CHILDHOOD OBESITY: BALANCING THE NATION'S INTEREST WITH A PARENT'S CONSTITUTIONAL RIGHT TO PRIVACY

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Would a “Happy Meal” served with fruits and vegetables, instead of French fries and a toy, help America’s overweight children slim down? Numerous bloggers, reporters, and elected officials, have criticized San Francisco’s Board of Supervisors’ decision to ban restaurants from giving away a toy with meals that have more than 600 calories. Why not just ban the fries or pay the people of San Francisco to stay thin?


The measure will make San Francisco the first major city in the country to forbid restaurants from offering a free toy with meals that contain more than set levels of calories, sugar and fat. The ordinance would also require restaurants to provide fruits and vegetables with all meals for children that come with toys.


Even Gavin Newsom thinks it’s a stupid idea, which puts this way out past the 99th percentile of dumb adventures in liberal governance. Seriously: We’ve all had the Happy Meal, we’ve all loved the Happy Meal, but how many of us as kids ordered the Happy Meal because of the prize? When I whined at mom to take me to McDonald’s, it wasn’t because my toy collection was woefully lacking a Hamburglar. It was because, like all Americans, I had my first order of fries before I had teeth and, from that moment on, knew I’d had to have more. Simple as that. If you’re going to ban something to improve people’s health, ban the fries. And thenceforth shall begin the most lucrative black market of all time.

Id. See also The Daily Show with Jon Stewart (Comedy Central television broadcast Jan. 3, 2011), available at http://www.thedailyshow.com/watch/mon-january-3-2011/san-francisco-s-happy-meal-ban. On the show, Aasif Mandvi conducts a mock interview suggesting McDonald’s replace action figures with government officials such as Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, or replacing the “Happy Meal” with the “Crappy Meal” in response to the ban’s requirement that toys only be given away with meals that include fruits and vegetables. Id.

4 AllahPundit, supra note 3.
Proponents of such a ban, including Ken Yeager, president of Santa Clara County’s Board of Supervisors, claim “[i]t helps parents make the choices they want for their kids without toys and other freebies luring them toward food that fails to meet basic nutritional standards.” Opponents of the ban argue two key points: first, it is the hamburger and fries, and not the toys, that make kids yearn for “Happy Meals,” and second, kids are not walking into McDonald’s on their own to buy these meals—their parents are making these purchases. Jot Condie, president of the California Restaurant Association noted: “Ultimately, parents decide what their children eat and whether a meal includes a toy or not—that is the role of a parent . . . . The county government does not need to serve as the parent of the parents.” In the end, McDonald’s has worked around the issue, requiring San Francisco McDonald’s franchisees to charge an additional ten cents for the formerly free toys.

The issue of governmental interference with parental rights for decision-making, such as the need to combat childhood obesity, as highlighted by San Francisco’s ban on “Happy Meals,” has become a national debate that remains unresolved. One parent and blogger, Travis Ramon, believes the government has overstepped its authority by forcing parents and private companies to limit their choices. Ramon says, “[s]tay out of my home and let me be the parent of my child.” Another blogger, Anthony Gregory, expresses concern that such government action is counter to American freedom and serves as an “attack on parents’ rights, childhood, common sense, and free enterprise.” The view favoring government interference in childhood obesity is that the San Francisco ban is a common-sense health intervention addressing a

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6 *Id.*

7 Mikaela Conley, *McDonald’s Skirts Ban; Charges 10 Cents Per Happy Meal Toy*, ABC News (Nov. 30, 2011), http://abcnews.go.com/blogs/health/2011/11/30/mcdonalds-skirts-ban-charges-10-cents-per-happy-meal-toy/ (discussing McDonald’s reaction to the new law and explaining that McDonald’s will donate the extra ten cents to the Ronald McDonald House).


9 *Id.*

national public health crisis. So the debate continues—should the government’s role in combating childhood obesity extend to interfering with private rights, including a parent’s right to decide what his or her child should eat? This Note proposes that the time is ripe for governmental interference into parental rights to privacy regarding decisions about raising children to be a healthy weight.

A parent’s constitutional right to privacy in raising children is considered a fundamental right dating back to the Supreme Court’s decisions in Meyer v. Nebraska12 and Pierce v. Society of the Sisters,13 which essentially held that the government could not interfere with a parent’s choice in child rearing unless the law passed strict scrutiny review.14 Childhood obesity has become a public health crisis in which widespread programming to stem and reverse the incidence of child obesity has reached schools and communities, but not the parents of obese children.15 Studies show that parents can be the exclusive agents of change in helping their children attain normal weights and learn to self-regulate to maintain these lower weights into adulthood.16 This Note argues that parents have a unique role in reducing childhood obesity; however,

12 Meyer v. Nebraska, 262 U.S. 390 (1923) (holding unconstitutional a state law prohibiting the teaching of a foreign language).
13 Pierce v. Soc’y of the Sisters, 268 U.S. 510 (1925) (holding that parents and guardians might direct the education of their children). Further, in famous dicta, the Court states: “The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.” Id. at 535.
14 Strict scrutiny is the standard of judicial review courts apply to determine if legislation interferes with certain fundamental rights. One such fundamental right is the parental right to privacy; specifically, to raise children without arbitrary government interference. The courts apply a two-part test to determine whether legislation violates a fundamental right. The first part is to determine whether the goal of the law satisfies a compelling government interest. Traditional areas of compelling government interests include, among other things, providing public education and protecting its citizenry. The second part of this test is to ensure that the means used to achieve the goal are narrowly tailored such that the law is the least restrictive means available. The burden of proof is on the government and failure to meet both parts of the test results in a law being deemed unconstitutional. See generally United States v. Carolene Products, 304 U.S. 144, 153 (1938); Griswold v. Connecticut, 381 U.S. 479, 497-98 (1965); Grutter v. Bollinger, 539 U.S. 306, 326-27 (2003).
15 See infra Part I.D.
they are not yet sufficiently engaged in this effort, and, therefore, it is essential and appropriate for the government to compel them to act. Further, this Note will address the government’s two-fold compelling interest in interfering with the parent’s constitutional right to privacy: the best interests of the child and the welfare of society.

Part I will describe the current status of the public health crisis, providing statistical information on the incidence of childhood obesity, risk factors, the consequences both to children and society if this crisis continues, and an overview of current approaches to combating childhood obesity. Part II will discuss a parent’s constitutional right to privacy and explain the government’s compelling interest in interfering with this fundamental, though not absolute, right. Part II will also look at existing parental responsibility statutes as examples of where this fundamental right has successfully been challenged.

Part III will discuss treatment of morbidly obese children, reviewing case histories where State intervention has classified these children as neglected, as well as arguments against applying criminal neglect classifications, and the subsequent removal of obese children into foster care, to the broader problem of childhood obesity. This Part will also demonstrate how that approach stigmatizes children and is ineffective in addressing the realities of childhood obesity in general. Part IV will discuss why it is appropriate to challenge and modify a parent’s right to privacy as it relates to child rearing of obese children, focusing on the crucial role that parents alone can play in a national approach to effectively stemming and reducing the incidence of childhood obesity. Finally, this Note recognizes that government intervention to compel parents to play a stronger role in combating childhood obesity, as a part of a broader comprehensive solution, is appropriate provided that the laws are narrowly tailored to meet the end goal.

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17 Childhood morbid obesity is not defined as precisely for children as it is for adults. For adults, morbid (extreme) obesity is defined as being 100% over one’s ideal weight and involves life-threatening illness. See Obesity: Definition, Mayo Clinic, http://www.mayoclinic.com/health/obesity/DS00314 (last visited Mar. 3, 2012). The University of Rochester provides a workable definition for childhood morbid obesity—children at or above the 99th percentile of their age appropriate body mass index (BMI) are considered morbidly obese. Almost 4 Percent of Children May be Morbidly Obese, U. Rochester Med. Center, http://www.urmc.rochester.edu/news/story/index.cfm?id=1475 (last visited Mar. 3, 2010). Approximately 4% of American children may fall in this range. Id.
I. CURRENT STATUS OF PUBLIC HEALTH CRISIS

A. Background

Currently, there are no federal or state laws requiring models for assessing and treating obesity in children. However, the Patient Protection and Affordable Care Act \(^\text{18}\) includes provisions to fund a Childhood Obesity Demonstration Project \(^\text{19}\) with $25 million for 2010–2014 to “develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such [a] project.” \(^\text{20}\) As with other programs to combat childhood obesity, discussed \(\textit{infra}\) Part I.D, the focus is on community-based efforts, with very little attention to the role of parents. \(^\text{21}\) Nonetheless, this federal funding is a positive and essential statement that much more is required to stem the ongoing childhood obesity epidemic.

