods represents yet another area where regulation would be appropriate, and would have important health and equity effects (Jeffery & Cappello 2012; MacKay 2015).

In addition to addressing food ingredients, there is some evidence now for effective regulatory approaches to addressing some of the capability-based contributors to obesity. Friel et al. (2015) report that Brazil and Mexico have achieved some reduction of health inequities through supporting social welfare initiatives. By linking education, school attendance and keeping appointments for health check-ups to income supplements, these countries have found improvements in nutrition-related indicators (Friel et al. 2015). This should not be surprising, given the link between food provision, education, and income. To be successful, initiatives like these need to be responsive to the context of daily living. This sensitivity to the conditions of people's lives was identified as one of the strengths of the Government of New Zealand's 'Breakfast Eaters' campaign (see Chapter 1). Recognising the constraints within which people must make decisions and act, including factors like limited time or the unavailability of fresh food, is crucial to demonstrating respect for those people as agents.

However, Friel et al. note that these social welfare initiatives (and the 'Breakfast Eaters' campaign) still focus on changing individual behaviour, rather than modifying the underlying conditions of various settings (2015). A criticism of programs like the examples from Brazil and Mexico is that they place certain groups who experience disadvantage under greater levels of government surveillance, and I am sympathetic to this critique. Redistributive policies can lead to better health indices, but this requires

serious policy change beyond income supplementation, ideally without increases in monitoring and the various demands that come with this. As Chaufan et al. (2015) argue, without major systemic changes in social conditions, including education, housing, employment, and food provisions systems, the chances of improving population health and decreasing health inequities are bleak. Addressing policies related to income supplements, food systems, housing systems, and transportation are thus essential to a public health response. Implementing a guaranteed minimum household income may be another kind of sustainable social policy to address food insecurity or insecure housing, and the inequities between socio-economic groups in advanced democratic nations. This is surely a tall order for public health agencies. On an optimistic note, however, public health has the ability to influence the political agenda just as they are influenced by it. Even when unsuccessful, as a body that is tasked with promoting the flourishing of the community, public health is obligated to undertake difficult policy or advocacy actions to try to achieve equity and justice.

In sum, public health has the responsibility to secure background social conditions that permit the flourishing of a population, which in turn provide a baseline for the achievement of individual levels of health-related capabilities. Measures to address obesity that would cohere with this responsibility and the stated aim of public health, to improve equity, must focus on repairing and improving systems. Anti-obesity campaigns, which influence people (often manipulatively) to make different individual choices, are not coherent with either the aim or the responsibility that public health holds. Although I acknowledge that changing systems of food procurement and production, or of housing, or of training and employment, are all very difficult and ambitious tasks, this does not

mean that public health can avoid their responsibility to undertake them. Such collective interventions are precisely the sort of things that public health is needed for, and where its work can be most productive.

Objection One: Such proposed actions are not the least-restrictive alternative
It may be objected that the interventions presented above are not the least-restrictive policy alternatives on individual liberty. In the liberal tradition, the principle of the least-restrictive alternative is well-established, and states that where policy alternatives are all effective, proportionate, and necessary to addressing an identified issue, and morally equivalent in all other respects, the option that is least restrictive of personal liberties ought to be preferred (Childress et al. 2002). This position obviously prioritises liberty over other relevant moral concerns.

I have two responses to this objection. The first response takes issue with the primacy of liberty. While I believe that liberty is important, and that public health and governmental agencies ought to provide justifications for overriding it, liberty can and sometimes ought to be overridden in the interest of social justice and other important values. Proponents of the principle of the least-restrictive alternative seem to agree with me in theory, even though they may end up prioritizing liberty unreflectively, incoherently, or without justification (Dawson 2016). While it has historical and philosophical roots (Powers et al. 2012; Saghai 2014), liberty's primacy in moral thinking may be the result of disproportionately favouring certain passages in canonical texts (e.g. Mill's 'On Liberty') combined with a cultural preference for individualism in the Western world. As a result, a tenacious bias in favour of personal liberty has emerged.

