ways of regulating a particular public health risk that have a better balance of moral benefits over moral costs. Costs to liberty are only one of the relevant factors. The very probable large costs to human life through waiting to see whether education and labeling policies are effective ways of reducing trans fat intake is also a relevant factor. Resnik provides no reason to think that the moral costs associated with these very probable deaths are smaller than those associated with the infringement of liberty.

Moreover, invoking the “principle of the least restrictive alternative” in public health regulation seems to be either almost entirely superfluous, or to involve an illicit form of double counting. If it means that we should adopt the least restrictive alternative out of the ones that have already been singled out as offering the best balance of moral benefits over moral costs, then presumably it can only operate as a tie breaker, and so will be unable to do the work Resnik requires.1 But if it is supposed to play a substantive role (as Resnik seems to imagine it will), then it seems to be clearly illicit, given that liberty has already been weighed in the balance against the other goods at the stage of working out which policies are proportional and necessary. Liberty is an important value, but it is not so important that it ought to be counted multiple times.

CONCLUSION

We have argued that Resnik overvalues liberty in three distinct ways. First, he fails to consider some powerful arguments for thinking that the state ought to intervene to create a safe environment for its citizens. Second, he overestimates the degree to which food choices are autonomous. Third, he puts his thumb on the scales when he comes to weigh liberty against protection of the health of the public. Giving liberty its due—but no more than its due—would allow us to adopt a more sensible policy, in which we ought to weigh the liberty to eat TFs less heavily than the protection of thousands from early death through a simple intervention that no member of the public will even notice.

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freedom, might it also be relevant to apply the same principles of medical ethics that have been established for individual medical interventions? This approach reveals another slippery slope, in addition to that insightfully articulated by Resnik.

Public health advocates have campaigned to restrict many products that people voluntarily consume—for example, a recent high-profile appeal to tax soda (Brownell 2009).

Public health can be defined as the “science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention” (“What is Public Health?” n.d.). However, there is a fundamental difference between many current interventions and those of past public health campaigns such as providing water free of sewage and air free of contamination.

**TWO SIDES TO THE EQUATION**

The totality of reasons (conscious and subconscious) for consuming a product is a function of two sides to an equation: harms and benefits. Nobody wanted to drink water flavored with the essence of feces. There were benefits in the disposal of waste into a convenient water system, but no one wanted to drink water containing organisms that cause cholera. While people may have wanted the benefits of processes that the industrial revolution brought, no one actively sought out toxic fumes. For many similar public health issues, there may have been utility in the process that lead to a harmful product/process, but there was no utility in the harmful product per se.

Contrast this to many current initiatives enacted on the grounds of public health. Fatty foods, soda, cigarettes, alcohol, drugs, video games, etc. all provide utility as well as the potential to cause adverse health effects. Even if the science of public health demonstrates that a product causes harm, it does not follow that consumption of that product is necessarily a bad thing; the utility may outweigh the harms. It is not valid to present one side of an equation.

At both individual and societal levels, would there be overall harm or benefit in banning trans-fats or any of the products just listed? Returning to the definition of public health, are we improving the health of the community by banning something? Was the prohibition of alcohol beneficial to the community’s health? What might be considered harmful through one perspective might be considered beneficial through another. How do we value the utility and harms? There are infinite permutations. Modern health ethics determine that we defer to the principle of autonomy.

Trans-fats seem to have minimal utility, but caution is needed when forcibly perturbing a complicated system: It may not produce the benefits expected and also conjure unforeseen harms. Banning trans-fats probably represents a different degree of paternalism than the regulation of things such as alcohol, fatty foods, or video games, which clearly have utility. However, does the utility of trans-fats approach zero? If there were zero utility, a ban would not be necessary as there would be a voluntary discontinuation of their use. Do trans-fats contribute something that other fats don’t? If there are economic benefits in manufacturers continuing their use, then that, by definition, constitutes utility. Will some vociferously argue for their use? Let there at least be opt-out rules from regulation, as would be considered mandatory for any individual health intervention.

Resnik discusses the issue of whether information alone will achieve the desired outcome. But what is the desired outcome? This question evokes a truly magnificent feature of autonomy. Autonomy obviates having your existence controlled by the whims of expert committees. The move away from paternalism in individual health ethics has become so dominant that its reemergence in public health justifiably evokes concern among the population that natural justice will be held hostage to Orwellian committees of politically installed “experts.”

