

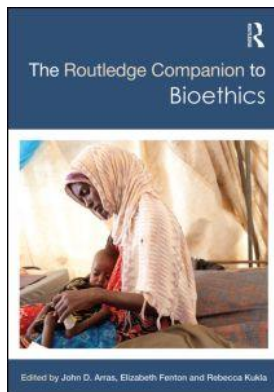
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CHILDREN, PARENTS, AND RESPONSIBILITY FOR CHILDREN'S HEALTH

Amy Mullin

We typically take children's health concerns very seriously, and severely blame those who contribute to children's ill health through negligence or abuse. But what are the grounds for holding people responsible for avoiding bad outcomes or aiming at good ones when it comes to children's health? Who should be held responsible—and for what? I argue that parents are among those to be held responsible, *but* expecting parents to maximize children's health is too high a standard *and* other individuals and groups share responsibility with parents. Different examples of how children's health can be affected will draw attention more to the responsibilities of some rather than others. As a result, this essay will survey five different contexts affecting children's health: Infant feeding, obesity, exposure to tobacco smoke, parental resistance to medical treatment, and emotional maltreatment.

Identifying Social Parents

In this essay I discuss only responsibility for children's health after they are born, and focus on responsibility that individuals and groups have for the health of children in their own society. I will not explore circumstances in pregnancy that affect the health of children.

It is relatively uncontroversial to say that parents have significant responsibility for children's health, but we need to be clearer about who counts as a parent, and why parents are responsible. It is important to distinguish between biological, legal, and social parents. A social parent is an adult who interacts regularly with a child over an extended time period with many of those interactions concerning the child's health, safety, and overall development. A social parent assumes significant responsibility for a child's well-being and development, and is recognized by others as having it. Social parents have accepted, if not always voluntarily assumed, responsibilities for care in a context in which "parental rights and obligations are attached to socially constructed roles" (Brake 2010: 151). Social parents may relinquish their responsibility when options such as adoption and foster parenting are available. Should parental roles unfairly distribute the work of caring for children, they could be critiqued for injustice, but until roles are transformed, social parents have assumed that work.

Social parents may discharge some of their responsibility by arranging for others to meet a child's needs, but nevertheless know a child well and interact regularly with him or her. A child's legal parent may fail to fulfill the role of social parent, culpably so if other social parents do not pick up the slack, and many biological parents will never know or engage with their genetic or gestational children. By contrast, extended kin, stepparents, and some long-term paid caregivers, often without the legal status of parent, may serve as a child's social parent.

Responsibility for Children's Health

If social parents assume significant responsibility for a child's health, what does that entail? Who else shares responsibility? To what standard of health are they required to aspire? Few would argue that parents are solely responsible. Medical professionals, occasional caregivers, teachers, social workers, youth program leaders, those who design and market products that affect children's health, and the state all plausibly share responsibility to keep children healthy. Some acquire responsibility in virtue of their roles or when their activities can predictably be expected to affect children's health. Some acquire a duty of rescue by becoming aware of a child in crisis. The state bears some responsibility for meeting the needs of its members.

Both the state and members of the community other than a child's parents are widely recognized to have a range of legitimate concerns that extend beyond children's interests. The state's legitimate concerns include the interests of adult citizens, non-citizen residents, and needy members of the international community. Other individuals and groups may be legitimately concerned with their own projects, health, and the flourishing of other adults they care about. Given the need to balance interests, it is implausible to expect those with responsibility for children's health, including their social parents, to strive always to maximize children's health and wellbeing.

We nonetheless frequently encounter references to the "best interests" of children in policy and legal contexts. The United Nations Convention on the Rights of the Child dictates: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (UN General Assembly 1989: article 3.1). Parents are assigned primary responsibility for children's care and it is expected that "the best interests of the child will be their basic concern" (UN General Assembly 1989: article 18.1), while article 24 of the convention outlines children's right to the "highest attainable standard of health." This could mean that parents would be obliged to make significant sacrifices to make generally healthy children better off.

In contrast to policy documents, philosophers who discuss children's interests find the requirement to maximize those interests vague, since children have as yet no stable sense of what makes for the best life for them. It is also too strict, as individuals with responsibility for children's health have other morally acceptable priorities. Søren Holm raises both objections: "There is no way family decision-making can make the best interest of the child paramount in real life. The interest of other family members must almost always play a role and there is furthermore in many cases no clear answer as to what the best interest of the child is" (Holm 2008: 22). A more plausible approach holds parents and others accountable for aiming to provide children with minimally decent care. For example, David Archard writes: "The state should . . . always be seen as a 'positive' guarantor that every child within its jurisdiction enjoys a minimally decent upbringing" (Archard 2004: 215).

