Analysis of critical features for establishing a monitoring system for childhood obesity: Ethics assessment
Report 2
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About the CO-OPS Collaboration
The Collaboration of Community-based Obesity Prevention Sites (CO-OPS Collaboration) is an initiative funded by the Department of Health and Ageing for 4 years until 2011. The initiative is managed by the WHO Collaborating Centre for Obesity Prevention and Related Research at Deakin University; and works in partnership with the University of Sydney and the University of Melbourne in delivering project outcomes.

Over recent years it has become clear that there are many community-based projects / programs promoting healthy eating, physical activity and healthy body weight in Australia and that evidence and knowledge is rapidly emerging from these projects. There is also a rapidly growing body of research evidence around the reasons this work is important, but additionally - advances in our understanding about ‘what works’ to improve healthy eating and increase levels of physical activity. CO-OPS is working to develop a collaborative approach to assist the translation and exchange of this knowledge amongst policy makers, practitioners and other key stakeholders who are involved in community-based obesity prevention initiatives or are working in policy and planning areas broadly relevant to obesity prevention.

As part of this process this evidence resource has been developed - it includes a series of evidence summaries designed to assist with policy and practice-level decisions and some useful resources to assist with using the evidence. This resource and additional resources are also available via the CO-OPS website at www.co-ops.net.au

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Analysis of critical features for establishing a monitoring system for childhood obesity

Executive Summary

Childhood obesity is a major health concern in Australia. It is associated with preventable, costly and chronic diseases and tracks strongly into adulthood. Monitoring the prevalence of childhood obesity is vital to targeting the groups at highest risk, formulating appropriate obesity-prevention interventions and policies and checking progress toward achieving obesity-related objectives. Determining the true prevalence of childhood obesity in Australia is difficult because there is currently no systematic method for collecting and reporting national and local childhood obesity prevalence data in a timely and consistent manner.

Several international organizations are regularly collecting epidemiological data on childhood obesity. Existing childhood obesity monitoring systems can be used to inform the design of an Australian childhood obesity monitoring system. In 2010, a three-part study was commissioned by the Collaboration of Community-based Obesity Prevention Sites (CO-OPS Collaboration) to provide advice on the way forward to address Australia’s lack of a systematic method for consistently and promptly collecting and reporting childhood overweight and obesity prevalence data. The research was led by three academics from Deakin University with extensive experience in the area of childhood obesity; Dr Peter Kremer, Dr Andrea de Silva-Sanigorski and Associate Professor Evie Leslie.

The final report, Analysis of critical features for establishing a monitoring system for childhood obesity, consists of three parts: the design of an obesity monitoring system, the ethical implications of implementing such a system and the best ways to communicate the information back. The purpose of the report was to make recommendations for the design of an Australian childhood obesity monitoring system based on established international systems while taking into consideration the Australian context.

Part 1:
Monitoring System Design aimed to identify, from the literature, ‘best practice’ in terms of design for a childhood obesity monitoring system and make recommendations for the establishment of a childhood obesity monitoring system in Australia. Recommendations to highlight include:

- An Australian childhood obesity monitoring system should be school-based
- If monitoring data are to be collected on children who are not of school age, then these data should be collected through the coordinated efforts of state-wide primary care organizations
- Data should be collected using pilot-tested standardized protocols and a web-based data management system
- Careful monitoring of potential negative consequences and adverse outcomes should be an integral component of the system
- Properly informed passive (otherwise known as ‘opt-out’) consent should be used

Part 2:
Ethics Assessment aimed to examine the ethical considerations relevant to Australia for using a passive parental consent method within a childhood obesity monitoring system. Conclusions to highlight include:
- Opt-out consent has several advantages to its use, including higher participation rates and more accurate obesity prevalence estimates
- Opt-out consent is used internationally for childhood obesity monitoring purposes
- Opt-out consent is used in Australia, but not for the collection of anthropometric data
- Properly informed opt-out consent should meet the ethical guidelines applicable to consent in Australia

