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Tipping the Scale: A Place for Childhood Obesity in the Evolving Legal Framework of Child Abuse and Neglect

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Tipping the Scale: A Place for Childhood Obesity in the Evolving Legal Framework of Child Abuse and Neglect

Shauneen M. Garrahan* & Andrew W. Eichner**

INTRODUCTION........................................................................................................ 338
I. HISTORICAL AND SCIENTIFIC PERSPECTIVES ON CHILDHOOD OBESITY ............................................................................................................. 339
   A. DEFINING OBESITY IN THE MEDICAL FIELD ........................................ 340
   B. ORIGINS OF THE CHILDHOOD OBESITY EPIDEMIC............................... 340
   C. CAUSES OF CHILDHOOD OBESITY ............................................................ 342
      1. FACTORS WITHIN PARENTAL CONTROL LINKED TO CHILDHOOD OBESITY ........................................................................................................ 342
         I. THE ROLE OF HEREDITY AND GENETIC SUSCEPTIBILITY .................. 345
         II. THE ROLE OF CHEMICAL FACTORS .................................................. 347
II. CHILD PROTECTION IN THE LEGAL SYSTEM AND THE BALANCING OF PARENTAL RIGHTS ........................................................................ 348
   A. THE HISTORICAL DEVELOPMENT OF CHILD PROTECTION LAWS........... 349
   B. SAVING CHILDREN FROM ABUSE AND NEGLECT IN THE PRESENT DAY... 351
   C. RELEVANT PARENTAL RIGHTS AND DUTIES TO CHILDREN .................... 354
III. CHILDHOOD OBESITY IN THE COURTS ......................................................... 356
IV. THE FUTURE DIRECTION OF THE LEGAL FRAMEWORK FOR CHILDHOOD OBESITY .......................................................................................... 364
   A. DEVELOPING A JUDICIAL AND LEGISLATIVE STRUCTURE TO ADDRESS CHILDHOOD OBESITY ........................................................................ 364
      1. SUGGESTIONS FOR FUTURE DEVELOPMENTS IN JUDICIAL INTERPRETATION.................................................................................................... 364

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CHILDHOOD OBESITY

2. SUGGESTIONS FOR FUTURE LEGISLATIVE DEVELOPMENTS .................. 365

B. CHILDHOOD OBESITY AND CHILD PROTECTION POLICY RECOMMENDATIONS .................................................. 366

CONCLUSION ................................................................................................................................................. 369
INTRODUCTION

In 2009, a South Carolina mother named Jerri Gray was charged with criminally neglecting her fourteen-year-old son, Alexander Draper. The State removed her son from her custody and placed him in foster care. Even as of August 2011, two years later, Gray’s charges were still pending and Draper remained with his aunt.

It is a well-known and sobering reality that child protective systems across the United States often must separate children from their abusive or neglectful parents in order to protect them from the harm inevitably caused by this type of home environment. Yet, in Ms. Gray’s case, her negligent behavior was not of a kind traditionally associated with child neglect. When removed from his mother’s custody, Alexander Draper weighed 555 pounds—well beyond a healthy weight for his age. Ms. Gray’s arrest came shortly after she missed a custody hearing, which was scheduled after doctors had expressed concerns to social services about her son’s weight.

Though the story of Jerri Gray and her son may seem unusual, it is not the only one of its kind. Numerous state agencies around the country have begun to remove obese children from their parents’ custody. As concerns about childhood obesity continue to grow, courts across the nation will have to struggle with the difficult legal and moral questions that arise in these scenarios. The idea that the government can reach into the traditionally private sphere of the family and remove a child merely on the grounds that the child is overweight is difficult to justify and the lack of a consistent legal framework further complicates the matter.

This Note considers the increasing need for state courts to apply child abuse and neglect laws to issues of childhood obesity and proposes practical reforms that will resolve the legal ambiguities that currently exist in the system. The system that we propose suggests state intervention in cases where parents negligently fail to address the medical needs of their morbidly obese children. In Part I, we examine historical and scientific perspectives on childhood obesity.

2. Id.
5. Id.
6. See Barnett, supra note 1 (“State courts in Texas, Pennsylvania, New York, New Mexico, Indiana and California have grappled with the question in recent years.”); Faure, supra note 4 (“Several other cases in recent years — in California, New Mexico, Texas and New York, as well as Canada — have garnered attention because a child’s obesity resulted in loss of custody.”).
Childhood Obesity

Considering the historic roots of childhood obesity in the United States and exploring the internal and external causes of obesity, we isolate those fundamental causes of childhood obesity that are within parental control. By identifying which of these causes are within parental control, we hope to provide clarity necessary to develop an effective legal standard that can serve as a guideline for legislatures to adopt and courts to enforce.

Part II describes the development of child protection laws in the United States and provides the framework for comparing childhood obesity to child abuse and neglect. The history of child abuse laws in the United States indicates a general progression towards greater government involvement in the family sphere when negligent parental actions put the health of a child at risk. The development of child protection laws nationwide indicates a trend towards earlier and more aggressive intervention.

With this understanding of the current law, Part III presents recent court cases that have examined the question of whether removal is warranted by a child’s obesity and evaluates the circumstances surrounding those decisions in order to determine the likely future direction of judicial treatment of this issue. We argue that the courts should employ the same legal standard in childhood obesity cases that they use for determining medical neglect.

Finally, Part IV proposes recommendations for future developments in child protection law and policy relating to childhood obesity. These suggestions include modifying the law to encompass morbid childhood obesity as part of medical neglect and permitting child protection services (CPS) to intervene earlier in morbid childhood obesity cases as a means of reducing the need for later removal. While these reforms would increase the government’s role in regulating the sphere of the family, they are intended to protect morbidly obese children, not to infringe the natural rights of responsible parents. The ultimate goal in all proposed reforms is to protect the sanctity of the family by informing parents of the dangers of childhood obesity well before the State must take drastic action.

I. Historical and Scientific Perspectives on Childhood Obesity

This Part explores the history of childhood obesity and examines some of the leading scientific perspectives regarding the causes of the current childhood obesity epidemic. This information provides useful background for the later discussion of the legal issues addressed in this Note. It also contextualizes the recommendations for future development of child obesity protection measures across the United States. It is important to understand this background because it has complicated courts’ analyses as to whether obesity is a result of parental neglect or, alternatively, factors beyond parental control.
A. Defining Obesity in the Medical Field

Body Mass Index (BMI) is the focal point for defining obesity in children. Unlike adults, whose weight status is determined by specifically set BMI categories,\(^7\) the weight status of children is determined by using an age- and sex-specific percentile for BMI to reflect the fact that children's body composition varies with both age and gender.\(^8\)

Children with abnormally high BMI levels fall into one of three categories. An "overweight" child has "a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex."\(^9\) An "obese" child has "a BMI at or above the 95th percentile."\(^10\) Finally, a "morbidly obese" child has a BMI over the 99th percentile.\(^11\)

This Note's legal discussion centers primarily on morbidly obese children. All parents would benefit from knowing about the importance of healthy eating and the responsibilities parents have to attend to the weight of their children well before their children become morbidly obese. However, in the interest of protecting the private family sphere and preserving limited state resources, intervention should focus on cases involving morbidly obese children, whose health is most significantly at risk. The court cases discussed in Part III focus entirely on this bracket of the epidemic, and the policy recommendations that we promote in Part IV are also largely intended to prevent children from becoming morbidly obese and to take legal action to protect those that already are.

B. Origins of the Childhood Obesity Epidemic

In order to understand the severity of the modern obesity epidemic, it is helpful to discuss the development of the problem. Morbid childhood obesity is a modern phenomenon that justifies greater state intervention. Until the last decades of the nineteenth century, the primary nutritional concerns relating to children's health were not about food excess but rather about food scarcity and childhood malnutrition.\(^12\) Hopes of improving chances of survival and productivity greatly incentivized parents to increase BMI for children in the underweight range.\(^13\)

By the early years of the twentieth century, federal, state, and local

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8. Id.
9. Id.
10. Id.
11. See Lindsey Murtagh & David S. Ludwig, State Intervention in Life-Threatening Childhood Obesity, 306 JAMA 206, 206 (2011) ("Severe obesity . . . [is] characterized by a body mass index (BMI) at or beyond the 99th percentile . . . .").
12. See Benjamin Cabellero, The Global Epidemic of Obesity: An Overview, 29 EPIDEMIOLOGICAL REV. 1, 1 (2007) ("Until the last decades of the 19th century, developed countries were still struggling with poverty, malnutrition, and communicable diseases.").
13. See id. ("Moving the body mass index (BMI) distribution of the population from the underweight range toward normality had an important impact on survival and productivity . . . .").
intervention in the form of government-subsidized, nutritional school lunches to fight malnutrition became justifiable on the grounds that childhood malnutrition was a serious, though avoidable, trouble. Additionally, with industrialization and the increased availability of commercial food products, malnutrition became less prevalent. However, many parents still acted as though food might not always be available and overfeeding became increasingly common. In regards to early feeding in infancy, doctors observed that it was “very difficult to convince the lay mind that rosy cheeks and a fine weight record can be of unfavorable augury.”

By the 1930s, there were indications that the health risks associated with obesity were more widely recognized; for example, during this time life insurance companies were using body weight data to determine premiums, due to the relationship between excess weight and premature death. Levels of obesity continued to rise, and by the early 1950s the direct link between the increasing prevalence of obesity and increasing rates of cardiovascular disease was well established.