The standard for determining normal weights for children is the body mass index (BMI), which measures weight in relation to height. \(^\text{22}\) For children, obesity is defined as having a BMI “at or above the 95th percentile for children [and adolescents ages two to nineteen (hereinafter children)] of the same age and sex.” \(^\text{23}\) “Overweight” is the medical term for the category of children with a BMI in the 85th–94th percentiles. \(^\text{24}\)

The prevalence of childhood obesity differs significantly when broken down by various demographics. The Centers for Disease Control and Prevention (CDC) estimate that 16.9% of children ages two to


\(^{19}\) See Patient Protection and Affordable Care Act § 4306.

\(^{20}\) 42 U.S.C.A. § 1320b-9a(e)(1) (West 2012) (establishing guidelines to conduct the Childhood Obesity Demonstration Project).

\(^{21}\) Only two sections of the Childhood Obesity Demonstration Project enactment mention parents—42 U.S.C.A. § 1320b-9a(e)(3)(B)(iv) (addressing healthy lifestyle classes or programs for parents or guardians) and 42 U.S.C.A. § 1320b-9a(e)(3)(D) (addressing educating and guiding parents and families).


\(^{23}\) Id.

\(^{24}\) Id.
nineteen are obese. Overall, over 30% of America’s children ages ten to seventeen are overweight or obese. Additionally, there were significant racial and ethnic disparities in obesity prevalence between 1988-1994 and present surveys.

For example, 26.8% of Mexican-American adolescent boys were found to be obese, compared to 16.7% of non-Hispanic white adolescent boys. Moreover, obesity prevalence among girls is even more dramatic by race and ethnicity; 29.2% of non-Hispanic black adolescent girls were obese, while 14.5% of non-Hispanic white adolescent girls were obese.

Finally, the disparity is statistically significant when socio-economic factors are considered. Among privately insured children (those whose parents or employers pay for insurance coverage), obesity prevalence is 12.7%, while it is 24.8% among publicly-insured children (those on Medicaid or other state options). Children below the poverty line are 134% more likely to become obese than children with family incomes exceeding 400% of the poverty threshold. The discrepancy between boys and girls, while noteworthy, is less extreme than differences based on racial and socio-economic variables: 17.8% of

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26 Christina Bethel et al., National, State, And Local Disparities In Childhood Obesity, 29 HEALTH AFF. 347, 349 (2010) (relying on data from the National Survey of Children’s Health, 2003 and 2007, which estimates the national prevalence of obesity at 16.4% among children between the ages of ten and seventeen, rather than examining the obesity rate among children between the ages of two and nineteen, as used by CDC).

27 Id.

28 Id.

29 Gopal K. Singh et al., Neighborhood Socioeconomic Conditions, Built Environments, and Childhood Obesity, 29 HEALTH AFF. 503, 508-09 (2010) (discussing the impact of neighborhood conditions and environment on childhood obesity). The CDC is devoting its portion of the Childhood Obesity Demonstration Fund to children between the ages of two and twelve who are covered by the Children’s Health Insurance Program. This program provides low-cost health insurance to seven million children of working families. Childhood Demonstration Obesity Project, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/obesity/childhood/researchproject.html (last updated Sept. 29, 2011).
boys between two and nineteen years are obese compared to 15.9% of girls of the same age.\footnote{Key Statistics from NHANES, Centers for Disease Control and Prevention, \url{http://www.cdc.gov/nchs/nhanes/bibliography/key_statistics.aspx} (last updated July 12, 2011).}

Although childhood obesity is a national public health crisis, its prevalence varies significantly across state lines.\footnote{Statewide prevalence of obesity will be discussed \textit{infra} in Part II, as governments' compelling interest in combating childhood obesity may vary by state.} Relying on data from the National Survey of Children's Health 2007 for children ages ten to seventeen, it is estimated that 17.9% of children in Mississippi are obese as compared to 8.7% of same aged children in Utah.\footnote{Jeffrey Levi et al., \textit{F as in Fat: How Obesity Policies Are Failing in America} 13 (2009), \url{available at http://healthyamericans.org/reports/obesity2009/Obesity2009Report.pdf} [hereinafter Obesity Report 2009].} When including the prevalence in the overweight category, 44.4% of children in Mississippi are overweight or obese, as compared to only 23.1% of same aged children in Utah and Minnesota.\footnote{Id. at 12. Data for overweight, as opposed to obese, is included in this Note because being overweight is a precursor to obesity. The consequences of childhood obesity, as discussed later in this section, are even more concerning given that so many children are on the threshold of obesity.}

In general, there is a strong relationship between poverty, region, and obesity, whereby the six states with the highest poverty levels are among the top ten states with the highest overall obesity, and eight of the ten states with the highest poverty are all in the South, where obesity rates are the highest.\footnote{Jeffrey Levi et al., \textit{F as in Fat: How Obesity Threatens America's Future} 20 (2010), \url{available at http://healthyamericans.org/reports/obesity2010/Obesity2010Report.pdf} [hereinafter Obesity Report 2010].} The question remains as to which factor is more controlling—living in poverty or living in the South.

\section*{B. Risk Factors}

As the statistics above show, the problem of childhood obesity crosses all demographics, but is clearly higher among certain groups. Underlying risk factors include genetics, lifestyle choices, access to healthy foods, and neighborhood conditions.

Scientists agree that genetics—the "thrifty genome" theory—may explain part of the obesity epidemic. The theory is that the same genes that helped past generations survive famines are now confronted...
with an environment in which food is plentiful throughout the year. Among adults, the "thrifty genome" theory explains only the tendency towards retaining extra weight. The actualization of this tendency emerges through the physical inactivity and overeating pervasive in industrialized countries and is therefore a tendency that can be controlled. Moreover, this is a dangerous oversimplification because it ignores the reality that families with different racial and ethnic backgrounds respond differently to the same environment.

Current research advises against this oversimplification when trying to understand the problem of obesity among children with "racial and ethnic, socioeconomic, and behavioral disparities." Some studies that looked beyond genetics have concentrated on neighborhood conditions and characteristics that appear to contribute to the risk for obesity. One such study examined neighborhood "built" environmental factors, such as access to grocery stores that sold healthy food, proximity and safety of playgrounds and recreational space, and sufficient housing, to determine if there was a correlation between obesity and the social environment in which children lived. The staggering results underscore the complexity of this epidemic. Children living in neighborhoods reported to be unsafe were 61% more likely to be obese than children living in neighborhoods reported to be safe. When combining neighborhood characteristics such as access to sidewalks or walking paths, parks or playgrounds, recreation/community centers, and libraries, children in neighborhoods with the least access to these health-promoting characteristics were 44% more likely to be obese than children living in neighborhoods with the greatest access. In short, the

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37 Id. The "thrifty genome" theory refers to the role of energy-saving genes that helped people survive during periods when food was scarce or not consistently available. These genes helped families survive famines in the past, but are now considered responsible for storing the excess energy we consume today, when food is plentiful. Id.
38 Id.
39 Id.
40 Singh et al., supra note 30, at 503.
41 Id.
42 Id. This study is based on a telephone survey covering over 90,000 children. Interviews were conducted with parents or guardians, so the data are self-reported. Id.
43 Id. at 508.
44 Id. at 509.
45 Id. at 507.
46 Id. at 503.
47 Id. at 507.
“higher the levels of neighborhood amenities, the lower the prevalence of childhood obesity.”

These studies underscore that a number of discrete and overlapping factors, including gender, ethnicity, parental income and education levels, and neighborhood conditions, contribute to the epidemic of childhood obesity. Children living in unsafe and/or poor neighborhoods are 30-60% more likely to be obese than children living in better environments. Children living in neighborhoods with fewer amenities—such as access to sidewalks, parks, playgrounds, or community centers—are 20-45% more likely to be obese than children who have access to these amenities.

These results suggest the government has a significant role to play in combating childhood obesity by providing the necessary infrastructure for neighborhoods to be more conducive to healthier living. However, these studies have not factored in the role of parents in reinforcing healthier lifestyles, such as exercising and eating fresh foods themselves, or supervising their children to minimize sedentary behaviors and unhealthy food choices. It is likely there will continue to be limitations on the impact that governmental programming will have on reducing childhood obesity when parents are not factored into the solution.

C. Consequences—The Basis of Government Interest in Childhood Obesity

Childhood obesity develops into adult obesity, with overweight children having a 70% chance of becoming obese adults, increased to 80% if one or more parent is overweight or obese. Overall, there is an association between obese children and high blood pressure, high cholesterol, type 2 diabetes, respiratory disease, adult obesity, and psycho-

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48 Id. The same study explored other contributing risk factors and reported that children whose parents did not have high school diplomas were 169% more likely to be obese than children with college-educated parents; children who watched more than two hours of television daily were 46% more likely to be obese than those who watched less than one hour per day; and children who did not engage in vigorous physical activity were 40% more likely to be obese than their counterparts who exercised at least five days per week. Id. at 509.

