Parents of Obese Children and Charges Of Child Abuse: What Is Our Response?

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The alarming rate of childhood obesity in the United States is, unfortunately, no longer news. Obese children are presenting as patients to hospitals and clinics for a variety of reasons, most of which were previously only seen in the adult population: type 2 diabetes mellitus, high blood pressure, high cholesterol, glucose intolerance, asthma, sleep apnea, menstrual abnormalities, impaired balance, and orthopedic problems (American Academy of Pediatrics [AAP], n.d.). Equally concerning are the negative mental and social effects of obesity, such as low self-esteem, depression, negative body image, stigma, teasing, discrimination, and social marginalization (AAP, n.d.). Evidence also demonstrates that childhood obesity is associated with lower math and reading scores (Mitgang, 2011). How should this growing problem in our country be resolved? One drastic proposal that made the headlines in the summer of 2011 was to consider removing severely obese children from their parents’ custody (Murtagh & Ludwig, 2011). Is this action what is best for these children?

This article provides an overview of the reasons for and against the prosecution of parents of obese children. Additionally, alternative perspectives that re-examine social policies that may contribute to childhood obesity will be explored. Finally, pediatric nurses will be encouraged to engage in policy discussions about childhood obesity. Excluded from the discussion are cases of obesity due to genetic conditions.

Reasons for Prosecution

Although the law recognizes that parents have the primary responsibility for raising their children, the state may intervene to protect a child from harm or abuse. One way a state may intervene is through its child abuse laws. Federal legislation identified the following minimum definition for each state to adopt in their respective child abuse statutes: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm” (U.S. Department of Health and Human Services, 2005). While people recognize a role for the State in addressing problems with children’s health, the extent to which government should be involved in issues of childhood obesity remains subject to debate (Tao & Glazer, 2005). The rationale for invoking child abuse laws for severely obese children is that the child faces imminent health risks and the parent has repeatedly failed to address these medical problems, thus meeting the definition for mandatory child abuse reporting (Murtagh & Ludwig, 2011). In an interview about Murtagh and Ludwig’s (2011) article, Dr. Norman Fost, a pediatrician and ethicist, explained that both morbid obesity and undernutrition are forms of malnutrition and that parents of undernourished children are routinely charged with abuse, so the same standard can apply for parents of obese children (Ogilvie, 2011). In other words, if a parent who endangers a child’s health by starving her or him can be charged with abuse, why should a parent who endangers a child’s health by over-feeding her or him not also be subject to these charges?

Using the legal system as a resource for health professionals to protect children from the health complications of obesity is not a new or recent phenomenon. In fact, a number of jurisdictions have recognized that morbid obesity is a justification for state intervention (Mitgang, 2011). For example, in 2002, a Texas court of appeals upheld the termination of a mother’s parental rights based, at least in part, on the child’s obesity. In this case, a five-year-old, G.C., weighed 136 pounds, experienced difficulty breathing, and had a mildly enlarged heart and mild congestive heart failure (In re G.C., 2002).

It is important to note that those who support removing an obese child from her or his home would do so only when necessary to address a current risk of serious harm or to prevent loss of life (Mitgang, 2011). However, determining exactly “when” harm becomes imminent is one of the challenges with this standard (Mitgang, 2011, p. 566-567). Attempts have been made to articulate objective criteria that establish a threshold for state intervention. Varness, Allen, Carrel, and Fost (2009) justify removal from the home when there is 1) a high likelihood of serious, imminent harm; 2) a reasonable likelihood that coercive state intervention will result in effective treatment; and 3) no other alternative options are present to address the problem. Varness et al. (2009) distinguished between four cate-

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categories of obese children, depending upon the presence of co-morbidities that predict serious harm and whether these are reversible in adulthood, or whether these constitute imminent harm in childhood. State intervention would be justified when the co-morbid conditions predict serious harm and are not reversible in adulthood, as well as when the co-morbid conditions constitute serious harm in childhood (Varness et al., 2009).

