

## **POLICING WILLPOWER: OBESITY AS A TEST CASE FOR STATE EMPOWERMENT OF INTEGRATED HEALTH CARE**

Julie A. Muroff, J.D., LL.M.\*

“A new legal authority is arising which seeks to integrate biomedical, holistic, and social models of health care in ways that maximize patients’ well-being.”<sup>1</sup>

In a book that was published over a decade ago, this statement heralded legal support for an integrated health care system. This system would accommodate conventional or allopathic medicine and complementary and alternative medicine (CAM), with the objective to augment safe and effective treatment options for patients.<sup>2</sup> The rise

---

\*Julie A. Muroff, J.D., LL.M. is a health care attorney in Bethesda, Maryland. She is a graduate of Georgetown University Law Center and the University of Pennsylvania. Prior to joining the Office of the General Counsel of the U.S. Department of Health and Human Services, she was in private practice in Washington, D.C. and Tampa, Florida. The views expressed herein are the author’s alone and do not represent the views of the United States government or any agency thereof. Acknowledgement: The author honors the memory of Carolyn D. Kramer Muroff, D.O., and gratefully acknowledges the support of her family and Professor Sherman Cohn, LL.B, LL.M. of Georgetown University Law Center, which recognized a 2007 draft of this article with the CALI Excellence for the Future Award.

<sup>1</sup> MICHAEL H. COHEN, *COMPLEMENTARY & ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES* 118 (1998).

<sup>2</sup> This discussion will use the following definitions adapted from the National Center for Complementary and Alternative Medicine at the National Institutes of Health: Conventional medicine is medicine practiced by holders of M.D. or D.O. degrees and their allied health professionals, such as physical therapists, psychologists, and registered nurses; CAM refers to “a group of diverse medical and health care systems, practices, and products that are not” presently considered to be part of conventional medicine; Complementary

in chronic diseases among Americans has intensified the need for comprehensive treatment resources, given the complex causes, manifestations, and implications of these conditions.<sup>3</sup> Yet the challenge of translating the theory of legal authority to the practice of integrated medicine persists. Although it is too soon to draw conclusions as to whether the Patient Protection and Affordable Care Act will realize this legal authority, the potential of the current U.S. health reform in this regard should be noted.<sup>4</sup> For example, among other measures, Section 4001 of the Act directs the President to establish an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health to contribute to the National Prevention and Health Promotion Strategy.<sup>5</sup> Specifically, the Advisory Group, including non-federal integrative health practitioners, will develop policy and program recommendations and advise the National Prevention Council on “lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.”<sup>6</sup>

To accelerate the development of “new legal authority” for integrated health care, state legislators can rely upon their seasoned legal authority for public health regulation. Specifically, “police power,” reserved to the states under the Tenth Amendment to the U.S. Constitution, enables states to implement legal measures that protect the public health, safety, and general welfare.<sup>7</sup> Indeed, public health law is defined by the legal powers, duties, and limits of states

---

medicine is used together with conventional medicine; Alternative medicine is used in place of conventional medicine; Integrated medicine combines treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness. See NAT. CTR. FOR COMPLEMENTARY & ALT. MED., CAM BASICS, 1 (2010), available at <http://nccam.nih.gov/health/whatiscam/D347.pdf>.

<sup>3</sup> See COHEN, *supra* note 1, at 2–4. See also Derek Yach et al., *The Global Burden of Chronic Diseases*, 291 JAMA 2616 (2004) (discussing chronic disease as a leading cause of death and reviewing impediments to prevention and control).

<sup>4</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 4001, 124 Stat. 119, 539–540 (2010).

<sup>5</sup> *Id.* at 538.

<sup>6</sup> See Exec. Order No. 13,544, 75 Fed. Reg. 33,983 (June 16, 2010).

<sup>7</sup> See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

to assure the conditions for people to be healthy.<sup>8</sup> States can function as “laboratories” for “social experiments” to that end.<sup>9</sup>

Accordingly, state legislation can target a public health issue as a catalyst to reinforce the legal foundation of an integrated health care system. Part I of this paper presents obesity<sup>10</sup> as an ideal subject for such police power “experimentation.” Part II provides a roadmap of legal, ethical, and practical considerations associated with state measures that contribute to the regression of obesity and to the progression of integrated health care.

## PART I

### A. Basis of Legal Authority

Obesity is considered a public health issue, and therefore within the scope of state police power authority, because of its significant, detrimental impact on the health of populations.<sup>11</sup> Specifically, obesity is associated with an increased risk of many debilitating health conditions, including hypertension, dyslipidemia, Type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and certain cancers.<sup>12</sup> These medical complications contribute not only to annual

---

<sup>8</sup> LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 4 (2d Ed. 2008).

<sup>9</sup> *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

<sup>10</sup> The term “obesity” will refer to a high amount of body fat, relative to lean body mass. Generally, the labels of “overweight” and “obesity” designate ranges of weight that exceed what is deemed healthy for a given height. Often, these categories are determined by a body mass index (BMI) calculation that is based on weight and height measurements. For example, an adult with a BMI between 25 and 29.9 is considered overweight, and an adult with a BMI of 30 or higher is considered obese. *See, e.g., Defining Overweight and Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm> (last updated Jun. 21, 2010). Obese individuals will be characterized as “patients” because this discussion presumes a context of treatment.

<sup>11</sup> *See, e.g., GOSTIN, supra* note 8, at 14 (discussing focus of public health on “organized community efforts to improve the health of populations”).

<sup>12</sup> *See, e.g., Health Consequences*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/obesity/causes/health.html> (last updated Aug. 19, 2009).

health care costs, estimated at \$147 billion,<sup>13</sup> but also to the high rank of obesity among the leading preventable causes of death<sup>14</sup> and to a decline in the average life expectancy of the U.S. population.<sup>15</sup> Statistics from the Centers for Disease Control and Prevention (CDC) indicate a trend of rising obesity rates across the country over the past two decades.<sup>16</sup> As of 2009, the self-reported prevalence of obesity among adults in the U.S. increased 1.1 percentage points from the 2007 data: only Colorado and the District of Columbia reported obesity rates under 20%; thirty-three states reported obesity rates of at least 25%, and nine of these states reported obesity rates of at least 30%.<sup>17</sup> In 1996, no state reported an obesity rate that exceeded 19%.<sup>18</sup> Furthermore, the prevalence of overweight among children and adolescents in the U.S. has continued to increase since tripling between 1980 and 2002,<sup>19</sup> which forecasts an ongoing strain on health

---

<sup>13</sup> See Press Release, Ctrs. for Disease Control & Prevention, Study Estimates Medical Cost of Obesity May be as High as \$147 Billion Annually (July 27, 2009), available at <http://www.cdc.gov/media/pressrel/2009/r090727.htm>.

<sup>14</sup> See Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 JAMA 1238, 1238 (2004) (discussing obesity as second leading cause of preventable death); Ali H. Mokdad et al., *Correction: Actual Causes of Death in the United States, 2000*, 293 JAMA 293, 293 (2005) (clarifying statistics cited in 2004 article). See also F. Ofei, *Obesity – A Preventable Disease*, 39 GHANA MED. J. 98, 98 (2005).

<sup>15</sup> See S. Jay Olshansky, et al., *A Potential Decline in Life Expectancy in the United States in the 21st Century*, 352 NEW ENG. J. MED. 1138, 1140–41 (2005).

<sup>16</sup> U.S. *Obesity Trends*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm> (last updated Sept. 1, 2010). But see Katherine M. Flegal, et. al., *Prevalence and Trends in Obesity Among US Adults, 1999–2008*, 303 JAMA 235 (2010) (finding that prevalence of obesity does not seem to be continuing at the same rate over the past decade.); Press Release, Ctrs. for Disease Control & Prevention, New CDC Study Finds No Real Increase in Obesity Among Adults; But Levels Still High, (Nov. 28, 2007), available at <http://www.cdc.gov/nchs/pressroom/07newsreleases/obesity.htm> (finding no significant change in obesity prevalence between 2003–2004 and 2005–2006 for men or women, yet emphasizing obesity as an ongoing public health concern, affecting 34% of U.S. adults aged 20 and older).

<sup>17</sup> Ctrs. for Disease Control & Prevention, *Vital Signs, State-Specific Obesity Prevalence Among Adults – United States, 2009*, 59 MORBIDITY & MORTALITY WKLY. REP. 1 (Aug. 3, 2010), available at <http://www.cdc.gov/mmwr/pdf/wk/mm59e0803.pdf>.