49 Id. at 510.

50 Id.

51 The role of parents in influencing and disciplining their children will be discussed infra Part IV.

logical disorders. The American Academy of Pediatrics notes that the emotional health of obese children is also damaged with resulting low self-esteem, negative body image, and depression. There are short-term and long-term individual, economic, and societal consequences resulting from the high incidence of childhood obesity for both the affected children and society in general. These consequences support the government’s compelling interest—the first prong of the strict scrutiny standard—in defeating this epidemic.

In addition to increased physical health risks, obese children also face bullying, discrimination, and social marginalization. "The psychological stress of social stigmatization can cause low self-esteem which, in turn, can hinder academic and social functioning, and persist into adulthood." A 2003 study shows the increased stigmatization of obese children in a nation obsessed with thinness. Fifth and sixth grade children ranked their biases using drawings of children who were either healthy, visibly disabled, or obese. Seventy percent of children ranked the drawing of the obese child last or second-to-last.

The impact of bullying and low self-esteem in obese children also affects their ability to perform well in school, resulting in further dis-
Discrimination as they reach working age. This is a self-fulfilling prophecy whereby obese children become underachievers, receive lower grades, and get fewer scholarships. Obese adults are less likely to succeed in job interviews and are more likely to earn lower salaries than their thinner peers. Additionally, employers assume that obese adults have compromised health conditions that "translate[] into assumptions of higher absenteeism, increased insurance rates, and greater workers' compensation costs."

The discrimination and perceived shortcomings of obese children and adults is, sadly, based in reality. Obese children as young as two or three-years-old tend to have delayed skill acquisition, while the costs to employers from obesity-related job absenteeism and lower productivity amount to $4.3 billion annually and $506 per obese worker per year, respectively. The health care costs of childhood obesity are $14.1 billion for annual prescription drug coverage, emergency room visits, and outpatient costs, with an additional $237.6 million for inpatient services. These costs explode when obese children become adults, with an estimated annual cost of treating obesity-related illness at $147 billion. To put these numbers into perspective, 27% of the increase in health care spending between 1987 and 2001 stems from the medical

59 Michelle Stover, Note, "These Scales Tell Us That There Is Something Wrong With You": How Fat Students Are Systematically Denied Access To Fair And Equal Education And What We Can Do To Stop This, 83 S. Cal. L. Rev. 933, 945 (2010), available at http://lawweb.usc.edu/assets/docs/contribute/SCalLRev83_4Stover.pdf. Stover's Note discusses how obese "students are routinely discriminated against, how this discrimination bars [obese] students from obtaining a fair and equal education, and the long-term social repercussions of denying fair and equal education to [obese] students." Id. at 939.

60 Id. at 947-48.


62 Id. at 70. One study showed that employers perceive overweight people to be "less competent, less productive, not industrious, disorganized, indecisive, inactive, and less successful." Moreover, "mentally lazy and lack[ing] self-discipline" were deemed more characteristic of the overweight than other "more ideal" employees. Id. at 67-68.

63 Id. at 69.

64 John Cawley, The Economics of Childhood Obesity, 29 Health Aff. 364, 367 (2010).

65 Id.

66 Id.

67 Id.
costs of obesity. Society in general pays for obesity-related treatment through taxes and/or higher insurance premiums.

Another consequence of childhood obesity is diminished national security. A group of 130 senior, retired military leaders, calling themselves “Mission: Readiness, Military Leaders for Kids,” has written a plea to Congress to implement policies in schools that help combat childhood obesity because the epidemic may prevent the military from filling its recruitment needs. The report, Too Fat to Fight, claims that 27% of all young adults ages seventeen to twenty-four are “too fat to serve in the military,” thereby threatening the future strength of our armed forces. The report notes that the military will not lower its high requirement standards for recruits because serving in the military is a matter of life and death.

As an example, the report includes an excerpt describing how one soldier in combat picked up his injured patrol leader, threw him over his shoulder, and sprinted back to his Humvee, all the while firing at his enemies while he ran. Although the military turns away most people who are unfit, some pass the entrance exams, only to be discharged during their first term as enlistees. The cost of replacing and training

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68 Id.
69 Id. According to Cawley:
In 2008 obesity-related illness cost Medicare $19.7 billion and Medicaid, $8 billion. These costs were borne by the general population, whose tax dollars fund these federal and state health insurance programs. In addition, private health insurance plans paid $49 billion to treat obesity-related illness in 2008. Some of this cost also was borne by the non-obese in the form of higher group health insurance premiums. Id. at 366.
71 Id. at 1. Obesity is the number one reason for turning away recruits, with the proportion of those potential recruits who fail their physicals rising—due to being overweight—to seventy percent between 1995 and 2008. Id. at 2.
72 Id. at 1.
73 Id. at 3 (“For office workers in civilian life, having a colleague who is overweight may raise the cost of their health care but is not likely to threaten their safety. But for military personnel the physical abilities of their colleagues can be the difference between life and death.”).
74 Recruiters usually turn away people who they think are too overweight to meet military fitness, but the military still had to turn away an additional 140,000 people between 1995 and 2008 who passed the initial screening but failed the entrance physical. Id. at 2.
75 Id. at 4 (noting that 1200 enlistees are turned away annually before their contracts are up due to weight concerns).
new recruits is over $60 million per year. Still, that cost is small when compared to the cost of treating obesity-related problems for military personnel and their families, who are all covered under the military's health care system, the majority of which is ultimately paid for by the American taxpayer.

In short, the consequences of childhood obesity impact both the child and society, both in the short-term and foreseeable future. Quality of life, health complications, healthcare costs, employment productivity and discrimination, and national security are all examples of these consequences. Given the state government’s interest in the welfare of children and society, and the federal government’s interest in maintaining a strong military for national security, government does have a compelling interest in reducing childhood obesity. It would then follow that, if a state government or the federal government were to pass a law challenging a parent's fundamental right to raise his or her children without governmental interference, the government would meet the first part of the strict scrutiny test requiring a compelling interest.

D. Current Approaches to Combating Childhood Obesity

On February 9, 2010, First Lady Michelle Obama unveiled a nationwide campaign, “Let’s Move,” to solve the problem of childhood obesity within a generation “through a comprehensive approach that builds on effective strategies, and mobilizes public and private sector resources.” That same day, President Obama signed a presidential memorandum to establish the Task Force on Childhood Obesity, which

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76 Id.
77 Id. Note, however, that the actual cost of treating obesity-related health problems is not provided in the report.

Let’s Move is comprehensive, collaborative, and community-oriented and will include strategies to address the various factors that lead to childhood obesity. It will foster collaboration among the leaders in government, medicine and science, business, education, athletics, community organizations and more. And it will take into account how life is really lived in communities across the country—encouraging, supporting and pursuing solutions that are tailored to children and families facing a wide range of challenges and life circumstances.

Id.
includes a variety of federal agencies that review federal programs and policies and set benchmarks to achieve the goals of “Let’s Move.” On May 11, 2010, the task force issued a report to the President with an action plan to reduce the rate of childhood obesity to 5% by 2030. The report, Solving the Problem of Childhood Obesity Within a Generation, outlines recommendations based on the four pillars of “Let’s Move.” These are to: “empower parents and caregivers, provide healthy foods in schools, improve access to healthy, affordable foods, and increase physical activity.” In addition to addressing those four areas, the task force made recommendations for prenatal care and early childhood, including informing women about healthy weights during pregnancy and encouraging breastfeeding.

These recommendations appear to be an excellent and comprehensive approach to combating childhood obesity because they recognize the importance of information and assistance that is necessary to protect children in their formative years. However, not a single recommendation places any responsibility on parents themselves; instead, the report focuses on implementing change in the food and beverage industry and at restaurants, health care providers, schools, and more.

