When does severe childhood obesity become a child protection issue?

Shirley M Alexander, Louise A Baur, Roger Magnusson and Bernadette Tobin

ABSTRACT

- Severe childhood obesity and its associated comorbidities are increasing in prevalence.
- Extreme childhood obesity may be viewed as a mirror image of severe non-organic failure to thrive. Parental neglect may be a causative factor in both circumstances.
- When suspicion of parental neglect arises, health care professionals may have both an ethical obligation and a statutory duty to notify child protection services.
- Guidelines on the point at which medical practitioners should seek state assistance in cases of severe childhood obesity would be helpful, not only for medical practitioners, but also for child protection services.

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Failure to thrive in infancy and childhood is a well recognised problem, often multifactorial in origin, and may occur as a result of parental neglect. When suspicion of neglect as the cause of failure to thrive arises, particularly in extreme cases, child protection services are notified. This is consistent with a doctor's ethical duty to provide proper care for a child, and may also be a statutory requirement. Severe childhood obesity is a common problem, also often multifactorial in origin, and may result in both acute and chronic life-threatening complications. In extreme cases of severe obesity, where parents seem unable or unwilling to adhere to management programs aimed at weight loss for their affected child, the question arises: Is this a form of medical neglect? Should child protection services be notified? We present a case of severe childhood obesity where child protection services were involved (Box), and discuss its medical, legal and ethical implications. We argue that in a sufficiently extreme case, notification to child protection services may be an appropriate professional response.

Discussion

This child and her family were referred to state child protection services because the child had severe health problems related to her obesity, on a background of continuing weight gain while receiving maximised therapy and support from hospital weight management services. Additionally, her ability to lose weight by means of simple dietary measures, increased activity and reduced sedentary behaviour while in hospital had been demonstrated. In cases of failure to thrive, decisions to refer to child protection services are usually based on similar principles regarding the health of the child, where health services support has been exhausted and the child's ability to gain weight by means of simple dietary and child care measures has been demonstrated. Notification under those circumstances would rarely be questioned; in fact, questions would arise if such cases were not referred. (In neither situation is demonstration of weight loss or gain in a hospital environment a prerequisite to notification, but it does lend credence to the concerns that are being raised.) However, in the case described in the Box, was referral to state child protection services a wise thing to do? What options do clinicians have when treating severely obese children under such circumstances? Cases like these raise a number of important issues, and we see many parallels between the treatment of severely obese children and treatment of children who have non-organic causes of their failure to thrive.

Case

At the age of 4 years, Jade* was referred to child Weight Management Services. She was 110 cm tall, weighed 40 kg, and had a body mass index (BMI) of 33 kg/m^2 (100th percentile for age; BMI *z* score, 4.05). She had acanthosis nigricans, hyperinsulinaemia, fatty liver identified on ultrasound, and abnormal sleep study results indicative of moderate obstructive sleep apnoea.

Jade came from a family with a strong history of obesity and obesity-related disorders. Her mother had a history of gestational diabetes and postnatal depression, and her father had a history of abuse as a child. Jade's parents were separated and a social worker was already supporting the family. Jade led a very sedentary lifestyle, watching television up to 6 hours a day, and there were issues about food, with Jade having temper tantrums if not allowed whatever she wanted to eat.

A family-focused multidisciplinary approach was taken, involving both parents with input from a clinical nurse consultant, dietitian, physiotherapist, clinical psychologist and paediatrician. The family found it very difficult to keep appointments and adhere to lifestyle changes, and Jade's mother felt unsupported by her ex-partner who continued to allow Jade to snack on high-energy foods and watch television. Jade's weight steadily increased.

Twenty months after initial referral, Jade, now hypertensive with symptoms of marked obstructive sleep apnoea, was referred to the hospital's Department of Psychological Medicine, for assessment of her progressively violent behaviour, and Child Protection Unit, because of concerns about her persistent weight gain. Subsequently, because all these interventions had not led to any significant improvement in Jade's condition, the relevant state child protection authorities were notified. Notification led to hospital admission, during which Jade underwent an adenotonsillectomy. With the institution of simple weight-management interventions of reduced dietary intake and a daily program of physical activity, Jade lost 3 kg in 2 weeks. Community-based support was established, visits to the father were supervised, and Jade continued to lose weight as an outpatient. At her most recent clinic visit, Jade had reduced a dress size, and her mother now feels much more confident in making healthy food and lifestyle choices.