<sup>18</sup> U.S. *Obesity Trends 1985–2009*, CTRS. FOR DISEASE CONTROL & PREVENTION, available at <http://www.cdc.gov/obesity/data/trends.html#State> (last updated Sept. 1, 2010).

<sup>19</sup> See Cynthia L. Ogden et al., *Prevalence of Overweight and Obesity in the United States 1999–*

care resources. Although obesity is not an infectious disease, there is evidence that obesity can be “socially contagious,” or “spread” through social networks.<sup>20</sup> Thus, the scope and implications of the nation’s weight problem corroborate references to obesity as an “epidemic”<sup>21</sup> and raise considerations of state police power authority for public health regulation.

National initiatives to counter obesity that engage states as leaders and key stakeholders provide additional support for state measures in this context. Indeed, the current Administration has designated the obesity epidemic as a priority at the federal, state, and local levels. In February 2010, President Barack Obama issued a Presidential Memorandum creating an inaugural Task Force on Childhood Obesity to review all programs and policies regarding child nutrition and physical activity and to establish a national action plan.<sup>22</sup> In May 2010, the Task Force released its report to the President.<sup>23</sup> The following month, the President issued an Executive Order to coordinate a national program to enhance physical fitness

---

2004, 295 JAMA 1549 (2006) (analyzing trends reported from previous cited studies and finding that increases in body weight continued among children and adolescents from 1999 through 2004).

<sup>20</sup> See Nicholas A. Christakis & James H. Fowler, *The Spread of Obesity in a Large Social Network over 32 Years*, 357 NEW ENG. J. MED. 370 (2007) (finding that obesity appears to spread through social ties).

<sup>21</sup> See, e.g., Press Release, Ctrs. for Disease Control & Prevention, Obesity Epidemic Increases Dramatically in the United States: CDC Director Calls for National Prevention Effort (Oct. 26, 1999), available at <http://www.cdc.gov/media/pressrel/r991026.htm>; See also Richard H. Carmona, United States Surgeon General, Remarks to the 2003 California Childhood Obesity Conference, (Jan. 6, 2003), available at <http://www.surgeongeneral.gov/news/speeches/califobesity.htm> (last modified Jan. 9, 2007) (referring to obesity as “the fastest-growing cause of illness and death in America”). But see Paul Campos et al., *The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?*, 35 INTL. J. EPIDEMIOLOGY 55 (2006) (challenging designation of obesity as an epidemic in light of political, socioeconomic, and ethical considerations).

<sup>22</sup> Memorandum Establishing a Task Force on Childhood Obesity, 75 Fed. Reg. 7197 (Feb. 9, 2010).

<sup>23</sup> WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY, SOLVING THE PROBLEM OF CHILDHOOD OBESITY WITHIN A GENERATION (May 2010), available at [http://www.letsmove.gov/pdf/TaskForce\\_on\\_Childhood\\_Obesity\\_May2010\\_FullReport.pdf](http://www.letsmove.gov/pdf/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf)

and nutrition.<sup>24</sup> First Lady Michelle Obama launched the *Let's Move!* Campaign to "engage every sector impacting the health of children" in a coordinated effort to curb childhood obesity and improve the overall health of the nation's children.<sup>25</sup> Previously, in 2007, the U.S. Department of Health and Human Services (HHS) announced a "Childhood Overweight and Obesity Prevention Initiative" which reinforced an ongoing collaboration between the federal government and the states to reduce obesity levels among children.<sup>26</sup> These initiatives highlight other partnerships between states and the federal government, such as CDC's Healthy Communities Program (formerly "Steps Program"), which has invested in local, state, and federal coordination of chronic disease prevention since 2003<sup>27</sup>, and CDC's "Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases" (NPAO), which was developed in 1999 to provide resources, including financial incentives, for state coordination of projects to reduce the rates of obesity.<sup>28</sup> Likewise, the National Governors Association (NGA) launched a "Healthy America" initiative in 2005 to foster "a culture of physical activity, prevention and wellness in the United States."<sup>29</sup> In 2005, the NGA created "Healthy Kids, Healthy America," the successor to "Healthy America," to focus state efforts on the prevention of obesity among children.<sup>30</sup> The compelling data on obesity discussed herein have prompted these measures and others that have transformed the

---

<sup>24</sup> Exec. Order No. 13545, 75 Fed. Reg. 37283 (June 22, 2010).

<sup>25</sup> ABOUT LET'S MOVE, <http://www.letsmove.gov> (last visited Sept. 04, 2010).

<sup>26</sup> Press Release, U.S. Dep't of Health & Human Servs., HHS Launches Childhood Overweight & Obesity Prevention Initiative (Nov. 27, 2007), available at <http://www.hhs.gov/news/press/2007pres/11/pr20071127a.html>. (last modified Jan. 8, 2008).

<sup>27</sup> See *Program Overview*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/healthycommunitiesprogram/overview/index.htm> (last updated Apr. 2, 2010).

<sup>28</sup> See *State-Based Programs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/obesity/stateprograms/index.html> (last updated May 13, 2010).

<sup>29</sup> Press Release, Nat'l Governors Association, NGA Announces Lead Governors for Healthy America, (Mar. 16, 2007) available at <http://www.nga.org> (follow "News Room" hyperlink; then follow "News Releases" hyperlink).

<sup>30</sup> *Id.*

cultural construct of obesity in the U.S. from a personal medical condition to a public health emergency, for which some believe “[w]hat is needed is substantial involvement of and investment by government at all levels.”<sup>31</sup>

## B. Scope of Legal Authority

States have broad legal authority to address obesity as a public health concern. Generally, American courts respect the discretion of states as regulators of the public health.<sup>32</sup> Courts demonstrate this deference by defaulting to a relatively lenient standard of review, which sustains state public health regulation that bears a rational relationship to the legitimate government interest in the health of its constituents.<sup>33</sup> When state legislation impacts a fundamental right or a protected class, courts may demand a closer “fit” between the public health regulation and the state’s objective.<sup>34</sup> Nonetheless, the fit need not be perfect. As the Supreme Court recognized over a century ago in verifying state police power to enforce mandatory vaccinations, “[a]ccording to settled principles, the police power of a state must be held to embrace, at least, such *reasonable* regulations established directly by legislative enactment as will protect the public health and the public safety.”<sup>35</sup> Thus, while precision may be the ideal, reasonableness is the standard.

Although this legal precedent establishes that states *can* intervene to address the effects of obesity on the public health, the question of whether states *should* intervene remains controversial. A survey by the Harvard School of Public Health in May 2007 found an even split in public opinion on whether legislative power should be used to address obesity.<sup>36</sup> Opponents of government involvement

---

<sup>31</sup> LAWRENCE O. GOSTIN & PETER D. JACOBSON, *LAW AND THE HEALTH SYSTEM* 209 (2006).

<sup>32</sup> *Id.* at 93.

<sup>33</sup> *See, e.g., Jacobson*, 197 U.S. 11.

<sup>34</sup> *See Lorillard Tobacco v. Reilly*, 533 U.S. 525 (2001) (relying on First Amendment and Supremacy Clause to invalidate aspects of Massachusetts’ regulations on tobacco advertising; concluding that scope of regulations did not demonstrate a “reasonable fit” with state’s objective to prevent smoking among minors).

<sup>35</sup> *See Jacobson*, 197 U.S. at 25 (emphasis added).

<sup>36</sup> Kate Zernike, *The Nation: Food Fight; Is Obesity the Responsibility of the Body Politic?*, N.Y.

have advanced two main arguments against the use of state police power in this context.

First, critics have insisted that obesity is a private matter, as opposed to a public health issue.<sup>37</sup> From this perspective, state intervention can marginalize obese individuals and infringe upon personal choices about food and exercise.<sup>38</sup> This position acknowledges valid concerns about discrimination against obese individuals and properly identifies diet and physical activity as critical factors in weight management.<sup>39</sup> However, the argument disregards the role of society in both the causes and effects of obesity; i.e., “harms that are apparently self-imposed, but also are deeply socially embedded and pervasively harmful to the public.”<sup>40</sup> For example, to hold individuals solely accountable for obesity would ignore socioeconomic limitations on options for nutritious food and regular exercise. Instead of “blaming the victims” of these circumstances, states can share responsibility for obesity as a public health problem *and* share accountability for an appropriate solution by making resources for health promotion and weight management more accessible. This type of state initiative would acknowledge that the “single greatest opportunity to improve health and reduce premature deaths lies in personal behavior,”<sup>41</sup> and would provide assistance to individuals to maximize this opportunity. Thus, states can use police power to facilitate individual empowerment through more expansive health care options and more informed health care decisions.