What constitutes minimally decent care? The capability approach, developed by Martha Nussbaum (2006) and Amartya Sen (1985), is a useful way to think about this question. On this approach, justice requires us to aim at universal access to important capabilities. The resources people need to develop and sustain capabilities differ depending on their traits (what some need to be mobile will differ from others, depending on their ability to walk) and social context (for some access to clean water might require long journeys). A capability approach to identifying minimally decent care is preferable to one that identifies a minimal bundle of resources children require because of the former's recognition of the impact of individual differences and social circumstances on the ability to realize important capabilities even when supplied with similar resources. The capability approach also reminds us that justice for children requires not only resources, but also people to interact with them in ways that develop their basic capabilities.

Lists of basic capabilities can be controversial, but not as controversial as accounts of the best life. Some capabilities such as the ability to survive and be healthy, the capacity to engage in various social relationships, and the ability to move about in and have some control over one's material environment, will be relatively uncontroversial. Minimally decent care will be care that strives to develop children's basic capabilities.

Theoretical Frameworks Explaining Responsibility for Health

What theoretical framework best explains parental responsibilities? The main contenders are claims about children's rights, and claims about the need to respond to dependency and vulnerability with care. Appeals to rights may be grounded in protection of choices (agency rights) or interests (welfare rights). Rights put limits on acceptable interactions others can have with a rights holder. Advocates of children's rights typically argue that: "children move gradually from having their rights primarily protect their interests to having their rights primarily protect their choices" (Brennan 2002: 62). For most advocates of children's rights, rights are ultimately grounded in what promotes one's most significant interests (Brennan 2002: 63; Brighouse 2002: 40; see also Archard 2004). On a rights-based approach, minimally decent care would be care that promotes children's most significant interests (for instance by developing their basic capabilities).

Children's interests in care will not be served by giving them rights only insofar as they are capable of making informed choices. Children who will predictably die before maturity and those who will not become autonomous will not have their interests respected if rights are grounded solely in potential for autonomy, or self-direction. Any rights-based approach should reflect a broader account of capacities worthy of moral respect (including the ability to enter into morally valuable relationships) (see Mullin 2011).

Rights-based approaches need not ground parents' responsibilities for children's health solely in children's significant interests, as children are not the only ones affected by their poor health. Children are societies' means of sustaining themselves over time. The social contributions children can make when they mature gives another reason for the state to ensure that parents assume some responsibility for children's health.

The second major theoretical approach focuses on obligations to respond to dependency (a need to rely extensively on others for survival and flourishing) and vulnerability (susceptibility to physical and emotional harm) with care. Children have significant and unavoidable dependency and are vulnerable because of their relatively fragile physicality and need for support to develop capacities important to their future. Physically or

emotionally damaging interactions that affect children not only cause temporary suffering and suspension of ability to engage in activities (as with adults). They also prevent children from developing basic capacities.

Martha Fineman (2010) and Eva Kittay (1999) emphasize the importance of recognizing vulnerability and unavoidable dependency, including that of children. Since children share vulnerability and dependency with others, including often their parents, this puts limits on requiring those with responsibility for their care to make children's interests paramount. No one should be expected to compromise their own basic needs, or the basic needs of others in their care, to maximize children's interests.

To understand the obligation to respond to dependency and vulnerability with care, we must define "care": "Care may be said to include everything we do directly to help others to meet their basic needs, develop or sustain their basic capabilities, and alleviate or avoid pain and suffering, in an attentive, responsive and respectful manner" (Engster 2005: 55). Everyone inevitably experiences periods of both vulnerability and dependency and so all of us are indebted to others' care for our health and our lives. Societies are not sustainable without extensive provision of care. Given the care that all have received and may urgently need in the future, and the stake members of a society share in its sustainability, both basic fairness and the moral value of belonging to a caring society make *prima facie* calls upon all who may meet dependency and vulnerability with care to do so. This is particularly true for care of children whose future prospects are affected dramatically by its lack.