A clear justification for ‘treading upon’ one’s liberty is the establishment that there is harm accruing to others. Without appeal to harm, individuals ought to be left alone to pursue their goals in peace. In my view, this is a problematic and potentially hazardous position for public health to take. Strict adherents to liberalism may advocate waiting to see proof of harm to others before taking action on an issue that would have benefitted from aggressive prevention work. More fundamentally, though, a focus on liberty may blinker public health agencies from seeing important problems in which their interventions would be helpful to most of the population. Work on the social determinants of health is of this nature, because even well-off individuals in society would benefit from concerted efforts to address these determinants, such as investments in education and the food provision system. A commitment to social justice in these areas means that public health ought to intervene, and releases us from the burden of proving that deficiencies in the social determinants of health are harming any particular person or group (though the entire community may be negatively impacted).

My second response is that the requirements for the principle of the least-restrictive alternative are too stringent for it to be activated in real questions of public health policy. Often, the efficacies of two interventions are debatable or similar, or they are not morally equivalent in other ways that would allow the principle to do its job of deciding between them. The principle of least-restrictive intervention appears in the literature to be a tie-breaking mechanism between options that are morally and efficaciously similar in all ways except for their impact on individual liberty. Dawson (2016) has recently presented two objections to the principle of the least restrictive alternative in his take-down of the Nuffield Council on Bioethics’ intervention ladder. To these objections, I would like to

add a third. The principle of the least-restrictive alternative is most plausibly designed to assist in selecting an option when two or more policy alternatives are equally effective and morally equivalent, but some are more liberty-restrictive than others. If we can demonstrate or argue that one alternative is either more effective or less morally objectionable, then the principle of the least-restrictive option is not required for us to make a decision.

In reviewing an example from earlier in this chapter, we can see that the principle of the least-restrictive alternative does not have a role if two options are morally dissimilar. I argued earlier that there is evidence that restricting advertising to children is more effective and morally preferable to having public health ‘level the playing field’ by creating anti-obesity campaigns. Limiting advertising is seen as a more interventionist approach, and therefore more restrictive to liberty, than taking a parallel action in the market, like creating competing campaigns. The liberty-based argument in favour of the creation of anti-obesity campaigns would say that by providing a counter-point, public health is advancing public knowledge and empowering people to make their own choices. However, the efficacy of restricting advertising to children is much better established than the efficacy of counter-campaigning by public health agencies (Friel et al. 2015; Standing Senate Committee 2016). Furthermore, the effects of anti-obesity campaigns, I have argued, include a raft of negative outcomes on the audience, and in particular on fat people. The negative effects of restricting advertising would mostly impact food companies, which is not an entity that public health holds duties toward, while the positive effects of freedom from the power of advertising would accrue to the people that public health does hold duties toward (Moore et al. 2015). Furthermore, as I have argued,

deepening the oppression of a particular group through utilizing stereotypes and stigma, as anti-obesity campaigns do, is not a morally permissible action for public health agencies.

Thus, the principle of the least-restrictive alternative is not relevant in this case, because the options are not morally or efficaciously equivalent. As Dawson writes, genuine ‘tie-break’ cases are rarely or never going to occur in reality (2016). The foregoing considerations would favour restricting advertising over creating anti-obesity campaigns, despite the former being more interventionist. Even when one intervention option is more effective but morally impermissible, and the other option is less effective but morally permissible, then we do not require the principle of the least-restrictive action to help us decide between them; it would seem that the morally impermissible option is always impermissible. Finally, if the moral status or efficacy of the two options were debatable, then it is not the case that a new decision principle (in the form of the least-restrictive alternative or something else) should be called upon to resolve the debate. Rather, the debate should continue until either new information about the options come to light or the strength of argument prevails, and one of the options becomes the favoured candidate. Thus, as Dawson (2016) remarks, the principle of the least-restrictive alternative can help us make decisions when all else remains equal, but all else rarely does. More often than not in questions of public health interventions, policy options are not similar enough at the outset for the principle of the least-restrictive alternative to come into play.

Objection Two: These policies do not respect individuals and their choices
The second objection to interventions that may prioritise justice or other values over liberty is that they do not sufficiently respect individuals and their choices. A form of this worry is the ‘nanny state’ objection, which essentially claims that in some interventions the government treats its citizens the way a nanny would treat the children in their care, and this is disrespectful to adults, who are autonomous decision-makers with great leeway to make independent choices about how to live their lives. This objection is used to undermine public health (and other) initiatives that could appear to curtail choice in a paternalistic manner.

