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Avoiding hypersensitive reluctance to address parental responsibility in childhood obesity

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ABSTRACT

Childhood obesity is an increasing health problem. Prior empirical research suggests that, although discussing lifestyle behaviours with parents could help prevent childhood obesity and its health-related consequences, physicians are reluctant to address parental responsibility in the clinical setting. Therefore, this paper questions whether parents might be (or might be held) responsible for their children's obesity, and if so, whether parental responsibility ought to be addressed in the physician–patient/parent encounter. We illustrate how different ideal-typical models of the physician–patient/parent interaction emphasise different understandings of patient autonomy and parental responsibility and argue that these models advocate different responses to an appeal for discussing parents' role in childhood obesity. We suggest that responsibility should be attributed to parents because of their parental roles in providing for their children's welfare. We also argue that whether, and how, this responsibility gives rise to a requirement to act depends on the parents' capacities. A deliberative-oriented physician–patient/parent interaction best captures the current ideals of antipaternalism, patient autonomy, and shared and evidence-informed decision-making, and might facilitate parental role development. We conclude that, while not discussing parental responsibility for childhood obesity in the clinical setting can be warranted in particular cases, this cannot be justified as a general rule.

INTRODUCTION

The epidemic of obesity in children and adolescents is acknowledged as an increasing health problem worldwide^{1–6} and interventions at the microlevel, mesolevel and macrolevel are being implemented to counteract avoidable obesity.^{7–11} Family environment, in general, and parent–child interactions, in particular, are among the risk factors for developing childhood obesity.^{12–14} A recent meta-synthesis suggested that discussing lifestyle behaviours with parents in the clinical setting could help prevent childhood obesity and its health-related consequences.¹⁵ Nonetheless, empirical studies indicate that physicians are reluctant to address parental responsibility because of lack of time and support in the organisation, concerns about the physician–parent relationships and fear of parent reactions, lack of parental acceptance of the problem and motivation to change, and fear of harm to the child due to stigma.^{15–18}

While it is easy to understand that physicians fear parents are sensitive about childhood overweight and obesity^{18 19} and that they feel uncomfortable, unable or ill equipped to discuss child weight and its management with parents,¹⁵ reluctance to address

parental responsibility for childhood obesity in the clinical setting is not necessarily justifiable from a *normative* viewpoint. Indeed, parental responsibility for obesity among children and adolescents has been heatedly debated in medical ethics literature.^{20–29} The more general debate concerns the idea that parents are responsible for the well-being of their children. While this idea is widely accepted,³⁰ there is persistent disagreement regarding its sources (eg, causality, capacity or role); whether parents might be held responsible (blamed or credited) for the consequences of (or of not) acting; and the normative implications of attributing parental responsibility (eg, what is required of parents and whether these requirements are relative to the children's decision-making capacities).

In the forthcoming sections, we focus on one aspect of the debate, asking whether parents might be (or might be held) responsible for their children's obesity, and if so, if parental responsibility ought to be addressed in a clinical setting. To aid this discussion, we use Emanuel and Emanuel's³¹ four ideal-typical models of the physician–patient relationship and expand the models in two directions. First, we consider the patient as being a child, with limited capacities to make decisions, and the parents as being surrogates for recognising the child's best interests; thus, we introduce the *patient/parent* category to investigate different models of the physician–patient/parent relationship. However, we do not enter the debate concerning whether obesity is a disease but do refer to children as 'patients' because the child is in contact with healthcare professionals for health-related purposes.³² Second, we include relevant notions of *responsibility attribution*. The (expanded) models are presented after a brief introduction of ideal-typical analysis. We argue that the deliberative model best captures the current ideas of antipaternalism, patient autonomy, and shared and evidence-informed decision-making and is, therefore, the ideal model of the physician–patient/parent interaction in clinical contexts characterised by conflicting values and ongoing interactions. Further, we assert that parental responsibility should be understood as role responsibility. That is, parents are responsible for the (non)exercise of role-based duties attached to their parental roles. Thus, the paper suggests that the physician–patient/parent interaction should aim to help the patients/parents determine which health-related values they could and should pursue, given the implications for the children's health and well-being. To this end, parental responsibility should be addressed in weight-related communication in clinical practice. We conclude that, while not discussing parental responsibility for childhood



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obesity can be warranted in particular cases, it cannot be justified as a general rule.