Primary responsibility for children's health falls upon parents who have assumed that responsibility in a social context. However, unmet needs and broader social causes of poor health make claims upon all with ability to respond—even if only by supporting state mechanisms to afford children a social safety net. Robert Goodin (1985: 779) argues that responsibility to meet vulnerable people's needs includes responsibility to assist those allocated primary responsibility, to set up collective mechanisms to respond to need, and to monitor the failures of others to meet their primary responsibility. Daniel Engster, in addition, draws our attention to the importance of ensuring that social allocation of responsibilities to care is not unjust (Engster 2005: 66).

Care ethics insists on the importance of thinking about both those who receive and those who provide care, with the latter's interests putting limits on any maximizing claims about those of the former. It recognizes social interests in raising children to be productive members of society, and avoids a narrow (economic) construal of productivity. A society will only be sustainable if its children develop capacities to serve as providers of care, and recognize a responsibility to do so.

Rights-based approaches that recognize the importance of significant interests and care ethics approaches both attribute direct moral status to children. This means children are held morally considerable in their own right: "If an entity has moral status, then we may not treat it in just any way we please, we are morally obliged to give weight in our deliberations to its needs, interests or well-being" (Warren 1997: 3). Both approaches assign responsibility to other actors to meet children's most significant interests.

Children's rights to care will differ considerably from more prototypical rights to limit others' interference with the rights holder. Some theorists worry that emphasis on children's rights will therefore encourage children and parents to have the wrong kind of attitude toward what needs to be a supportive and emotionally close relationship, by pitting children (or at least their advocates) against parents and demanding that parents do not interfere with their children (O'Neill 1989). However, children's rights are not

primarily rights to freedom from interference, and insistence on their rights may be strategically important as a way to emphasize children's moral status: Appeals to rights remind us of "the independent standing of the child, and the centrality of her interests in determining policy" (Brighouse 2002: 36). Care ethics can additionally draw attention to injustices in the allocation of responsibilities for children's care, both in terms of the burdens on children's parents (especially mothers), and the inequities that result for children when the only resources available to meet their needs are those possessed by their families. The two approaches, in the versions sketched above, are not fundamentally incompatible.

Examples Highlighting Shared Responsibility for Children's Health

The remainder of this essay will present five instances in which parents have some, but not all responsibility for children's health, and discuss how that responsibility must be shared with others, including the state. The first draws attention to the gendered nature of some aspects of responsibility for children's health, and the importance of context for balancing the interests of mothers and children.

Infant Feeding

Infant feeding, before children can eat solid foods, can involve either breastfeeding or formula. There are clear health advantages to breastfeeding, but the extent of the advantage depends on the ability of families to access high-quality alternatives. When formula is affordable and clean water is easily available, the main health advantages are lowering the risk of gastrointestinal and ear infections (Wolf 2006). There are many claims about other health benefits from breastfeeding, such as reducing childhood obesity, but evidence is not always compelling, with small sample sizes and no adjustment for other factors that may lead to differences, or signs of only modest benefits (Armstrong and Reilly 2002: 2003). When alternatives to breastfeeding do not compromise children's ability to lead minimally decent lives, it is important to recall that a standard of maximizing children's health is too high, particularly when breastfeeding involves significant burdens on the mother.

By contrast, in situations where formula is of low quality, or clean water is not reliably available, health advantages are huge: "suboptimum breastfeeding, especially non-exclusive breastfeeding in the first 6 months of life, results in 1.4 million deaths and 10 percent of disease burden in children younger than 5 years" (Black et al. 2008: 243). In countries where more impoverished families live, only 47–57 percent of infants under two months old, and far fewer older children, are exclusively breastfed (Black et al. 2008: 250). Yet studies of infants in low-income countries show that breastfeeding significantly reduces child death and disease (Black et al. 2008: 250). This points to the clear difference social context makes in determining the relative merits of different approaches to infant feeding—and to the need to regulate claims about safety of infant formula to reflect that context. The extent of maternal responsibility to breastfeed, since based on provision of minimally decent care, will depend upon the safety and quality of available alternatives. Either when social context makes infant formula unavailable or unreliable or when a child's particular health needs make formula feeding a poor alternative (as when infants cannot tolerate formula, or risk very significant negative outcomes

from gastrointestinal infections), breastfeeding may be important to protect children's basic capabilities.