Citing concerns for bias and conjecture in reaching a decision about obesity as child abuse, Mitgang (2011) underscored the importance of objective, physical evidence in an abuse analysis. She would justify state intervention when necessary to prevent loss of life or to address a current risk of serious harm and only after home-interventions had failed (Mitgang, 2011). Mitgang (2011) identified four factors that should be used by a court in determining whether actual medical harm caused by the child’s obesity warrants state intervention:

- The severity of child’s illness associated with obesity.
- The degree in which medical treatment can mitigate the resulting health effects.
- The child’s complete physical and mental health picture.
- When the just answer is unclear, the child’s risk of remaining obese as an adult.

**Response to Murtagh and Ludwig**

As one would expect, Murtagh and Ludwig’s (2011) article was met with a strong response from the medical and legal communities. Each of these three letters to the editor, including Ludwig and Murtagh’s response, will be discussed in turn.

Ms. Carol Erskine, a justice in a Massachusetts county juvenile court, wrote to underscore that in these cases, state intervention may occur only under clearly defined legal parameters (Erskine, 2011). The state has to meet the burden of proof required to disrupt the privacy rights of the family; the mere suggestion of state intervention does not change the state’s actual burden (Erskine, 2011). Ludwig and Murtagh (2011) agreed with Ms. Erskine in their response to her letter and indicated their intent was to work within the existing legal structure, not to change it.

Robert Siegel (staff physician for the Northern Kentucky Children’s Advocacy Center) and Thomas Inge (director of the Surgical Weight Loss Program for Teens & Center for Bariatric Research) took issue with Murtagh and Ludwig’s (2011) suggestion, stating that it might be unethical for an obese child to undergo bariatric surgery without first considering foster care (Siegel & Inge, 2011). For these physicians, weight-loss surgery and social service intervention are mutually exclusive (Siegel & Inge, 2011). Suitable candidates for this surgery would not be appropriate candidates for state intervention, and children under consideration for social service referral would not be appropriate candidates for surgery (Siegel & Inge, 2011). They explained that any family that met the Varness et al. (2009) criteria for state intervention would not meet the best-practice criteria for weight-loss surgery (Siegel & Inge, 2011). They also cited evidence that foster care may, in fact, be an obesogenic environment (Siegel & Inge, 2011). Ludwig and Murtagh (2011) responded to this criticism by noting that there are children who fall in between these categories, where they experience inadequate parenting that does not meet the legal definition of neglect.

Finally, Drs. Susan Yanovski, Jack Yanovski, and Mary Horlick (2011) noted that Murtagh and Ludwig’s (2011) article held two false assumptions: 1) severe childhood obesity necessarily resulted from poor parenting rather than genetics, and 2) type 2 diabetes requires removal from the home, and foster care is beneficial to obesity treatment. These authors argued that there is no evidence that foster families control the weight of obese children better than the children’s families of origin, and that greater social resources should be provided to parents of obese children so that medical complications can be prevented or treated within their own homes (Yanovski, Yanovski, & Horlick, 2011). Ludwig and Murtagh (2011) responded that they recognized genes affect weight and that foster care would not be appropriate for most severely obese children, noting that the primary treatment for type 2 diabetes is lifestyle modifications and weight loss. While they agreed the foster care program should receive greater scrutiny, they also noted one case where a young teenager died while waiting for custody hearing (Ludwig & Murtagh, 2011). Finally, Ludwig and Murtagh (2011) agreed that greater resources should be provided but raised the practical question of who would actually provide those resources. They conclude that in the interim, existing resources that would preclude the need for foster care or bariatric surgery should be used (Ludwig & Murtagh, 2011).

**Additional Reasons Against Prosecution**

Other reasons to oppose the removal of obese children from their homes stem from a broad range of concerns. These include 1) severe emotional or psychological harm to the child, especially in light of the lack of evidence that foster care for these children is effective “treatment;” 2) inconsistencies in the legal process that might lead to unfair outcomes; and 3) a social and political landscape that arguably has a net effect of promoting childhood obesity.

