tential ethical conflicts between the interests of the parent and those of the child, preoperative preparation should include extensive attempts towards medical weight loss. Options include hospitalization and a certification from the child's primary care physician that further medical interventions would not likely benefit the child, informed consent procedures encompassing both parent and child, and strong indicia that the child will successfully complete the post-operative regimen. The child probably does not need to have an independent legal authority, such as the probate court or child protective services, consent to the procedure on her behalf.

"Pediatric obesity is the most common nutritional disorder among children and adolescents in the U.S."[5] Pediatric obesity has risen in recent decades, increasing not only the number of children with unhealthy weights, but also those with co-morbid conditions such as high blood pressure, high lipids, and diabetes. Historically, the most common sufferers of these ailments were the elderly and adult obese, but the rapid increase of obesity in children has required pediatricians to learn how to treat the ailments in children.[6] Pediatrics providers overwhelmingly agree that childhood obesity requires treatment, affects chronic disease, and diminishes quality of life.[7] Obese children have a greater risk of adult obesity, the consequent persistence of co-morbid conditions, and a shortened life span from these complications.[8]

The modern recognition of pediatric obesity as a threat to long-term health has given rise to a legal recognition that parents who fail to treat their child's obesity can be held accountable for medical neglect.[9] Medical neglect rates have hovered at about .5 per 1,000 children per year for the last five years, or about one-fifth the rate of physical abuse or one-fourteenth the rate of other neglect claims, but still affect a substantial number of children.[10] There are over 25,000

5. Jack Adam Yanovski, *Pediatric Obesity*, 2 REV. ENDOCRINE & METABOLIC DISORDERS 371, 371 (2001).

6. Daniel Q. Haney, *More Children Getting Diabetes*, ASSOCIATED PRESS ONLINE, Apr. 13, 2003; Francine Ratner Kaufman, *Type 2 Diabetes Mellitus in Children and Youth: A New Epidemic*, 15 J. PEDIATRIC ENDOCRINOLOGY & METABOLISM 737, 737 (Supp. 2002).

7. Mary T. Story et al., *Management of Child and Adolescent Obesity: Attitudes, Barriers, Skills, and Training Needs Among Health Care Professionals*, 110 PEDIATRICS 210, 211 (2002).

8. Yanovski, *supra* note 5, at 374.

9. *See, e.g.*, *In re G.C.*, 66 S.W.3d at 520.

10. U.S. DEP'T OF HEALTH AND HUMAN SERV., ADMIN. FOR CHILDREN AND FAMILIES, CHILD MALTREATMENT (2000), http://www.acf.hhs.gov/programs/cb/publications/cm00/

medically neglected children each year in the thirty-nine states that segregated out medical neglect for reporting to the United States Department of Health and Human Services.[11] While only a very small number of these cases involve obesity, in at least one instance the parents' failure to maintain the child at a healthy weight led to the temporary removal of the child from the home;[12] and in another, it led to the termination of a mother's parental rights.[13] With pediatric obesity on the rise, an increasing number of medical neglect cases will reach the courts.

Treatments for pediatric obesity vary in efficacy, but generally lack long-term data to demonstrate success.[14] Gastric bypass procedures have demonstrated long-term success, but only in small-scale studies. Gastric bypass remains a controversial treatment because of mortality risks, high complication rates over the short term, and the potential development of nutritional deficiencies and affiliated developmental problems over the long term.

Parents facing decisions regarding treatment of their obese child confront a variety of conflicts. First, they must weigh the risk of their child's death or disability in surgery and the certainty of lifelong dietary restrictions against the potential benefits of significant weight loss and avoiding the attention of the child protection authorities. Second, they may face a conflict between the child's desires and their own. In states with a mature minor doctrine, the decision to proceed with the operation may rest entirely with the child, but the costs of the procedure may be the parents' responsibility.[15] Third, parents may face the resistance of the primary care provider or nutrition staff, who may favor intensive medical therapy over surgery.

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figure3_3.htm (last visited Mar. 17, 2004).

11. U.S. DEP'T OF HEALTH AND HUMAN SERV., ADMIN. FOR CHILDREN AND FAMILIES, CHILD MALTREATMENT (2000), http://www.acf.hhs.gov/programs/cb/publications/cm00/table3_4.htm (last visited Mar. 17, 2004).

12. Bill Briggs, *Growing Pains: Overweight 4-Year-Old New Mexico Girl Stuck in the Middle of Child-Rearing Battle*, DENVER POST, Aug. 5, 2001, at I1.

13. *In re G.C.*, 66 S.W.3d at 520.

14. Jack A. Yanovski, *Intensive Therapies for Pediatric Obesity*, 48 PEDIATRIC CLINICS N. AM. 1041, 1050 (2001).

15. The "mature minor" doctrine allows a child to make decisions regarding his or her own medical care if he or she (1) has reached a certain age (specified under state law), (2) is found by a court to have the requisite maturity to make such decision, or (3) is otherwise emancipated. Ann Driggs, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 690-91 (2002). The majority of states do not have mature minor doctrines. *Id*. at 696. Many states that have the doctrine absolve parents from financial responsibility for a mature minor's decisions. *Id*.