Because only women can breastfeed, they bear the burdens associated with it—burdens that may be psychological (attitudes towards the display of breasts, or sexuality and breastfeeding, as outlined in Kukla (2006)), but can also include prolonged pain and discomfort in breastfeeding (cracked and bleeding nipples, blistering, exhaustion, and infections like mastitis). In a study (based on a small sample), several women found breastfeeding more painful than labor and childbirth (Kelleher 2006: 2731). Breastfeeding women have increased nutritional needs, and may need to monitor their diet and refuse medications in order not to compromise their breast milk. Problems with breastfeeding and decisions not to breastfeed often involve guilt, shame, and feelings of failure in a context in which public health messages emphasize the superiority of breastfeeding over formula feeding (Kukla 2006). Given the range of potential burdens on women, more balanced public health messages about infant feeding choices should be encouraged.

Evidence is clear that mothers with working conditions less favorable to breastfeeding (no or short paid maternity leave, little opportunity to take breaks to pump, no facility for keeping pumped milk) are less likely to initiate or continue breastfeeding (Kelly and Watt 2005). As a result children whose mothers are in lower socioeconomic classes are far less likely to be breastfed. Justice requires measures to ensure that breastfeeding is accommodated and supported (for instance, with the ability to pump at work, and public provision of medical advice for breastfeeding women who forego regular medication) whenever it is important to providing minimally decent care. Societies that share in funding the potentially increased health costs associated with formula feeding (such as more infections in infants) have reasons beyond a commitment to protecting children's basic capabilities to support breastfeeding. However, support for breastfeeding should not make women who cannot or choose not to breastfeed feel that they have failed their infants. When breastfeeding is undertaken even though not required for minimally decent care, an increase in the share of childcare done by parents who are not breastfeeding would help compensate for the increased burden of mothers who do.

Obesity

Undernutrition is the cause of extensive death and disease in children: "Maternal and child undernutrition is the underlying cause of 3.5 million deaths, 35 percent of the disease burden in children under 5 years and 11 percent of global DALYs [that is, disability-adjusted life years]" (Black et al. 2008: 243). Parents are not typically blamed for undernutrition (supposing they live in impoverished conditions). Undernutrition instead raises questions about the responsibility of states to allocate more fairly the resources available within them, and of other states (and individuals) to provide international assistance. There are effective interventions available to remedy undernutrition, such as access to a larger supply of food and provision of missing micronutrients (Bhutta et al. 2008: 417). By contrast, child obesity raises questions about parental responsibility.

Child obesity affects more than one-fifth of children in developed countries, with considerable impact on future health (increased risk of cancer, cardiovascular problems, and diabetes) and current health (physical and psycho-social) (Lotz 2004). Public health authorities are often reluctant to intervene directly with family practices around food intake and exercise, because this would require fairly extensive interference with parental

liberty, although interventions would be justified by risk of harm to children's health that undermines their development of basic capabilities. Instead public health interventions are typically indirect, such as education campaigns, or campaigns to provide information about nutrition or limit portion size in restaurants.

Mianna Lotz recommends direct intervention in the form of mandatory obesity programs—parents would have to get medical advice and monitoring, supply nutritious food, limit high-fat and high-sugar foods, and get children to exercise (Lotz 2004: 291). However, this may require parents to change their own patterns of eating and physical exercise; nutritious food can take more time to prepare than higher calorie alternatives (and be more expensive/less available); and parents of older children may have limited ability to control what their children eat and how often they exercise. To achieve short-term reductions in children's weight, families must change their lifestyles considerably, including reducing sedentary activities such as watching television and using computers. To be sustainable, these changes likely need to be supplemented by broader societal changes in what are often termed "obesogenic" societies (including limiting the significant exposure children have to advertising of foods high in fat and sugar, reducing portion sizes in restaurants, and making more low-cost opportunities for physical activity available). Moreover, few direct interventions in family practices have been proven to be effective in sustaining long-term weight loss in children. Holm argues that there are "no known interventions targeted at individuals and families that lead to long-term sustainable reductions in obesity" (Holm 2008: 23). Clearly we cannot support invasive interventions in the absence of evidence they are effective.

Despite Lotz's careful use of the term "parents," most public health and media coverage of obesity tends to differentially blame mothers, who are often culturally expected to buy and prepare food and monitor children's behavior (Maher et al. 2010: 240). This not only excludes fathers from sharing responsibility, but also ignores the significant contribution that socioeconomic class makes to obesity, with lower socioeconomic class correlating to increased obesity (Bell et al. 2009). It also ignores the extent to which older children share responsibility when they both make choices about what they eat and how often they exercise, and can understand the impact of their choices.