A second criticism of state action in the context of obesity challenges the efficacy of anti-obesity initiatives. From this perspective, “traditional justifications for the use of police power in

---

TIMES, Nov. 9, 2003, <http://www.nytimes.com/2003/11/09/weekinreview/the-nation-food-fight-is-obesity-the-responsibility-of-the-body-politic.html>.

<sup>37</sup> See, e.g., Campos et al., *supra* note 21.

<sup>38</sup> *Id.* at 58–59.

<sup>39</sup> *Id.*

<sup>40</sup> Lawrence O. Gostin, *Law as a Tool to Facilitate Healthier Lifestyles and Prevent Obesity*, 297 JAMA 87, 90 (2007). See also discussion, *supra* Part I.A.

<sup>41</sup> Steven A. Schroeder, *We Can Do Better – Improving the Health of the American People*, 357 NEW ENG. J. MED. 1221, 1222 (2007).



the case of obesity are much weaker because the causal link between any given intervention and reducing obesity is questionable.”<sup>42</sup> Although concerns about the efficacy of treatment are important for state legislators to consider,<sup>43</sup> this position confuses the *means* of public health regulation with the *end* of public health. The requirement of a rational relationship between a state measure and its objective underscores that legislators need not guarantee the success of state initiatives. Indeed, a court’s evaluation of public health regulation will not expound on whether the evidence that state legislators relied on was “medically sound or empirically correct”; the court will require only a reasonable basis for state action.<sup>44</sup> In this regard, the responsibility of public health regulators can be compared to the responsibility of physicians under the Hippocratic oath: the objective is to help; the obligation is to avoid causing harm.

### C. Opportunity for Integrated Action

The multifactorial etiology of obesity, including genetic, physiological, psychological, and behavioral components,<sup>45</sup> invokes the “mind-body-spirit” philosophy of healing that is the hallmark of integrated medicine.<sup>46</sup> Accordingly, neither conventional medicine nor CAM has a monopoly on the treatment of obesity; both communities have acknowledged a need for collaboration to improve options for long-term weight management. For example, a former director of the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health (NIH) noted that “[o]besity results from complex interactions among biology, behavior, and the environment. Therefore, multidisciplinary approaches . . . are needed to fully understand, prevent, and treat

---

<sup>42</sup> GOSTIN & JACOBSON, *supra* note 31, at 220 (quoting E.P. Richards III, *Is Obesity a Public Health Problem?*, 3 L. & BIOETHICS REP. 11, 11 (2004)).

<sup>43</sup> See discussion, *infra* Part II.B.

<sup>44</sup> See NYC C.L.A.S.H., Inc. v. City of N.Y., 315 F. Supp. 2d 461, 491 (S.D.N.Y. 2004).

<sup>45</sup> See Scott M. Grundy, *Multifactorial Causation of Obesity: Implications for Prevention*, 67 AM. J. CLINICAL NUTRITION 563S (1998).

<sup>46</sup> See COHEN, *supra* note 1, at 2–4.

it.”<sup>47</sup> Likewise, the American Medical Association (AMA) Task Force on Obesity has recommended that the AMA work with other organizations to explore diverse perspectives on the prevention, assessment, and management of obesity.<sup>48</sup> To that end, the *Journal of the American Medical Association* featured an article on obesity, which concluded that “a wide range of population groups, including physicians and other health care professionals, public health professionals, legislators, communities, work sites, and organizations, must become engaged in working toward a solution.”<sup>49</sup> Thus, strategic state initiatives to address obesity can reflect the value, and the values, of integrated health care by augmenting safe and effective treatment resources to maximize therapeutic benefit.

## PART II

The concept of obesity as a public health problem has generated a demand for states to coordinate a durable solution, which has yielded a supply of state legislation that is growing with the public’s waistline.<sup>50</sup> Authorized by state police power, these legal measures can be categorized into three vehicles of state action. First, state legislators have relied on *restrictive* measures to limit access to

---

<sup>47</sup> *Researching CAM Approaches to the Problems of Obesity*, COMPLEMENTARY & ALT. MED. AT THE NIH 1 (Fall 2004), available at <http://nccam.nih.gov/news/newsletter/pdf/fall2004.pdf>.

<sup>48</sup> AM. MED. ASS., NATIONAL SUMMIT ON OBESITY, EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS 1 (Oct. 2004), available at [http://www.ama-assn.org/ama1/pub/upload/mm/433/exec\\_sum.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/433/exec_sum.pdf) [hereinafter AMA RECOMMENDATIONS].

<sup>49</sup> Ali H. Mokdad et al., *The Spread of the Obesity Epidemic in the United States, 1991–1998*, 282 JAMA 1519, 1521 (1999).

<sup>50</sup> See *State Legislation*, ROBERT WOOD JOHNSON FOUND. CTR. TO PREVENT CHILDHOOD OBESITY, <http://www.reversechildhoodobesity.org/content/state-legislation> (last visited Sept. 5, 2010), for several resources related to proposed and enacted legislation at the state level. The federal government has demonstrated an interest in exploring the impact and implications of these legislative initiatives. For example, the CDC sponsored a National Summit on Legal Preparedness for Obesity Prevention and Control in 2008. A previous draft of this article was shared informally with several members of the Summit’s planning committee, and the author attended the Summit. The CDC also hosted Weight of the Nation, its inaugural conference on obesity prevention and control, in 2009.

resources that can contribute to obesity, such as trans fatty acids or food products high in calorie or fat content relative to overall nutritional value.<sup>51</sup> Second, state legislators have enacted *enabling* measures to promote access to resources that can contribute to weight management, such as options for nutritious food or physical activity in the public school systems.<sup>52</sup> Third, some state officials have expressed preliminary support for certain *conditional* measures that link health promotion in general, or weight management in particular, to eligibility for specific “enhanced benefit packages.”<sup>53</sup>

While these measures represent a significant commitment to address obesity as a public health concern, the strong association between obesity and disease(s)<sup>54</sup> also suggests a need for access to comprehensive resources for treatment and prevention, including conventional and CAM therapies. To meet this need, state legislators can design restrictive, enabling, and conditional measures to promote integrated health care. Because allopathic treatment is the current standard for conventional health care in the U.S., this discussion will focus on the incorporation of CAM resources into state measures to curb obesity, with the objective to advance the public health and holistic health.

### A. Restrictive Measures

State legislators have used restrictive measures to limit access to resources not only that can contribute to obesity, but also that can

---

<sup>51</sup> See, e.g., IND. CODE § 20-26-9-19 (2006) (requiring sales of “better” food and beverage choices in schools to restrict students’ intake of saturated fats, trans fats, and sugars); N.J. STAT. ANN. § 18A:33-15 (West 2007) (establishing nutritional restrictions on food and beverage options sold or distributed in public and certain nonpublic schools).

<sup>52</sup> See, e.g., PA. CONS. STAT. ANN. § 14-1422.2 (West 2006) (providing for recommendations on teaching about nutrition and obesity in schools); CONN. GEN. STAT. § 10-203a (West 2006) (providing for student exercise and wellness in schools).

<sup>53</sup> See, e.g., Press Release, State of Rhode Island Office of the Governor, OHIC Approves United and Blue Cross Wellness and Health Benefit Plans for Small Employers, (April 3, 2007), available at <http://www.ri.gov/GOVERNOR/view.php?id=3874> (discussing Governor Donald L. Carcieri’s perspective on wellness health benefit plans that incorporate, among other terms, a pledge by beneficiaries to either remain at a healthy weight or participate in weight management programs if morbidly obese).