During the 1970s and 1980s, obesity among six- to eleven-year-olds increased from 6% to 9% for boys and from 6% to 13% for girls. Since then, childhood obesity has continued to increase at an alarming rate. Among preschool children aged two to five, obesity increased from 5% to 10.4% between 1976 and 2008. During this time, obesity also swelled from 6.5% to 19.5% among children aged six to eleven and from 5% to 18.1% of adolescents aged twelve to nineteen. Today, more than nine million American children and adolescents are obese.

Because obesity is associated with a number of adverse health outcomes, the


15. Cabellero, supra note 12, at 1.


17. Lester Breslow, Public Health Aspects of Weight Control, 42 AM. J. PUB. HEALTH 1116, 1118 (1952).

18. Id. at 1117.

19. Sara Gable & Susan Lutz, Household, Parent, and Child Contributions to Childhood Obesity, 49 FAM. REL. 293, 293 (2000). For an indication as to why obesity levels might be higher amongst girls than boys, see Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity, 117 PEDIATRICS 1834, 1835 (2006) (“According to a meta-analysis, boys were approximately 20% more active than girls.”).


21. Id.

22 Id.
growing incidence of this condition among children is a serious concern. Obese children are at an increased risk for developing glucose intolerance, high blood pressure and abnormal lipid profiles, as well as chronic illnesses like type 2 diabetes and cardiovascular disease. As a result, obesity-related annual hospital costs for children total more than $121 million each year, over triple the amount from 1979.

Despite the fact that overnourishment is a large issue in the United States, parents seem to instinctively worry about underfeeding their children. As we will argue in Parts III and IV, state intervention holding parents equally responsible for both over- and undernourishing is the most effective way to combat this misguided instinct. Understanding the similarities between under- and overfeeding provides the background to appreciate why the courts should treat both kinds of neglect as equivalent.

C. Causes of Childhood Obesity

Difficulties in combating childhood obesity, both medically and through the legal system, may be partially explained by the wide variety of factors that directly contribute to the development of the condition. In addition to internal factors like hereditary traits and a variety of chemical factors, external factors such as the cultural environment and a lack of parental supervision over children’s eating habits may also perpetuate obesity. Thus, the cause of a child’s morbid obesity can be difficult for courts to determine. While parental care cannot influence hereditary or chemical factors, it can have an impact on environmental factors such as eating habits. This Section provides a general overview of potential sources of childhood obesity and considers their respective roles in the obesity epidemic.

1. Factors Within Parental Control Linked to Childhood Obesity

Certain external factors have been noted as important in the debate over causes of childhood obesity. When evaluating the possible sources of the obesity epidemic, the impact of raising children in an obesogenic environment is not to be understated. Some scientists even believe that, given the short timeframe in which population-level changes in body weight have occurred across the globe, it is almost certain that the causes are environmental and behavioral rather than biological. This Subsection presents some of the primary environmental factors

23. Gable & Lutz, supra note 19, at 293.
25. Id.
27 See infra note 55.

342

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CHILDHOOD OBESITY

attributed to the development of childhood obesity, specifically the role of parents, the evolution of the obesogenic environment, and the impact of sociocultural and socioeconomic status.

i. The Impact of Parents on Childhood Obesity

Because parents directly influence their children’s eating habits and weight in a variety of ways, the legal system must recognize parental accountability for childhood obesity. One such influence involves the type of food that parents choose to have in the house. Not surprisingly, children are more likely to be obese if they live in a household where prepared food items high in fat and sodium are frequently served.29 One study also showed that between 1977 and 1998, parents substantially increased the size of portions they served to their children.30 Generally speaking, today’s children consume approximately 350 more calories per day than children did in the 1970s.31 This problematic trend increases the risk of childhood obesity.

Parents also have the ability to influence their children’s eating habits by modeling an unhealthy lifestyle for their children. Children born to obese parents are much more likely to be obese.32 A few long-term studies have shown that the daughter of an overweight mother is ten times more likely to be obese by the time she reaches the age of eight than a daughter born to a slim mother.33 Likewise, according to one group of researchers, the son of an obese male is six times more likely to be overweight.34 According to the Early Bird Diabetes Project, overeating behavior learned from parents, rather than genetics, is the primary cause of childhood obesity.35 Although scholars often cite lack of physical activity as a major cause of childhood obesity, according to one study “physical activity does not lead to obesity, but rather obesity to inactivity, suggesting that the primary cause of childhood obesity is overnutrition.”36 The inactivity of parents may also negatively inspire children to behave in

29. Gable & Lutz, supra note 19, at 293.
30. See generally Samara Nielsen & Barry Popkin, Patterns and Trends in Food Portion Sizes, 1977-1998, 289 JAMA 450 (2003) (describing the trends of parents feeding their children from 1977 to 1998). For example, the average number of calories in a portion of salty snacks increased from 132 to 225 and hamburger portions increased from 389 to 486 calories. Id. at 452 tbl.2.
34. Id.
35. Id.
36. Id.
unproductive and unhealthy ways by influencing children to choose a sedentary lifestyle early on. Because these parental factors are controllable, the courts should carefully consider these influences when allocating responsibility in cases of morbid childhood obesity.

**ii. The Impact of Sociological, Economic, and Cultural Factors on Childhood Obesity**

Many scientists believe that there are also a number of sociological, economic, and cultural factors that directly impact the obesity epidemic, complicating the attribution of fault for a child’s obesity. The years of the obesity epidemic have been a period of considerable change in the ethnic and cultural mix of many developed countries. The United States, long considered a cultural melting pot, has become increasingly diverse, with minority groups making up a growing percentage of the population in every state except for West Virginia. The changing ethnocultural atmosphere in the United States relates to ethnic disparities in obesity prevalence amongst American children. As of 2008, 26.8% of Mexican-American male youths were obese compared with 16.7% of non-Hispanic white male youths. In addition, a staggering 29.2% of non-Hispanic black female youths were obese, compared to 14.5% of non-Hispanic white female youths. Considering these racial dividing lines, differences in weight appear at least partially attributable to ethnocultural variation.

Economic disparities may also in part account for high rates of childhood obesity amongst certain social groups. Studies have indicated that there is a socioeconomic gradient in diet in which persons in higher socioeconomic groups tend to have a healthier diet, characterized by greater consumption of fruit, vegetables, and lower-fat milk, as well as a lower intake of fats. This disparity may be a reflection of an individual’s economic capacity to purchase healthy foods, which are more expensive than less nutritious food items. The living conditions that lower socioeconomic classes face also may contribute to the


40. Ogden & Carroll, supra note 20, at 1–2.

41. Id. at 2.

42. Id.

43. For a comprehensive discussion of the ethnic differences between groups which may contribute to obesity patterns, see generally Patricia B. Crawford et al., *Ethnic Issues in the Epidemiology of Childhood Obesity*, 48 PEDIATRIC CLINICS N. AM. 855 (2001).


45 Id.
CHILDHOOD OBESITY

childhood obesity problem among these groups. Living in disadvantaged neighborhoods can present many obstacles for children’s weight, including “less access to healthy foods and more unhealthy fast-food outlets.”46 Children living in these neighborhoods also often lack safe places to play outdoors, reducing opportunities for energy expenditure through physical activity.47

Though the relative contribution of each of these causes to childhood obesity is unknown, the combination of social, economic and cultural factors is clearly important in future efforts to understand and ultimately resolve the problem of childhood obesity. Though representatives from child protective services should be aware of these factors, courts should refrain from mitigating parental responsibility on the basis of culture or socioeconomic status. Also, while there is debate over whether the legal system should be more lenient towards parents who are stuck in “food deserts” without safe places for exercise, it is important that the child’s health be given first consideration. Cases will only be resolved in a satisfactory manner if the courts do not treat socioeconomic factors as excuses, but only as mitigating factors in a comprehensive analysis of the causes of a child’s morbid obesity. While child protection services must vigilantly guard against drawing inferences about parental practices based on unreliable and prejudicial socioeconomic factors alone, by continuing to study and acknowledge these factors, health advocates may learn to target the specific practices that lead to the disproportionate prevalence of obesity in these groups.

2. Internal Factors Linked to Childhood Obesity

Heredity and chemical factors are the two internal variables most commonly linked to childhood obesity. To understand the actual impact of these traits on the childhood obesity epidemic and the role that they should, therefore, play in evaluating whether parents should be held responsible, it is important to consider their importance and biological connection to obesity.

i. The Role of Heredity and Genetic Susceptibility

Scientists and nutritionists commonly document heredity’s role in creating genetic susceptibility to obesity for both children and adults.48 A twin study


47. Childhood Obesity Linked to Neighborhood Social and Economic Status, supra note 46.

48. See, e.g., Jane Wardle et al., Evidence for a Strong Genetic Influence on Childhood Adiposity Despite the Force of the Obesogenic Environment, 87 Am. J. CLIN. NUTRITION 398, 398 (2008) (“If genetic influence is important, monozygotic twins must be more similar than dizygotic twins.”). Specifically, “[t]win studies can . . . estimate the extent to which the family environment makes family members more similar than would be expected from their genetic relatedness . . . [and] can go beyond pitting nature against nurture to consider interactions between genes and environment.” Id.