**Part 3:**
Feedback Systems aimed to gather parents’ and adolescents’ opinions, thoughts and suggestions about ways of providing sensitive information to parents about their children and to adolescents about themselves, the appropriateness of the language used to talk about weight, body size and weight status with parents about their children and with adolescents about themselves and the types of resources about growth and body size that parents and adolescents want to receive. Two small focus groups with parents of 2- to 11-year-olds and two small focus groups of adolescents aged 12-17 years were conducted in Geelong, Victoria to collect information. Focus group highlights include:
- Parents and adolescents prefer accurate, sensitive, accessible and convenient information on healthy lifestyles and weight status
- Parents and adolescents prefer to have information delivered to them by specified health professionals with a good knowledge of nutrition and general health
- Parents and adolescents may be more responsive to lifestyle information and potential options for change, rather than simply receiving a weight status label
Introduction

Obesity is a public health issue in Australia and worldwide [1]. International [2, 3] and national experts [4-7] consider routine measuring and weighing of children to be an important part of a population approach to preventing childhood obesity. Several international organisations regularly collect epidemiological data for the purposes of monitoring childhood overweight and obesity prevalence. Such programs include the Nutrition and Food Security Programme of WHO/EURO (23 countries participate) [8], the National Child Measurement Programme in the United Kingdom (UK) [9] and several programs established by state governments in the United States (US) [10, 11].

In Australia, there is currently no systematic method for collecting and reporting national and local childhood overweight and obesity prevalence data in a timely and consistent manner [5, 12]. However, population monitoring to track trends in the prevalence of overweight and obesity in childhood and adolescence has been identified as a priority [5-7], and establishing a childhood obesity monitoring system would be an important next step in Australia’s national obesity-related initiatives (see Report 1: Analysis of critical features for establishing a monitoring system for childhood obesity: Monitoring system design for a detailed review). Recommendations have been proposed for the design of such a system and the full description of these recommendations can be found in Report 1: Analysis of critical features for establishing a monitoring system for childhood obesity: Monitoring system design. In brief, it has been recommended that a nationally representative sample of children should be used to establish obesity prevalence rates. The system should be school-based and, if possible, school nurses should collect anthropometric data. If data are to be collected on children who are not of school-age, then these data should be collected through the coordinated efforts of state-wide primary healthcare organisations. Passive (‘opt-out’) parental consent is the preferred method of consenting for data collection.

Establishing a childhood obesity monitoring program necessitates consideration of a number of ethical issues, including consent, privacy and confidentiality. Some existing and well-established international monitoring systems utilise passive (‘opt-out’) parental consent [9, 13], which involves informing parents of the data collection purposes and procedures and assuming that their child may participate in data collection unless the child’s parent(s) indicates otherwise. This differs from active (‘opt-in’) parental consent because parents are not required to provide written consent if they wish for their child to participate in data collection. The National Child Measurement Programme in the UK, which has the world’s largest database of its kind, uses passive parental consent [9]. Although passive parental consent has been successfully utilised abroad, whether this type of consenting process is appropriate for use in an Australian childhood obesity monitoring system deserves attention. The primary aim of this report is to examine the ethical considerations relevant to Australia for using a passive parental consent method within an obesity monitoring system, including gathering opinions from relevant ethical institutions such as the National Health and Medical Research Council (NHMRC). A secondary aim of this report is to consider associated ethical issues raised by the proposed design of an Australian childhood obesity monitoring system.

Methods

We undertook a systematic approach in order to identify potential sources of information (research and grey literature) related to this topic.

Information Sources

Five databases (MEDLINE, ScienceDirect, PubMed, The Cochrane Library, Google Scholar) and the internet search engines Google and Google Australia were used to collect sources using the search terms in Table 1.
Table 1. Search terms used to collect research and grey literature relevant to using a passive consent method within an Australian obesity monitoring system.

<table>
<thead>
<tr>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>opt-out consent, mechanisms, schools</td>
</tr>
<tr>
<td>opt-out consent, Australia, school, measuring obesity</td>
</tr>
<tr>
<td>opt-out consent, BMI, schools</td>
</tr>
<tr>
<td>passive consent, schools, BMI, screening</td>
</tr>
<tr>
<td>passive consent, children, BMI, reporting</td>
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<tr>
<td>opt-out consent, ethical considerations, issues, children</td>
</tr>
<tr>
<td>de-identification, sensitive information, children</td>
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<tr>
<td>requirements, opt-out consent, BMI</td>
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<tr>
<td>parents, opt-out consent, children, BMI</td>
</tr>
<tr>
<td>de-identification, sensitive information, children, BMI, monitoring</td>
</tr>
<tr>
<td>requirements, opt-out consent, BMI, surveillance</td>
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In addition to collecting sources via databases and search engines, relevant documents were identified through consultation with experts in the field and key organisations responsible for ethics and the conduct of population-level research. These organisations included the National Health and Medical Research Council, the Department of Human Services, the Maternal and Child Health Service, the Department of Education and Early Childhood Development and the Australian Bureau of Statistics. Additionally, information specifically pertaining to Australian population-level monitoring was obtained primarily through internet searches of Australian government websites and Google Australia. In cases where identified sources cited relevant references, the original references were collected and included in this report where appropriate.