Parents have some responsibility for children's obesity, because they influence children's food intake, physical activity, and sedentary habits. There is some as yet preliminary evidence that a preventive approach may be effective, given that different parental feeding styles are associated differentially with obesity. The style least associated with obesity involves parents making healthy foods available but not controlling what children eat, to encourage children's development of self-control and attentiveness to internal cues of hunger (Golan and Crow 2004: 43; Patrick et al. 2005). However, if parents are to make healthy options available and let children choose, this may increase time and costs associated with meal preparation. Some new interventions include parent counseling, with emotional support for parents working to reduce their children's weight, and acknowledgment of difficulty in changing children's behavior, but there are as yet little data on their effectiveness (Golan and Crow 2004: 46). Treatment programs have to date not been proven to be effective long term.

In addition to lack of evidence about their effectiveness, we have another reason to be concerned about mandatory imposition of obesity programs. Obesity is higher in children from lower socioeconomic backgrounds and therefore poorer families are more likely to be expected to participate in mandatory programs to combat obesity than families with more resources. Mandatory participation would add stress and public oversight

to lives that are already subject to high stress and greater monitoring than wealthier families. Instead I recommend further research and public education with respect to evidence-based claims about approaches to feeding children, and support for parents who choose to seek interventions. In addition, public health campaigns should continue to support broader societal changes with respect to easy availability and advertising of high-fat and high-sugar foods, and call for better access for lower-income families to free and inexpensive forms of enjoyable physical recreation.

Exposure to Tobacco Smoke

As with obesity, there is a clear social gradient with respect to children's exposure to tobacco smoke, since people from lower socioeconomic positions are more likely both to smoke and to have their health negatively affected by smoking (Graham 2004: 104). Many advocate legislation against exposing children to secondhand smoke, because of the demonstrated negative health effects and importance of protecting children from harm (Brennan and White 2007: 105). Few may be willing to devote significant state resources to entering homes to detect parental smoking, or willing to countenance extensive interference with family privacy. However, making it illegal to smoke in enclosed spaces (homes, cars, or public spaces) could lead to significant moral pressure for smokers to reduce children's exposure to tobacco. Alternatively or additionally, states could increase taxes on cigarettes, since demand is sensitive to price. Meredith Minkler notes that "A 10% increase in the price of cigarettes, for example, has been shown to decrease teen smoking by 14%, and it is projected that a \$2 per pack tax would decrease adolescent tobacco use by almost 46%" (Minkler 1999: 129).

Monique Jonas and Simon Thornley argue that when significantly harmful effects of a parental practice are widely established, interference with parental liberty and privacy is warranted on the basis of children's interests (Jonas and Thornley 2011: 130). One could further argue there are social interests in ensuring that children's health is not diminished to the point that they require substantial care and will be less likely to make constructive contributions to their societies. Jonas and Thornley claim that smoking in enclosed spaces around children meets the following criteria for prohibiting a parental practice: It is clearly identifiable; strong evidence suggests it typically leads to significant harm; it is avoidable without great difficulty (since parental smoking could take place outside enclosed spaces they share with their children); it does not have significant benefits; harm reduction is not easily attainable by other means; there will be no troubling consequences (Jonas and Thornley 2011: 136–8).

There is significant evidence that children's regular exposure to tobacco smoke harms their health to the extent of compromising provision of minimally decent care (especially increasing children's susceptibility to respiratory illness), and the studies are high quality, with large sample sizes conducted in different settings (Jonas and Thornley 2011: 138). However, Jonas and Thornley's claim that there are no potentially troubling consequences to prohibition of parental smoking is unwarranted. If parental smoking around children is prohibited, it is foreseeable that children may be left unsupervised and/or parents may become more stressed, and so any such prohibition would need to be accompanied by some limited public provision of paid childcare, particularly when parents are in the process of ceasing or decreasing their smoking.

It is reasonable to assume that people are generally aware of the negative effects of smoking, and an educative approach (that includes limits on tobacco advertising) has not been

sufficient to stop parents and others from smoking around children. While less coercive approaches should be tried (including public funding for smoking cessation programs for smokers from lower socioeconomic classes or financial incentives for people willing both to stop smoking and having their success monitored), legislation that prohibits parental smoking around children in enclosed spaces may be called for. Any such legislation should generally not be accompanied by intrusive practices with respect to family privacy within the home. One exception would be children whose health status is such that their basic capabilities are threatened by even occasionally being in enclosed spaces with smoking parents. With the exception of these cases, any legislation would serve primarily as a clear statement of social values with respect to protection of children's health, and a way to limit children's exposure to smoking in situations that are already open to public observation.