345
published in 2008 in the *American Journal of Clinical Nutrition* examined over five thousand families with twins born between 1994 and 1996. The results of the study were surprising: the authors calculated that 77% of the BMI variation between children was attributable to genetic differences. The authors of the study urged that excessive weight gain in children should be more greatly attributed to genetics than to parental neglect.

Similarly, in formulating parental advice, some nutritionists have focused their attention on the role of genetics in weight gain. In exploring the idea of personalized dietary advice based on a person’s DNA, some nutritionists have argued that “genetic testing . . . might be used to predict . . . [an individual’s] susceptibility to certain dietary-related conditions.” By focusing on a person’s genetic predisposition towards obesity instead of blaming parents, nutritionists can better target the individual’s nutritional needs before obesity sets in and can “direct[] more intensive lifestyle interventions to [identified] high-risk groups.”

These studies indicate that genetic research should continue to play a role in society’s exploration of possible means of battling childhood obesity and genes should be a factor that the legal system considers in determining the responsibility of parents for the obesity of their children. Though changes in a population’s genetic makeup occur too slowly to be responsible for the rapid rise in obesity, genes do play a role in the development of obesity and, therefore, are an important consideration in constructing a comprehensive picture of the causes of childhood obesity. The relationship between genetics and the modern obesogenic environment is only beginning to be understood and continued attention must be paid to the subject by those looking to mitigate the dangers of childhood obesity.

49. *Id.* at 399. The total sample group was composed of 5,902 families. The twins were all between ages eight and eleven at the time of the study. *Id.*


51. See Wardle et al., *supra* note 48, at 403 (“What is important is this finding means that ‘blaming’ parents is wrong.”).


55. An “obesogenic environment” is defined as an environment promoting weight gain and which is not conducive to weight loss—in other words, an environment that contributes to obesity. See generally Pamela Powell et al., *What Is Obesogenic Environment?*, U. NEV. COOPERATIVE EXTENSION (2010), http://www.unce.unr.edu/publications/files/hn/2010/fs1011.pdf (describing the obesogenic environment and how it contributes to obesity).
ii. The Role of Chemical Factors

In addition to each individual’s hereditary design, chemical factors are other immutable variables that influence a person’s weight. Two notable examples of chemical involvement in the obesity epidemic are the hormone leptin and the interference of chemicals known as endocrine-disrupting chemicals (EDCs), or what are more commonly referred to as obesogens.\(^{56}\)

In the mid-1990s, scientists discovered leptin, which is “an appetite-suppressing hormone secreted by fat tissue.”\(^ {57}\) In the years since, scientists have continued to study the hormone, discovering that it plays a critical role in controlling the eating habits of humans. Humans have developed a complex physiological system for optimally regulating fuel stores and energy balance, in which leptin and its receptor signal nutritional status to other physiological systems.\(^ {58}\) Leptin deficiency has been shown to result in excessive obesity in children,\(^ {59}\) particularly in children who suffer from other genetic diseases, such as Down syndrome.\(^ {60}\) Though genetically based leptin deficiency is beyond parental control, knowledge of a child’s condition could help a parent determine what needs to be done to maintain a healthy weight.

As medical science has advanced, scientists have continued to research ways to address leptin deficiency for both children and adults. Experimentation has shown that daily subcutaneous injections of leptin can drastically and beneficially reduce fat mass and body weight.\(^ {61}\) However, treatments for leptin deficiency remain imperfect; many individuals undergoing leptin supplementation rebound back after a temporary period of weight loss.\(^ {62}\) The tendency of obese individuals to have increased leptin resistance also complicates matters,\(^ {63}\) leaving scientists


\(^{59}\). See I. Sadaf Farooqi, Genes and Obesity, in CLINICAL OBESITY IN ADULTS AND CHILDREN 81, 86 (Peter G. Kopelman et al. eds., 2d ed. 2005) (discussing the impact of leptin deficiency on the weight of children).


\(^{62}\). See Obesity: Reviving the Promise of Leptin, supra note 57 (“Unfortunately, when obese humans took the hormone [leptin], they lost weight only temporarily – then rebounded back.”). This is not to say that the control of leptin deficiency has been totally ineffective. At least one scientist has reported success with weight management through leptin injections with children. See Farooqi, supra note 59, at 87 (“Thus far, we have been able to regain control of weight loss by increasing the dose of leptin.”).

\(^{63}\). See Obesity: Reviving the Promise of Leptin, supra note 57 (“Most humans who are obese
and doctors with the question of how to resolve leptin deficiency appropriately, while circumventing a person's heightened resistance to the hormone. 64

In addition to struggling with leptin deficiency, scientists must also resolve difficulties caused by other chemical factors, such as obesogens. These chemicals disrupt the function of hormonal systems and are believed to “lead to weight gain and, in turn, numerous diseases that curse the American populace.” 65 Obesogens can enter our bodies from a variety of sources: natural hormones found in soy products, hormones administered to animals, plastics in some food and drink packaging, ingredients added to processed foods, and pesticides used on produce. 66 Once internalized by an individual, obesogens can act in a variety of ways, including mimicking human hormones, misprogramming stem cells, and altering gene function. 67

Recent studies have indicated that obesogens may also be an underlying cause of obesity. 68 This possibility is an especially worrisome prospect for fetuses and newborns, for whom obesogens are thought to “act on genes . . . to turn more precursor cells into fat cells, which stay with you for life[,] a]nd . . . may alter metabolic rate[] so that the body hoards calories rather than burning them, like a physiological Scrooge.” 69 Unfortunately, it seems that scientists understand the exact connection between obesity and obesogens even less than the genetics behind leptin deficiency. 70

In the debate over the contribution of different variables to the childhood obesity epidemic, chemical factors, whether internal since birth or later introduced into the body from an external source, are much like genetics. Both are immutable physiological factors that can contribute to obesity in certain individuals, but cannot be identified as the sole cause of excessive weight gain.

II. CHILD PROTECTION IN THE LEGAL SYSTEM AND THE BALANCING OF PARENTAL RIGHTS

After decades of development, today the United States provides a fairly robust system of child protection laws. This Part will recount the evolution of the legal framework that has led to the current standards for both child and parental rights, as well as the place for childhood obesity within the existing system.

64 Id. (“For years, industry and academic laboratories have been searching for a drug to make peoples' brains sensitive to leptin again, without success.”).
65 Perrine & Hurlock, supra note 56.
66 Id.
67 Id.
68 Id.
70 Considering “the ubiquity of obesogens, traces of which are found in the blood or tissue of virtually every American,” it is unclear why the chemicals do not have an equally drastic affect on the weight of all individuals; “[f]or now, all scientists can say is that even a slight variation in the amounts and timing of exposures might matter, as could individual differences in physiology.” Id.
CHILDHOOD OBESITY

A. The Historical Development of Child Protection Laws

Over the course of U.S. history, child protection laws have "evolved according to changing beliefs and attitudes about what role government should play in the protection and care of abused and neglected children." The result is a system that has increased protections for children by enlarging government involvement in American family life.

At the time of the nation's founding, there were no real governmental protective measures for abused or neglected children. In the nineteenth century, the legal system still did little to address the need for child protection reforms. In 1899, the United States first established juvenile courts, which "were not focused on protecting maltreated children as much as they were concerned with keeping the streets free of poor and vagrant children."

During the twentieth century, public concerns over child protection increased dramatically and, in response, both state and federal governments became far more involved in efforts to protect children. The early 1900s saw the genesis of a wave of new organizations designed to protect children and their rights. In 1932, the Supreme Court, in Powell v. Alabama, expressly held that children have constitutional rights when it declared that Alabama had denied the child defendants—"young, ignorant, illiterate, [and] surrounded by hostile sentiment"—their constitutional right to counsel in violation of the Fourteenth Amendment. The Court's dicta has been interpreted as declaring that "children clearly had certain fundamental constitutional rights such as a Thirteenth Amendment right not to be enslaved and rights under the Due Process Clause not to be deprived arbitrarily of life or liberty," providing constitutional justification for modern child protection laws.

Three years later, Congress passed the Social Security Act of 1935 (SSA), a monumental piece of New Deal legislation that introduced child protection

72. Id.
73. Most of the efforts to help children at this time were undertaken by private actors. In the early 1800s private religious and charitable organizations had established the first orphanages and by the latter half of the nineteenth century private agencies had begun to place orphans with foster families "out of concern about the effects of growing up in orphanages." Id. In these early foster family appointments, however, prospective families were rarely screened and agencies seldom monitored placements. Id.
75. Id.
78. Id. at 58 ("Under the circumstances disclosed, we hold that defendants were not accorded the right of counsel in any substantial sense.").
79. Dailey, supra note 76, at 2100.
provisions. The SSA’s Aid to Dependent Children (ADC) provision\textsuperscript{80} authorized the first federal grant for child welfare services,\textsuperscript{81} which served as an impetus for states to establish their own child protection measures through child welfare agencies and local programs that deliver child welfare services.\textsuperscript{82} In 1961, legislative amendments to the SSA created mandatory ADC requirements stating that states could not ignore the needs of children in unsuitable living situations. Specifically, it has been interpreted as demanding that the states provide appropriate services to make the child’s current house suitable or otherwise relocate the child to a more suitable living situation while providing financial support on behalf of the child.\textsuperscript{83} In the following year, an additional set of changes, collectively titled the Public Welfare Amendments, required state agencies to report to the court system those “families whose children were identified as candidates for removal.”\textsuperscript{84} This led to a growing number of out-of-home placements of children in the mid- to late-1960s.\textsuperscript{85}