FOUR MODELS OF THE PHYSICIAN–PATIENT/PARENT RELATIONSHIP

To better understand physicians' reluctance to address parental responsibility and to evaluate the possible reasons for this, we have employed Emanuel and Emanuel's³¹ four ideal-typical models of the physician–patient relationship as an analytical point of departure. These models highlight specific characteristics of and beliefs about interactions between physicians and patients and are constructed as a conceptual tool to aid analysis. They enable study of the essential features of physician–patient interactions and, by comparing reality to the ideal type, help develop knowledge about the specifics of the particular physician–patient interaction under investigation. While (Weberian) ideal types were originally developed neither as a representation of reality nor as a normative ideal,³³ Emanuel and Emanuel's four models are explicitly constructed for normative purposes.³¹ The present study uses the ideal-type models of interaction to illuminate certain features of practice by abstracting from the details. We have sought to identify how different ideals of the physician–patient/parent relationship might yield different prescriptions of responsibility attributions. To this end, Emanuel and Emanuel's models are expanded in two directions.

First, we include parents as part of the interaction, assuming that the patient is a child, with limited capacities for decision-making and that the child's parents are surrogates for recognising the child's best interests. Accordingly, the child and the parents have identical preferences for the child's well-being. In this way, the relational physician–patient–parent triangle is reduced to a dyad. The clinical situation is conceived of as a two-part relationship between the physician and the patient/parents. Thus, we have abstracted from (at least) three facts: (1) that the child (normally), over time, develops autonomous agency and preferences and that the parents consequently lose their authority; (2) that the parental role(s) may be filled by a single caregiver or by a pair of or multiple parents with or without identical preferences; and (3) that the caregiver(s) taking up the parental role(s) might or might not be genetically or biologically related to the child.

Second, we expanded Emanuel and Emanuel's models to include different understandings of parental responsibility. The following provides a brief description of the four models in their adapted forms, summarised in [table 1](#).

The paternalistic model

According to the paternalistic model of the physician–patient/parent relationship, the physician's goal and obligation is to

ensure the best health outcomes for the children. Objective criteria define the children's medical conditions and the best intervention strategies. Children suffering from obesity, as well as their parents, are thought to lack insight into the medical condition. The paternalistic-oriented physician acts as a guardian, assessing the children's best interests, weighting the benefits and harms relevant to medical care and implementing the best interventions. Thus, the current preferences for intervention that children and their parents hold are of limited value. Since the physician makes the best possible decisions on behalf of the children, he or she takes on the responsibility for the interventions' consequences, and the children and their parents have limited involvement in discussing alternative intervention strategies. Parental responsibility, thus, has limited relevance in this model.

The informative model

The informative model sees the physician as an expert who provides the children and their parents with information to make informed choices. This model assumes that the patients/parents' intervention preferences should be exercised without any interference in their control over medical decision-making. The patients/parents are presumed to have well-defined preferences for medical interventions. Thus, the physician should provide all available facts about the children's conditions, so the children and their parents can select interventions that best realise their values. The conception of autonomy underlying this model is autonomy as control over decision-making. It makes a clear distinction between facts and values, and the physician's role is to ensure that all facts are given to patients. Responsibility attributions have limited relevancy to this model—merely establishing a causal link between the parents/children's behaviours and the patients' health outcomes. Causal responsibility might be attributed, however, when the parents' actions (or omissions) are identified as the main cause, among other factors, of the children's health outcomes.³⁴ Causation may have a retrospective orientation, when assessing the historical causes behind an event, but also a prospective orientation, when explaining how to achieve desired outcomes or avoid bad outcomes.³⁵ The attribution of parental responsibility has an explanatory function in this model and occurs when the physician provides parents with relevant factual information concerning how lifestyle changes would impact the children's conditions. However, patients/parents' values are neither assessed nor discussed. If the parents decide to take a non-intervention strategy, the physician should not impose his or her will on them. According to the informative model, value-based recommendations about lifestyles would be 'moralistic' and unsubstantiated.

Table 1 Four models of the physician–patient/parent interactions (adapted from Emanuel and Emanuel [31])

	Paternalistic	Informative	Interpretive	Deliberative
Physician role	Guardian	Expert	Advisor	Teacher
Physician obligation	Promoting well-being independent of current patient preferences	Providing factual information and implementing interventions	Interpreting patient values, providing factual information and implementing interventions	Articulating and persuading the patients about values, providing factual information and implementing interventions
Patient/parental values	Objective and shared by patient/parents and physician	Defined and known to the patients/parents	Conflicting, requiring elucidation	Open to development and revision through discussion
Patient/parental autonomy	Assenting to objective values	Self-rule	Self-understanding	Self-development
Patient/parental responsibility	Limited responsibility	Causal responsibility	Capacity responsibility	Role responsibility
Function of responsibility	–	Explanatory	Ontological	Normative evaluative