Parental Resistance to Children Receiving Medical Treatment

Parents have legitimate interests in having intimate relationships with the children they rear, and the importance of privacy to the realization of intimacy requires a certain freedom from state or social interference with childrearing arrangements (Brighouse and Swift 2006). However, as Harry Brighouse and Adam Swift note, freedom from interference should apply only when parents are doing an adequate job (Brighouse and Swift 2006: 97), in other words, providing minimally decent care. It should not extend to resistance to medical treatment for children's serious health problems that lead to children's death or limit their basic capabilities.

In the U.S., for many years religious exemption clauses allowed religious parents "to withhold preventive and diagnostic measures from and to refuse medical care for their sick children," and most states permitted religious defenses to criminal charges of medical neglect of children (Hughes 2004: 253). In 1996, federal requirements that states have such exemptions (to be eligible to receive federal grants to deal with child abuse) were withdrawn. As a result, and due to increased attention to very difficult deaths of children whose parents believed that all healing should be spiritual (Hughes 2004), many states repealed these exemptions. It is hard to disagree with Richard Hughes' conclusion that the "duty to care is more compelling than a subjective right of religious liberty" (Hughes 2004: 265).

James Dwyer similarly argues that children should be afforded the same respect as other persons incompetent to make health care decisions, and their interests in being treated medically for significant health problems should outweigh parents' religious liberty (Dwyer 2000: 177). By contrast, Susan Dudley focuses on parents whose views about medical treatment differ from many health care professionals for cultural reasons (Dudley 2003). She recommends a balanced approach to court cases concerning children whose parents' beliefs about appropriate medical care clash with the medical establishment. She urges courts to acknowledge the complexity of the issues involved including the potential injustice of giving greater autonomy to parents whose disputes concern religion than those whose disagreements with contemporary medical practice concern culture. She recommends that courts identify the costs and benefits of different options for treating children's health problems and recognize the possibility that medical decisions may be in error (Dudley 2003: 1295).

Dudley's encouragement of dialogue between medical professionals and patients' families is to be supported, and her reminder that medical professionals can err in their

judgments is salutary. However, parents' pursuit of alternative medical treatment cannot be supported when children's basic capabilities are at serious risk and there is substantial evidence that one option will be much better for a child than the other. When the stakes are not high (with respect to provision of minimally decent care), or when the stakes are high but the balance of evidence does not strongly support one option, then it is appropriate to let parents choose. Agents of the state, such as judges, should assess not only the scale of consequences of making one choice versus another but also the presence (or lack) of expert consensus with respect to medical care.

Emotional Maltreatment

Children's emotional health was for years considered secondary to physical health, but is now widely recognized as significant. A World Health Organization Commission outlines the "importance of early child development, including not only physical and cognitive or linguistic development but also, crucially, social and emotional development" for health (Marmot et al. 2008: 1662). Children's emotional maltreatment is a better predictor of long-term negative outcomes for children than physical abuse (Glaser 2002: 698). But how should emotional maltreatment be understood?

To identify emotional maltreatment one must identify children's basic emotional needs and how parents meet them. Children need to feel safe by having parents comfort them when they are upset. When this need is unmet, they find it hard to trust anyone or develop empathy (Davidov and Grusec 2006). Children also need to experience positive emotions such as warmth and interest in relationships with their parents. These emotionally positive interactions correlate with children's developing a conscience and being accepted by others (Grusec and Davidov 2007, 301). Without them, children's basic capacity to have relationships with others is threatened. Emotional maltreatment may therefore be understood as patterns of interactions between parents and children that do not provide comfort in response to distress and do not include warmth and interest. Maltreatment may be due to various causes, including parental indifference or hostility, parents' mental health needs, and misunderstanding of children's emotional needs. When children are emotionally maltreated, their basic capabilities are threatened.

Social parents are primarily responsible for meeting children's emotional needs, but other members of society, and the state, have important subsidiary responsibilities to ensure children receive minimally decent care, as is typically well recognized when it comes to physical abuse or neglect. Public responsibilities include improving education about children's emotional needs (this could be introduced as part of health curricula in public schools), improved detection of emotional maltreatment, support for parents who need assistance in meeting the emotional needs of children, and supplying alternative forms of care when parents are unwilling or unable to meet those needs.