Taking recent regulatory attempts where the nanny state objection has been used, the strength of the popular worry about governments overstepping boundaries regarding people’s independent decisions becomes clear. These attempts were made by New York City, in banning large sizes of soft drinks, and Denmark, in implementing a tax on fat content in certain foods. To begin with, I think both of these attempts were misguided because they operated at the level of individual choice, and did not address problems with the communities’ food systems. This, however, was not the primary objection to them that appeared in the public discourse.

In Denmark in 2009, a tax was levied on certain food products, including ice cream, cooking oils, and some dairy products, that had specific saturated fat content (Nestle 2011). This was done partly to motivate people to purchase food with lower fat content, and to increase revenues to put toward government programs. However, people objected to this measure. Levying a tax on certain foods places the costs of buying them with the individual consumer, rather than with the producer. This meant that people felt that they

were being unfairly punished for buying foods they liked or wanted. In the long term, it may have been hoped by the government that producers would reformulate their products to contain less fat, avoid the tax, and win back any customers who changed their behaviours, but the Danish tax did not last long enough for this to become evident (Nestle 2012). The tax was repealed in 2012.

The New York City cap on the serving size of cups for soda fountains at restaurants, sporting venues, and food stands was, likewise, framed as placing restrictions on individual behaviour, of a sort (Bateman-House 2017). This was, at least, how the soft drink industry's lobby and certain libertarian-leaning commentators described the regulation. Though an individual could still drink the same amount of soda that they could before the cap by refilling their cup (which, if we think that people should reduce their soda intake, may itself be a failure of this initiative), the regulation was seen as inappropriately treading upon individual liberty by telling adults how much soda they were permitted to have in a single serving (Bateman-House 2017). What the regulation did not do is address the manufacturers of soda in any way.

Both of these initiatives ultimately failed and were rescinded. The Danish tax on fat content and the New York City soda cap both miss an important feature of public health problems, and that is that they are resistant to individual-level solutions. An issue that requires public health's action is precisely the kind of problem that cannot be solved by individuals making individual choices alone, and must be approached collectively. It is important to note that individuals cannot choose not to be affected by these kinds of problems. Whether the example is sanitation or obesity, at the level of systems (the sewage system, the food provision system) no one is able to choose not to be affected. If

certain environments are glutted with sugary beverages and soda advertising, like sporting venues or food stands, everyone in those environments will be affected by this, regardless of discreet individual choices about what to drink. Certain socio-economic privileges may lessen the impact of unhealthy environments or poorly-functioning systems for some, but everyone will be worse off than they would be with health-protective environments and well-functioning systems. Additionally, because public health ought to intervene at the level of systems, most individual choices that could be made before such a public health action could be undertaken after it as well.

Framing obesity as an individual choice with solutions at the point of consumption in these cases left public health open to the objections that not everyone requires such interventions (i.e. not everyone is fat), that public health qua government treats adults without full respect when intervening in such a way (the ‘nanny state’ objection), and that such interventions allow governments to appear to be taking action while actually not making any real commitments (Bateman-House 2017; MacKay 2015; Moore et al. 2015; Wiley et al. 2013). This framing, or acceptance of framing, of obesity as an individual-level problem by public health advocates and opponents to regulations, alike, ties the hands of public health to a certain degree, and further undermines the possibility of undertaking systems-level change. Rather than buy into the framing of issues it is concerned about as entirely individual-level problems with solutions based in consumer choice, public health should highlight the collective need for change. There may be a role for individual behaviours or choices, but the systemic nature of problems and solutions must be emphasised.

It seems that we may worry about the issue of disrespecting individual choices less when the topic is sanitation and more when it is something like obesity, even though it seems that appropriate and effective measures to address the latter would be at the same systems-level as the former. This worry may be what gave rise to the idea of the ‘old’ and the ‘new’ public health, which I have argued is a false distinction. There is a sense that the government may restrict certain choices in addressing obesity that are morally different from those related to sanitation. Providing well-functioning food-production systems, which may require placing restrictions on the kinds of food ingredients that food companies are permitted to use, such as trans fats or sugar additives, are appropriate system-level actions, just like providing water treatment and sewage systems. Such interventions do not impede individual choices in a meaningful way, given that individuals consume such ingredients largely unawares and potentially unwillingly (MacKay 2015). Thus, as I wrote at above, initiatives to restrict the trans fats added to various products in the food system is fair game for public health intervention, while anti-obesity messaging is inappropriate, for targeting the consumer rather than the producer. This coheres with public health’s responsibilities to improve conditions at the collective level, while also achieving its aim to improve health equity, and avoids stigmatising groups or contributing to their oppression.