The interpretive model

The interpretive model understands the children's and their parents' values as being inchoate and often conflicting. The physician should, therefore, serve as an advisor, providing children and parents with information about the children's conditions and the benefits and risks of alternative interventions. The physician should elucidate and interpret the values of the children and their parents by reconstructing relevant goals and commitments and instituting a joint process to interpret patients/parents' objectives and suggest therapeutic efforts that best realise these values. Here, patient autonomy is conceptualised as 'self-understanding'. The physician should not attempt to persuade children and their parents to adopt other values. The interpretive-oriented physician assumes that parents have the ability to reflect and act on their first and second-order preferences and have the capacity to revise their values. The attribution of parental responsibility compatible with this model is capacity responsibility, as parents are presumed to have a set of physical and mental capacities that give them a degree of control over their conduct and lead them to act responsibly.³⁶ The attribution of responsibility has an ontological function, which allocates the 'ownership' of conduct and outcomes.³⁵

The deliberative model

According to the deliberative model, the physician's goal is to help children and their parents determine and choose the best health-related values that can be realised. Children and their parents are thought to have some insight into the medical conditions. The physician should, therefore, act as a teacher, delineating relevant information on the patients' clinical situations and possible therapeutic alternatives. However, the physician's role in this model also entails pointing out why some health-related values should be preferred over others. The deliberative-oriented physician will engage with the children and their parents to discuss the best intervention strategies, aiming to persuade them to voluntarily accept the preferred intervention. Autonomy is understood as 'self-development' relevant to medical care, and the children and their parents' current preferences are open to revision through discussion. Through the deliberative process, the physician may appeal to parents to take responsibility for their children's health. A deliberative model would be compatible with considering responsibility as role responsibility. Role responsibility may be attributed based on the parents' distinctive role as being primarily responsible for their children. This role gives rise to certain duties, constituted by social norms, to provide for the welfare of those children. When a person occupies a role to which specific duties are attached, that person 'is properly said to be responsible for the performance of these duties, or for doing what is necessary to fulfil them'.³⁷

Role responsibility is commonly grounded in capacity and control.³⁶ The attribution of role responsibility to parents might have a normative function—a future-oriented specification of the duties and obligations that are attached to their role—and an evaluative function—a backward-looking attribution of responsibility, which assesses whether the responsibilities have been fulfilled.³⁸

DISCUSSION

This section will consider the four models further. Paternalistic-oriented physicians perceive themselves as responsible for children's well-being, and the autonomy of the children and parents is reduced to their consenting to the physicians' judgement. This diminishes the basis for parental responsibility (although there

could be instances in which where responsibility and autonomy do not necessarily overlap³⁹). However, in the paternalistic model parental responsibility is essentially irrelevant because the model assumes that physicians and parents have similar values and beliefs about what will benefit the children. While the paternalistic model can be legitimate in extraordinary situations (eg, emergencies), it is problematic in routine practice. Such an approach deprives parents of the opportunity to choose and can become counterproductive by fostering negative parental reactions towards physicians' prescriptive recommendations and, thus, undermining the therapeutic process.

Informative-oriented physicians provide information relevant for treatment, explaining to parents how health-related behaviours affect their children's health. However, physicians should not, according to this model, compete with the parents' decision-making capacities and should refrain from giving any recommendations. Parents should not be called on to reflect on or revise their preferences as the model presupposes that values are predetermined. Parents are believed to know best which lifestyles they value, and physicians should be careful not to impose their wills or values on parents. According to this model, physicians may attribute causal responsibility for outcomes to parents but would still be inclined to refrain from responsibility attribution if the causal link is weak or cannot be established.

Interpretive-oriented physicians assume that parents' values may be conflicting. Therefore, parents should be helped to interpret and articulate their goals, and they will subsequently resume capacity responsibility. However, since interpretive-oriented physicians should refrain from trying to persuade the parents to adopt a given lifestyle, there is no room for discussing what parents 'ought to do' to ensure their children's well-being.

Finally, deliberative-oriented physicians view parents as carrying specific role responsibilities. These physicians act as teachers by trying to educate parents about their role and (normatively) persuading parents to choose the best interventions for their children. Role responsibility may be attributed to parents because of their specific role, regardless of their capacity to control their children's conduct or the circumstances in which they make their choices. However, the very point of a deliberative-oriented physician–patient/parent interaction is to develop capacities to engage in necessary behaviour changes by critically reflecting on the parental role and its requirements—trying to prevent children from becoming obese and to adequately intervene if this should happen.