Given the power and responsibility of the state, its interventions should not reflect discriminatory views about who is likely to abuse or neglect children. For instance, in the U.S. there is evidence that "racism may affect child welfare decision making, leading to disproportionate scrutiny and reporting" (McRoy 2004: 483) Given that over half of children are in foster care because their caregivers have substance abuse problems, it is also important for the state to develop better substance abuse and treatment plans (McRoy 2004: 479). Finally, once there is greater public awareness of the nature of children's emotional needs, it will be important for all adults to recognize a responsibility to report suspicions of emotional maltreatment—with the understanding that suspicions

will be investigated, and may lead to better education of parents, or treatment and support, rather than only removal of children from their homes.

Conclusion

Parents, particularly mothers, are sometimes assigned too much responsibility for children's health and expected to aim at too high a standard. Parents share responsibility with the state, and with other individuals and groups, including those who are in a position to detect that children's basic emotional needs are not being met, and those who can effect changes in policy that affect children's lives. Public policies should aim to ensure that children receive care that develops their basic capabilities. Since these policies include those that distribute social resources in ways that impact on children's health, citizens who choose government representatives, as well as the state representatives themselves, all bear a share of the responsibility for protecting children's health.

Related Topics

Chapter 32, "Reproductive Testing for Disability," Adrienne Asch and David Wasserman
Chapter 34, "Family Caregivers, Long-Term Care, and Global Justice," Lisa Eckenwiler

References

- Archard, D. (2004) *Children: Rights and Childhood*, 2nd edition, London: Routledge.
- Armstrong, J. and Reilly, J. (2002) "Breastfeeding and Lowering the Risk of Childhood Obesity," *Lancet* 359: 2003–4.
- Bell, K., McNaughton, D. and Salmon, A. (2009) "Medicine, Morality and Mothering: Public Health Discourses on Foetal Alcohol Exposure, Smoking around Children and Childhood Overnutrition," *Critical Public Health* 19 (2): 155–70.
- Bhutta, Z., Ahmed, T., Black, R., Cousnes, S., Dewey, K., Giugliani, E. et al. (2008) "What Works? Interventions for Maternal and Child Undernutrition and Survival," *Lancet* 371: 417–40.
- Black, R., Allen, L., Bhutta, Z., Caufield, L., de Onis, M., Ezzati, M. et al. (2008) "Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences," *Lancet* 371: 243–60.
- Brake, E. (2010) "Willing Parents: A Voluntarist Account of Parental Role Obligations," in D. Archard and D. Benatar (eds.) *Procreation and Parenthood*, Oxford: Oxford University Press, pp. 151–77.
- Brennan, S. (2002) "Children's Choices or Children's Interests: Which Do Their Rights Protect?" in C.M. MacLeod and D. Archard (eds.) *The Moral and Political Status of Children*, Oxford: Oxford University Press, pp. 53–69.
- Brennan, S. and White, A. (2007) "Responsibility and Children's Rights: The Case for Restricting Parental Smoking," in S. Brennan and R. Noggle (eds.) *Taking Responsibility for Children*, Waterloo, ON: Wilfrid Laurier Press, pp. 97–111.
- Brighouse, H. (2002) "What Rights (if Any) Do Children Have?" in C.M. MacLeod and D. Archard (eds.) *The Moral and Political Status of Children*, Oxford: Oxford University Press, pp. 31–52.
- Brighouse, H. and A. Swift (2006) "Parents Rights and the Value of the Family," *Ethics* 117 (1): 80–108.
- Davidov, M. and Grusec, J. (2006) "Untangling the Links of Parental Responsiveness to Distress and Warmth to Child Outcomes," *Child Development* 77: 44–58.
- Dudley, S. (2003) "Medical Treatment for Asian Immigrant Children: Does Mother Know Best?" *Georgetown Law Review* 92: 1287–307.
- Dwyer, J. (2000) "Spiritual Treatment Exemptions to Child Medical Neglect Laws: What We Outsiders Should Think," *Notre Dame Law Review* 76: 147–77.
- Engster, D. (2005) "Rethinking Care Theory: The Practice of Caring and the Obligation to Care," *Hypatia* 20 (3): 50–74.
- Fineman, M. (2010) "The Vulnerable Subject and the Responsive State," *Emory Law Journal* 60: 251–75.
- Glaser, D. (2002) "Emotional Abuse and Neglect," *Child Abuse and Neglect* 26: 697–714.