<sup>54</sup> See discussion, *supra* Part I.A.

treat obesity, namely CAM practitioners.<sup>55</sup> Historically, states have relied on police power to provide the authority, if not the obligation, to protect the public health and safety from charlatans through the regulation of health care providers.<sup>56</sup> CAM scholars have argued that this rationale has been exploited to maintain the exclusive “turf” of conventional medicine at the expense of CAM practitioners.<sup>57</sup>

Specifically, state statutes establishing the practice of medicine can create barriers to patients’ relationships with CAM practitioners because of the entrenched association between the use of CAM modalities and the unauthorized practice of medicine.<sup>58</sup> State courts generally have construed these “practice of medicine” statutes broadly to encompass all aspects of diagnosing, curing, and treating disease.<sup>59</sup> As a result, CAM practitioners without a conventional medical license have been vulnerable to legal challenges based on the unauthorized practice of medicine.<sup>60</sup> CAM practitioners with a medical license also have been disciplined for using unconventional, and therefore unauthorized, CAM modalities.<sup>61</sup>

The justification for an inherent regulatory bias against CAM modalities or practitioners has become more vulnerable, as the paradigm of CAM has shifted from the stereotype of snake oil to the discipline of scientific research. Indeed, NCCAM, the lead agency of the federal government for scientific research on CAM, has enjoyed a budget of over \$120 million in recent fiscal years, in contrast to the \$2 million appropriation for fiscal year 1992 at NCCAM’s inception as the Office of Alternative Medicine.<sup>62</sup> Additionally, a growing number of health care entities, insurers, and practices have incorporated

---

<sup>55</sup> See discussion, *supra* Part II.

<sup>56</sup> See discussion *supra* Part I.B.

<sup>57</sup> See, e.g., MICHAEL H. COHEN, BEYOND COMPLEMENTARY MEDICINE 9–17 (2000).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> See NCCAM Funding: Appropriations History, NAT. CTR. FOR COMPLEMENTARY & ALT. MED. <http://nccam.nih.gov/about/budget/appropriations.htm> (last updated Jan. 4, 2010).

CAM therapies.<sup>63</sup> For instance, a survey of academic health centers in 2004 found that twenty-one out of twenty-two respondents, representing states in almost half of the country, offered clinical care by CAM practitioners.<sup>64</sup> Indeed, as of 1991, Americans already had made more visits to CAM providers than to primary care physicians.<sup>65</sup> In light of these trends, the 2005 Institute of Medicine report, *Complementary and Alternative Medicine in the United States* (the "IOM Report"), observed that "the proper attitude is one of *skepticism* about any claim that conventional biomedical research and practice exhaustively account for the human experiences of health and healing."<sup>66</sup> This statement encapsulates a profound cultural transition from skepticism about a health care system *with* CAM to skepticism about a health care system *without* CAM.

To accommodate these developments in the perception and practice of CAM, state legislators can modernize their regulatory framework to enable an integrated health care system that validates patient autonomy without sacrificing patient safety. One option is to enact state statutes defining the nature and scope of CAM practices, independent of conventional medicine. State licensure of CAM practitioners also can be useful to authorize the practice of a CAM discipline and to increase patient access to qualified CAM providers, e.g., by facilitating the licensee's participation in insurance plan networks.<sup>67</sup>

For further consideration by state legislators, David Eisenberg and his colleagues have proposed a comprehensive credentialing framework that is based on standards for malpractice insurance.<sup>68</sup>

---

<sup>63</sup> See, e.g., COMM. ON THE USE OF COMPLEMENTARY & ALT. MED. BY THE AM. PUB. BD. OF HEALTH PROMOTION & DISEASE PREVENTION, INST. OF MED. OF THE NAT'L ACADS., *COMPLEMENTARY AND ALTERNATIVE MEDICINE IN THE UNITED STATES* 278 (2005) [hereinafter IOM REPORT].

<sup>64</sup> Anne Nedrow, *Status of Credentialing Alternative Providers within a Subset of U.S. Academic Health Centers*, 12 J. ALT. & COMPLEMENTARY MED. 329 (2006).

<sup>65</sup> David M. Eisenberg et al., *Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use*, 328 NEW ENG. J. MED. 246, 251 (1993).

<sup>66</sup> See IOM REPORT, *supra* note 63, at 171 (emphasis added).

<sup>67</sup> See COHEN, *supra* note 57, at 16.

<sup>68</sup> David M. Eisenberg et al., *Credentialing Complementary and Alternative Medical Providers*, 137 ANNALS INTERNAL MED. 965 (2002).

Minimum requirements for CAM practitioners under the Eisenberg framework include state licensure, national certification, continuing education, and a review of malpractice insurance claims and coverage.<sup>69</sup> The framework also considers demographic information related to the experience and environment of the practitioner, references from other health care practitioners, site visits, and assessments of professional policies, procedures, and practices.<sup>70</sup> Finally, the framework accounts for the practitioner's use of CAM modalities and techniques that other CAM practitioners rely upon most frequently, in order to gauge consistency with "best practices."<sup>71</sup>

The emphasis in Eisenberg's credentialing framework on patient access to comprehensive knowledge about a CAM practitioner dovetails with three broad objectives of an integrated health care system advanced by Michael Cohen, one of the collaborators on Eisenberg's proposal.<sup>72</sup> These objectives include health protection, health promotion, and health freedom.<sup>73</sup> Specifically, Cohen argues that state regulation should not be used solely as a means to guard against the fraud and incompetence of providers.<sup>74</sup> Instead, an integrated credentialing framework should seek to enrich health care choices by providing patients with information and quality assurances with regard to available providers.<sup>75</sup> Consistent with Cohen's position, state legislators can take additional measures to update their regulatory framework. For instance, states can choose to limit penalties for the unauthorized practice of medicine to circumstances in which there is evidence that CAM modalities caused physical harm to patients or otherwise exceeded the safety risks of comparable conventional treatments.<sup>76</sup>

---

<sup>69</sup> *Id.* at 970.

<sup>70</sup> *Id.* at 970-71.

<sup>71</sup> *Id.* at 971.

<sup>72</sup> *Id.* at 965.

<sup>73</sup> See COHEN, *supra* note 57, at 18-19.

<sup>74</sup> *Id.* at 19.

<sup>75</sup> *Id.*

<sup>76</sup> Kristen J. Josefek, *Alternative Medicine's Roadmap to Mainstream*, 26 AM. J.L. & MED. 295, 303

While considering the implementation of these restrictive measures, or the development of alternatives, state legislators must anticipate concerns from the CAM and conventional medicine communities that can affect the feasibility of an integrated health care system. For example, state legislators should be mindful that restrictive measures can constitute a “double-edged regulatory tool.”<sup>77</sup> On the one hand, measures such as credentialing can increase the profile and perceived legitimacy of CAM from the perspective of the general public and can facilitate the coordination and development of CAM practitioners as a professional community. On the other hand, these measures can impose unwelcome interference, formality, and rigidity on the practice of CAM, especially with regard to CAM therapies that were premised on the rejection of such hallmarks of conventional medicine. Specifically, credentialing can introduce requirements of an M.D. or other conventional degree to qualify for state licensure or other standards that some CAM practitioners may deem undesirable, unattainable, or irrelevant.

Moreover, there is considerable variability in the terms of licensure across states and among CAM specialties.<sup>78</sup> Some CAM disciplines, such as chiropractic and acupuncture, are licensed in most, if not all states; whereas other CAM disciplines, such as homeopathy, remain predominantly unlicensed.<sup>79</sup> This inconsistency can not only undermine a sense of cohesion or community among CAM practitioners but also can disrupt the continuity of patient care if practitioners or patients move to states with practice requirements that differ from those of their former location. Therefore, state legislators must weigh the relative benefits and disadvantages of these restrictive measures from the perspectives of health care practitioners and patients.

Furthermore, state legislators should anticipate that turf battles between conventional practitioners and CAM practitioners can create political and practical barriers to integrated health care. This tension can compromise the ideal of an integrated health care system, “in

---

(2000).

<sup>77</sup> See COHEN, *supra* note 57, at 17.

<sup>78</sup> Eisenberg et al., *supra* note 68, at 965–67.

<sup>79</sup> *Id.*

which biomedical professionals function cooperatively with complementary and alternative professionals, as well as with patients, in a partnership of care and healing.”<sup>80</sup> Discord among conventional and CAM practitioners can also jeopardize the health of patients. For example, the failure of CAM practitioners and conventional medicine practitioners to communicate about all the types of treatment that their patients have pursued can result in dangerous consequences, such as adverse interactions between certain prescription drugs and dietary supplements.<sup>81</sup> Fortunately, the need to collaborate in the context of obesity treatment, as acknowledged by conventional medicine and CAM communities alike, can be an impetus to transcend these barriers to integration.<sup>82</sup>

### *Ethical Considerations*

The rationale that a state government should use restrictive measures that limit the practices of providers and the treatment options of patients in order to protect the public health invokes concerns of paternalism. Because the U.S. is a democratic nation that values autonomy, some Americans resent government interference in what are perceived as personal health care decisions. This sentiment, as it applies to state action in the context of obesity, is captured in the argument that “[T]he bad reason for state intervention is that governments should help citizens look after themselves. . . .”<sup>83</sup>

While this criticism may appeal to the personal integrity of individuals, it defies the social obligations of a community. The premise of police power is that the rights of individuals can be compromised, or even sacrificed, to promote the common good; the safety, health, or general welfare of society. Accordingly, states have justified restrictive measures on the tenet that “the liberty secured by

---

<sup>80</sup> COHEN, *supra* note 1, at 118.