In addition to “Let’s Move” and the Task Force on Childhood Obesity, there are numerous federal departments, agencies, and programs that can address both adult and childhood obesity. Within the

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80 Id.
82 WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY: REPORT TO THE PRESIDENT, SOLVING THE PROBLEM OF CHILDHOOD OBESITY WITHIN A GENERATION (2010), available at http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FULLReport.pdf. The ninety-eight page report includes twelve recommendations for early childhood. Id. at 89-90. There are thirteen recommendations for empowering parents and caregivers. Id. at 91-92. It includes seventeen recommendations for healthier foods in school. Id. at 93-94. Eleven recommendations for access to healthy and affordable food are in the report. Id. at 95-96. Finally, seventeen recommendations for increasing physical activity are included. Id. at 97-98.
83 Id. at 12. Breast-feeding is associated with lower rates of obesity among children. OBESITY REPORT 2010, supra note 35, at 23.
84 REPORT TO THE PRESIDENT, SOLVING THE PROBLEM OF CHILDHOOD OBESITY WITHIN A GENERATION, supra note 82, at 89-98.
85 This section does not address the potential for obesity prevention under the Patient Protection and Affordable Health Care Act of 2010, which would increase insurance coverage for millions of Americans. It is not clear what effect this federal legislation could have on childhood
Department of Health and Human Services (HHS), there are more than 300 obesity-related programs nationwide. Outside the HHS, the United States Department of Agriculture is responsible for a wide range of food and nutrition programs that impact obesity, including obesity education campaigns and the National School Lunch Program. The Federal Trade Commission focuses on advertising to limit marketing junk food to children and monitors false advertising about the health benefits of food or diet products. The United States Department of Transportation offers grants for infrastructure improvements and educational programs that enable and encourage children to walk or bike to school. In addition to these important programs, the CDC issues a variety of grants to states in order to fight obesity through programs improving nutrition, physical activity, school-based health education, community resources, and efforts to reduce racial and ethnic disparities in obesity.

Just as federal policies and recommendations do not encroach on a parent’s role in reducing childhood obesity, state legislation also places the burden of reducing this epidemic elsewhere, primarily in schools.

trust for America’s Health (TFAH), a non-profit organization that addresses prevention, protection, and community in making disease pre-

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86 OBESITY REPORT 2010, supra note 35, at 73. Among these are the Centers for Medicare and Medicaid Services, which is estimated to pay for more than half the obesity-related health care costs nationwide; the Food and Drug Administration, which oversees food-labeling requirements and encourages restaurants to make available nutritional and caloric information; the National Institutes of Health, which conducts research and education programs, including a $37 million program to develop more effective interventions to reduce obesity; and the Office of Minority Health, which seeks to improve the health of high risk racial and ethnic minorities. Id. at 73-74.


88 OBESITY REPORT 2010, supra note 35, at 74-75.

89 Id. (noting that Safe Routes to School grants provide funding for safe street crossings).

90 Id. at 73. Appropriations for CDC programs were in excess of $400 million for fiscal year 2010. Id.
vention a national priority,91 issued an update tracking and summarizing enacted state legislation on childhood obesity.92

According to TFAH, although all fifty states have school physical education requirements, they are limited, poorly enforced, and inadequate; forty-eight states and the District of Columbia have school health education requirements, but there is no enforcement mechanism; twenty-eight states and the District of Columbia set nutrition requirements on food sold within schools, but outside the regular school meal program; five states have menu labeling requirements for restaurants to post calorie information on menus; and thirty-three states have sugar-sweetened beverage sales taxes.93 Possibly the most forward-looking legislation is found in the twenty states that have passed BMI screening or other weight-related assessment requirements in schools.94

All of these programs, policies, and recommendations are vitally important to the fight against childhood obesity, and this Note does not seek to criticize any of these valuable efforts. Many of these efforts lay essential foundations for creating opportunities to inform people about healthier lifestyles, provide greater access to more nutritious food, improve neighborhood conditions to enable physical activity, and encourage consumption of healthy foods. Additionally, the programs recognize and address the increased prevalence of obesity among higher risk demographics, especially those resulting from racial, ethnic, and socioeconomic differences.

However, there remains a gaping hole when it comes to improving conditions inside the home, and these programs fail to place any requirements on parents who are undoubtedly the key authority in the home and, most likely, the most influential people in their children’s lives. This gap in programming is likely connected to the national debate on government interference with parental rights on childrearing.

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91 About the Trust for America’s Health, TR. FOR AM.’S HEALTH, http://healthyamericans.org/about/ (last visited Dec. 27, 2011). Trust for America’s Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. Id.
92 OBESITY REPORT 2010, supra note 35.
93 Id. The supplement lists other related legislation, none of which applies to parents.
94 Id.
II. CURRENT STATUS OF PARENTS' CONSTITUTIONAL RIGHT TO PRIVACY

A. Development of Fundamental Right to Privacy and Child-Rearing

During the twentieth century, the Supreme Court recognized several rights relating to family and individual privacy that are constitutionally protected. The landmark case officially recognizing a right to privacy was *Griswold v. Connecticut* in 1965, though two earlier Supreme Court decisions recognized a parent's fundamental right to make decisions about his or her children's upbringing without arbitrary State interference. Today, the specific right of parents to decide how to raise their children falls under the substantive liberty right (privacy), and while it is a fundamental right, it is neither absolute, nor fully defined. The concept behind the right to privacy is that some interests are "rights presumed to be based on the fundamental nature of certain personal and interpersonal concerns that have been acknowledged by society, although not explicitly guaranteed by the Constitution." Courts have generally accorded great deference to the decisions of parents in raising their children because society values family integrity and parents are presumed to act in the best interests of their children.

In the 1923 *Meyer v. Nebraska* decision, the Court held unconstitutional a state law that prohibited Nebraska schools from teaching German. The Court did not label this a "privacy" right, but rather reframed the "liberty" right to include more than freedom from bodily restraint, such as the right to "establish a home and bring up children." This fundamental right was reinforced two years later in *Pierce v. Society of the Sisters*, when the Supreme Court held unconsti-

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96 *Griswold v. Connecticut*, 381 U.S. 481 (1965) (holding that the right to decide whether to use contraception and abstain from bearing children belongs to the parents, without undue State intervention).
99 Sher, *supra* note 95, at 170-71.
100 *Id.* at 171-72.
102 *Id.* at 403.
103 *Id.* at 399.
tional an Oregon law prohibiting private and parochial school education because, as in *Meyer*, it was an arbitrary interference with a parent's decision about child-rearing. Again, the Court relied on the "liberty" interest enshrined in the Fourteenth Amendment. This "liberty" right evolved to become a "privacy" right via *Griswold v. Connecticut*, when the Supreme Court found privacy to be implied through the Bill of Rights.

Regardless of the nomenclature of the right, the Court in *Pierce* wrote that "[t]he child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." This privacy right implies an element of duty to account for the best interests of the child, and it can hardly be argued that this should not also include a duty to minimize the adverse consequences, to both the child and society, of childhood obesity, where a parent is able to do so. Moreover, where a parent is unable to exercise this duty, the government, which has a compelling interest in the welfare of the child as well as in society, may constitutionally interfere with this right.

The Supreme Court decision regarding grandparent visitation in *Troxel v. Granville* explained that a parent's "liberty interest ... in the care, custody, and control of their children ... is perhaps the oldest of the fundamental liberty interests recognized by this Court." Justice O'Connor, writing for the plurality, noted that when a parent adequately cared for his or her children, there would normally not be a reason to justify State interference with decisions about upbringing.

In dissent, Justice Stevens was particularly focused on the tension between the parent's privacy and liberty right and the government's

105 *Meyer*, 262 U.S. at 403.
106 See *Pierce*, 268 U.S. at 535.
107 *Meyer*, 262 U.S. at 399; *Pierce*, 268 U.S. at 535.
109 Id. at 483 (discussing the notion of a privacy right). Other justices did not accept a privacy right, but later decisions accepted it, so it will be used for this Note's purposes.
110 *Pierce*, 268 U.S. at 535.
112 Id. at 65 (holding that a state court's decision to allow grandparent visitation, despite objection from the surviving mother, violated the mother's substantive due process rights). Two key issues in *Troxel* were that 1) the mother was deemed a "fit parent" and 2) the state court decision granting visitation did not factor in the mother's objections, but instead, made what it thought was a better decision. Id.
113 Id. at 69.
compelling interest regarding the welfare of the child. Citing a line of visitation cases, Justice Stevens pointed out that a parent's right with respect to their child is not absolute, and the "constitutional protection against arbitrary state interference with parental rights should not be extended to prevent the States from protecting children against the arbitrary exercise of parental authority that is not in fact motivated by an interest in the welfare of the child." The Due Process Clause of the Fourteenth Amendment "leaves room for States to consider the impact on a child of possibly arbitrary parental decisions that neither serve nor are motivated by the best interests of the child." Although Troxel is a visitation case, both the plurality, implying that State interference may be less necessary with fit parents, and the dissent, underscoring that the State traditionally has a role in the best interests of the child, work together to show the parent's privacy right is not absolute.

In Prince v. Massachusetts, the Supreme Court found that a parent's claim of denial of religious freedom was not sufficient to overcome the State's interest in preventing minor children from soliciting for their religion in a place where other children were prohibited from doing the same. Here, the Court recognized that the right to make parenting decisions is not absolute and can be interfered with by the State in the interest of the child; in this case, by upholding the child labor laws. More precisely, the Court held "the family itself is not beyond regulation in the public interest, as against a claim of religious liberty . . . and neither rights of religion nor rights of parenthood are beyond limitation.