Conclusion

Public health fails to meet its responsibilities to the public, and acts against its own goals, when it adopts advertising behaviours that result in manipulation (as I argued in Chapter 3), increasing stigma (as I argued in Chapter 4), and undermined self-directed decision-making and heightened oppression (as I argued in Chapter 5). Together, these effects undermine the achievement of health-related justice conditions. All of these are actions

that are inappropriate for a public health authority, but also prevent the achievement of public health's own health-related goals. One of the reasons that these campaigns undermine public health's goals to promote and protect the flourishing of the community's health is that, as I have argued in this chapter, anti-obesity campaigns reinforce the message that obesity is an individual responsibility when, in fact, it is a systemic problem that must be addressed by collective actions. Framing obesity as solely an individual-level issue undermines collective action to address its systemic contributors, and leads the public to hold conflicting beliefs about who is responsible for obesity and what should be done about it.

To claim that there is no place for education by public health agencies would be too strong; surely, there is a role for the kinds of campaigns that encourage people to wash their hands frequently in a kitchen to prevent contamination, or to get a flu shot to reduce the spread of a virus. There may be a role for similar communication in matters relating to body size. However, these communications would need to look very different from their current state to be ethical, and must be the accompaniment to policies and regulations directed upstream at improving food, housing, education, and other systems. Public health agencies are in a difficult position: they must implement collective and regulatory measures at a time when public attitudes and governments may be largely unsympathetic to such projects. This is regrettable, but it does not change the nature of public health's responsibilities, nor the appropriate targets of public health work. If we hope to improve the health of the entire society, then we must focus on creating regulatory solutions to tenacious and challenging problems with various social influences and systematic contributors, which disadvantage some groups in predictable ways.

Conclusion

This dissertation has argued that anti-obesity campaigns are unacceptable tools for use by public health bodies. On an agency-based model of communication, which says that in order for a communicative transaction to successfully occur, both parties must share a number of background commitments and assumptions, including shared knowledge, values, language, social contexts and understandings, and a variety of other things, communication is inherently a normative undertaking that relies on the agency of both speaker and audience. Persuasion happens when a person presents evaluable reasons for coming to a certain conclusion, and is a communicative act that takes place between agents or groups in a context of mutual respect. Persuasion is, therefore, morally permissible. Manipulation happens when a communicator attempts to bypass the reasoning faculties of the audience, to engender a predetermined reaction. Manipulative communication fails to respect the agency of the audience, and thus is morally impermissible. Through analysis of a variety of anti-obesity campaigns, I find that many use manipulative communication techniques, frequently relying on alarming, displeasing, or frightening text, sounds, or images to relay a message about the health risks related to obesity.

Manipulative communications include fear-based and stigmatising campaign messages. Contrary to those who have argued that stigma ought to be used to influence people to make different decisions in health-regarding behaviours, I argue that the harms of stigma dramatically outweigh any benefits that may be brought about. Furthermore, stigma involves the sort of harms that are unacceptable, regardless of the benefits that may accrue from its use. These harms include observable reductions in material well-being, such as negative impacts in employment prospects, as well as identity-

undermining effects, such as shame and reduced capacity for self-governance and self-authorisation. The impact of these campaigns on self-authorisation may make it virtually impossible for people to take the kind of self-directed actions regarding their health that public health advocates. Public health recommends that people make various changes, which require a high degree of self-efficacy, and the campaigns public health uses to send these messages undermine that self-efficacy. Employing stigmatisation and stereotypes in public health campaigns thus deepens and promotes the oppression of fat people based on their body size, and makes it more difficult for people to make health-regarding behavioural changes.

Clearly, promoting oppression of some groups is antithetical to the work of public health. Many public health professionals take themselves to be engaged in a project of promoting greater equity among groups in society; oppressing some groups, even unintentionally, undermines this project. Though we may currently be living in a time when (or societies where) individualism is privileged over community-based concerns, and governments are loath to be seen as interfering with individual liberty, public health's central aim can only be achieved via collective, systems-level interventions. Additionally, there is evidence to suggest that obesity itself can only effectively be addressed by those same sorts of systems-level initiatives. Thus, campaign projects, which aim to 'educate' or 'raise awareness' among the audience while leaving it up to the individual to make any changes as a result of these messages, do not address the sorts of systems that we now know contribute to obesity. So, they are ineffective ways of addressing obesity, in addition to being positively harmful and morally inappropriate.