<sup>81</sup> This risk can be significant, as patients tend not to volunteer their use of CAM therapies to conventional providers. *See, e.g.,* IOM REPORT, *supra* note 63, at 278 (noting that one-third of adults in the U.S. use CAM, “yet less than forty percent disclose such use to their physician and other health care providers”).

<sup>82</sup> *See* discussion, *supra* Part I.C.

<sup>83</sup> GOSTIN & JACOBSON, *supra* note 31, at 207 (referencing *The Shape of Things to Come*, ECONOMIST, Dec. 11, 2003, at 11).



---

the Constitution of the United States. . .does not import an absolute right in each person to be. . .wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good.”<sup>84</sup> Thus, state legislators can reconcile the ideals of patient protection and patient autonomy by modernizing the regulatory framework from a means of excluding all unconventional providers and practices, to a means of informing and enhancing all patients’ health care decisions.<sup>85</sup>

## B. Enabling Measures

With the safeguard of restrictive measures to regulate information about and/or standards for health care practitioners, states can use enabling measures to increase access to safe and effective CAM resources for obesity treatment. Approximately one-third to one-half of the country already relies on CAM modalities to enhance wellness, and such use is particularly common among patients with chronic diseases associated with obesity.<sup>86</sup> Indeed, “diet and nutrition” constitutes one of the seven major fields of holistic practice,<sup>87</sup> and CAM treatments for obesity- including supplements, herbs, meditation, hypnosis, diets, and acupuncture- overlap with several of the other fields of CAM as well. To capitalize on the utilization and utility of CAM therapies for obesity, state legislators should consider several options.

First, by including CAM resources in state initiatives to reduce obesity, state legislators can raise patients’ awareness of health care options, which can contribute to more informed health care decisions.

---

<sup>84</sup> *Jacobson*, 197 U.S. at 26.

<sup>85</sup> *Id.*

<sup>86</sup> See David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States, 1990–1997*, 280 JAMA 1569, 1571–72 (1998) (reporting 42.1% of Americans used at least one of sixteen designated alternative therapies in 1997, compared to 33.8% in 1990); see also *The Use of Complementary and Alternative Medicine in the United States*, NAT’L CTR. FOR COMPLEMENTARY & ALT. MED. (DEC. 2008), available at <http://nccam.nih.gov/news/camstats/2007/camuse.pdf> (reporting statistical use of CAM by Americans at 38%).

<sup>87</sup> COHEN, *supra* note 1, at 4–5 (listing categories of CAM described in *Report to the National Institutes of Health on Alternative Medical Systems and Practices in the United States*, i.e., “Chantilly Report”).

This type of enabling measure is consistent with a public policy approach to obesity “that focuses primarily on informing personal choices rather than restricting them.”<sup>88</sup> For example, state offices, task forces, and committees that coordinate information, programs, and services related to obesity can disseminate information about CAM to the public and can appoint CAM liaisons or CAM (sub)committees to contribute to state policies and programs on obesity. The fact that education is the leading sociodemographic variable that predicts the use of alternative medicine, i.e., the use of CAM is associated with higher levels of education, reinforces the need for enabling measures to bridge this knowledge gap.<sup>89</sup> Health care practitioners of all disciplines can also benefit from greater knowledge of CAM modalities. According to the committee responsible for the IOM Report, “because CAM use is becoming so widespread, all doctors, nurses, and other health care providers should receive education about these treatments during their professional education . . . .”<sup>90</sup> Thus, state action to improve information and communication about comprehensive resources for obese patients can be an important “enabler” of integrated health care.

Second, state legislators can consider health insurance incentives to facilitate access to CAM therapies for obesity. Historically, insurance coverage of CAM modalities has been restricted or denied based on conclusions that CAM methodologies were “experimental” or otherwise lacked the requisite evidentiary basis to be deemed medically necessary.<sup>91</sup> CAM scholars have argued that these coverage determinations reflect the dominance, if not the bias, of the

---

<sup>88</sup> Michelle M. Mello et al., *Obesity-The New Frontier of Public Health Law*, 354 *NEW ENG. J. MED.* 2601, 2608 (2006); see also M. Gregg Bloche, *Obesity and the Struggle Within Ourselves*, 93 *GEO. L.J.* 1335, 1353 (2005) (arguing that studies have shown that external controls can undermine people’s motivation to avoid negative behaviors).

<sup>89</sup> See John A. Astin, *Why Patients Use Alternative Medicine*, 279 *JAMA* 1548, 1551 (1998) (citing results of study showing that individuals with higher education were more likely to use alternative forms of healthcare).

<sup>90</sup> Press Release, The Nat’l Acads., *Complementary and Alternative Therapies and Conventional Medical Therapies Should Be Held to Same Standards; Revised Regulation of Dietary Supplements Is Needed to Ensure Product Quality and Safety* (Jan. 12, 2005), <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=11182>.

<sup>91</sup> See COHEN, *supra* note 1, at 101.

conventional biomedical paradigm in the U.S. health care system.<sup>92</sup>

Notwithstanding the rationales that may sustain them, these coverage limitations have impeded the use of CAM, particularly by patients of lower socioeconomic status, and have yielded billions of dollars in out-of-pocket expenses for CAM patients each year.<sup>93</sup> In light of these obstacles, state legislators should ensure that the scope of insurance coverage reflects current research and clinical practices associated with CAM. Many insurance companies are beginning to update their coverage policies accordingly. For example, in 2007, Guardian Life Insurance Company of America (Guardian) introduced a CAM discount program that facilitates patient access to CAM therapies by offering discounts of up to 30% on treatments in thirty eight CAM disciplines.<sup>94</sup> Commenting on the rationale for this program, a Guardian spokesperson observed, "CAM, once considered fringe, is now firmly part of the mainstream."<sup>95</sup> This perspective on the growing acceptance of CAM treatments by the insurance industry and the general public is consistent with the findings of a survey of 3,000 employers in 2004, which revealed that 47% offered health plans with acupuncture coverage and 87% offered chiropractic coverage.<sup>96</sup>

Although there are restrictions on the number, duration, or circumstances of visits to CAM practitioners, these insurance

---

<sup>92</sup> *Id.* at 96; *see also* discussion, *supra* Part II.A.

<sup>93</sup> *See, e.g.*, IOM REPORT, *supra* note 63, at 1 (estimating annual out-of-pocket costs to exceed \$27 billion); *see also* *Paying for CAM Treatment*, NAT'L CTR. FOR COMPLEMENTARY & ALT. MED. (May 2010), <http://nccam.nih.gov/health/financial/D331.pdf> (citing 2007 National Health Interview Survey report that adults in America spent \$33.9 billion out-of-pocket on CAM treatments over the previous 12 months; \$22 billion for CAM products, classes, and materials; the remaining \$11.9 billion on visits to CAM practitioners).

<sup>94</sup> Press Release, The Guardian Life Ins. Co. of Am., Guardian Expands Medical Plan Discounts for Yoga, Pilates, Massage Therapy, Ayurvedic and Other Alternative Procedures (Apr. 18, 2007), [http://www.guardianlife.com/company\\_info/press\\_releases/april\\_18\\_2007.html](http://www.guardianlife.com/company_info/press_releases/april_18_2007.html) [hereinafter Guardian Press Release].