After the child welfare provisions of the SSA, the 1974 Child Abuse Prevention and Treatment Act (CAPTA) is the second most significant piece of federal child protection legislation.\textsuperscript{86} CAPTA was the first major federal legislation to address child abuse and neglect.\textsuperscript{87} Congress designed CAPTA primarily to focus on physical abuse cases by providing states with federal funding for the investigation and prevention of child maltreatment\textsuperscript{88} conditioned on the states’ adoption of mandatory reporting laws with reporter immunity, confidentiality, and the appointment of guardians ad litem for children.\textsuperscript{89} In recent decades, there have been numerous other state and federal legislative

\textsuperscript{80} In 1962, the program’s name was changed to Aid to Families with Dependent Children (AFDC). See Murray & Gesiriech, supra note 71, at 2.
\textsuperscript{81} Id. at 1.
\textsuperscript{82} Id.
\textsuperscript{83} See id. at 2 (describing the legislative amendment introducing the Flemming Rule into the Act, which demands that “states could not simply ignore the needs of children living in households deemed to be unsuitable[, but] [i]nstead, . . . required states to either (1) provide appropriate services to make the home suitable, or (2) move the child to a suitable placement while continuing to provide financial support on behalf of the child”).
\textsuperscript{84} Id.
\textsuperscript{85} Id.
\textsuperscript{86} At the time of its passage, CAPTA was criticized for infringing upon federalism. See Caroline T. Trost, Note, Chilling Child Abuse Reporting: Rethinking the CAPTA Amendments, 51 VAND. L. REV. 183, 194 (1998) (citation omitted) (“[CAPTA] was still criticized both for not providing enough funding and for involving the federal government in an area that had thus far been reserved entirely to the states.” (citation omitted)). The changes we propose in this Note are focused on state-level reforms and respect the boundaries of the Tenth Amendment.
\textsuperscript{87} Id.
\textsuperscript{88} Child Maltreatment, supra note 74; see 42 U.S.C. § 5106c (2010) (describing CAPTA-based grants to states for programs designed to curb child abuse and neglect).
pushes to improve the safety of children by protecting them from abuse and neglect. While one could devote an entire article to exploring these legislative actions and their effects, the underlying point is nevertheless clear: the government has come to recognize the importance of protecting children from harmful living situations and has come to demand that the State intervene in the family sphere when parents have failed to supply suitable care. Just as the State has a strong interest in ensuring justice for children who suffer abuse from strangers, government intervention is also necessary to protect children from irreparable harm caused by a family member. The legal system focuses on the fact that an unjustifiable harm has occurred, regardless of its origin.

B. Saving Children from Abuse and Neglect in the Present Day

This Section will attempt to present a coherent framework for understanding the current status of abuse and neglect within the American legal system. Evaluating the practice of child protection in the modern legal system involves first examining and defining the key legal terms used to identify child maltreatment: “child abuse” and “neglect.” Because the laws regarding child abuse and neglect vary from state to state, there is no single national definition for these terms. Commonalities, however, run through various states’ definitions of child mistreatment. In almost every state, the concept of child maltreatment encompasses physical abuse, sexual abuse, neglect, and emotional

90. See generally Murray & Gesiriech, supra note 71 (detailing legislative acts and reforms that have been designed to benefit and protect children). For an example of another important piece of legislation, see Marygold S. Melli, Protecting Children in Child Abuse and Neglect Proceedings, PARENTHOOD IN AMERICA (1998), http://parenthood.library.wisc.edu/Melli/Melli.html. The author writes:

The Adoption Assistance and Child Welfare Act of 1980 required states as a condition for receiving federal reimbursement for foster care to create social programs to help the family before a child is at risk and to prevent the need for removal. These services include, for example, temporary child care and counseling services.

Id.

91. Today, as during the early years of child protection laws, “[t]he primary responsibility for child welfare services rests with the States, and each State has its own legal and administrative structures and programs that address the needs of children and families.” Major Federal Legislation Concerned with Child Protection, Child Welfare, and Adoption, U.S. DEP’T OF HEALTH & HUMAN SERVS. 1 (Apr. 2011), http://www.childwelfare.gov/pubs/otherpubs/majorfedlegis.pdf. The federal government still plays an important role in this system, as states must comply with specific Federal requirements and guidelines in order to be eligible for Federal funding. Id. The combined efforts of these multiple levels of government involvement help to achieve more effective protection for children.

abuse. The dividing lines between these four categories of maltreatment are not always clear and it is common for children to be subjected to more than one type of abuse, particularly when emotional abuse is involved. It has been estimated that less than 5% of cases involve only one type of abuse. This Section will focus on the categories most relevant to childhood morbid obesity: physical abuse and medical neglect.

Physical abuse of a child is one of the most difficult categories of maltreatment to properly define because its origin may be difficult to prove and the intent of the abuser is often hard to discern. The absence of a universally accepted definition for physical abuse complicates the task of understanding the epidemiology of child abuse in all of its forms. A very simplistic definition of physical abuse is “[n]on-accidental physical injury as a result of caretaker acts,” which includes, for example, “shaking, slapping, punching, beating, kicking, biting and burning.”

While this broad definition provides some general guidance to the courts as to the types of behavior that constitute physical abuse, it erroneously focuses on the injurious act rather than on whether the intent of the actor is justified or unjustified. The term “injury” implies some sort of observable physical malady such as a bruise, a cut, or a broken bone. Yet, a test requiring one to identify a physical injury of this kind may lead the court to altogether miss the problem. Consider the following example: a child and a parent are walking outside and suddenly the parent shoves the child to the ground, breaking his nose on impact. While an injury has obviously been sustained, whether abuse occurred cannot be discerned until the intent of the actor is discovered. If the parent was acting out of the malicious intent, then it is clear that an abusive act has occurred. Alternatively, if the parent pushed the child in order to prevent him from being hit by an oncoming speeding car, then the act was justified and not abusive. An analogous approach to morbid childhood obesity cases would similarly seek to determine the underlying causes of a child’s morbid obesity and whether a parent’s response is reasonable and justified.

It is also extremely difficult to clearly define neglect due to the large number of forms this kind of maltreatment can take. Under state law, neglect is often defined as “the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child’s health, safety, and well-being are threatened with

94. OATES, supra note 93, at 2 (citing P. Ney et al., The Worst Combination of Child Abuse and Neglect, 18 CHILD ABUSE & NEGLECT 705 (1994)).
95. Id. at 3.
96. Child Maltreatment, supra note 74 (emphasis omitted) (citing OATES, supra note 93).
97. Id. (internal citation omitted).
98. See OATES, supra note 93, at 2 (noting the advantages of definitions that “recogniz[e] the vulnerability of the child and ... plac[e] responsibility on the child’s caretaker”).
99. Id. at 3.
harm. 100

Neglect is also considerably more difficult for observers to detect than physical abuse because the changes in the neglected child's body and behavior are slower to develop and more easily mistaken for symptoms of poor health or a shy personality. 101 In some ways, neglect may actually be more injurious to a child than physical abuse. Research shows that neglect can have deeper and longer lasting consequences than physical abuse. 102 Because “[t]he neglected child is treated more as if he were not there, or as if his parents wished he were not there, . . . this insidious and fundamental rejection can inflict deep psychological wounds” 103 that have the potential for a lifelong negative impact on a child’s mental state. Physically abused children “frequently are cared for in other ways by their abusers,” often receiving “food, clothing, playthings, and even enjoy[ing] good times with others in the family.” 104 By contrast, neglected children are denied many (if not all) of these benefits.

While the level of neglect warranting removal is traditionally associated with a failure to provide food, 105 some courts have begun to acknowledge that neglect could also come in the form of a failure to care for those aspects of the child’s physical well-being that are related to obesity. Most courts that have examined this issue have categorized this failure as a form of medical neglect. 106 Like neglect generally, the definition of medical neglect varies from state to state. For example, seven states define medical neglect as “failing to provide any special medical treatment or mental health care needed by the child,” 107 while four other states define it as “the withholding of medical treatment or nutrition from disabled infants with life-threatening conditions.” 108 Notably, as of February 2011, the other thirty-nine states and the District of Columbia had not provided a specific statutory definition of medical neglect. 109 The absence of a definition in most jurisdictions may complicate the task of courts attempting to apply the legal

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100. Definitions of Child Abuse and Neglect, supra note 92, at 3.
102. Id. at 4.
103. Id.
104. Id.
106. For examples of courts that have relied on medical factors to justify their findings of neglect see In re L.T., 494 N.W.2d 450, 452–53 (Iowa Ct. App. 1992); In re D.K., 58 Pa. D. & C.4th 353, 356 (Com. Pl. 2002); and In re G.C., 66 S.W.3d 517, 520 (Tex. Ct. App. 2002).
107. U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 92, at 3 (definition used in Mississippi, North Dakota, Ohio, Oklahoma, Tennessee, Texas, and West Virginia).
108. Id. (definition used in Indiana, Kansas, Minnesota, and Montana).
In sum, it is difficult to determine how exactly childhood obesity fits within the multitiered and complex system of standards grouped under the terms abuse and neglect. This difficulty highlights the need for legislation defining the legal standards for those cases of childhood obesity that ought to be characterized as maltreatment. We will explore this concern in greater depth through the lens of state judicial systems in Part III, where we analyze obesity cases in the state judicial system, and in Part IV, where we present our policy recommendations.