Information Selection

One researcher reviewed titles and abstracts for the results of each of the terms per database and engine search. Where database and engine searches produced more than 100 results, only the first 100 results were reviewed. This occurred in a few instances for searches in databases and Google Australia (five searches ranged from 110 to 246 results per search) and in several Google searches (five searches ranged from 152 to 158,000 results per search). Full papers of potentially relevant references were independently reviewed by two researchers.

Research versus monitoring

Before considering the ethical issues raised by a childhood obesity monitoring system, it is important to distinguish between monitoring and research. Monitoring is designed to track trends in a population (for example, paediatric obesity rates) and variables already known to be relevant (for example, physical activity-related behaviours) [5]. On the other hand, research aims to explore or determine causal...
pathways and create new insight and knowledge, sometimes in relation to specific populations or characteristics [5]. Monitoring data are often reported in more routine or systematic ways compared to research (for example, on a yearly basis) [5].

Public Health Monitoring in Australia

The Australian Government has monitored population health indicators for decades [14]. The Australian Bureau of Statistics (ABS) has been the leading government-funded body in the provision of these population statistics and trends [14]. The information collected by the ABS is classed as ‘population monitoring’ as most of it is used to define trends or changes in population characteristics over time [14]. The data compiled by the ABS can be used by the government to design policies and programs and to allocate funding [14, 15]. There are many population-based monitoring programs currently undertaken in Australia. Three of these programs that are relevant to the implementation of a monitoring system for obesity include the Census of Population and Housing, the National Health Survey and the National Nutrition Survey [14].

The Census of Population and Housing

The Census of Population and Housing (Census) is an official periodic collection of data on many aspects of the Australian population, such as income levels, population numbers, and health indicators [16]. It is administered every five years and can be completed electronically or using a mailed survey [16]. It is the largest statistical collection obtained by the ABS [16]. The Census is compulsory as dictated by the ‘Census and Statistics Act 1905’ (Census Act) [17], and if it is not completed or contains false information, responsible individuals are considered to have committed an offence under Australian law and may be fined [17]. The Census Act also details privacy and data handling requirements for the Census [18]. The Census provides a full and accurate dataset and helps to determine the progress of the nation in many areas. It also helps the Government to establish priorities when allocating funding [16].

National Health Survey

The National Health Survey (NHS) was initiated in 1995 by the ABS and has been conducted every three years since 2001 in Australia [19]. The survey is distributed to a randomised sample of the population under the authority of the Census Act [17]. Every individual in each state or territory has an equal chance of being selected to complete the survey [19]. Under the Census Act, individuals who are selected are obliged to participate. While self-reported height and weight have been collected in previous NHS assessments, height and weight measurements were conducted on persons five years of age and older for the first time in the 2007-08 survey [19]. The results are used to track the progress of the population and to identify priority areas for research, policy and funding [19].

National Nutrition Survey

The National Nutrition Survey (NNS) is another ABS survey used to explore health characteristics within the Australian population. The NNS was conducted in 1995 on a subsample of the 1995 National Health Survey respondents [20]. The NNS was conducted under the Census Act on a voluntary basis [20]. Specially trained nutritionists conducted interviews in participants’ homes to collect information on food and beverage intake and food-related habits and attitudes [20]. Physical measurements were also taken. The overall objective was to assist with the design and implementation of Australia’s Food and Nutrition Policy and future revisions of the Recommended Dietary Intakes and National Health Goals and Targets [20]. Written consent was obtained for interviewers to measure the height, weight, blood pressure, waist and hip circumference of participants aged 16 years and older [20].
Consent for a childhood obesity monitoring system

Although the Census Act gives the Australian Government the authority to collect select survey data, in its present form, it does not provide the Government with the authority to conduct height and weight measurements. Specifically, the Census Act describes the collection of forms and answering of questions, but it makes no mention of collecting information via direct measurement. Anthropometric monitoring in Australia is currently reliant on the collection of returned and signed consent forms (active consent) [4]. Even if the Census Act were to be amended to include provisions to be able to perform direct measurements, it would be recommended that informed parental consent for children to be measured is obtained as this may help to avoid opposition to the program [4].