<sup>95</sup> *Id.*

<sup>96</sup> *See* Sarah Rubenstein, *Health Plans Embrace Alternatives: Acupuncture, Chiropractic Often Can Save Money, Enhance Employee Options*, WALL ST. J., Sep. 22, 2004, at D7 (discussing Kaiser Family Foundation Health Research and Educational Trust, Employer Health Benefits, 2004 Survey).

incentives can facilitate integrated health care by increasing the accessibility of safe and effective CAM modalities for obesity treatment. Another Guardian spokesperson directly connected the need for expanded insurance coverage of CAM therapies to the prevalence of obesity, affirming that “a more holistic approach can help fight obesity . . . and ultimately help reduce healthcare costs.”<sup>97</sup> To that end, a primary recommendation of the AMA Obesity Task Force was to “work with . . . health insurers to recognize obesity as a disease, secure appropriate reimbursement and refocus reimbursement on health promotion and wellness.”<sup>98</sup> State legislation can further that objective by providing mandatory insurance coverage of obesity treatment that expressly include CAM therapies.<sup>99</sup> State incentives for integrated treatment of obesity can be extended to the private sector as well. For example, states can provide tax incentives to employers that offer private health plans with comprehensive insurance benefits to facilitate integrated health.<sup>100</sup>

As a third option, state legislation can enhance patient access to integrated treatment resources in general. For example, several states have recognized either the express authority of providers to practice integrated medicine or the affirmative right of patients to seek integrated therapies.<sup>101</sup> Current and former members of Congress

---

<sup>97</sup> Guardian Press Release, *supra* note 94.

<sup>98</sup> AMA Recommendations, *supra* note 48, at 6.

<sup>99</sup> The terms for coverage of obesity treatment in the Medicare program could set the pace or precedent for state policies to that end. To date, Medicare coverage is limited to certain types of bariatric surgeries, with specifications regarding the comorbidities of obesity and the qualifications of the treating surgeon and surgery facility. *See, e.g.*, Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Expands National Coverage for Bariatric Surgery Procedures (Feb. 21, 2006), *available at* <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1786>.

<sup>100</sup> *See, e.g.*, Schroeder, *supra* note 41, at 1223 (arguing that laws and regulations at the state and local levels led to smoke-free public places and increases in taxes on cigarettes in the government’s campaign to decrease smoking). While a detailed discussion of the federal Employee Retirement Income Security Act of 1974 (ERISA) is beyond the scope of the present discussion, the potential impact of ERISA on state health care legislation, including health insurance initiatives, should be noted.

<sup>101</sup> *See, e.g.*, COHEN, *supra* note 57, at 21 (discussing bill in Hawaii and rules adopted by State Board of Medical Examiners in Texas to advance integrated medicine).

have endorsed similar measures at the federal level. For instance, members in several Congressional sessions have introduced the “Access to Medical Treatment Act,” a bill that would improve access to “any medical treatment (including a medical treatment that is not approved, certified, or licensed by the Secretary)” that a patient desires.<sup>102</sup> In a statement of support for the bill, former Senator Tom Daschle acknowledged the need “to remove some of the access barriers that consumers face when seeking certain alternative therapies.”<sup>103</sup> This legislative activity at the state and federal levels puts enabling measures concerning obesity into the broader context of enabling an integrated health care system.

### *Ethical Considerations*

While the concept of integrated medicine presumes a baseline of safety and efficacy, state legislators must anticipate inevitable questions about those two factors as they pertain to integrated obesity measures. To date, there are no definitive answers to such questions because conclusive, long-term validation of both conventional and CAM interventions for obesity has been elusive.<sup>104</sup> Thus, state legislators can be subject to ethical, if not legal, criticism, to the extent that state implementation of integrated obesity measures is perceived as encouraging treatment that can jeopardize, instead of protect, the public health.<sup>105</sup>

---

<sup>102</sup> Access to Medical Treatment Act, S. 2618, 109th Cong. § 3(a) (2006).

<sup>103</sup> Josefek, *supra* note 76, at 307 (citing to hearings on bill before Senate Committee on Health, Education, Labor, and Pensions, 106th Cong. (1999)).

<sup>104</sup> See, e.g., AMA RECOMMENDATIONS, *supra* note 48, at 3 (noting that “[m]edication and obesity surgery can sustain moderate to significant weight loss, but long-term outcomes data are not available and both can produce adverse effects”); see also J.M. Lacey et al., *Acupuncture for the Treatment of Obesity: A Review of the Evidence*, 27 INT’L J. OBESITY 419, 425–26 (2003) (finding a need for further evaluation of acupuncture’s potential as an adjunct in weight management).

<sup>105</sup> See, e.g., Melissa McNamara, *Diet Industry is Big Business*, CBS NEWS (Dec. 1, 2006), <http://www.cbsnews.com/stories/2006/12/01/eveningnews/main2222867.shtml?tag=mncol;lst:1> (noting that Americans spend approximately \$35 billion per year on weight-loss products and suggesting that individuals striving to lose weight can be vulnerable to psychological and financial exploitation). Additionally, information about safety and efficacy is relevant to various requirements under the federal Food, Drug, and Cosmetic Act and may be applicable to treatments for obesity. See generally 21 U.S.C. §§ 301–99 (2009).

As the “outsider” of mainstream medicine, CAM has shouldered the brunt of criticism caused by the lack of safety and efficacy assurances. Indeed, a common criticism of CAM modalities in general is that they have not been validated.<sup>106</sup> While this concern is significant, state legislators evaluating the implications should note that a “lack of evidence of effectiveness . . . is not evidence of lack of effectiveness.”<sup>107</sup> Moreover, by definition, innovation challenges the status quo. Therefore, it may seem contradictory to criticize innovative, integrated treatments for failing to conform to standards of safety and efficacy that are confined by the present knowledge base of conventional medicine.

Many CAM scholars and practitioners have argued that traditional clinical standards of safety and efficacy for allopathic medicine are not appropriate for evaluations of CAM modalities.<sup>108</sup> Specifically, the multidisciplinary nature of certain CAM therapies and the refractory nature of the conditions they treat may not always be conducive to randomized controlled trials or studies with short timelines.<sup>109</sup> For some of these CAM modalities, and even for their counterparts in conventional medicine with similar limitations, the IOM Report conceded that novel methods may be necessary to generate, interpret, and evaluate evidence of safety and efficacy – although the IOM Report otherwise “recommended that the same principles and standards of evidence of treatment effectiveness [should] apply” to conventional and CAM modalities.<sup>110</sup> Additionally, if the U.S. health care system seeks to embrace a global perspective, it would seem logical to consider how, and to what extent, CAM methodologies are validated in the other countries of their origin or use. Thus, while safety and efficacy are valid priorities,

---

<sup>106</sup> See Robert M. Sade, *Complementary and Alternative Medicine: Foundations, Ethics, and Law*, 31 J.L. MED. & ETHICS 183, 184 (2003) (reviewing Lawrence Schneiderman’s criticism of CAM).

<sup>107</sup> *Id.* at 185 (discussing David Hufford’s rebuttal of scientific criticisms of CAM).

<sup>108</sup> See *id.* at 184–86 (considering David Hufford’s explanation of limits on ability of science to evaluate CAM and Ruiping Fan’s assertion that “traditional Chinese medicine and modern scientific medicine . . . are fundamentally incommensurable and cannot be evaluated by the same standards”).

<sup>109</sup> See, e.g., IOM REPORT, *supra* note 63, at 278.

<sup>110</sup> See, e.g., *Id.*

state legislators should set reasonable expectations and clear definitions for these terms that do not unnecessarily or unfairly stifle innovation and ultimately progress in medicine.

The surge of research on obesity may alleviate some of these safety and efficacy concerns, as state measures can accommodate academic and clinical developments over time. To that end, the Office of the Surgeon General of HHS issued a “Call To Action To Prevent and Decrease Overweight and Obesity” in 2001, designating obesity research and treatment as national priorities.<sup>111</sup> The NIH and other federal agencies have supported thousands of scientific studies related to obesity in the past decade,<sup>112</sup> and hundreds of clinical trials on obesity are currently recruiting human subjects for further research.<sup>113</sup> NCCAM has been an active contributor to these efforts.<sup>114</sup> The agency has confirmed research on obesity as a priority and serves as a member of the NIH Obesity Research Task Force,<sup>115</sup> established in 2003 to coordinate scientific advances to address obesity.<sup>116</sup> The insight gained through these ongoing investigations in

---

<sup>111</sup> See OFFICE OF THE SURGEON GEN., SURGEON GENERAL’S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY 33–35 (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

<sup>112</sup> See *Research Portfolio Online Reporting Tools*, NAT’L INSTS. OF HEALTH, <http://projectreporter.nih.gov/reporter.cfm> (last visited Sep. 15, 2010) (searchable online database that provides information on current and past research projects).