I have found no arguments in favour of manipulative anti-obesity campaigns by public health that can justify, either morally or pragmatically, their use. The result of this dissertation is that these campaigns appear on all fronts to be an inappropriate choice for public health agencies, and ought to be discarded as a means to achieving reductions in obesity rates.

Some topics of interest that are related to this project, but which haven't been investigated for reasons of scope, include the impact of anti-obesity messages on mothers specifically, and upon the body-image (and psyche) of women, including straight, queer, and transgendered women. When seen from the abstract level of population rates of obesity, all fat people are equally problematic. However, the messages in public health campaigns and the images that are chosen to accompany them betray deep gender biases. There is a tendency to target (cis)women in these campaigns as mothers, food providers, and primary caretakers of the family. A proper analysis of the ethical implications of campaign materials that feature mothers or are directed toward mothers is required. The scrutiny of mothers' bodies and behaviours in relation to obesity prevention is ever-increasing. Women are pressured to breastfeed; their weights before, during, and after pregnancy are closely monitored; and increasing research into maternal epigenetic contributors to childhood levels of body fat is placing mothers under intense surveillance (Dablea and Crume 2011; Heerwagen et al. 2010).

The negative body-image effects of public health campaigns may also be greater among women than men. Body fat has a deeply gendered meaning, and fat women and fat men face different stereotypes and occupy different social spaces (Bordo 2003; Harris et al.1991; McPhail and Bombak 2015). Research into stereotypes about fat people has

found that stereotypes of fat women are significantly more negative than those of fat men. Accordingly, “women are both more concerned about their weight and more likely to be judged on their appearance than men” (Harris et al. 1991, p 1562). That said, fat men’s gender identity may be threatened by the social meanings of fat. Susan Bordo writes that “soft, protuberant body parts... evoke helpless infancy and symbolise maternal femininity” (2003, p 208). Thus, body fat that gives the appearance of breasts or large hips may have “a ‘feminizing characteristic’ that has significant implications for [men’s] gender identity” (McPhail and Bombak 2015, p 541). However, Deborah McPhail and Andrea Bombak write that while fat may be feminizing for men (including trans men), it is paradoxically masculinizing for women. Fat women take up physical space that is typically reserved for men, while the “undesirability” of their bodies removes them from stereotypical heterosexual gender roles and renders their bodies asexual (2015).

McPhail and Bombak argue that lesbian communities are problematic from public health’s perspective because, through rejecting traditional gender and sexual identity expectations, these groups tend toward fat positivity, and, therefore, public health considers them in need of intervention. Through public health’s efforts, however, fat as “illness” contributes to a recoding of lesbianism as “sick” (McPhail and Bombak 2015, p 542). Sexual minority women, they write, are thus targeted as populations that are particularly “at risk” for obesity, and are further marginalised. While I have not been able to do justice in this dissertation to the important criticisms of public health messages that come from critical gender and fat studies, it should be made clear that the political, gendered, and body-situated meanings in public health anti-obesity campaigns are problematic for straight and queer communities of women, albeit in different ways. One

important commonality, however, is the undermining of feelings of self-worth, and the fostering of feelings of shame and self-doubt, which are incompatible with self-authorisation. This topic, too, requires further investigation.

Finally, this dissertation also points to the need for further research into the theory of social justice appropriate for public health. We need an account of legitimate public health that captures all central public health activities, including communicable and non-communicable disease. In the foregoing arguments, I drew from current conceptions of public health as focussed on promoting equity. Going forward, I think we need to investigate and present an account of social justice that ought to guide public health interventions. In order to discover which account of social justice might be most appropriate for public health, consideration of a number of possible models will be needed, along with the identification of the kinds of goods important in public health, and how these fit together. Undertaking the research in this dissertation has led me to wonder what public health would look like, what kind of projects it would take up, and how it would communicate with people, if it allowed itself to be guided by a model of social justice. I hope to discover, in future work, what public health could look like if it attended to features of oppression and was grounded in compassion for those worst off, instead of operating on a model based in individual responsibility and maximisation of liberty.

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