* Patient and case details are an amalgamation of those from several different patients to protect patient confidentiality. ◆

Childhood overweight and obesity are common, with prevalence rates doubling or tripling in many countries in recent years.[1,2] Obesity has a significant adverse effect on a child's wellbeing, as both immediate and long-term medical and psychosocial health problems affect many organ systems.[3,4] The result of chronic energy imbalance, obesity has a strong underlying genetic predisposition, with environmental and behavioural factors modifying its manifestation. Although many factors contribute to the development of childhood obesity at a societal level, parental responsibility is also an essential element in the prevention and treatment of obesity in children — an idea with which the food and beverage industries, government organisations and medical opinion concur.[5-7] Public opinion recognises the primary responsibility of parents to provide healthy choices of foods and physical activities for their children.[8] However, to take ownership of this responsibility, it is first necessary to acknowledge that the child has a weight problem. Most parents of children with a weight problem fail to recognise it, and the initial presentation of an obese or overweight child to a physician is usually not because of weight concerns.[9]

Can severe childhood obesity be considered a form of neglect, in particular, medical neglect?

Definitions of "neglect" and "medical neglect" (parental neglect of a child's medical needs) are not universally consistent.[10] However, there are generalised concepts and standards that are expected of parents towards their child. Failure to meet these standards may legitimately be considered neglect. Clearly not all obese children are neglected — indeed, parents of obese children may be very devoted to their child. However, there may be concerns about parenting skills such as lack of parental limit-setting or parental supervision. In 1989, a case series report of 12 children with severe obesity in early childhood observed that, in all cases, parental limit-setting around parent–child interactions, including eating, was impaired; the authors likened severe obesity in early childhood to the "mirror image of environmental deprivation".[11] However, recent reports on the possible associations between family characteristics, parenting patterns and childhood obesity do not show definite correlations.[12,13]

The assessment and management of severe obesity in childhood is complex, requiring a family-based approach with a dedicated multidisciplinary team of health care professionals. Instituting a weight-management program requires dietetic, physiotherapy, exercise science, nursing and psychotherapy input and support, assessment by a paediatrician with expertise in the care of severely obese children, and assessment by subspecialty teams for obesity-related comorbidities. This is not unlike the multidisciplinary approach to assessing and managing families with undernourished children. The weight-management program aims to help the family and child adopt behavioural and lifestyle changes to enable the child to lose weight, but to be successful in the case of a pre-adolescent child, parents need to be involved.[14]

What, then, should be done in situations when parents of severely obese children seem unwilling or unable to adhere to weight-loss programs? Should the child and/or parent be considered "non-compliant"? If so, is this non-compliance, whether deliberate or unintentional, a form of medical neglect? At what point does non-compliance constitute a danger to the child? Published reports highlight the quandary of notification to state child protection services when parents fail to follow medical advice in the treatment of their child's illness, whether this is for failure to administer asthma medication to a child with poorly controlled asthma[15] or for parents rejecting treatment for their HIV-infected child.[16]

Legal duties

In cases of failure to thrive and in cases of severe obesity, clinicians may observe immediate health risks as well as longer-term risks, including psychological harm. The "immediate" or "urgent" risks more often associated with failure to thrive will — for that reason alone — be seen to be important. However, risks to a child's health that are progressive and have lifelong consequences are also important, even if there is no particular point in time at which they constitute an "urgent" risk of "immediate harm". In cases of *severe* paediatric obesity, clinicians will need to decide at what point the longer-term risks are sufficiently important that notifying the case to child protection services is the *best thing to do now,* even if the circumstances are not "urgent".

Both the duty of care that a physician owes to a child who is a patient and statutory duties support the physician's duty to report severe cases of inadequately managed paediatric obesity to child protection agencies. There seems no reason why passive acquiescence by a doctor in the neglect of a severely obese child, through failure by the child's parents to ensure a minimally adequate diet and exercise, could not constitute a breach of a doctor's duty of care. Case law in the area of sexually transmitted diseases, for example, makes it clear that doctors can be liable for failing to protect patients who are in a sexual relationship with a person whom the doctor knows, or should know, is infected with HIV.[17]

In addition, statutory duties exist in all Australian states and territories except Western Australia that authorise or require health professionals to report when they have reasonable grounds to suspect that a child is being abused or neglected.[18] Although framed in different ways, these provisions would authorise and, in some cases, require notification when a treating physician concluded that a parent's continuing failure to ensure treatment for paediatric obesity constituted a severe risk to the child's health.[18] In New South Wales, legislation states that a child will be "at risk of harm", triggering the duty to report, in circumstances including those where the child's parents are unable or unwilling to arrange for the child to receive necessary medical care.[19] The point at which the child's circumstances trigger the duty to report will be a matter of judgement, and the values of the health professional will come into play. For example, could chronic exposure to tobacco smoke, resulting in respiratory ill health and asthma, qualify? In severe cases, the answer would seem to be yes. If children's health matters, it must matter in cases where serious risks of long-term harm result from chronic and ongoing exposures or patterns of neglect, as well as in cases where urgent intervention is required to arrest an imminent risk of harm.