The line of family privacy cases demonstrate that the Supreme Court has treated certain aspects of family autonomy as a fundamental right, including the right to control the upbringing of one's children. The Court has established that governmental interference will only survive where the government has a compelling interest for an act or statute that is narrowly tailored to achieve its goal. In Prince, the compelling

114 Id. at 89 (Stevens, J., dissenting).
115 Id. at 91.
116 See id.
118 Id. at 170.
119 Id. at 166.
120 Id.
interest was protection of the child from the dangers of working in the street and child labor laws were a necessary means to produce this result.

B. Government Interference with the Parental Right to Privacy

The Supreme Court reviews claims of an infringement of a fundamental right under the “strict scrutiny” standard of review.121 “Strict scrutiny” requires that a fundamental right only be interfered with when the government has a vital or “compelling” interest in getting involved and when it uses “narrowly tailored” means for achieving that interest.122 Examples of compelling interests are winning a war and ensuring that children receive adequate care.123

For the means to be narrowly tailored, they must be the least restrictive in that there are no less intrusive means available for achieving the government’s interest.124 In Zablocki v. Redhail,125 although the state’s interest in ensuring that a child received support payments from his non-custodial father was compelling, the means used to achieve that interest were not the least restrictive available.

In Zablocki, the means used to achieve this end were a Wisconsin statute that required a parent with support obligations to prove he or she was meeting that obligation before granting permission for that parent

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121 For the government to interfere with a constitutionally protected fundamental right, such as childrearing, the government must demonstrate both a compelling interest and a means narrowly tailored to achieve that objective. As discussed supra in Part I.C, the government’s interest in the welfare of children, the public health of society, the economic strength of society, and national security may well be considered compelling interests. Each of these interests is clearly vital to the continuing well-being of our society as a whole and, if challenged, a court would likely find these interests sufficient to meet the first prong of the strict scrutiny test.

122 Zablocki v. Redhail, 434 U.S. 374, 388 (1978) (“When a statutory classification significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests.”).

123 Korematsu v. United States, 323 U.S. 214 (1944) (holding that Japanese-Americans on the West Coast could be evacuated to protect against espionage during World War II); Zablocki, 434 U.S. 374 (recognizing the State has an interest in ensuring that children receive support payments from their non-custodial parent).

124 United States v. Stevens, 130 S. Ct. 1577, 1584 (2010) (holding that a statute could not survive strict scrutiny as a content-based regulation of protected speech because it lacked a compelling government interest and was neither narrowly tailored to preventing animal cruelty nor the least restrictive means of doing so).

125 Zablocki, 434 U.S. 374 (decided under the Equal Protection Clause of the Fourteenth Amendment, but applied strict scrutiny because the right to marry is fundamental). See also Loving v. Virginia, 388 U.S. 1 (1967) (holding that laws that arbitrarily deprive one of the right to marry are unconstitutional).
to obtain a marriage license.\textsuperscript{126} The purpose of the statute was to prevent the child from becoming a ward of the state. However, the Court found that there were other means available to ensure that non-custodial parents would support their children, including: garnishing wages, filing civil contempt proceedings, or applying criminal penalties.\textsuperscript{127} Thus, the state statute was held to be unconstitutional because the second prong of the strict scrutiny test was not met.\textsuperscript{128}

The challenge for government intervention into parental rights regarding obese children will be to develop means that are narrowly tailored—those that are specific and necessary to achieve a compelling objective. The government’s approach to childhood obesity may need to mimic the various existing parental responsibility state statutes in which the means of achieving a compelling objective pass strict scrutiny.

C. Parental Responsibility Statutes

At common law, parents were held responsible for “negligent supervision” when their children committed torts.\textsuperscript{129} Today, under various state statutes, parents can now be held civilly or criminally liable for not adequately controlling their children when they engage in delinquent acts.\textsuperscript{130} This responsibility grows out of society’s recognition that minors should be under some type of guidance and scrutiny.\textsuperscript{131} Although the remedies vary, every state has a form of statutory civil remedies against parents for wrongful actions of their children, such as property damage and malicious behavior.\textsuperscript{132}

For example, in Texas, intentional malicious property damage by a child can result in up to $25,000 in liability for the parent.\textsuperscript{133} Some states, starting with Colorado in 1903,\textsuperscript{134} also impose criminal sanctions for parents who, either by doing or failing to do something, such as

\textsuperscript{126} Zablocki, 434 U.S. at 375.

\textsuperscript{127} Id. at 390.

\textsuperscript{128} Id. at 381.


\textsuperscript{130} Jason Emilios Dimitris, Comment, Parental Responsibility Statutes—And the Programs that Must Accompany Them, 27 STETSON L. REV. 655, 655 (1997).

\textsuperscript{131} Id. at 656.

\textsuperscript{132} Brank et al., supra note 129, at 6.

\textsuperscript{133} Id.

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purchasing a firearm that is accessible to a minor child,\textsuperscript{135} have contributed to the delinquency of their children.\textsuperscript{136} These statutes unquestionably impact a parent’s privacy right. The statutes, however, have withstood constitutional challenges when they focus on specific parental behavior and are not “void for vagueness.”\textsuperscript{137}

Also relevant to the discussion of childhood obesity are truancy statutes that may impose strict liability on parents who do not take measures to ensure their minor children attend school. For example, Maryland has a compulsory public school attendance statute requiring parents or legal guardians to ensure that children ages six to sixteen attend school or receive similar such instruction, imposing either a fine or ten days imprisonment for a violation.\textsuperscript{138} Under a similar statute, a mother in Baltimore was sentenced to ten days in jail because her daughter was a truant and the mother failed to attend scheduled meetings with school officials.\textsuperscript{139}

As with parental responsibility statutes, the truancy statutes are rarely invoked, but the reasoning behind them lays important groundwork for government intervention into parental responsibility for childhood obesity. The existing parental liability statutes hold parents liable for damage caused by their children to others; the truancy statutes hold parents responsible for failure to adhere to the state’s educational requirements.\textsuperscript{140} The two reflect governmental interest in protecting both society and minor children who are not yet fully able to care for themselves.\textsuperscript{141} The laws serving these interests have been upheld when the means have been specific enough to avoid condemnation for vagueness. These same principles should necessarily apply to governmental interference with a parent’s role in raising obese children.

\textsuperscript{135} Dimitris, supra note 130, at 669.
\textsuperscript{136} Brank et al., supra note 129, at 9 (noting that these statutes—CDMs—generally impose criminal liability upon all adults, not just parents). But see Davidson, supra note 134, at 26 (noting that sanctions under these statutes are not frequently applied).
\textsuperscript{137} Davidson, supra note 134, at 25. See also Dimitris, supra note 130, at 677 (discussing the ACLU’s generally unsuccessful assertions that parental responsibility statutes are unconstitutionally vague). For example, one court found a statute violated due process because the statute “criminalized the status of parenthood.” State v. Akers, 400 A.2d 38 (N.H. 1979).
\textsuperscript{138} Dimitris, supra note 130, at 667.
\textsuperscript{139} Id.
\textsuperscript{140} Davidson, supra note 134, at 25.
\textsuperscript{141} See discussion infra Part IV about constitutional scrutiny of parental responsibility for childhood obesity.
III. Morbidly Obese Children May Be Considered Neglected

A critical area in which a parent's constitutional right to privacy has been successfully challenged is where a child has been neglected or abused, either by the parent directly or because of a parent's ineffectiveness in preventing such abuse and neglect. This typically entails physical violence—either sexual or domestic—but it is not so limited and has been relied on by some states to criminalize parents of morbidly obese children.142 The statutory definition of child neglect varies by state but falls within the range provided by the Child Abuse Prevention and Treatment Act (CAPTA). CAPTA defines child abuse and neglect as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."143 Several state courts have interpreted the definition of neglect to include morbid childhood obesity.144 While some states narrowly interpret CAPTA's definition, every state neglect statute holds the parent, legal guardian, or caretaker responsible for their child's well-being.145

The statutory inclusion of childhood morbid obesity within the definition of neglect is an effective means of demonstrating when a State


The key Federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (P.L. 93-247). This Act was amended several times and was most recently amended and reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects. Additionally, CAPTA identifies the Federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates the National Clearinghouse on Child Abuse and Neglect Information. CAPTA also sets forth a minimum definition of child abuse and neglect.

144 Sciarani, supra note 142, at 314. California, Iowa, Indiana, New Mexico, New York, Pennsylvania, and Texas are the states that have previously addressed morbid childhood obesity as a form of neglect through the courts. California has not expanded the statutory definition of neglect to include morbid obesity. Id.
145 Id. at 322.
may constitutionally interfere with a parent's right to raise his or her child. Assuming that strict scrutiny is required, it is apparent that the government has a compelling interest in keeping children alive and sometimes removal from the home may be the only, let alone least restrictive, means of achieving this objective. There are several tragic cases of failure to intervene on behalf of severely malnourished children who have died from starvation, resulting in murder charges against their parents. When childhood obesity becomes life threatening, the State also has a duty to intervene, remove the child from his home, and possibly terminate parental rights. "In severe instances of childhood obesity, removal from the home may be justifiable, from a legal standpoint, because of imminent health risks and the parents' chronic failure to address medical problems."

