Parental Obligation and Medical Neglect in Childhood Obesity

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Abstract. Despite unprecedented medical advancements and the near eradication of many serious diseases, there are growing epidemics of preventable illness brought about in part by the overemphasis on individual autonomy and the neglect of obligations to others. Insofar as these diseases develop because of individual choice, this permissiveness hampers the moral analysis of growing epidemics like childhood obesity. While society has contributed to its rapid progression, childhood obesity finds its origins in lifestyle choices implemented at home. Consequently, parents have an unparalleled duty to prevent and correct obesity and unhealthy lifestyles in their children. Failure to do so undoubtedly violates a parent's duty and suggests medical neglect. However, our current understanding of medical neglect is too narrow to be applicable to chronic, preventable illnesses. Relevant principles of tort law may broaden our understanding of neglect to better reflect the nature of parental and societal liability in preventable illnesses. *National Catholic Bioethics Quarterly* 19.1 (Spring 2019): 47–54.

The Childhood Obesity Epidemic

Childhood obesity is an alarming epidemic in the United States, with rates consistently rising over the last several decades.[1] Current estimates suggest that

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1. "National Health and Nutrition Examination Survey," fact sheet, National Center for Health Statistics, https://www.cdc.gov/nchs/data/factsheets/factsheet_nhanes.pdf.

approximately 17 percent of children are obese, and another 16 percent are overweight, as compared with 5 percent and 10 percent, respectively, in 1971.[2] Numerous studies have identified a link between childhood obesity and overweight and the rates of these diseases in adulthood.[3] These conditions are associated with serious comorbidities, including diabetes mellitus, cardiovascular disease, high blood pressure, and hyperlipidemia.[4] Additional complications include increased risk of stroke and certain types of cancer and an increase in all-cause mortality.[5] In addition to serious physical comorbidities, obesity may impose significant psychosocial and economic consequences. Studies have demonstrated an increased frequency of psychological disorders such as depression among adults who suffered from childhood obesity. There is strong evidence of negative socioeconomic outcomes, including less education, higher poverty rates, and decreased rates of marriage among obese individuals.[6]

Any serious analysis of childhood obesity and its consequences reveals the profound harm of this epidemic to both the individual and society. The cost to humanity writ large is now so profound as to necessitate an assessment of accountability for the development of this preventable disease. However, difficulty in discussing the obesity epidemic, its origins, and any potential solutions arises from the notion that obesity is a result of individual choice and the misperception that such autonomy must be respected above all else.

Any examination of the childhood obesity epidemic and the nature of medical neglect must acknowledge the sensitive nature of this topic. Any discussion of

2. Cheryl D. Fryar, Margaret D. Carroll, and Cynthia L. Ogden, "Prevalence of Overweight and Obesity among Children and Adolescents Aged 2–19 Years: United States, 1963–1965 through 2013–2014," *Health E-Stats*, July 4, 2016, https://www.cdc.gov/.

3. A. M. Magarey et al., "Predicting Obesity in Early Adulthood from Childhood and Parental Obesity," *International Journal of Obesity and Related Disorders* 27.4 (April 2003): 505–513, doi: 10.1038/sj.ijo.0802251.

4. D. C. Chan et al., "Waist Circumference, Waist-to-Hip Ratio and Body Mass Index as Predictors of Adipose Tissue Compartments in Men," *QJM: An International Journal of Medicine* 96.6 (June 2003): 441–447, doi: 10.1093/qjmed/hcg069. Peter W. F. Wilson et al., "Overweight and Obesity as Determinants of Cardiovascular Risk: The Framingham Experience," *JAMA Internal Medicine* 162.16 (September 9, 2002): 1867–1872, doi: 10.1001/archinte.162.16.1867; and Ninh T. Nguyen et al., "Association of Hypertension, Diabetes, Dyslipidemia, and Metabolic Syndrome with Obesity: Findings from the National Health and Nutrition Examination Survey, 1999 to 2004," *Journal of the American College of Surgeons* 207.6 (December 2008): 928–934, doi: 10.1016/j.jam collsurg.2008.08.022.

5. Kathryn M. Rexrode et al., "A Prospective Study of Body Mass Index, Weight Change, and Risk of Stroke in Women," *JAMA* 277.19 (May 21, 1997): 1539–1545, doi: 10.1001/jama.1997.03540430051032; and Eugenia E. Calle et al., "Overweight, Obesity, and Mortality from Cancer in a Prospectively Studied Cohort of U.S. Adults," *New England Journal of Medicine* 348.17 (April 24, 2003): 1625–1638, doi: 10.1056/NEJMoa021423.