C. Relevant Parental Rights and Duties to Children

Another relevant debate about how childhood obesity fits into the doctrines of child abuse and neglect involves the question of how much control parents should be allowed to exert over their children’s lives. This Section examines the roots of parental control within the legal system and explains why parental rights are a double-edged sword. After this analysis, we conclude that while parents should continue to be afforded the prima facie right to decide how to feed their children, this right is limited by the responsibility to ensure that their actions do not cause their children irreparable harm.

The historical jurisprudence of parental rights comes from three primary Supreme Court decisions: Meyer v. Nebraska, Pierce v. Society of Sisters, and Prince v. Massachusetts. These cases acknowledged that parents have a due process liberty right to control the methods and choices involved in child rearing. In identifying the fundamental right of a legal parent over his or her child's well-being, we must also consider the due process guarantees against the State are derived from the Fourteenth Amendment, which guarantees that "[n]o State . . . shall deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, § 1.


13. Due process guarantees against the State are derived from the Fourteenth Amendment, which guarantees that “[n]o State . . . shall deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, § 1.

14. See Weaver, supra note 112, at 270 nn.127–29. Meyer v. Nebraska also held that “a state statute forbidding the teaching of subjects in foreign languages impermissibly interferes with the parents’ right to control the education of their children.” Id. at 270 n.127; see also Meyer, 262 U.S. at 402 (“The desire of the Legislature to foster a homogeneous people with American ideals prepared readily to understand current discussions of civic matters is easy to appreciate. Unfortunate experiences during the late war and aversion toward every character of truculent adversaries were certainly enough to quicken that aspiration. But the means adopted, we think, exceed the limitations upon the power of the state and conflict with rights assured to plaintiff in error.”). Pierce v. Society of Sisters held that “an Oregon statute requiring all children to attend public schools was invalid because it unreasonably interfered with the liberty of parents and guardians to direct the upbringing and education of children under their control.” Weaver, supra note 112, at 270 n.128; Pierce, 268 U.S. at 535 (“The fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the state to standardize its children by forcing them to accept instruction from public teachers only.”). Prince v. Massachusetts “recogniz[ed] that parents have the right to provide a child with religious training but, when
CHILDHOOD OBESITY

child, the Court found support for the “parental rights doctrine” through various cases defining the sphere of rights derived from the privacy of the family. Parental rights are afforded strict scrutiny within the legal system and “[a] state may infringe on these rights only for a compelling reason and only insofar as that infringement is necessary to protect the state’s interest.”

Though parental rights play a valuable role in protecting certain family liberties from governmental intervention, these rights are not plenary and may be infringed by the State in certain circumstances. In the 1944 case Prince v. Massachusetts, Justice Rutledge, writing for the majority, asserted as part of his reasoning that “[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies.” According to Justice Rutledge, a state “may secure [this healthy growth] against impeding restraints and dangers” by asserting governmental powers, including the power to stop a parent from putting their children under threat of physical danger or either emotional or psychological harm.

When parents threaten the State’s compelling interest in promoting the health of children, through their actions— or, in the case of neglect, inaction—the State reserves the authority to restrict or burden the parental right in order to protect its interests in the welfare of children. Though no single, universal test

children may be harmed by their religious activities, the state has more authority over children.” Weaver, supra note 112, at 270 n.129; Prince, 321 U.S. at 166–67 (“The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.”).

115. Weaver, supra note 112, at 270–71; see also Stanley v. Illinois, 405 U.S. 645, 651 (1972) (“It is plain that the interest of a parent in the companionship, care, custody, and management of his or her children ‘come(s) to this Court with a momentum for respect lacking when appeal is made to liberties which derive merely from shifting economic arrangements.’” (quoting Kovacs v. Cooper, 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring))).

116. Weaver, supra note 112, at 271; Stanley, 405 U.S. at 652 (“[R]emoving [a child] from the custody of his parents [is] only [acceptable] when his welfare or safety or the protection of the public cannot be adequately safeguarded without removal . . . . These are legitimate interests, well within the power of the State to implement. We do not question the assertion that neglectful parents may be separated from their children.” (citation omitted)).

117. See Weaver, supra note 112, at 271 (“Prince established that parental authority is not absolute and can be permissibly restricted, if doing so is in the interests of a child’s welfare.”).

118. Prince, 321 U.S. at 168.

119. Id.

120. See id. at 170 (“Other harmful possibilities could be stated, of emotional excitement and psychological or physical injury. Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”).

121. See JILL GOLDMAN ET AL., A COORDINATED RESPONSE TO CHILD ABUSE AND NEGLECT: THE FOUNDATION FOR PRACTICE 51–52 (2003), available at www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf. Describing the foundation for the State’s authority, the authors write: “The basis for intervention in child maltreatment is grounded in the concept of parens patriae—a legal term that asserts the government’s role in protecting the interests of children and intervening when parents fail to provide proper care.” Id. at 51. The authors also note that the “parent-child relationship grants certain rights, duties, and obligations to both parent and child . . . [and if] a parent . . . is unable or unwilling to meet this
determines when children must be removed from parental custody, many states mandate the following requirements before ordering removal: the State must (1) prove imminent danger to the physical health or safety of the child, (2) determine whether it is contrary to the welfare of the child to remain in the home, and (3) make reasonable efforts to prevent the removal of the child from his or her home.122

As evidenced by the third requirement of the above test, states always view the separation of children from their parents as a last resort and will make reasonable efforts to avoid separating a family.123 The State, however, will break apart a family if necessary to protect endangered children.124 Though the definition of “reasonable efforts” varies from state to state,125 such efforts can include drug rehabilitation, parenting classes, psychological or psychiatric counseling, education or job training, and therapy.126

Judges must consider the constitutionally protected parental right against the relatively new threat that childhood obesity presents to the State’s interest in the protecting the children’s health. However, obesity cases would not present an unconstitutional challenge to the parental right if they were framed in terms of the existing standards of medical neglect, since courts have a long history of upholding restriction on the parental right in those situations. In Part III, we analyze judicial decisions that have handled the obesity issue and argue that courts should focus on incorporating the legal issue of childhood morbid obesity into existing standards of medical neglect.

III. CHILDHOOD OBESITY IN THE COURTS

Given the pervasive ambiguity of established child protection laws, it is not surprising that the courts that have begun to address the novel child obesity cases have taken inconsistent approaches.127 Most courts have held that states may intervene only in the most extreme circumstances. For example, states may order medical treatment for a child contrary to a parent’s wishes when it is necessary to

122. See Weaver, supra note 112, at 269 (“Most states generally use a three-prong legal standard to determine whether a child should be removed from his or her parents’ home when there are allegations of child abuse and neglect.”).

123. See id. at 273 (citing 42 U.S.C.A. § 671(a)(15)(B) (West 2010)) (“If the state can prevent the child from being removed from his or her home, it must make reasonable efforts to do so.”).

124. See id. at 274 (“If the current risks or harm to the children cannot be controlled, the state removes the children and places them in foster care.”).


126. Weaver, supra note 112, at 275.

CHILDHOOD OBESITY

save the child's life or to avoid serious physical, mental, or emotional harm.\textsuperscript{128} Other courts, however, have used alternative standards for removing children, such as classifying them as "dependent children"\textsuperscript{129} or "children in need of assistance."\textsuperscript{130} Although states have the right to develop their own legal standards, the standards applied by the courts in the following cases are less than ideal. While this Part details the legal standards currently evolving in state courts, Part IV will address the benefits of adopting the predominant approach of applying the standard for medical neglect to these types of cases.

A Pennsylvania case, \textit{In re D.K.}, involved a sixteen-year-old boy who suffered from morbid obesity, weighing 451 pounds despite his five-foot-three stature.\textsuperscript{131} Records showed that he had been overweight since infancy and that his parents had never taken him to see a dietician or any other specialist.\textsuperscript{132} In the year prior alone, he had gained one hundred pounds, putting his health in a "life threatening situation."\textsuperscript{133} In addition to morbid obesity, he suffered from an enlarged liver, hypertension, respiratory problems requiring oxygen at night, insulin resistance, sleep apnea, knee pain, and a depressive disorder.\textsuperscript{134}

On the basis of a medical referral, the Northumberland County Children and Youth Services Department (CYS) initially obtained a voluntary entrustment agreement from the boy's mother that placed D.K. in the custody of CYS as a dependent child.\textsuperscript{135} Under Pennsylvania law, a dependent child is one who is "without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals."\textsuperscript{136} After being under CYS's care for three months and receiving a physician-supervised diet and regular exercise, D.K. lost fifty pounds.\textsuperscript{137} This indicated that D.K.'s weight problem was most likely due to irresponsible parental choices rather than hereditary or chemical factors. Both D.K. and his mother, however, challenged his designation as a "dependent child" and advocated for his return.\textsuperscript{138}