Reporting a child to be at risk of harm will trigger an assessment of whether the concern is reasonably based and how the risks to the safety, welfare and wellbeing of the child can be mitigated.[20] This assessment could prompt the child protection authorities to introduce additional support mechanisms, including financial ones, to enable the child and family to cope more effectively in what are often adversarial conditions, thus increasing the likelihood of a positive outcome for the child's health. In NSW, it could extend to the development of "responsibility contracts" with parents that seek to encourage parents, with adequate support, to provide more effectively for the health and wellbeing of the child.[21]

Notification to child protection services may not necessarily resolve all problems. For example, it may remain difficult for a physician to provide ongoing care for the child without active collaboration with the parents. Where a specific medical procedure or intervention is required, parental consent will normally be required, although parents must give or refuse such consent in the best interests of the child.[22] In circumstances where a parent's ongoing inability to manage severe obesity in a child has resulted in serious health problems, and specific medical interventions are indicated, it is open to clinicians or provider organisations to seek court assistance. Courts have been willing to override parents' wishes to ensure that they do not put their child's health at risk; most frequently in cases where parents refuse to consent to life-saving blood transfusion.[23]

On the other hand, knowing that referral to child protection services may occur could result in fewer parents seeking medical help to treat their severely overweight child. To avoid disincentives for parents, health care professionals should only consider notifying child protection authorities in extreme cases of child obesity, in which all other measures available to the health care professional have failed. Such cases should be notified even though there is a risk that parents could lose custody of their child or be liable to criminal prosecution, as has occurred in the United States.[24-26]

Ethical challenges

What did morality (or "ethics") require of the health care practitioners who looked after Jade? In reflecting on this question, it is useful to distinguish between two kinds of requirements that morality makes of us: that we do not violate its negative precepts against things that are truly wrong in and of themselves (killing, torture, cruelty, etc); and that we live up to its positive exhortations to take proper care of the things that are truly good in themselves (such as health, safety, respect for family, care for children, etc). The former requirement is relatively straightforward (although there *is* confusion, in health care as in the rest of life, about what the prohibition on killing actually condemns); the latter requirement depends on a kind of judgement that Aristotle called "practical wisdom", the most important element of which is the capacity to see things aright *in the particular case*.

There is no doubt that health care practitioners should not avert their eyes when they think parents are acting in a manner that is seriously contrary to a child's health and wellbeing. On the other hand, the benefit to the child of taking his or her care out of the hands of the parents may come at too great a cost *to the child*. For example, the child might become alienated from parents and family over the longer term: there are few harms to a child that are worth that cost.

So the shape of sound judgement will be: What are the likely benefits and harms of leaving Jade in the care of her mother? What are the likely benefits and harms of notifying the state protection authorities about Jade? Which collective set of likely benefits and harms is to be preferred? Perhaps guidelines (preferably by a professional society whose members have day-to-day experiences of the challenges of caring for severely obese children) could usefully inform the careful consideration of these questions. Ultimately, sound reflection and reasoning about when it is that severe childhood obesity should become a child protection issue must be oriented to *the particular child in his or her particular circumstances*.

Final comments

As media reports illustrate, obesity has already become a child protection issue in Britain and the US.[27] There are general guidelines on referral of children about whom there are concerns of neglect or abuse, published by organisations ranging from medical colleges to state welfare services. However, there are currently no specific guidelines for possible referral of severely obese children. Were such guidelines to be developed, aspects such as length of time of maximised health support interventions, family circumstances, and even the relative amount of excess weight gain over a period of time would have to be considered. Though guidelines could never determine a particular case, they would be helpful not only for medical practitioners, but also for child protection services and any other health professional working with children, given the rising prevalence of childhood obesity.

The introduction of measures to reduce the prevalence of childhood obesity will take time. In the meantime, we must ensure that we protect any child whose health is at serious risk through medical neglect, including where this is the result of severe and untreated obesity.

Author details

Shirley M Alexander, MB ChB, MRCPCH, FRACP, Staff Specialist in Weight Management Services[1]
Louise A Baur, BSc(Med), PhD, FRACP, Professor, Discipline of Paediatrics and Child Health[1,2]
Roger Magnusson, BA, LLB(Hons), PhD, Professor, Faculty of Law[2]
Bernadette Tobin, MA, MEd, PhD, Director[3]

1 The Children's Hospital at Westmead, Sydney, NSW.
2 University of Sydney, Sydney, NSW.
3 Plunkett Centre for Ethics, St Vincent's and Mater Health Sydney, and Australian Catholic University, Sydney, NSW.

Correspondence: shirleya@chw.edu.au

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