A. Case History

In cases where the government has intervened before the death of a morbidly obese child, the tendency has been to remove the child from the parental home. In each of these cases, a determination of neglect was made prior to removal, but in most cases, that determination

146 See infra Part III.A (discussing cases on removal of morbidly obese children from their homes).
148 George, supra note 147, at 58.
151 Sciarani, supra note 142, at 325-26 (defining neglect generally as it relates to parents of morbidly obese children).

[T]he parents' failure to act in treating their child's condition is an omission under general negligence principles. Under these principles, parents have a special relationship with their child that includes a duty to aid and protect their minor children from unreasonable, foreseeable risk of harm. Parents of children with morbid obesity are in breach of their duty by failing to exercise reasonable care toward their child's health.

Id.
came after either court-ordered programs or doctor-recommended steps to address the child’s life-threatening morbid obesity.

In *In re L. T.*, a ten-year-old child was in the physical custody of her mother after having witnessed domestic violence by her alcoholic father. She was diagnosed by a psychiatrist as being psychologically disturbed and in need of long-term inpatient treatment for morbid obesity. She was five foot three inches and weighed 290 pounds, though her weight fell to 266 pounds after a one-month hospital stay. L.T.’s mother declined to provide her with the required medical treatment and the State found her to be a “child in need of assistance.” As there was no physical cause for her obesity, her child psychiatrist believed she developed an eating disorder to cope with the strife between her parents. Placement in a residential group home was considered the least restrictive means available to help L.T. address both her psychological and life-threatening physical problems.

In *In re G. C.*, a Texas case involving the termination of parental rights, a mother refused to allow a doctor to determine the cause of obesity in her four-year-old son who weighed ninety-seven pounds. The Texas Department of Protective and Regulatory Services (TDPRS) began an investigation into medical neglect, during which time the boy’s weight increased to 136 pounds. The mother, despite having changed doctors three times, failed to adhere to the recommended strict diet her son needed. Soon after, her son was hospitalized with an enlarged heart, difficulty breathing, and mild congestive heart failure.

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152 *In re L. T.*, 494 N.W.2d 450 (Iowa Ct. App. 1992) (holding that a ten-year-old girl suffering from morbid obesity, depression, and a personality disorder following the breakup of her parents’ marriage was properly adjudicated a “child in need of assistance”).
153 *Id.* at 451.
154 *Id.*
155 *Id.* at 452 (defining a “child in need of assistance” under Iowa law as “an unmarried child who is in need of medical treatment to cure or alleviate serious mental illness or disorder, or emotional 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”). *Id.*
156 *Id.* at 451.
157 *In re G. C.*, 66 S.W.3d 517 (Tex. App. 2002). The court affirmed the trial court’s determination that parental rights should be terminated. In doing so, it did not find convincing the mother’s arguments that the Texas law violated her right to privacy and that she was denied due process in having a jury of six, rather than twelve, make that finding. *Id.*
158 *Id.* at 520.
159 *Id.*
160 *Id.*
Upon release from the hospital, the doctor contacted Child Protective Services and the boy was placed in foster care, during which time his weight dropped.\footnote{161} Despite TDPRS's efforts to teach the mother to take better care of her son by providing a "homemaker" as a role model, the mother remained non-compliant, and TDPRS moved to terminate parental rights.\footnote{162}

In \textit{In re Brittany T.},\footnote{163} a New York court reversed the family court's order\footnote{164} that a morbidly obese child be removed from her home, despite her excessive weight, because the court did not find evidence of "willful violation" of the family court order.\footnote{165} Here, the Chemung County Department of Social Services intervened several times between October 2002 and May 2006 to help the child achieve a normal weight and attend school more regularly.\footnote{166} During that period, the child was repeatedly removed from her parents' home, with consent, to the maternal aunt, where she lost weight.\footnote{167} However, every time she was returned to her parents' home, she gained weight and failed to attend school regularly.\footnote{168} During this four-year period, her weight increased from 237 pounds at age eight to 266 pounds at age twelve.\footnote{169} The family court found the parents guilty of willfully violating court orders to, \textit{inter alia}, keep the child on a diet, get nutritional counseling, exercise, and attend school more regularly. The court ordered the child to be removed to foster care.\footnote{170}

On appeal, the court determined the Chemung County Department of Social Services had not proved "willful violation" of the court orders and instead found that the parents had been trying to comply,

\footnote{161}{\textit{Id.}} \footnote{162}{\textit{Id.} at 521.} \footnote{163}{\textit{In re Brittany T.}, 852 N.Y.S.2d 475 (N.Y. App. Div. 2008) (holding that the Chemung County Department of Social Services failed to show that the parents "willfully violated" conditions requiring them to (1) sign releases of information for themselves and their child requested by the Department; (2) cooperate with the Department; (3) use all resources available to ensure the child's mental, physical, and emotional well-being, and to enroll child in gym; (4) take all actions necessary to ensure the child attend school regularly; and (5) participate with the child in nutrition program).} \footnote{164}{\textit{In re Brittany T.}, 835 N.Y.S.2d 829 (N.Y. Fam. Ct. 2007), \textit{rev'd} 852 N.Y.S.2d 475 (N.Y. App. Div. 2008).} \footnote{165}{\textit{In re Brittany T.}, 852 N.Y.S.2d at 480.} \footnote{166}{\textit{In re Brittany T.}, 835 N.Y.S.2d at 831-32.} \footnote{167}{\textit{Id.}} \footnote{168}{\textit{Id.}} \footnote{169}{\textit{Id.}} \footnote{170}{\textit{Id.}}
despite the child's increased weight.\textsuperscript{171} The parents had taken her for nutritional counseling and enrolled her in a gym, which she attended once a week for twenty-seven of thirty-one weeks recorded; had only taken her out of school for court-ordered appointments; and had no ability to supervise what she ate while at school.\textsuperscript{172} The appellate court shared concern with the family court that the child's condition was not ideal. However, the court was powerless, under the state's neglect statute, to affirm an order removing the child from her home without the requisite "willful violation" on the part of her parents.\textsuperscript{173}

Finally, in an unpublished California case that made national headlines about this country's "fat-frenzy," a thirteen-year-old girl, Christina Corrigan, weighing 680 pounds, died of congestive heart failure due to morbid obesity.\textsuperscript{174} Prior to a trial for felony child endangerment, one of the detectives who found Christina said: "She was lying in her own filth. It wouldn't matter if she was 30 years old or 50 or 80 or if she weighed two pounds or 5,000 pounds. This case is going to trial because of the conditions the girl was living in."\textsuperscript{175} Christina had been out of school for over a year and had not left her home in three months.\textsuperscript{176} Christina's mother was found guilty of "passive misconduct"\textsuperscript{177} misdemeanor child abuse.\textsuperscript{178} One reason the verdict was not more severe may be that the court found Christina's obesity to be a medical condition, rather than one of neglect. A speaker for the National Association of Fat Acceptance spoke before the trial and said that Christina had been on seizure medication until she was three and only began to gain weight after the medications stopped.\textsuperscript{179}

\begin{footnotes}
\item[171] \textit{Id.}
\item[173] \textit{Id.}
\item[174] George, \textit{supra} note 147, at 61; Sciarani, \textit{supra} note 142, at 324; Lori Leibovich, \textit{Death of a Fat Girl}, \textit{Salon} (Sept. 22, 1997), http://www.salon.com/life/hot/1997/09/22/obese970922/index.html ("Her body was covered with sores, and feces were encrusted within the folds of her skin. Her room smelled like urine. Food containers were strewn around her body. And according to the coroner's report, there was evidence that insects had been feeding on her flesh."). Note, however, an internal autopsy was never done and the coroner concluded that Christina died from congestive heart failure simply based on her weight. \textit{Id.}
\item[175] Leibovich, \textit{supra} note 174.
\item[176] Sciarani, \textit{supra} note 142, at 325.
\item[178] George, \textit{supra} note 147, at 62.
\item[179] Leibovich, \textit{supra} note 174.
\end{footnotes}
B. Problems With Treating Childhood Obesity as Neglect

The four cases above highlight the complexity of evaluating neglect in the case of morbidly obese children. Each state operates under different neglect statutes and a finding of neglect is frequently compounded with issues that are unrelated to the child’s weight or the parents’ ability to reduce that weight. While this controversial approach towards childhood morbid obesity may be gaining recognition across the country, it is likely to be ineffective in addressing the national public health crisis of childhood obesity. Nonetheless, the debate about removing extremely obese children from their parents has recently gained momentum. This is evident from an opinion piece in the *Journal of the American Medical Association* by Dr. David Ludwig, an obesity specialist. Ludwig argues that temporary foster care is more ethical than surgery. The opinion also notes that removal of extremely obese children from their parents would not require any new legal approaches. According to Ludwig: “Health care providers are required to report children who are at immediate risk, and that can be for a variety of reasons, including neglect, abuse and what doctors call ‘failure to thrive.’ That’s when children are severely underweight.”