**Lack of Evidence about Foster Care And Potential for Harm**

A more compelling argument against prosecution of parents is the most glaring: the lack of evidence regarding the effectiveness of protective custody or foster care (Diekema, 2011; Siegel & Inge, 2011; Yanovski et al., 2011). Diekema (2011), a pediatrician and ethicist, argued that without any evidence of its effectiveness, removing a child from her or his home should not be a mechanism used to treat childhood obesity. As a correlating factor, Diekema (2011) called attention to the significant psychological harm experienced by a child when removed from the home, and noted that this must be considered in any protective custody decision. This is compounded by a concern that some foster homes may not offer a nurturing environment. It is interesting to note that even those who support state intervention have cited concerns about the quality of foster care (Murtagh & Ludwig, 2011). Without evidence that the potential benefit of removing an obese child from her or his home outweighs the harm of doing so, the disruption of a family relationship cannot be justified (Diekema, 2011).

**Potential for Unfair/Disparate Impact**

Another concern is the very real possibility that the interpretation of criteria to remove children from families may vary between different communities and jurisdictions.
that result in, albeit unintended, negative social consequence. For example, a New York trial court agreed with the Department of Social Services and found that parents of an obese girl were unwilling to comply with a court order to ensure that the child attended school, gym, and other activities. However, the parents appealed this decision, and the appeals court found there was a lack of evidence that the parents had not complied with the court order (In re Brittany, 2008). It is disturbing to consider the injustice of what might have happened had the parents not appealed the initial decision. Compounded to these questions of fairness is the concern that state action may result in a disproportionate impact on minority families because majority children in the United States are disproportionately represented in overweight/obese statistics (Mitgang, 2011).

The Role of Society in Childhood Obesity

A final reason for opposing prosecution of parents is that it is unfair to place the blame solely on parents when society has also played a role in the obesity epidemic. Our modern environment encourages a sedentary lifestyle through limited outdoor and unstructured activity opportunities; an increased reliance on automobiles for transportation; increased use of television, video, and other technology as entertainment; and less meals prepared with fresh foods at home (Brody, 2011). Although parents are responsible for their children, they do not have control over their child’s behavior inside or outside the home (Diekema, 2011). Parents do not raise their children in a vacuum; our environment is in tandem with social policies, especially regarding marketing and school lunches, can have a powerful influence on family health. In looking at childhood obesity then, a wider lens must be incorporated that includes an examination of the social and political landscape that so strongly influences our culture. To illustrate this landscape and demonstrate the general public’s concern about childhood obesity, this author will include citations from general public, or non-medical, resources.

In the summer of 2011, there were two national initiatives targeted toward addressing the country’s obesity epidemic. First Lady Michelle Obama brought the issue of obesity to national attention with the “Let’s Move” campaign (Let’s Move, 2011). Second, the United States Department of Agriculture launched its new food icon MyPlate (Vilsack, 2011) that replaced the food pyramid with the goal of helping consumers choose healthier food options. These recent public education initiatives are helpful, but unfortunately, cannot counter the effects, past and present, of the food marketing industry.

Food and beverage marketing is very effective among children and is associated with increasing obesity rates (Brody, 2011). Food advertisements on television watched by children promote products high in fat, sugar, or sodium (Harris & Graff, 2011). Research has revealed that food marketing affects children’s brand and specific food preferences, and has demonstrated an association between soft drink advertising, specifically, and consumption of sugar-sweetened drinks (Harris & Graff, 2011). The obesity crisis cannot be solved without significant changes to the marketing environment that surrounds children (Harris & Graff, 2011). Although the food industry has taken some self-regulatory steps to address advertising concerns, the fine-print reveals that these steps are fraught with exclusions and limitations that will not improve existing marketing practices (Harris & Graff, 2011).