6. Milda R. Saunders et al., "Social Factors in Childhood and Adulthood Associated with Adult Obesity in African American and White Women," *ISRN Public Health* (2012), 931854, doi: 10.5402/2012/931854.

childhood obesity which explores parental responsibility and assigns liability risks conflating condemnation of poor choices with condemnation of character. The suggestion that parents whose children are obese bear responsibility for that condition, in both a legal and a moral sense, is a serious allegation that must be carefully characterized, narrowly applied, and compassionately understood. It is therefore of utmost importance to distinguish between the assertion that permitting the development of obesity falls short of our moral and legal obligations as parents, and the inaccurate presumption that this shortcoming somehow reflects a lack of love or concern for our children or a paucity of character.

Multifactorial Etiology

The etiology of childhood obesity is undoubtedly multifaceted, and the complexity of its origins necessitates a similarly multidimensional solution. At the most basic scientific level, overweight and obesity develop as the result of a prolonged and consistent excess of caloric intake as compared with energy expenditure. Of course, this mechanism is influenced considerably by medical and social factors.[7] A small percentage of obese individuals suffer from known genetic or endocrine diseases which contribute to the development of obesity. Modern medicine has also acknowledged and better characterized the role of genetics in regulation of weight.[8] Certainly, unique circumstances may render overweight and obesity matters of inevitability rather than choice for some individuals. However, this is not the case for a majority of those who become obese, particularly as children.

Our children are surrounded by powerful forces, from parents and peers to caregivers and educators. Among these, parents are uniquely obligated to shape the health habits of their children. Parents are also uniquely empowered to intervene on behalf of their children if these habits get off track and therefore to help correct overweight and obesity in children who suffer from these conditions. In addition, educators, medical professionals, and society as a whole undoubtedly contribute to an environment that either promotes or discourages development of this preventable disease and its many sequelae.

With widespread, convenient access to cheap fast food and a general lack of community and society-wide programs to address childhood obesity, there is abundant fault to be found on many levels for our failure to protect children from developing a serious preventable condition. Understanding that childhood obesity is a multifaceted problem symptomatic of profound, society-wide failures, to what extent are parents responsible for overweight and obesity in their children?

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7. Jana Jarolimova, James Tagoni, and Theodore A. Stern, "Obesity: Its Epidemiology, Comorbidities, and Management," *Primary Care Companion for CNS Disorders* 15.5 (2013), 12f01475, doi: 10.4088/PCC.12f01475.

8. Jane Wardle et al., "Evidence for a Strong Genetic Influence on Childhood Adiposity Despite the Force of the Obesogenic Environment," *American Journal of Clinical Nutrition* 87.2 (February 2008): 398–404, doi: 10.1093/ajcn/87.2.398.

Obligations of Parents and Society

The Church teaches that parents have a unique obligation to their children's well-being: "Parents have the first responsibility for the education of their children. … The home is well suited for *education in the virtues*. This requires an apprenticeship in self-denial, sound judgment, and self-mastery—the preconditions of all true freedom. … Parents have a grave responsibility to give good example to their children."[9] Being the first teachers, parents must educate both by word and by action. Surely this education must include not only moral and spiritual instruction, but also education in how to live in a way that reflects our inherent dignity as human beings and children of God.[10]

An important component of raising our children in a manner consistent with their human dignity is ensuring, to the best of our ability, their physical well-being. This obligation is shared by parents and society. Speaking directly to the issue of respecting health and the human body, the Church instructs us that "life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good. *Concern for the health* of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment, and social assistance."[11] Parents compromise this obligation when they permit the development of preventable illnesses, such as childhood obesity, that threaten life and physical health. While there are many acceptable ways of raising children, surely such universal principles as ensuring physical, emotional, and psychological well-being underlie all parental philosophies.

Childhood obesity implicates each of those principles. Physical health requires appropriate nutrition, both in terms of substance and volume, as well as regular physical activity. Learning thoughtful and consistent healthy habits during childhood sets the stage for lifelong habits which are critical in the prevention of obesity and associated diseases. If we as parents bear the first responsibility in the education and rearing of our children, and if an important component of this duty is respect for physical health, then the development of preventable illness is a violation of that duty. Although it is clear from the Church's teachings that society's obligations to children encompass the promotion of physical health, there is no doubt that parents are uniquely responsible for the same. Therefore, to the extent that we fall short of fulfilling these obligations, we are uniquely liable.

It is critical to note, however, that this liability can extend only as far as our freedom to influence a child's upbringing. It is indisputable that the ability of parents to promote a healthy lifestyle is highly variable. To ignore the social and economic factors at play in such decisions is insensitive and unfairly assigns moral responsibility to parents for the larger shortcomings of our social and economic policies.

9. *Catechism*, n. 2223, original emphasis.
10. Ibid., n. 2222.
11. Ibid., n. 2288, original emphasis.