The major problem with a “neglect” evaluation is that it removes the child from his or her parental home. Advocates for a libertarian view of parental rights note that State intervention itself poses risks to the health of the child due to the lack of permanent relationships. “[F]amily integrity is especially vulnerable when child welfare agencies remove the child from the home because removal disturbs the ‘[c]ontinuity of relationships, surroundings and environmental influ-

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181 Harris & Conley, supra note 149.


rences [that] are essential for a child’s normal development.” Propo-
nents of this view only support court intervention when parents
withhold “life-preserving medical treatment” from their children. However, advocates for State paternalism argue that the threshold for
State intervention is lower, and that under the government’s role as
*parens patriae*, a court should permit intervention if it will improve a
child’s situation.

Currently, the latter approach is not accepted by most jurisdictions
and State intervention is limited to cases in which there is a compelling
interest in preventing harm to the child. Nonetheless, if advocates of
paternalism gain support, it is conceivable that their definition of “harm
to the child” could result in removal from the home in less severe cases
of childhood obesity, thereby threatening the important permanent
relationships that are developed through family integrity. In addition to
feelings of separation from one’s family, a removed child also suffers
from the stigmatization of her family being labeled “neglectful.”

Another concern with the “neglect” approach is that it only
addresses the most severe cases of medical neglect where a child’s life is in
danger, and the remedies are only tailored to the individual child, rather
than for obese children in general. While this might be manageable
for the handful of morbidly obese children identified by state agencies
and doctors, an individual approach to childhood obesity would be un-
realistic given that almost 17% of children ages two to nineteen are
considered obese, with over 30% of children ages two to nineteen being
overweight or obese. Unless a parent is classified as neglectful, an
obese child’s assistance will be limited to national and state programs to
reduce obesity, none of which address the problems caused by the gap in

184 *Id.* (citing JOSEPH GOLDBEIN, ANNA FREUD & ALBERT J. SOLNIT, *BEYOND THE BEST
INTERESTS OF THE CHILD* 31-32 (2d ed. 1979) (arguing that placement decisions should safe-
guard the child’s need for continuity of relationships)).
185 *Id.* at 881.
186 *Id.* (defining *parens patriae* as “parent of the country” with the “power and responsibility,
beyond its police power over all citizens, to protect, care for, and control citizens who cannot
take care of themselves”). *See also* Natalie L. Clark, *Parens Patriae and a Modest Proposal for the
Twenty-first Century: Legal Philosophy and a New Look at Children’s Welfare*, 6 MICH. J. GENDER
188 O’Connor, *supra* note 150, at 153.
189 *Id.*
190 Ogden & Carroll, *supra* note 25.
programming at home. Consequently, the “neglect” approach to
childhood morbid obesity does not help combat the widespread
problem of childhood obesity in general.

If the “neglect” categorization were extended to obese and mor-
bidly obese children, a large group of parents would be labeled as
criminals under neglect statutes, even though many parents do not have
the resources or abilities to change their child’s condition. A Time artic-
le in 2009 points out that a parent’s responsibility for a child’s weight
gain is not always easy to judge. Dr. Dana Rofey, whose weight-
management clinic is frequently involved in custody battles in which
one parent blames the other for their child’s weight, says, “[i]t’s unfair
to blame solely the parents, when there’s a myriad of other factors influ-
encing a child’s weight.” She lists other contributing factors, includ-
ing genetic predisposition, socioeconomic status, environmental factors,
and children sneaking extra food without their parents’ knowledge.

Moreover, as discussed in Part I, childhood obesity is most preva-
lent in the South, among racial and ethnic minorities, and within fami-
lies living below the poverty line. Solangel Maldonado, a law professor
at Seton Hall Law School, posted a blog on the issue of parents losing
custody of their obese children. Maldonado expressed concern that
such an approach would disproportionately affect minority families,
especially since minority children are already over-represented in the fos-
ter care system.

It is fundamental to our system of justice that a person be proven
guilty before he or she is liable for a criminal action. As a society, are
we prepared to find parents guilty of neglecting their children when

191 See supra Part I.D.
www.time.com/time/health/article/0,8599,1930772,00.html.
193 Id.
194 Id.
195 Solangel Maldonado, Should Parents Lose Custody of Obese Kids?, CONCURRING OPINIONS
(Jan. 12, 2009, 10:59 AM), http://www.concurringopinions.com/archives/2009/01/should_par-
ents_1.html.
196 Id.
197 Id.
198 Victor v. Nebraska, 511 U.S. 1, 8 (1994). “All the presumptions of law independent of
evidence are in favor of innocence; and every person is presumed to be innocent until he is
proved guilty. If upon such proof there is reasonable doubt remaining, the accused is entitled to
the benefit of it by an acquittal.” Id. See also U.S. CONST. amend. V; U.S. CONST. amend.
XIV, § 1.
parents allow their children to become obese, especially when the parents also may suffer from the same disability? After all, studies have shown that 80% of children with obese parents will become obese, while only 10% of obese children have an obese parent. It is disputed whether obesity is simply genetic or also a factor of an environment, in which a child mimics his or her parents' improper eating habits. Either way, treating the obese child of an obese parent as neglected has the effect of criminalizing obesity among parents. Our justice system will not tolerate that.

Another concern with extending the neglect approach is that, as we have seen with morbidly obese children, the obese child may be placed in foster care and suffer further trauma. A 2006 episode of Primetime discussed the problems associated with placing children in an already-burdened child welfare system. According to this report, 80-90% of placements in foster care are associated with substance abuse; children wait, on average, three years before being reunited with their families or being adopted; children are moved, on average, into three different homes during their stay in foster care; children are separated from both their parents and their siblings; and finally, about 25% of people who were once in prison were also in foster families. Clearly, foster care should be a last resort for removing an otherwise healthy, albeit obese, child from the stability of his or her biological home.

IV. WHY IT IS APPROPRIATE TO INTERFERE WITH A PARENT’S RIGHT TO PRIVACY REGARDING CHILDHOOD OBESITY

The numerous risk factors for, and consequences of, childhood obesity discussed in this Note reinforce the reality that a remedy to this public health crisis must be multi-faceted. It is logical that government involvement is required to address such a serious and widespread problem. This is especially true in areas where government traditionally serves the community and exerts influence, such as providing public education and schools, building public infrastructure, offering assistance

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199 Lisa Smith & Brian A. Liang, Childhood Obesity: A Public Health Problem Requiring a Policy Solution, 9 J. MED. & L. 37, 40 (2005) (discussing the broad influences on obese children and approaches to addressing the problem).

200 Sciarani, supra note 142, at 317.

201 See supra Part III.A.


203 Id.
CHILDHOOD OBESITY

A. Gap in Current Programming Does Not Extend into the Family Home

Despite the myriad of federal and state policies and programs that reach into communities, schools, and the food and beverage industry in an attempt to stem the surge of childhood obesity, there is not one single regulation or best practice requirement for parents. So what happens to these important efforts once a child leaves a controlled school environment and returns home, either after school, on weekends, or during summer breaks? A study published in the *Journal of the American Dietetic Association* describing patterns of consumption of "empty calories," those in low-nutrient, energy-dense foods such as sugar-sweetened beverages, found the majority of "empty calories" were consumed at home.\(^\text{204}\) However, students who participated in the National School Lunch Program consumed fewer high-calorie beverages than non-participating students, and they did not compensate for that lower calorie intake by drinking more sugary drinks at home.\(^\text{205}\) The study concludes that it is necessary to improve home eating behaviors, while simultaneously enforcing school wellness policies. Limiting access to low nutrient food can impact consumption of "empty calories" in school.\(^\text{206}\)

During the summer months, in addition to losing the nutritional gains provided by school wellness programs, children also experienced decreased physical activity.\(^\text{207}\) Rather than losing weight during summer vacation as some might assume, children lacking supervision actually gain weight two to three times faster than they do during the school

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\(^{204}\) Ronette R. Briefel et al., *Consumption of Low-Nutrient, Energy-Dense Foods and Beverages at School, Home, and Other Locations among School Lunch Participants and Nonparticipants*, J. AM. DIETETIC ASS'N, Feb. 2009, at 579-90 (discussing a national sample of 2314 children in grades one through twelve). Of the 527 calories consumed in a twenty-four hour period, 276 were consumed at home, 174 at school, and 78 at other locations. *Id.*

\(^{205}\) See *Obesity Report* 2009, supra note 33, at 72.

