Ethical Issues in Childhood Obesity: When is Removal Justifiable?

By David Staudt

This scenario’s central conflict is between the autonomy of parents to make child-rearing decisions and the well-being of that child. Supporting parents, the US Supreme Court has determined that child-rearing decisions are Constitutionally protected privacy rights.\(^1\) Opposed to these rights are the child’s “best interests.” Although highly criticized, this standard is widely used in decisions to treat children against their parents’ wishes when those wishes are sufficiently detrimental and could constitute neglect.\(^2,3\)

Wisconsin law defines neglect as “failure, refusal, or inability on the part of a parent... to provide necessary care, food, clothing, medical or dental care... so as to seriously endanger the physical health of the child.”\(^4\) In obesity cases, one group of physicians asserted that parents are negligent if they “fail to seek medical care, fail to provide recommended medical care, or fail to control their child’s behavior to a degree that places the child at risk of serious harm, including death.”\(^5\) This child’s parents have failed to follow medical advice, and she is at serious enough risk that she required PICU treatment. By these criteria, these parents’ actions may be considered negligent.

While Wisconsin law permits taking custody of a child if parents neglect to provide care to a degree that compromises that minor’s well-being, home removal by child protective services (CPS) is a drastic measure.\(^6\) What is legal is not always what is ethical. Some physicians consider removal justifiable when there is: “(1) a high likelihood that serious, imminent harm will occur; (2) a reasonable likelihood that coercive state intervention will result in effective treatment; and (3) the absence of alternative options for addressing the problem.”\(^5\) Are those criteria met in this situation?

Regarding “high likelihood of serious, imminent harm”, a large-scale review reports that obese children are at risk of metabolic syndrome, type II diabetes mellitus, atherosclerosis, hypertension, left ventricular hypertrophy, obstructive sleep apnea, asthma, non-alcoholic fatty liver disease (NAFLD), amongst other conditions.\(^7\) While serious, whether these conditions pose imminent harm is debatable. Childhood obesity-associated cardiovascular disease has not been associated with increased risks of childhood MI, stroke, or malignancy.\(^7\) Obese children with NAFLD are at increased risk of mortality or liver transplant as young adults.\(^8\) A two to three decade timeframe hardly seems “imminent.”\(^9\) More relevant is a correlation between obesity and asthma requiring ED services.\(^10\) Each year, 200 children die from asthma.\(^11\) While this represents a tiny fraction of asthmatic and obese children, this child’s disease has progressed to a need for PICU care: this could certainly constitute “serious, imminent harm.”\(^5,11\) However, PICU stay versus ward care is often subjective, and without report of invasive treatments (intubation, tracheostomy), determining the significance of this PICU care is difficult.

Regarding effective treatment, one review of pediatric lifestyle interventions reported that <10% of patients had sustained, significant weight loss. Successful interventions lasted over 6 months, targeted younger youth who were overweight (not obese), and involved motivated children and parents.\(^12\) Thus, in this scenario, CPS-mandated lifestyle intervention seems unlikely to be effective. Some argue that the goal of intervention isn’t some degree of BMI reduction; only weight loss sufficient
to improve comorbidities.\textsuperscript{5} Even with this goal, weight regain still poses a major problem: over 90% of children regain lost weight with recurrence of comorbid conditions.\textsuperscript{12}

Advocates of CPS intervention hold that removal should only occur when no alternatives exist. In this case there are unexplored therapies. Orlistat is a medication associated with minor weight loss approved for children 12 and up.\textsuperscript{12,13} Bariatric surgery is associated with reduced BMI and improved comorbidities in obese children.\textsuperscript{14,15} One small RCT found extremely positive results in a group of older teens who underwent laparoscopic banding.\textsuperscript{15} Surgical approaches, however, are new; lack data; and have problems with complications, payment, and parental consent.\textsuperscript{14} Another option is aggressive management of the most symptomatic comorbidities—treating the sleep apnea with CPAP, coupled with aggressive pharmacologic therapy of hypertension, asthma, and diabetes—while continuing to work with the patient and her parents.

This last option seems preferable. The long-term conversation with this family would move in the direction of addressing underlying obesity while comorbidities are managed. Motivating the family is critical, as motivation improves success rates of lifestyle or surgical interventions.\textsuperscript{12,14} CPS could be involved in this discussion, and could also assist the parents in meeting care expectations. However, removal at this point is not warranted. It is a future option, but given the uncertain efficacy of removal and associated negative psychological effects, this should be considered as a last resort when all alternatives are exhausted.\textsuperscript{16}
1. United States v Orito, 413 U.S. Supreme Court (1973)
4. Wis. Stat. § 48.981(1)(d)
6. Wis. Stat. § 938.205(1)(b)