Additionally, national social programs contribute to unhealthy diet in school children. The National School Lunch Program, originally intended to provide healthy meals to children regardless of income, was also designed to subsidize agribusiness, such as beef and dairy (Yeoman, 2003). As a result, critics of the program argue school lunches contain too much fat, additives, and preservatives and not enough vegetables (Parker-Pope, 2009; Yeoman, 2003). In fact, a group of retired generals, called “Mission: Readiness,” has even advocated for healthier school lunches and described the current program as a national security issue, citing obesity as the leading medical disqualifier for military service (Mission: Readiness, 2011). In spite of the growing national concern for childhood obesity, Congress’ initial reaction to regulatory changes, which would have made school lunches healthier, was a refusal to accept these changes (Nixon, 2011).

Despite the national attention to the public health concern of childhood obesity, the public does not seem to have reached a consensus as to whether our elected officials should control the conditions of the sale of some foods, restrict advertising of certain foods, subsidize healthier alternatives, and restrict or ban certain ingredients (Kersh, Stroup, & Taylor, 2011). The American Nurses Association has taken note of this as well. “While the effects of previous policies that have contributed to decreased physical activity and increased intake of ‘empty calories’ are beginning to be acknowledged in public policy debates, current policy initiatives are more likely to focus on individual choices than sweeping economic and social changes” (Tao & Glazer, 2005).

The social policy contributions to obesity may seem daunting, but several first-steps have been proposed. The Robert Wood Johnson Foundation has funded evidence-based interventions and made efforts at community, state, and federal levels to advance the following policy priorities: 1) ensure all food/beverages served and sold in schools meet or exceed the Dietary Guidelines for Americans; 2) increase access to affordable foods through new or improved grocery and corner stores that sell more healthful foods; 3) increase time, intensity, and duration of children’s physical activity at and out of school; 4) use pricing strategies (incentives and disincentives) to promote the purchase of healthier foods; and 5) reduce exposure to marketing of unhealthy foods through regulation, policy, and effective industry self-regulation (Govea, 2011; Kersh et al., 2011). Other suggested interventions include controlling the conditions of sale, subsidizing healthy foods that are frequently more expensive, and restricting certain ingredients (Kersh et al., 2011).

When industry practices render a significant negative effect on the health of a country’s citizens, especially their most vulnerable, and when these industries do not voluntarily make changes; then all levels of government are obligated to intervene where they are able (Harris & Graff, 2011). It is disheartening to note on one hand, the apparent willingness of our society to prosecute individual parents for childhood obesity and accept those social costs, monetary and otherwise; and yet, on the other hand, be unwilling to take steps that would help to prevent childhood obesity in the first place. Diekema (2011) notes the irony of a country that allows removing obese children from their homes but that does not support healthier children through controlled advertising, legislating a living wage, or making healthy foods affordable. A responsibility
of government is to promote public health, especially for children (Harris & Graff, 2011). If the state is allowed to remove an obese child from her or his home, it should also be required to advance sound, consistent health policies that promote the health of children.

**Role of Pediatric Nurses**

Nurses are privileged to hold the public’s trust (Jones, 2010), and as such, it is important for them to thoughtfully and critically think about the social conditions and public policies that have profound effects on health. The Nurses Code of Ethics mandates that nurses promote and advocate and work to protect the health and rights of patients, collaborate with others to promote efforts to meet health needs, and shape social policy (American Nurses Association, 2001). Because pediatric nurses care for children who live within a broad range of family and social situations, they must be comprehensive in their approach to addressing the problem of childhood obesity. Does the adversarial process of removing obese children from their homes benefit children in the short or long term? Does the practice (or threat of) removing obese children from their homes serve as a deterrent to other parents who may raise obese children? Do clinics and hospitals, in practice, support healthy food choices for their patients? Do health care providers and organizations actively encourage laws that will protect or ensure children’s health? Do we elect representatives that introduce or support these laws? As public health professionals, patient advocates (Tao & Glazer, 2005), and participants in a democracy, nurses can influence public discussion and initiate solutions that benefit the whole child.

**References**


References


**Additional Reading**