\(^{206}\) Briefel et al., supra note 204.

\(^{207}\) See *Obesity Report* 2009, supra note 33, at 72.
Moreover, summer weight gain is more pronounced among those children who are generally at higher risk of being obese—black, Hispanic, or already overweight. As an Ohio State University statistician and one of the researchers who provided data for these results surmised:

"If you have some Tom Sawyer idea that kids are climbing trees all summer and only eat when called to dinner, that doesn’t square with the fact that they’re gaining weight so quickly. The other stereotype—that kids are watching TV, playing video games, and eating chips out of a bag—may be closer to the truth."

To further prove this point, children who experienced summer weight gain actually lost weight when they returned to school.

It is clear that school-based nutrition and physical activity programs are vital in the battle against childhood obesity. However, it is notable that obesity prevention efforts that concentrate solely on schools have little effect if the gains made during the school year dissipate when schools “lose control” of children during summer vacation.

B. Parents’ Ability to Address Childhood Obesity

A group of researchers from Harvard University, relying on a wide array of studies on parental involvement in reducing childhood obesity, concluded that parents have a critical role to play in the multifaceted, community-wide programs that have been developed to prevent and control childhood obesity. They suggest that successful programs and intervention will work best when they directly involve parents to support healthful activities both in, and out, of the home. Beginning with gestation, and moving through early years into school age, before

208 Paul T. von Hippel et al., *The Effect of School on Overweight in Childhood: Gains in Children’s Body Mass Index During the School Year and During Summer Vacation*, 97 Am. J. Pub. Health 696, 701 (2007) (reporting the findings of a study that explored whether school or non-school environments contribute more to a child’s weight gain).

209 Id. at 696.

210 See OBESITY REPORT 2009, supra note 33, at 71.

211 von Hippel et al., supra note 208.

212 OBESITY REPORT 2009 supra note 33, at 72.


214 Id.

215 Id.
finally ending with adolescence, the researchers identify a role for parents to play at each stage. Children of mothers with diabetes or nutritional aberrations are at a higher risk of becoming overweight, with gestational diabetes being the most risky.\textsuperscript{216} Screening for and preventing gestational diabetes is key in lowering the risk of obesity at this stage.\textsuperscript{217}

Toddlers already have taste preferences and are predisposed to limiting their energy intake from food, but their exposure to food can reshape natural tendencies. Parents can mold their early environment to be more healthful.\textsuperscript{218} Moreover, at an early age, children will eat what their parents eat. If parents overeat, it is likely that their children will also overeat.\textsuperscript{219} Children will also expend energy based on direction from their parents, and one study of three to five-year-old children shows that toddlers who are physically active have a lower BMI than their less active counterparts.\textsuperscript{220} Another study showed that children with two active parents were almost six times more likely to be active than children of sedentary parents.\textsuperscript{221} The researchers suggest that parents should encourage their children to play outside, while recognizing that children of minority and lower-income parents are less likely to have access to safe parks, bicycle paths, and other outdoor exercise options.\textsuperscript{222}

School-age children are still influenced by parental behavior and control. Researchers have found that eating dinner as a family encourages greater consumption of fruits, vegetables, and whole grains.\textsuperscript{223} Consumption of sugar-sweetened beverages is closely linked to being overweight. One long-term study of children ages eleven to twelve found that the odds of becoming overweight increased 60\% for each sugar-sweetened beverage consumed daily.\textsuperscript{224} The researchers state that parents should not only ensure that healthier foods are available at

\textsuperscript{216} Id. at 170.
\textsuperscript{217} Id.
\textsuperscript{218} Id. at 171.
\textsuperscript{219} Id. at 172.
\textsuperscript{220} Id.
\textsuperscript{221} Id.
\textsuperscript{222} Id. at 173.
\textsuperscript{223} Id.
\textsuperscript{224} Id. at 174.
home, but parents should consume healthier foods to encourage the same behavior in their children.\textsuperscript{225}

One additional key factor in reducing physical activity is television watching. Several studies have linked the amount of television watching to lower activity.\textsuperscript{226} School-age children spend more time watching television than any other activity, with an average of two hours of television per day, and as much as five hours per day among African-American children.\textsuperscript{227} Sixty-eight percent of children have a television in their rooms, and studies show that these children watch ninety more minutes of television than other children.\textsuperscript{228}

A study compared parents as the exclusive agents of change (experimental group) in the treatment of childhood obesity with the conventional model in which children were the agents of change (control group). The results showed that adherence to the intervention program and weight reduction were better in the experimental group, with almost two times greater weight loss and a drop out rate nine times lower than the control group.\textsuperscript{229} Moreover, six months after the one-year study ended, children in the control group maintained only 40\% of their weight loss, while children in the experimental group maintained 85\% of their weight loss. The study explains that children in the experimental group had lower resistance to changes in their consumption and activity levels because the family was treated as a unit without singling out any overweight children. In addition, the parents were responsible for decisions regarding food and exercise changes.\textsuperscript{230} Many children in the control group found it impossible to avoid temptations at home, and they were frustrated and stressed by their inability to achieve or maintain weight loss.\textsuperscript{231}

A seven-year follow up to the above study confirmed the earlier findings. Both treatment groups demonstrated weight loss, but the mean reduction in overweight children was 29\% in the experimental

\textsuperscript{225} Id. at 173.
\textsuperscript{226} Id.
\textsuperscript{227} Id. at 174.
\textsuperscript{228} Id.
\textsuperscript{229} See id. at 1133.
\textsuperscript{230} See id. at 1133.
\textsuperscript{231} Id.
group and only 20.2% in the control group. After seven years, 60% of the children in the experimental group were no longer obese, as compared to only 31% in the control group. These differences were both statistically and clinically significant. The researchers attribute these results to parenting style, ability to create a healthy environment in the home, and support for their child’s autonomy and self-esteem. A key finding is that parental authority, rather than parental control, is crucial for the development of the child’s ability to self-regulate and thereby maintain a healthy weight.

Studies always have some limitations, but they can provide information and clear guidance on the causes and prevention of childhood obesity. While parents cannot isolate their children from external unhealthy influences, they can exercise control over diet and physical activity, serve as good role models for their children, and provide the support and encouragement necessary for children to self-regulate as they mature and move away from their parents’ authority. Given this unique and long-lasting component to reducing and preventing childhood obesity, it is imperative that childhood obesity programs include parents as agents of change. The parental right to privacy should not continue to be an obstacle to fully resolving this national public health crisis.

CONCLUSION

“Public opinion polls indicate that most Americans consider childhood obesity to be a major public health problem. In a 2008 nationwide survey, obesity was ranked as the number one health problem for children.” Unstopped, this problem will result in children who suffer physical and emotional setbacks, more obese adults, and an increased strain on the economy due to higher healthcare expenditures and lower productivity. Additionally, the current levels of childhood obesity place the strength and effectiveness of our armed forces at risk. Comprehensive programming and policies have reached into communities, schools,

232 See Moria Golan & Scott Crow, Targeting Parents Exclusively in the Treatment of Childhood Obesity: Long-Term Results, 12 OBESITY RES. 357, 359 (2004) (noting that the follow up was conducted at one, two, and seven-year intervals).
233 Id.
234 Id. at 360.
235 Id.
236 Id. Authoritative parenting involves parents being firm and supportive, taking a leadership role in the environmental change, and controlling child-feeding practices. Id. at 358.
237 Cawley, supra note 64, at 367.
and businesses to make progress toward reducing childhood obesity. However, parents have not been legislatively factored into the equation. A parent’s fundamental right to privacy, as it relates to childrearing, presently remains untouched as the public health crisis continues. With a compelling government interest in protecting both the welfare of children and society in general, it is logical that a narrowly tailored program that respects the sanctity of the home, but requires parental involvement, should emerge.

The first step in determining when a parent’s childrearing right should be legislatively challenged is identifying when children are obese. One example of appropriate interference might include requiring children to be screened for their BMI at school. Once obese children are identified, their parents should be required to attend information and training programs to alter out-of-school unhealthy behavior. These parents should also receive assistance and monitoring in measuring their children’s progress in achieving healthy weights. This approach would require legislators to recognize that not all parents will have the opportunity or means to affect the necessary lifestyle changes, but all parents can benefit from increased knowledge about the environment in which their children are growing up.

Despite the current approach that skirts around the role of parents in affecting healthy weights for their children and fears of a “nanny state,” there is ample evidence that both state and federal governments should not be afraid to interfere with parental rights and provide legislation that requires parents to become part of the solution in combating childhood obesity. The primary goal should be to protect children first, and laws can be designed to provide effective safeguards for both children’s health and parents’ rights.