Consider an upper-middle-class family with two parents in the household, living in a safe neighborhood where outdoor play, family walks, bike rides, and trips to the playground are possible. Similarly, they have access to highly rated, well-funded schools, which can provide nutritious lunches and offer enrichment activities such as gym and specialty athletics. It would be reasonable to presume that this family has the means to choose any food at the grocery store and enroll their children in sports or other physical activities. It is easy to make healthy choices in these circumstances: nutritious food is abundant, and opportunities for safe physical activity are readily accessible.

Contrast this with another family, perhaps a single parent with multiple children. Imagine that this family utilizes government subsidies for food. The single parent, having limited resources to obtain food, may be forced to maximize quantity rather than quality to ensure all family members are fed. Imagine that this family lives in a dilapidated neighborhood where drugs and street violence are prevalent and safety is best found indoors. There may not be safe access to parks or sidewalks or even a front yard in which a child might play.

Do these parents have the same freedom of choice when it comes to implementing the "right" healthy habits for their children? Without a doubt, the answer is no. Where there is limited freedom of choice because of social and economic constraints, there is a parallel reduction in the scope of parents' ability to make healthy choices for their children, and therefore also in volitional action and subsequent liability. Recognizing socioeconomic disparities and how they affect downstream opportunities is essential to understanding how neglect and parental liability apply to childhood obesity. Such disadvantages limit the scope of parental liability; one can be under no obligation to provide an impossibility.

Although each situation obviously is profoundly nuanced and highly individualized, all parents have a responsibility to promote their children's well-being to the best of their ability. In light of the principles enumerated above, does the development or persistence of childhood obesity fall so short of parental duty as to constitute medical neglect? If so, could such a designation ever be enforced? And if not, how might we more effectively discourage the kinds of failures that have contributed to the preventable epidemic of childhood obesity?

Medical Neglect

The theory of medical neglect stipulates that parents or caregivers fall below a minimum societal standard of care when, through act or omission, they cause or risk serious harm to a child. A claim of medical neglect carries with it not only legal implications, but also a weighty moral judgment of both the behavior and the perpetrator. The application of this theory seems straightforward enough in obvious cases such as physical abuse. But to what extent might it apply to preventable harms, such as childhood obesity, in which individually benign acts and omissions summate to cause profound and often lifelong harm?

Medical neglect as a theory of law and policy is narrowly defined at the federal level by the Child Abuse Prevention and Treatment Act (CAPTA), which defines *child abuse and neglect* as "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."[12] This definition is problematic when applied to the development of preventable, chronic diseases such as childhood obesity for a few reasons, which will be further elucidated below. The current definition of medical neglect requires close temporal proximity: a "recent" act or failure to act and "imminent" harm. The nature of the harm caused by obesity is insidious, presenting itself throughout a lifetime in the form of diabetes, heart disease, endocrine disorders, and numerous comorbidities. Therefore, the lack of immediacy between the act and the subsequent harm renders the current definition of medical neglect inapplicable to the development and perpetuation of childhood obesity.

Moreover, it is difficult to precisely identifying a specific harmful act or omission. For example, poor nutrition choices and sedentary activities are harmful not as individual acts but rather because they are repeated. Indulging in the occasional treat or skipping a workout to sleep in or socialize with friends may be a valuable opportunity for enjoyment and pleasure, and this may well enhance our mental health. Sharing these experiences with others is an important part of our social upbringing and, for some, may be a foundational component of cultural identity. To condemn acts which individually may be not only benign but perhaps even beneficial smacks of logical inconsistency. Rather, it is the aggregate of these individually benign acts and omissions which, *in excess*, attains the gravity of harm that CAPTA requires.

Whether an expanded definition of medical neglect could ever be enforced in the context of childhood obesity is entirely distinct from whether, conceptually, the principles underlying medical neglect *ought* to apply to parents whose children develop preventable diseases. The answer to the former question is most likely no. How our justice system could ever codify and monitor the multitude of small, daily actions and choices that summate to result in overweight and obesity is the sort of governmental overreach that most people presumably would reject. Yet there is surely a point, although difficult to define in practice, when the summation of chronic irresponsible decisions put a child in such obvious danger of physical, psychological, and social harm that it seems not only inaccurate but unjust to deny the philosophical applicability of medical neglect.