<sup>113</sup> See *ClinicalTrials.gov*, U.S. NAT’L INSTS. OF HEALTH, <http://www.clinicaltrials.gov/ct2/results?term=obesity> (last visited Sep. 15, 2010) (searchable online database that provides information about federally and privately supported clinical research).

<sup>114</sup> See *About NIH Obesity Research*, NAT’L INSTS. OF HEALTH, <http://www.obesityresearch.nih.gov/about/about.htm> (last visited Sept. 17, 2010).

<sup>115</sup> *Id.* (discussing role and membership of Task Force and outlining strategic plan and collaborations related to obesity research, including the National Collaborative on Childhood Obesity Research (NCCOR)). NCCOR was developed in 2009 with CDC, the NIH, and the Robert Wood Johnson Foundation to promote awareness of, and best practices related to, the management of childhood obesity; See Press Release, Robert Wood Johnson Found., Leading Research Funders Launch Collaborative to Accelerate Nation’s Progress in Reducing Childhood Obesity (Feb. 19, 2009), available at <http://www.rwjf.org/childhoodobesity/product.jsp?id=38988>.

<sup>116</sup> NIH OBESITY RESEARCH TASK FORCE, STRATEGIC PLAN FOR NIH OBESITY RESEARCH 2 (Aug. 2004), available at [http://www.obesityresearch.nih.gov/About/Obesity\\_EntireDocument.pdf](http://www.obesityresearch.nih.gov/About/Obesity_EntireDocument.pdf).

conventional medicine and CAM can refine the understanding and expectations of state legislators and the general public for safer, more effective integrated treatments for obesity in the coming years.<sup>117</sup>

### C. Conditional Measures

As a third vehicle for state action to promote the public health and integrated health care, state legislators can consider conditional measures that address obesity. Two opportunities can be explored to prompt further analysis, in the spirit of states as police power laboratories. The first scenario reconsiders the context of health benefits, and the second scenario introduces the context of domestic litigation.

First, states can incorporate CAM resources in present and future programs that condition the receipt of certain benefits on a commitment to health promotion in general or weight management in particular. Examples of these programs include West Virginia's Medicaid initiative, which requires recipients of enhanced benefit packages to uphold responsibilities of health promotion enumerated in a "Member Agreement,"<sup>118</sup> and "wellness health benefit plans" in Rhode Island, which can include a pledge by beneficiaries "either [to] remain at a healthy weight or [to] participate in weight management programs if morbidly obese."<sup>119</sup> To help beneficiaries meet these objectives, states can use the enabling measures discussed *supra* to increase awareness of conventional and CAM resources for the prevention and treatment of obesity and other health conditions.

Domestic litigation offers a second context for conditional state measures to advance integrated obesity treatment and the public health. Courts in several states have made decisions limiting or denying the custody of minor children on the basis that obesity jeopardizes the health of the children either directly (when the children are obese) or indirectly (when the children's caregivers are

---

<sup>117</sup> *See Id.* at 2, 53.

<sup>118</sup> West Virginia Medicaid Member Agreement Draft, W. Va. Medicaid Program (last modified Sept. 13, 2005), <http://www.wvdhhr.org/medRed/handouts/WVMedicaidMemberAgrmnt.pdf>.

<sup>119</sup> State of Rhode Island Office of the Governor, *supra* note 53.



obese).<sup>120</sup> These judicial decisions, seeking to advance the best interests of the affected children, can be premised on theories of neglect, to the extent that caregivers have not appropriately managed the children's health. Alternatively, courts can pursue theories of capacity, with the argument that the compromised health of obese caregivers precludes the fulfillment of their childcare responsibilities.<sup>121</sup> Before or after rendering the custody determinations, state judges can order obese caregivers and children to participate in nutrition and exercise programs to evaluate their potential to alleviate these concerns.<sup>122</sup> In this regard, the privilege of child custody has been conditioned upon a commitment to weight management.

In a review of these state programs, one commentator concluded that long-term weight management can be impeded by a lack of sustained resources and support.<sup>123</sup> The incorporation of integrated treatment in these programs can help to fill this gap. Specifically, state courts can approve obesity programs that include both conventional medicine and CAM resources in order to augment treatment options and reinforce patient accountability for ongoing weight management. Engaging both conventional and CAM professionals and therapies to address the multidisciplinary complications and implications of obesity can increase long(er)-term compliance of patients, which in turn can reduce the administrative burden and improper entanglement of state courts.

Notably, there is precedent for this type of integrated treatment program. For example, as an alternative to incarceration, a diversion program in an Oregon county had success in using routine acupuncture and psychological counseling services to treat the drug

---

<sup>120</sup> See, e.g., Shireen Arani, *State Intervention in Cases of Obesity-Related Medical Neglect*, 82 B.U. L. REV. 875, 875-77 (2002) (discussing case in New Mexico where state officials removed a three-year-old and charged parents with failing to follow a doctor's instructions to treat their child's obesity); see also Lindsey Murtagh, *Judicial Interventions for Morbidly Obese Children*, 35 J.L., MED. & ETHICS 497, 497 (2007) (listing California, Iowa, Indiana, New Mexico, New York, Pennsylvania, and Texas as states which have removed children from parents on the basis of morbid obesity).

<sup>121</sup> See Arani, *supra* note 120, at 876-77 & n.5.

<sup>122</sup> See generally Murtagh, *supra* note 120, at 497-99.

<sup>123</sup> *Id.* at 498.

addiction of certain criminals.<sup>124</sup> The efficacy of this program can be instructive for the design of conditional measures that address obesity, especially to the extent that obesity involves an addiction to food.<sup>125</sup> Thus, by studying the Oregon program, and other integrated treatment protocols such as those in many hospitals, states can refine conditional measures to better serve public health and individual needs.

### *Ethical Considerations*

The related risks of marginalizing patients and undermining treatment can threaten the viability of conditional state measures. For instance, some commentators have cautioned that linking a requirement of health promotion to eligibility for enhanced benefit packages can be a counterproductive strategy.<sup>126</sup> Specifically, critics are concerned that this type of program can create unnecessary and potentially insurmountable barriers to accessing treatment, raising ethical questions that have both legal and medical implications.<sup>127</sup>

---

<sup>124</sup> MICHAEL W. FINIGAN, AN OUTCOME PROGRAM EVALUATION OF THE MULTNOMAH COUNTY S.T.O.P. DRUG DIVERSION PROGRAM 2-3 (Jan. 5, 1998), available at <http://www.oregontreatmentworks.org/OPE.pdf> (finding lower rates of recidivism among program participants relative to eligible non-participants).

<sup>125</sup> See, e.g., Sarah Avery, *Is Big Fat the Next Big Tobacco?*, RALEIGH NEWS & OBSERVER, Aug. 18, 2002, [http://nl.newsbank.com/nl-search/we/Archives?p\\_action=print&p\\_docid=0F57FBB32D049279&p\\_docnum=3&s\\_accountid=AC0110091900011116339&s\\_orderic](http://nl.newsbank.com/nl-search/we/Archives?p_action=print&p_docid=0F57FBB32D049279&p_docnum=3&s_accountid=AC0110091900011116339&s_orderic) (noting that statistics exist showing a parallel between the rise in junk-food consumption and obesity, and also describing research investigating whether large amounts of fat combined with sugar can trigger a craving); see also Schroeder, *supra* note 41, at 1224 (listing commonalities between obesity and tobacco use). But see Mello et al., *supra* note 88, at 2602 (noting “no one has shown that foods have physically addictive properties, much less that food companies manipulate their addictive content to encourage dependence”).

<sup>126</sup> See Robert Steinbrook, *Imposing Personal Responsibility for Health*, 355 NEW ENG. J. MED. 753, 753-56 (2006) (cautioning that some beneficiaries may not change their behavior in a way that improves their health and that there may not be any overall cost savings if too many patients remain ineligible for enhanced health coverage); see also Gene G. Bishop & Amy C. Brodkey, *Personal Responsibility and Physician Responsibility – West Virginia’s Medicaid Plan*, 355 NEW ENG. J. MED. 756, 756-58 (2006) (arguing that the plan’s emphasis to increase patients’ personal responsibility is misguided because Medicaid patients are less able to control various factors in their lives that impact their health).

<sup>127</sup> See Steinbrook, *supra* note 126, at 754; see also Bishop & Brodkey, *supra* note 126, at 756.