- Golan, M and Crow, S. (2004) "Parents Are Key Players in the Prevention and Treatment of Weight-Related Problems," *Nutrition Reviews* 62 (1): 39–50.
- Goodin, R. (1985) "Vulnerabilities and Responsibilities: An Ethical Defense of the Welfare State," *The American Political Science Review* 79 (3): 775–87.
- Graham, H. (2004) "Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings," *The Milbank Quarterly* 82 (1): 101–24.
- Grusec, J. and Davidov, M. (2007), "Socialization in the Family: The Roles of Parents" in J. Grusec and D. Hastings (eds.) *Handbook of Socialization: Theory and Research*, New York: Guilford Press, pp. 284–308.
- Holm, S. (2008) "Parental Responsibility and Obesity in Children," *Public Health Ethics* 1 (1): 21–9.
- Hughes, R. (2004) "The Death of Children by Faith-Based Medical Neglect," *Journal of Law and Religion* 20: 247–65.
- Jonas, M. and Thornley, S. (2011) "Smoky Rooms and Fuzzy Harms: How Should the Law Respond to Harmful Parental Practices?" *Public Health Ethics* 4 (2): 129–42.
- Kelleher, C. (2006) "The Physical Challenges of Early Breastfeeding," *Social Science and Medicine* 63: 2727–38.
- Kelly, Y. and Watt, R. (2005) "Breast-Feeding Initiation and Exclusive Duration at 6 Months by Social Class: Results of the Millennium Cohort Study," *Public Health Nutrition* 8 (4): 417–21.
- Kittay, E. (1999) *Love's Labor: Essays on Women, Equality and Dependency*, New York: Routledge.
- Kukla, R. (2006) "Ethics and Ideology in Breastfeeding Advocacy Campaigns," *Hypatia* 21 (1): 157–80.
- Lotz, M. (2004) "Childhood Obesity and the Question of Parental Liberty," *Journal of Social Philosophy* 35 (2): 288–303.
- Maher, J., Fraser, S. and Wright, J. (2010), "Framing the Mother: Childhood Obesity, Maternal Responsibility and Care," *Journal of Gender Studies* 19 (3): 233–47.
- Marmot, M. and Field, S., Bell, R., Houweling, T. and Taylor, S. (2008) "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *Lancet* 372: 1661–9.
- McRoy, R. (2004) "Expedited Permanency: Implications for African-American Children and Families," *Virginia Journal of Social Policy and Law* 12 (3): 475–89.
- Minkler, M. (1999) "Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End," *Health Education Behavior* 26: 121–41.
- Mullin, A. (2011), "Children and the Argument from 'Marginal' Cases," *Ethical Theory and Moral Practice* 14: 291–305.
- Nussbaum, M. (2006) *Frontiers of Justice: Disability, Nationality, Species Membership*, Cambridge: Cambridge University Press.
- O'Neill, O. (1989) "Children's Rights and Children's Lives," in O. O'Neill (ed.) *Constructions of Reason*, Cambridge: Cambridge University Press, pp. 445–63.
- Patrick, H., Nicklas, T., Hughes, S. and Morales, M. (2005) "The Benefits of Authoritative Feeding Style: Caregiver Feeding Styles and Children's Food Consumption Patterns," *Appetite* 44: 243–9.
- Sen, A. (1985) *Commodities and Capabilities*, Oxford: Oxford University Press.
- UN General Assembly (1989) *Convention on the Rights of the Child*, United Nations, Treaty Series. Available at: <http://www.unhcr.org/refworld/docid/3ae6b38f0.html> (accessed July 18, 2012).
- Warren, A. (1997) *Moral Status: Obligations to Persons and Other Living Things*, Oxford: Oxford University Press.
- Wolf, J. (2006), "What Feminists Can Do for Breastfeeding and What Breastfeeding Can Do for Feminists," *Signs: Journal of Women in Culture and Society* 31 (2): 397–424.

Further Reading

- Brake, E. and Millum, J. (2012) "Parenthood and Procreation," *Stanford Encyclopedia of Philosophy*. Available at: <http://plato.stanford.edu/entries/parenthood/> (accessed May 28, 2012).
- Nettle, D. (2010) "Why Are There Social Gradients in Preventative Health Behavior? A Perspective from Behavioral Ecology," *PLoS ONE* 5 (10): e13371.