The court determined that D.K.'s mother was not capable of providing adequate care for his physical needs because she had failed to take any steps to address her child's morbid obesity, such as bringing D.K. to a dietician.\textsuperscript{139} In support of the court's finding that D.K. was a dependent child, it noted:

\begin{itemize}
  \item \textsuperscript{128} Michael MacDonald et al., \textit{Consent to Medical Treatment, in Health Care Law: A Practical Guide} § 19.06 (2d ed. 2010).
  \item \textsuperscript{129} See D.K., 58 Pa. D. & C.4th at 354.
  \item \textsuperscript{130} See L.T., 494 N.W.2d at 451.
  \item \textsuperscript{131} D.K., 58 Pa. D. & C.4th at 354.
  \item \textsuperscript{132} Id. at 354–55, 359.
  \item \textsuperscript{133} Id. at 355.
  \item \textsuperscript{134} Id.
  \item \textsuperscript{135} Id.
  \item \textsuperscript{136} Id. at 357 (quoting 42 Pa. Cons. Stat. Ann. § 6302(1)).
  \item \textsuperscript{137} D.K., 58 Pa. D. & C.4th at 356.
  \item \textsuperscript{138} Id.
  \item \textsuperscript{139} Id. Though this appears to be an example of neglect, the court never explicitly uses that term.
\end{itemize}
If a child does not receive necessary medical care for a health problem, there is usually no difficulty in a court making a finding of dependency, and especially in the situation where a child was malnourished to the point of near starvation. . . . This situation here is on the other end of the nourishment spectrum, but it is no less dangerous to the child’s physical and mental well-being.\textsuperscript{140}

This discussion illustrates the fairly recent acceptance that overfeeding is just as harmful as underfeeding. Furthermore, the court seemed to base its decision on the mother’s own extreme obesity that rendered her homebound and unable to bring D.K. to medical appointments.\textsuperscript{141} The opinion noted that since she had not been able to address her own severe obesity problem, “it [was] highly unlikely that she will now be able to do so with regard to her son’s identical problem.”\textsuperscript{142} The court’s reasoning in ordering the child’s removal relied on an analogy to traditional medical neglect. After the court had determined that the mother could have taken measures to combat her son’s obesity, it framed her failure to do so as a harm much like failing to provide medical treatment.

Though the court ordered D.K.’s removal, it acknowledged that D.K. could be reunited with his mother once his mother demonstrated her ability to address her son’s morbid obesity.\textsuperscript{143} By discussing how children should be separated from their families only in cases of clear necessity,\textsuperscript{144} the court recognized the importance of trying to uphold parents’ fundamental right to determine how to raise their children.

Other state courts have applied similar logic but different legal standards for removal. An Iowa case involved parents of a ten-year-old girl, Liza, who weighed 290 pounds.\textsuperscript{145} Her obesity was so severe that a yeast infection, growing out of control in the skin creases on her abdomen and producing an extremely strong body odor, caused her to be hospitalized.\textsuperscript{146} Upon her release from the hospital, the doctors recommended her placement in a residential treatment facility.\textsuperscript{147} When her parents declined, the juvenile court intervened, determined that she was a “child in need of assistance” (CINA), and ordered her placement in residential treatment foster care.\textsuperscript{148}

Iowa law defines a CINA:

\begin{quote}
\text{an unmarried child who is in need of medical treatment to cure or alleviate serious mental illness or disorder, or emotional}
\end{quote}
damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior toward self or others and whose parent, guardian, or custodian is unwilling or unable to provide such treatment.\footnote{149}

Her mother appealed the juvenile court’s determination that Liza was a CINA.\footnote{150}

On appeal, the Iowa Court of Appeals noted evidence from psychologists that Liza suffered from severe depression, which contributed to her obesity by causing her to overeat.\footnote{151} Evidence also showed that Liza’s obesity was “a potentially life-threatening condition,”\footnote{152} which would “likely result in a significantly increased risk of hypertension and a decreased life expectancy.”\footnote{153} In addition, her severe obesity interfered with her ability “to develop physically, mentally, and emotionally.”\footnote{154} Based on this evidence, Liza was at serious risk of developing lifelong conditions due to her weight and, therefore, fit the criteria for being a CINA.

The court also observed that Liza’s mother exacerbated her child’s obesity by encouraging her to overeat as a method of coping with stress. Specifically, she provided food as a reward and refused to allow Liza to enter residential treatment.\footnote{155} Therefore, the court affirmed the juvenile court’s order, holding that the “best interests of the child” dictated her placement into the custody of the Department of Human Services so that she could enter the residential treatment for her morbid obesity.\footnote{156} The court in this case justified state intervention in part by employing definitions of what constitutes a CINA and by drawing connections to medical neglect. Nonetheless, the decision established a dangerous precedent by instituting the “best interests of the child” standard. Because this standard allows for a more subjective determination by the State of when intervention should be allowed as compared to the dependent child standard based on clear necessity used in \textit{In re D.K.}, it opens the door to unjust government intrusion into the otherwise private family sphere.

In another case using the “best interests of the child” standard, the Court of Appeals in Michigan affirmed the trial court’s termination of parental rights in a case involving a morbidly obese four-year-old named Jered.\footnote{157} The Family Independence Agency first became involved when Jered was almost three years old and weighed approximately 106 pounds.\footnote{158} Although the Agency offered numerous services to his mother, five months later Jered weighed 120 pounds.
and frequently used a wheelchair because he had trouble walking. The Agency ruled out any alternative medical reasons for his weight. Additionally, Jered had ten cavities, delayed physical and verbal skills, head lice, scabies, and infections from improper cleaning. Although the court removed him from his mother’s care due to a combination of these factors, it is not clear whether his morbid obesity alone would have been enough to motivate the court to rule this way. Jered thrived in foster care and soon lost over sixty pounds. Just as in In re D.K., this type of recovery indicated that Jered’s weight problem was most likely due to irresponsible parental choices. Under the standard of medical neglect that we will propose, however, Jered’s obesity alone would have been sufficient to warrant removal because his parents had failed to address his serious medical needs.

The Agency eventually sought termination of all parental rights. At the termination trial, evidence introduced by the State showed that Jered’s mother “had not truly accepted responsibility for Jered’s obesity,” had continued to feed him fast food during parenting time after completing nutritional education, had failed to attend Jered’s occupational therapy appointments, and did not have a close bond with her son. For these reasons, the trial court determined that terminating his mother’s parental rights was in Jered’s best interest. On appeal, the appellate court affirmed, holding that the trial court “did not clearly err in finding that [termination of parental rights] was established by clear and convincing evidence.”

It is not always evident which standard a court has used to determine if termination of parental rights is necessary. A California Court of Appeals did not invoke a clear standard when it affirmed the termination of parental rights in a case that involved a morbidly obese eleven-year-old boy, Jo. The Los Angeles County Department of Children and Family Services originally became involved with Jo’s family when Jo was four years old and weighed 160 pounds. The Department determined Jo to be at high risk for diabetes, heart disease, and sleep apnea. Although the Department helped arrange numerous appointments “for diagnosis, testing and treatment of Jo’s condition,” his parents failed to cooperate. After a year, Jo’s weight increased to 200 pounds. A physician explained that his obesity “was not the result of a genetic or endocrine disorder

159. Id.
160. Id.
161. Id.
162. Id.
163. Id. at *3.
164. Id. at *4.
165. Id. at *3.
166. Id.
168. Id. at *1.
169. Id.
170. Id.
171. Id.

360
CHILDHOOD OBESITY

and was likely caused by behavioral and environmental factors,"172 thereby eliminating internal causes and shifting the blame onto the parents. For example, in order to quiet Jose down during his tantrums, his parents gave him food, and Department agents observed that "the family home lacked the structured environment necessary for Jo to lose weight and improve his behavior."173

As a result, Jo was declared a court dependent and sent to live in a group home.174 After being away from his parents for eighteen months, his weight dropped to 150 pounds and his behavior improved.175 Since the goal was still family reunification, the State returned Jo to his parents’ custody on the condition that they comply with the treatment plan.176 By the time of the parental review hearing two months later, however, “Jo’s weight had ballooned to 213 pounds and he was reverting to aggressive behavior.”177 Due to Jo’s pattern of losing weight during out-of-home care and gaining massive weight when returned to his parents’ custody, and his parents’ lack of response to numerous health-based services, the Department sought the termination of the parental rights.178 The juvenile court granted the order under the standard that “the child is suffering severe emotional damage and there are no reasonable means to protect the child’s emotional health without removing the child from the physical custody of the parents.”179 While the court did not explicitly invoke medical neglect,180 the language of the decision implied that the court was relying on this standard when it noted that Jo’s mother and father “failed to ensure his proper care”181 and placed him “at risk of physical and emotional harm.”182 The appellate court upheld this decision.183

In In re Brittany T., a family court in Chemung County, New York, considered whether it was in the best interest of a morbidly obese eleven year-old girl to be removed from her parents because they consistently failed to address her severe medical condition and also failed to ensure her proper school attendance.184 Following the best interests of the child standard,185 the court ordered Brittany’s parents, who were under observation of the Chemung County

172. Id.
173. Id.
174. Id. at *2, *4.
175. Id. at *5.
176. Id. at *4.
177. Id.
178. Id. at *6.
179. Id. at *7.
180. In California, the standard of medical neglect is if “[t]he child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness as a result of . . . the willful or negligent failure of the parent or guardian to provide the child with adequate . . . medical treatment.” CA. WELF. & INST. CODE § 300 (West 2006).
182. Id.
185. Id. at 838.
Department of Social Services, to abide by certain enumerated conditions designed to facilitate improvement of Brittany’s health and educational needs. Her parents failed to comply, however, and the court placed Brittany in foster care. During the time that she was in foster care and receiving treatment, Brittany lost about one to two pounds per month, and she was eventually returned to her parents.