Given that childhood obesity is harmful and that addressing parental responsibility is likely to be effective, the negative consequences of ignoring parental responsibility can be considerable. In a clinical context characterised by conflicting values and ongoing physician–patient/parent interactions, it seems that attempts to persuade parents about the desirableness of a course of action might be justified, and even encouraged. In these settings, we claim that the deliberative model should be preferred. It seems to best capture current ideas of antipaternalism, patient autonomy, and shared and evidence-informed decision-making. A deliberative-oriented physician–patient/parent might also facilitate parental role development. Consequently, reluctance to address parental responsibility in the physician–patient/parent encounter is difficult to defend. The following paragraphs present three points to support this claim.

First, parents have role responsibilities by virtue of being parents. Children generally lack the moral, emotional and cognitive capacities to be responsible for themselves; thus, parents take on the responsibility for ensuring their children's well-being. Though different parents have different opportunities

and capacities for guiding and helping their children, we believe physicians should avoid a ‘hypersensitive’ stance and engage parents in deliberations about the parental role in childhood obesity. Addressing the topic is a necessary condition, and employing a deliberative model for physician–patient/parent interaction may facilitate such conversations.

Second, not addressing parental responsibility can *de facto* individualise the problem and make it more difficult for parents to articulate social and environmental barriers for lifestyle change. This may indirectly result in a search for causal explanations in the children themselves. If the children remain the only subject of scrutiny, and if other relevant explanations are disregarded, this can place an additional burden on the children. Hence, to activate the parents’ role is an independent argument.

Third, it is not unlikely that parents feel culpable and perhaps even ashamed when their children are overweight or obese. Obesity is a stigmatised condition,⁴⁰ viewed by many as a moral failing caused by poor lifestyles and a lack of willpower.⁴¹ Physicians have the authority to address responsibility and make distinctions between the role of parents, the causal explanation of obesity and parents’ potential culpability and guilt for their children’s situations. Not articulating the topic of responsibility poses the danger of consolidating a belief about guilt. In light of the evidence of environmental, genetic and epigenetic influence on childhood obesity, much explanatory power lies outside the control of both parents and children. Since some see childhood obesity as a structural, rather than an individual, problem and believe that responsibility must be grounded in capacity and control, attributing responsibility to parents may seem normatively unjustifiable. However, an idea of parental responsibility, which accentuates the parents’ requirements to care for the health-related welfare of their children, would still be relevant.

Limitations and future research

This article have applied four models of physician–patient interaction to study responsibility and autonomy in childhood obesity. However, some limitations warrant discussion. As mentioned above, we have made a number of assumptions that simplify a complex reality. For example, to accommodate the ideal-type models’ two-part relationship between the physician and the patient, we have assumed that patients and their parents have identical preferences. However, as children, and particularly adolescents, develop decision-making capacities, a physician–patient–parent triangle will more precisely describe the relationship. Such an expansion of the models will make it possible to address potential opportunities for engaging (at least) older children in deliberations about healthier behaviour. We believe that a deliberative model may be well extended into third-party interactions.

This research has also sidestepped the issue of the many forms of parenthood and the possible consequences of discussing parental responsibility. Thus, it is beyond the scope of this article to determine whether collective responsibilities are attached to a pair of (or multiple) parents.

Previous studies have indicated that a deliberative ideal might, in practice, lapse into paternalistic-oriented reasoning.⁴² Several factors can explain this finding, including conflicting preferences and values following a more complex, multiparty interaction and the physicians’ insecurity in their professional role. We can only speculate that there will be tension between a deliberative ideal and a paternalistic-oriented reasoning in the context of childhood obesity. Further, future research should address the important question of what exactly a deliberative model should look like, in practice, to provide clinicians with guidance in

these difficult encounters. The present study provides a fruitful normative framework, which can underpin elaborations of the model for clinical practice applications.

CONCLUSION

This paper’s point of departure was its recognition that, while parents are involved in the development and treatment of childhood obesity in many ways, physicians seem reluctant to discuss parental responsibility, due to issues of parental autonomy and the physicians’ fear about being harsh and moralistic.

We have investigated four models of the physician–patient/parent interaction, which consider the autonomy and parental responsibility related to childhood obesity. We have found that a deliberative ideal of the physician–patient/parent interaction, with a dynamic conception of parental autonomy aiming at self-development, provides fertile soil for introducing parental responsibility understood as role responsibility. Thus, we conclude that reluctance to address the issue of responsibility is not warranted and that addressing responsibility in terms of normative role responsibility can encourage active engagement and responsibility while avoiding attributing blame.

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