There’s a somewhat naive view among some that science will be able to give us the “facts” and give an “objective” answer as to the balance of people’s freedom and health. The folly of this is represented by Benjamin Disraeli’s admonition, “lies, damn lies and statistics.” Thus, the science of public health may identify a lifestyle that causes harm and seek to advise the public—not compel people to assume a certain risk-benefit position. This mirrors the acceptance within the medical profession that intervening to save life at all cost is unacceptably paternalistic.

**CAPACITY TO CONSENT**

For public health initiatives, the justification for usurpation of autonomy is based on two fundamental principles: (i) The person lacks the capacity to choose; (ii) health care costs justify overriding autonomy.

From Resnik (2010), we have, “Proponents of trans fat bans have asserted that they are necessary, because the other methods for promoting public health are not effective enough, since consumers may not understand the risks of trans fats or heed warnings or advice” (27).

A population-wide lack of decision-making capacity was used as an argument to justify an appeal to place a tax on soda drinks (Brownell 2009). Yet the very data presented demonstrated that people were aware of the deleterious health implications of drinking soda. (Keane 2010).

From a discussion on the role of health contracts to reduce the health care costs of indulgence in certain lifestyle products comes the following:

Given that respect for the autonomous choices of patients runs deep in modern healthcare, there are strong reasons to value the claim that competent and well-informed individuals are the best interpreters of their own interest and that they should be free to make choices others would regard as non-beneficial to them (Feiring 2008, 36).

What standard should be used when judging people’s competence to autonomously choose to consume a product? Electing to do something that may lead to a harmful
outcome does not define a lack of understanding of the conse-
quences.

By banning a product (because people don’t heed warn-
ings that it is harmful), public health advocates necessarily
define a large part of the population as lacking the capac-
ity to make autonomous decisions. Could this lead to a
slippery slope of paternalism into individuals’ health care?
If a person cannot consent to eating fatty meals or drinking
soda, then what should the logical benchmark be regarding
individual treatment? This is indeed a complex topic and
cannot be comprehensively surveyed in this OPC. But if pro-
ponents of public health intervention argue that autonomy
should be usurped on the grounds of lack of competence,
then they must describe the standard they use. Certainly
a court would not declare someone incompetent solely on
the grounds of the long-term consequences of a decision
regarding treatment.

A question arising from both my thesis and that of ad-
vocates of bans concerns the default position for interven-
tion. A tax, or ban, by definition, inhibits two parties from
participating in an exchange. But what is the intervention?
Should the seller of a trans-fat-containing burger obtain the
informed consent of the buyer? Or should the onus be on
policymakers who intervene in that exchange for the health
of the purchaser? The intervention forces the consumer to
take an alternate course of action for the supposed sake of
his or her health.

Usurping people’s autonomous decisions under the
guise of public health is the equivalent of forced participa-
tion in a health intervention. Similarly, even under Resnik’s
sophisticated measures, it could logically follow that people
could be forced, in certain circumstances, to participate in
medical experiments against their will.

HEALTH CARE COSTS

The second justification for usurping autonomy is that
the person indulging in a product inflicts harm on third
parties, with the third parties being those that are com-
pelled to pay for the health care costs of someone else’s
indulgences.

Of the ethical principles popularized by Beauchamp
and Childress (2009), the nebulous principle of justice
is often raised in this setting. However, if the health
care cost argument is accepted, then we have to ac-
cept the ethical precedent that this sets. It would then
be ethically permissible to forcibly inflict medical treat-
ment on a legally competent adult against that person’s
will as long as that treatment would lower government
expenditure.

Resnik’s concern for a slippery slope is particularly rel-
levant in this context. Any harm resulting from human be-
aviour can be codified as a medical problem and treated
within the medical system, incurring health care costs. Thus,
reductio ad absurdum, every facet of our existence could
be controlled by the government in order to control health care
costs.

Further relevant issues that need to be addressed in
relation to public health initiatives that override auton-
omy include (i) the neuroscience behind decision making
and the resulting philosophical constructs regarding
autonomy and (ii) that formulating deleterious behavior
as public health problems may promulgate a culture of
lack of individual responsibility. This may shift the over-
all equilibrium of behavior and end up causing more
lifestyle-related harm than that prevented by bans and
taxes.

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