Within six months of returning home, however, Brittany’s weight increased from 238 pounds to 263 pounds, an average weight gain of almost five pounds per month. According to doctors, Brittany’s morbid obesity was due to “excessive caloric intake and a sedentary lifestyle,” rather than any genetic or psychiatric syndrome, indicating that her parents had the opportunity to control the causes of her weight gain. If she did not return to treatment and receive the necessary and proper attention for her morbid obesity, doctors predicted that Brittany would have continued gaining weight, resulting in further deterioration of her health. The doctors classified these medical concerns as “life-limiting.” As a result, the Department charged her parents with neglect and alleged that they had violated the court orders to address her obesity.

At trial, the Department alleged that Brittany’s parents violated the terms of the court’s dispositional order by “failing to take [Brittany] at least two to three times per week to the gym” and “failing to actively and honestly attend and participate in a nutrition education program.” Department witnesses also testified that despite receiving education on nutrition from the Department, Brittany’s parents continued to feed her “lots of chicken nuggets, lots of pop tarts, hot dogs and pizza.” Furthermore, the State revealed that “Brittany suffer[ed] from a significant amount of emotional distress related to her excessive weight” and that her weight had “a detrimental effect on her physical and emotional well-being.”

Under New York law, an alleged violation of a court order of supervision can be sustained if the court finds sufficient proof that the violation was performed “willfully and without just cause.” Here, the court determined that Brittany’s parents’ “unequivocally” met this standard by their “unwillingness to follow doctors’ and others’ advice,” which “convincingly and patently had a very negative physical, emotional and mental impact on Brittany.”

186. Id. at 831.
187. Id.
188. Id. at 834.
189. Id. at 831.
190. Id. at 834.
191. Id. at 833.
192. Id. at 834.
193. Id.
194. Id. at 831–32.
195. Id.
196. Id. at 834 (internal quotation marks omitted).
197. Id. at 835.
198. Id. at 836 (citing N.Y. FAM. CT. ACT § 1072).
199. Id. at 837.
CHILDHOOD OBESITY

According to New York statute, a child is neglected when his or her “physical, mental or emotional condition has been impaired as a result of the failure of his or her parent to exercise a minimum degree of care in supplying the child with adequate education or medical care though financially able to do so.” Here, the court held that Brittany’s parents’ behavior, in failing to take steps to address her obesity, “indicate[d] an unwillingness or inability to take the steps necessary to assume responsibility for [their] child[].” The court also reasoned that removal on the basis of morbid obesity was no less justified than removal for any other situation in which “a child is at risk of life-limiting consequences due to malnourishment, inadequate supervision or other heretofore well-established bases for removal.” This comparison between overfeeding and malnourishment echoes the analysis of In re D.K., in which the court considered the two symptoms to be analogous in the charging of neglect.

Unlike the other cases so far discussed, however, this decision was subsequently reversed by the Appellate Division of the Supreme Court of New York, which determined that the facts did not support a finding of the parent’s willful violation of the court’s order. Acknowledging that the parents’ care had been far from ideal, the court held that there was nevertheless no “clear and convincing evidence” that the parents exhibited a “continuous, willful and unjustifiable refusal’ to comply with the terms of th[e] order.”

In support of the decision that Brittany’s parents were not willfully violating the terms of the court order, the appellate court found that by requiring their daughter to attend the gym at least once a week for twenty-seven of the thirty-one weeks, Brittany’s parents made a “good faith attempt” to fulfill their court-mandated obligation to take Brittany to the gym two or three times a week. Significantly, the court was not convinced that Brittany’s weight gain could be completely attributed to her parent’s neglect. The court noted that “[i]t is true that the child gained weight after being returned to respondents, but other factors outside of their control may well account for this increase.” The court’s decision acknowledges the difficulty in deciphering the cause of weight gain, holding that, despite findings that Brittany’s parents fed her an unhealthy diet and failed to consistently take her to the gym, it could not rule out the possibility that her morbid obesity was caused by factors beyond her parents’ control. The court noted that Brittany had an eating disorder and consumed inappropriate foods at school, when she was not under her parents’ direct supervision and control.

The court’s reasoning recognized the existence of factors external to parental

200. Id. at 838 (quoting N.Y. FAM. CT. ACT § 1012(f) (internal quotation marks omitted)).
201. Id. at 836.
202. Id. at 839.
204. Id. at 479.
205. Id. at 480 (quoting In re Rachel A., 716 N.Y.S.2d 829, 830 (App. Div. 2000))
206. Id. at 479.
207. Id. at 480.
208. Id.
209. Id.
care that may affect weight. Because the court found it difficult to attribute responsibility primarily to the parents, the court was unwilling to take drastic action such as the termination of parental rights. Therefore, the lower court’s order was reversed, and Brittany was returned to her parents.

It can be gleaned from these cases that some state courts have begun to recognize that morbid childhood obesity can become sufficiently severe so as to trigger state action under child neglect laws. At the same time, courts appear to have carefully restricted state involvement and removal to only the most extreme instances, where the child greatly exceeds the medical standard for morbid obesity, where the child suffers from numerous serious health concerns, and where the parents have blatantly failed to address the child’s obesity-related health needs. As the jurisprudence of childhood obesity continues to develop, it needs to reconcile its approach in these cases with the need for clearer standards and guidelines. In the next Part, we will argue that courts should apply the standard of medical neglect to instances of morbid childhood obesity.

IV. THE FUTURE DIRECTION OF THE LEGAL FRAMEWORK FOR CHILDHOOD OBESITY

It is clear, based on the court cases discussed in Part III, that the designation of childhood obesity as a form of child abuse or neglect is quickly becoming a legal reality in the United States. That said, the current framework is inadequate because it often gives too much power to judges in deciding when to terminate parental rights, thereby risking inconsistent application of legal standards. Furthermore, the existing framework does not distinguish between the different legal standards for intervention as opposed to removal. The legal standards currently governing state intervention in childhood morbid obesity cases are problematic because they are broad and imprecise. Moving forward, reforms are needed both in the judicial and legislative arenas. In this Part, we provide interpretative guidelines for courts and suggest legislative changes aimed at offering clearer guidance on the issue of childhood obesity.

A. Developing a Judicial and Legislative Structure To Address Childhood Obesity

1. Suggestions for Future Developments in Judicial Interpretation

There are various options for judicial interpretation that can be taken to improve the legal system’s handling of morbid childhood obesity. The simplest approach might be for more courts to continue applying existing child abuse and neglect laws to situations involving morbid childhood obesity. This would allow judges to work within existing legal standards. However, courts’ application of the law would likely continue to be inconsistent and the benefit of early

210. See supra Section I.C, discussing the numerous other factors that may affect an individual’s weight, such as biological, chemical, or certain external factors.
211. Brittany T., 852 N.Y.S.2d at 480.
intervention would never be realized. Similarly, following standards like the 
"best interest of the child" invites judges to act "in accord with their own 
personal child-rearing preferences," which can lead to "discrimination against 
the poor, minorities, and other disfavored children." 2 Imprecise statutory 
definitions "inexorably lead to often unpredictable and unjustified intervention 
into family life." 2

Courts could also analogize overnourishment to undernourishment, which 
has a widespread and longstanding precedent of state intervention. This would 
allow judges to perform an analysis similar to the one with which they are 
already familiar and could provide greater consistency in the legal system. 
Furthermore, malnourishment cases often warrant early intervention by the State, 
which would be a procedural step forward for morbid obesity cases. Morbid 
obesity is essentially nutritional neglect at the other end of the spectrum. Since 
both extreme under- and overfeeding of children cause severe health 
consequences, it makes sense to treat both situations analogously under the law.

Some critics fear that any laws holding parents liable for childhood obesity 
would "place a tremendous burden on parents—and an unfair one." These 
people note that governments and companies that market unhealthy foods to 
children should also share the blame for obesity. While it is certainly true that 
there are many causes of childhood obesity, this does not mean that legislatures 
and courts should avoid intervening where parents are at fault, especially in 
extreme instances of morbid obesity. Many of the factors that cause morbid 
obesity are directly within the control of parents and their contribution to the 
problem should not be minimized by shifting the blame to other causes.

2. Suggestions for Future Legislative Developments

One legislative solution that should be adopted is to add a subsection to 
existing child neglect laws specifying that a failure to follow medical advice to 
address childhood morbid obesity constitutes medical neglect. The more specific

212. Douglas J. Besharov, "Doing Something" About Child Abuse: The Need To Narrow the 
213. Id. (quoting J. Goldstein et al., Before the Best Interests of the Child 15–17 
(1980)).
214. Id. (citing Note, In the Child's Best Interest: Rights of the Natural Parents in Child 
Placement Proceedings, 51 N.Y.U. L. REV. 446 (1975)).
215. See Jessica Pauline Ogilvie, Pro/Con: Does Obesity Qualify as Child Abuse?, L.A. 
custody-20110829 ("Morbid obesity is just another form of malnutrition. It doesn't require new 
legislation or a change in the criteria for state intervention.").
216. S. Romeo & P. Nicolás, Morbid Obesity in Children and the Law, GLOBAL FOOD 
SECURITY: ETHICAL AND LEGAL CHALLENGES 176, 181 (Carlos M. Romeo Casabona et al. eds., 
2010).
217. Philip Yam, Should Morbid Childhood Obesity Be Considered Child Abuse?, SCI. AM, 
childhood-obesity-be-considered-child-abuse/.
218. Id.
a legislature can be in crafting statutes for medical neglect in childhood morbid obesity cases, the less likely judges will be able to employ their own policy preferences about what ought to be the proper standard of removal. If the legislature were to expressly describe when child obesity does constitute neglect, it would reduce the risk of courts incorrectly interpreting the statute to encompass less severe instances in which children are merely overweight. The law could also refer to the medical definition of morbid obesity so that courts are not in the position to perform an arbitrary weight analysis that could lead to judicial disparity and the unjust termination of parental rights. Such a law should also include a provision safeguarding against situations where the child’s morbid obesity is caused by an underlying genetic condition despite the parents’ best efforts to follow medical advice and provide healthy nutrition.