For example, the fact that participants in this type of program may have financial, physical, and/or psychological impediments to optimal health can exacerbate the perception, if not the reality, that compliance obligations impose an undue burden on patients' access to health care. To that end, while such programs can be framed as conditional, they can be experienced as compulsory, particularly if the loss of premium benefits removes or obstructs a patient's preferred, most viable, or perhaps only means of health care.<sup>128</sup> Critics can take this analysis a step further to construe the programs as punitive: instead of rewarding patients for seeking access to improved health, conditional programs can penalize patients for failing to sustain it.

State involvement in conditional measures can also raise concerns about paternalism.<sup>129</sup> Specifically, state administration of conditional programs can infringe upon the sanctity of patients' relationships with their health care providers.<sup>130</sup> This imposition can further alienate vulnerable patients from the health care system: "[a]s physicians become agents of the state, poor patients' distrust of the medical system can only increase."<sup>131</sup> While not necessarily insurmountable, these ethical concerns raise complicated questions that should be considered from the multidisciplinary perspectives of an integrated health care system.

---

<sup>128</sup> See Rich Maloof, *The Anti-Fat Shot*, MSN HEALTH & FITNESS, <http://health.msn.com/fitness/articlepage.aspx?cp-documentid=100172213>

(last visited Sep. 18, 2010) (discussing injection lipolysis, an injection of two drugs that kills fat cells and dissolves the fat within those cells); see also Martin H. Bosworth, *Scientists Develop Potential Anti-Obesity Vaccine*, CONSUMERAFFAIRS.COM (Aug. 1, 2006), [http://www.consumeraffairs.com/news04/2006/08/obesity\\_vaccine.html](http://www.consumeraffairs.com/news04/2006/08/obesity_vaccine.html)

(last visited Sep. 18, 2010) (announcing vaccine that stimulates hormones which prevent weight gain in rats but requires more testing before it will be available for human use). If such a treatment were developed, state legislators would need to consider its protocol, efficacy, and side effects, among other issues, to justify its implementation under state police power as a reasonable public health measure. See discussion, *supra* Part I.B.

<sup>129</sup> See discussion, *supra* Part II.A.

<sup>130</sup> *Id.*

<sup>131</sup> Bishop & Brodkey, *supra* note 126, at 757.

#### D. Practical Considerations

The development, oversight, and enforcement of integrated obesity measures, whether restrictive, enabling, or conditional, will invoke a number of practical challenges. Among other logistical issues, state legislators should weigh the costs of the measures, the implications for the state judiciary and the state legislature, and the prospect of constituent support. These practical considerations can be factored into the calculus of legal and ethical considerations discussed here to maximize the potential of state initiatives.

First, state legislators must consider the costs of implementing integrated obesity measures relative to competing demands for limited state funding. The financial strain of innovation is a pervasive problem for the field of CAM in general. For example, the final report of the White House Commission on Complementary and Alternative Medicine Policy, issued in March 2002, referred to increased levels of public and private funding for CAM as an "immediate need."<sup>132</sup>

To meet this fiscal need, state legislators can consider a number of resources. For instance, state initiatives have received a considerable boost from the federal government.<sup>133</sup> Among other programs referenced herein, the CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) has provided approximately half of the country with financial and administrative support to coordinate obesity measures.<sup>134</sup> Participation in this CDC initiative has reinforced obesity as a funding priority at the federal and state levels and has solidified public-private partnerships to contain the obesity epidemic. CDC also has offered funding and technical support to hundreds of communities and to state and territorial health departments through its Healthy Communities Program.<sup>135</sup> The NGA has provided additional support for state

---

<sup>132</sup> See Sade, *supra* note 106, at 189 (reviewing summary of report by Kathleen Boozang).

<sup>133</sup> See discussion, *supra* Part I.A.

<sup>134</sup> *State-Based Programs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/obesity/stateprograms/index.html> (last updated May 13, 2010); see discussion, *supra* Part I.A.

<sup>135</sup> *CDC's Healthy Communities Program*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/healthycommunitiesprogram> (last visited Sep. 18, 2010).

efforts to curb obesity. To promote the NGA “Healthy America” initiative, the NGA Center awarded grants of up to \$100,000, supported by private industry, to thirteen states to encourage community and worksite wellness programs.<sup>136</sup> One year later, the NGA Center awarded ten state grants of \$100,000, supported by the CDC and the Robert Wood Johnson Foundation, to facilitate the prevention of childhood obesity through “Healthy Kids, Healthy America.”<sup>137</sup> Thus, states can partner with the federal government and with other public and private entities to support innovative and integrated obesity initiatives that promote the public health.

Second, state legislators should be cognizant of the implications of obesity measures for the state judiciary. Raising public awareness of external, societal factors that contribute to obesity can prompt litigation to assign legal blame for this public health problem. Therefore, state legislators should assess the need for legislation to preclude a pattern of obesity-related lawsuits that could overwhelm the state judiciary. For example, in the wake of litigation against McDonald’s restaurants for allegedly contributing to the obesity of patrons, numerous states enacted laws to limit the liability of the food and restaurant industries for the obesity of consumers.<sup>138</sup>

Third, state legislators must anticipate that state action in the context of obesity can be perceived as inconsistent, if not hypocritical, to the extent that states are exacerbating the obesity problem that they are trying to solve. For example, state-funded public schools often contract with soda and snack food vendors to supply

---

<sup>136</sup> Press Release, Nat’l Governors Ass’n, NGA Center Awards Grants for Healthy States, (July 27, 2006), available at <http://www.nga.org>.

<sup>137</sup> Press Release, Nat’l Governors Ass’n, NGA Awards 10 States \$100,000 Grants to Combat Childhood Obesity, (July 11, 2007), available at <http://www.nga.org>.

<sup>138</sup> See Lawrence O. Gostin, *Law as a Tool to Facilitate Healthier Lifestyles and Prevent Obesity*, 297 JAMA 87, 87 (2007) (discussing “commonsense consumer” laws that limit tort liability in twenty-one states); see also *Pelman v. McDonald’s Corp.*, 237 F. Supp. 2d 512 (S.D.N.Y. 2003), amended by, *Pelman ex rel. Pelman v. McDonald’s Corp.*, No. 02-CIV-7821, 2003 WL 22052778 (S.D.N.Y. Sept. 3, 2003), vacated in part, 396 F.3d 508 (2d Cir. 2005), remanded, 396 F. Supp. 2d 439 (S.D.N.Y. 2005) (ordering plaintiffs to provide a more definite statement of their claims, including a brief description of the injuries suffered by reason of defendant’s conduct, in suit brought by parents on behalf of minor children against fast-food restaurant chain, alleging violations of New York’s consumer protection statutes and negligence in connection with children’s over-consumption of fast-food products).

unhealthful products.<sup>139</sup> Yet the same states may pass legislative measures to prevent or limit the sales of such items on school campuses.<sup>140</sup> Likewise, for meal services in public school cafeterias, states may have contracted with vendors that fail to meet the government's nutritional standards.<sup>141</sup> Additionally, states may subsidize or otherwise incentivize manufacturers or producers of products such as sugar, which can increase the use and potential abuse of these products, thereby contributing to obesity and its attendant health complications.<sup>142</sup> Accordingly, state legislators must seek to reconcile any inherent conflicts among state laws and policies related to obesity.

Finally, the viability of state obesity measures relies upon the compliance and commitment of constituents. Holding states accountable for the means of public health does not excuse individual accountability for the end of personal health. Once states have exercised their police power authority through measures that ensure the conditions for integrated health care, individuals must make constructive and responsible use of these resources, with the appropriate guidance of qualified health care practitioners.

## CONCLUSION

Using state police power to promote integrated treatment for obesity can enhance the means to achieve public health and personal health. To further that dual objective, this paper examined legal, ethical, and practical considerations associated with the accommodation of CAM resources in restrictive, enabling, and conditional state measures to address obesity. Through an integrated approach to obesity and other public health issues, states can reinforce individual and collective responsibility for the nation's

---

<sup>139</sup> See Gostin, *supra* note 138, at 89.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> See Sugar and Sweeteners: Policy, USDA ECONOMIC RESEARCH SERVICE, <http://www.ers.usda.gov/Briefing/Sugar/Policy.htm> (last updated Jan. 7, 2010) (discussing "domestic price support" Federal government subsidies for sugar beet and sugar cane growers).

health - a deliberate balance between state police power and individual willpower.