This concept is perhaps more easily understood in the context of failure to thrive. Similar to childhood obesity, failure to thrive because of neglect, as opposed to an organic medical etiology, is the result of a summation of multiple acts. There is no one harmful act; rather, the pattern of profound deprivation is detrimental. What renders this form of medical neglect legally actionable while childhood obesity is not? This difference possibly reflects a societal valuation on excess, inferring a correlation between parental affection and the provision of abundant food. Failure to thrive, in

12. CAPTA Reauthorization Act of 2010, Pub. L. 111-320, 124 Stat. 3459 (2010), §142(a)(2); and Children's Bureau, Administration for Children and Families, "Definitions of Child Abuse and Neglect," accessed January 25, 2019, https://www.childwelfare.gov/pubPDFs/define.pdf.

contrast to childhood obesity, is a physical manifestation of unmet needs, a reminder of the profound penury that is often associated with want of character. It may even suggest a lack of parental affection or love. For these reasons, neglect manifesting as failure to thrive may simply feel like a worse kind of harm than childhood obesity.

Fundamentally, however, they both derive from a similar pattern of failures, which makes the law's inconsistent treatment of the two conditions puzzling. A weak justification for the difference may be the imminence of the harm presented by the two conditions; with failure to thrive, there may be a truly immediate risk of severe medical events and even death, whereas childhood obesity generally wreaks havoc over a long period of time, as previously discussed. This is a poor excuse for the law's differential applicability. Parents are responsible for safeguarding and ensuring the well-being of their children, and allowing the development and persistence of serious, preventable diseases such as childhood obesity without legal ramifications is antithetical to the social goal of protecting children and their health. Therefore, the inability of our legal theories to reflect liability seems a mere limitation of language because, in fact, these harms embody the very *spirit* of medical neglect.

Expounding on Medical Neglect through Theories of Tort Law

Excluding those instances where obesity is a consequence of an underlying metabolic or endocrine disorder, the development of preventable obesity in a child is proof in itself of fault, a principle reflected in Anglo-American tort law by the doctrine of *res ipsa loquitur* (the thing speaks for itself). This theory holds that the mere occurrence of a consequence is evidence in and of itself of negligence: the consequence or harm would not have occurred absent negligence.[13] The preventability of diseases such as childhood obesity is precisely what renders their existence an indication of neglect on the part of parents and society.

Applying concepts of tort law to childhood obesity may help refine our understanding of medical neglect, rendering it more applicable to assessing liability in the context of preventable diseases. Traditionally, to constitute negligence, an act must satisfy four requirements: (1) there must be a duty that is owed, (2) that duty must be breached in some material way, and (3) harm (4) must be caused by that breach.[14] The many nuances of those four elements are outside of the scope of this discussion. However, the general principles inherent in the above framework are useful when conceptualizing how parental responsibility for childhood obesity may be analogous to instances of legal negligence.

The elements of negligence in the context of childhood obesity are simple to identify. First, the *duty* of parents and society to promote the physical health and well-being of children has been established. *Breach* of that duty occurs when parents, of their

13. Fred E. Heckel and Fowler V. Harper, "Effect of the Doctrine of Res Ipsa Loquitur," *Illinois Law Review* 22 (1928): 724.

14. *Wex*, s.v. "negligence," accessed January 25, 2019, https://www.law.cornell.edu/wex/negligence.

own volition, tolerate a pattern of unhealthy choices which cumulatively result in development of preventable obesity. Society as a whole breaches its duty to its child citizens insofar as it fails to "help in the attainment of living-conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment, and social assistance."[15] The grave *harm* which results from the development and persistence of childhood obesity has been previously described.

It is the fourth element of negligence, causation, which is most elucidative to our understanding of medical neglect in the context of preventable disease. Unlike CAPTA, which requires close temporal proximity between the act and the harm and requires the threat of harm to be imminent, the theory of negligence under tort law necessitates no such temporal relationship. Lack of temporal proximity could of course suggest a lack of causation, but there can be little doubt that the cumulative effect of consistently poor health choices is a meaningful cause in the development of childhood obesity. Refining our definition of medical neglect to require meaningful causation but not temporal proximity would alleviate much of the conceptual burden of applying principles of medical neglect to the development of preventable disease.

Concluding Thoughts

It is apparent in Church doctrine that parents have a unique obligation to their children which requires raising them in a manner that ensures their physical, emotional, and spiritual well-being. The development of childhood obesity is largely preventable, and its persistence implicates all aspects of a child's well-being, which parents are uniquely, although not solely, responsible for nurturing. Meaningful intervention will require a society-wide reformation to bring our policies into alignment with the virtues of charity, care for our neighbors, and concern for the well-being of all citizens rather than an exclusive valuation on individual autonomy.

We must recognize, accept, and embrace our obligations to our fellow human beings rather than focusing inward on our own needs and wants. The family unit represents a microcosm of these issues and is a front line for intervention and prevention—provided we can exchange our inclination toward convenience and immediate gratification for the more noble virtues of physical, emotional, and spiritual purity. As parents and members of the human society, we must tirelessly seek these goods in our own lives, in the lives of our children, and on behalf of our fellow citizens.

15. *Catechism*, n. 2288.