Another strategy could be to revise child neglect laws to permit state involvement at a lower threshold than “imminent danger.” While the threshold for removal should continue to use this high standard, the law should provide for earlier intervention whenever a child’s condition is serious and threatening to his or her health or places him at an unreasonable risk of harm. Having a lower standard for intervention in those cases would allow state child protective services to intervene earlier to guide parents to the support they need, such as nutritionists, doctors, and personal trainers, in order to help prevent serious cases of childhood obesity from becoming life-threatening. While a state would be allowed to intervene and parents would benefit from accepting the State’s services, the parents’ fundamental and constitutional rights to rear their children would not be violated because they would not be required to accept this assistance. However, regardless of whether they accept these earlier offers of state assistance, parents would still be held to the same standards for potential removal. By making these involvements optional, the State would also ensure that its limited resources were allocated to the individuals who would likely take the best advantage of them. Addressing childhood obesity early also has the benefit of saving significant money for parents and taxpayers in the long run, since annual overweight- and obesity-attributable medical care spending is estimated to be approximately $78.5 billion per year.219

Following these proposals for legislative action would ensure that, to the fullest extent possible, parents maintain their rights to determine how to raise their children without unnecessary levels of government interference. Additional policy considerations can help solidify the new legal framework and balance the interests of parents with those of the State.

B. Childhood Obesity and Child Protection Policy Recommendations

This Section explores some of the major policy topics in this field, namely, the dilemma of how best to enforce new rules in this field and what sort of recommendations should be made to parents in order to help them avoid these

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CHILDHOOD OBESITY

troubling legal issues.

There is opposition to establishing a new system of laws in which children can be removed from their parents due to weight problems. Parents rebel against the idea that the government can get involved in the private choices of family life. In order to have the system function properly and to avoid widespread social opposition to such a legal framework, it is important that enforcement procedure be clearly defined and generally known. A well-defined system provides clarity to both those bound by the laws and those seeking to enforce them.

Ideally, the first step to the system should not involve state intervention but instead take the form of a consultation between parents and doctors at an early stage in a child’s development of weight problems. This opportunity could be used to bolster public awareness about the causes and implications of childhood obesity. Parents should be informed of the potential ramifications of allowing excessive weight gain in their children, such as court interference with their family life and, in the most extreme cases, the termination of parental rights.

If a parent fails to heed a doctor’s warnings about his or her child’s weight and the child becomes morbidly obese, the doctor should then give an ultimatum to the parents wherein either the child becomes enrolled in a weight treatment program or, alternatively, the pediatrician notifies a court-based CPS worker of a parent’s failure to successfully monitor his or her child’s health. Mandatory reporter laws could lessen the risk of parents vilifying the medical professional when the doctor explains the latter option. Giving such an ultimatum may provide sufficient incentive to certain parents to become more proactive in the child’s dietary and behavioral habits.

Where a parent refuses to take these necessary steps to reduce his or her child’s weight, a CPS worker should become an active participant in the monitoring and handling of the child’s weight. Unfortunately, there is a strong social stigma associated with the involvement of protective services in the life of


222. See generally In re G.C., 66 S.W.3d 517 (Tex. Ct. App.) (affirming the termination of the appellant’s parental rights on the grounds that she neglected her child’s weight problem).

223. Although there is concern over patient-physician confidentiality, many states have already enacted mandatory reporting laws for child abuse amongst doctors. See generally U.S. DEP’T OF HEALTH & HUMAN SERVS., MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT: SUMMARY OF STATE LAWS (2010), http://www.childwelfare.gov/systemwide/lawspolicies/statutes/manda.pdf. Morbid childhood obesity could be included as a reportable offense.

224. Murtagh & Ludwig, supra note 11, at 206 (“Nevertheless, mandated reporter laws may obligate physicians to contact child protective services in the cases of children for whom chronic parental neglect has resulted in severe weight-related health complications.”). For a general description of mandatory reporter laws as they relate to child abuse and neglect, see U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 223.
a child. 225 In many instances, however, this stigma is misguided: “[s]tate intervention ideally will support not just the child but the whole family.” 226 In this sense, early involvement of child protection services is not about punishing parents but instead about educating them and returning the family to normalcy as quickly and efficiently as possible. Also, while there is a common perception that CPS involvement means that of children will be removed from their parents’ custody, 227 this is only one possible tactic in a long list of techniques used by such services. 228 Lesser types of intervention, such as recommendations for physical therapy or nutritional guidance, may be sufficient and preferable in many cases. 229

If parents fail to follow the guidelines put in place by CPS while the child still remains with his or her family, the next step would be to temporarily remove the child from the parents’ custody in order to place him or her in a residential treatment center or with a foster family prepared to meet the child’s nutritional needs. 230 This would be a necessary step where “support services may be insufficient to prevent severe harm.” 231 During the time apart, parents would be able to work towards regaining custody of their child by following guidelines established by CPS. They would also be able to continue their own education regarding how best to control the dietary habits of children. 232 The ultimate goal of this step would be to reunite the child with his or her family once the child becomes healthier, and to educate the parents as to the child’s needs.

If the parents are unwilling or unable to properly educate themselves regarding their child’s nutritional needs and the child faces severe imminent health risks to the extent of medical neglect, the final step of the process would be the termination of parental rights, which is done to uphold the State’s interest in protecting children. 233 By removing children from parents who neglect to meet

225. See Jennifer Sykes, Negotiating Stigma: Understanding Mothers’ Responses to Accusations of Child Neglect, 33 CHILD. & YOUTH SERVICES REV. 448, 448 (2011) (“Mothers who undergo child protective service (CPS) investigations have this identity called into question and may wrestle with the profound stigma as a result.” (internal citation omitted)).


228. See Murtagh & Ludwig, supra note 11, at 207 (“Child protective services typically provide intermediate options such as in-home social supports, parenting training, counseling, and financial assistance, that may address underlying problems without resorting to removal.”).

229. Id.

230. But see id. (“Moreover, the quality of foster care varies greatly; removal from the home does not guarantee improved physical health, and substantial psychosocial morbidity may ensue.”).

231. Id.

232. The education of parents is an important part of most state-created programs designed to curb childhood obesity. See, e.g., In re Brittany T., 852 N.Y.S. 2d 475, 480 (App. Div. 2008) (describing the nutrition program that both Brittany and her parents were required to attend).

233. See Murtagh & Ludwig, supra note 11, at 207.
CHILDHOOD OBESITY

their nutritional needs, the State also aims to improve the chances that the child will grow up and live a healthier lifestyle free from long-term weight-related illnesses such as type 2 diabetes. In a properly functioning legal system, termination of parental rights should be used only as a last resort—even in cases of morbid obesity, “state intervention would clearly not be desirable or practical, and probably not be legally justifiable, for most of the approximately two million children in the United States with a BMI at or beyond the 99th percentile.”234

There is a high social cost associated with removing children from their parents in all but the most extreme circumstances.235 Such intrusive actions should only be taken when there is a definitive risk of life-threatening health problems and the parents have made the personal choice to avoid their obligations.

Instituting a system of clearly defined steps in the legal system like those listed above would be a useful means of educating parents, providing clear explanations of the law, and plainly expressing the expectations of the State. Hopefully, as the laws governing childhood obesity and child abuse and neglect develop further in both the courts and legislative bodies, a system similar to the one described here will begin to emerge as a means of helpful guidance.

CONCLUSION

Childhood obesity is a growing concern that is putting the health of millions of children at risk. Several state courts have begun to consider whether childhood obesity warrants state intervention under child abuse and neglect laws. These courts have held that court-ordered services and removal are appropriate in extreme situations where parents have neglected to follow medical advice to address the dire health complications from their child’s morbid obesity.

Although all levels of obesity present health concerns, it is preferable for courts and legislatures to focus their efforts on morbidly obese children, rather than the merely obese or overweight. Because morbid obesity presents the most immediate and serious health complications, it demands rapid action that trumps the constitutional right otherwise belonging to parents to rear their own children. Enacting laws that specify when childhood morbid obesity falls within the definition of neglect provides greater clarity within the legal system and reduces the likelihood of judicial activism. By allowing intervention earlier in the process, our recommendations would likely decrease the need for removal in all but the most severe cases, where the parents chronically fail to make reasonable efforts to address the imminent danger to the child’s physical health.

Unless widespread efforts are undertaken to address the childhood obesity epidemic, the present generation of children will not live as long as their parents.236 By developing new standards that help ensure that children are

234. *Id.* (“An increasing proportion of US children are so severely obese as to be at immediate risk for life-threatening complications including type 2 diabetes.”).

235. *See generally* Besharov, *supra* note 212, at 561 (describing the high social cost of removing children from their parents).

protected against the negative nutritional influences of their parents, the United States’ legal system will be able to ensure a healthier future for our youth.