Comparing Passive and Active Consent

Obtaining a sample that is representative of the population is vital to meeting the aim of an obesity monitoring system and it is important that the consent method utilised will yield accurate results and the highest participation rates [4]. There is evidence to suggest that the type of consent used in obesity research and monitoring can affect estimated obesity prevalence rates [13, 21, 22]. For example, in the US state of Utah’s Height and Weight Measurement Project [13], investigators examined the effects on participation rates and obesity prevalence estimates of using active versus passive parental consent. When compared with students from schools where passive parental consent was used, response rates and obesity prevalence estimates were lower for students from schools where active consent was used.

The response rates for active and passive parental consent were 74.4% and 90.7%, respectively. Likewise, when Grimmett et al. [21] invited 786 parents to allow their children to participate in a school-based weight-screening intervention utilising active consent, only 51% of parents provided consent. Additionally, much lower overweight and obesity prevalence rates were reported for the sample compared to previously reported estimates for a similar group of children [21]. In contrast, Rudolf et al. [22] observed only 8 cases out of over 1000 in which parents refused to consent to their child being weighed and measured when using a passive parental consent method. In this instance, the prevalence rates that were estimated from the sample closely matched those of the previous population estimates [22]. Taken together, these findings suggest that to achieve accurate calculation of obesity prevalence estimates and increase the generalizability of results [21], passive parental consent is more advantageous than active parental consent [13].

There are several other disadvantages to using active parental consent. These include often not being able to determine the reasons for which consent forms are not returned (loss of consent form [4], inconvenience of returning consent form [23] or decline to participate), participant and personnel burden, and expense. In the previously mentioned weight screening program using an active parental consent process, Grimmett et al. [21] reported that almost half (46%) of the 786 parents invited to participate in the program did not respond to the invitation and only 3% of parents actively declined participation and cited reasons for their decision. Active consent may require personnel to perform rounds of follow-up in order to obtain a high response rate [24], which may become burdensome and expensive [24].

In their paper on informed consent in schools, Ross et al. [24] discussed the merits of passive and active consent. They examined the assumption that active consent provides greater assurance that a parent has indeed seen, read, understood and signed the consent form. The authors contend that there is no guarantee that these things have happened and, for this reason, suggest that requiring active parental permission may not be more ethical than using passive parental consent [24].
Type of Consent for an Australian Obesity Monitoring System

It has been demonstrated that consent type can ultimately affect participation rates and overweight and obesity prevalence estimates, particularly in paediatric obesity research [4, 13, 22]. Passive parental consent is preferred as it not only generates higher participation rates, but it is less affected by volunteer bias, and obesity estimates are more likely to be accurate using this method [13]. Passive parental consent also involves less administrative burden than the active consent method, which requires the return of written consent from all participants’ parents [24].

Stubbs and Achat [4] argue that the only way for a childhood obesity monitoring system to work in Australia is for passive parental consent to be incorporated into the design of the system. They suggest that this type of consent normalises the measurement process by making it a routine activity, which can make parents and children less likely to be opposed to participation [6]. This is the key to obtaining an accurate estimate of the prevalence of childhood obesity in the population [4]. Furthermore, Stubbs and Achat [4] also suggest that anthropometric monitoring fits the Australian National Health and Medical Research Council’s [25] criteria for ‘low risk’ research, which others have argued should automatically necessitate passive consent [26, 27].

Passive parental consent is already being used to collect nationally representative data in the Australian Early Development Index (AEDI). The AEDI is being conducted by the Centre for Community Child Health at the Royal Children’s Hospital, Melbourne, in partnership with the Telethon Institute for Child Health Research in Perth [28]. AEDI data are collected from teachers who complete the AEDI checklist for children in their first year of full-time school using a web-based data entry system [28]. The AEDI is not compulsory; a passive parental consent process is used in which schools advise parents in writing of the school’s participation in the AEDI and parents can opt-out of data collection by contacting their child’s teacher or school principal [29]. A high participation rate has been achieved using passive parental consent. In 2009, data were collected for 261,203 children (97.5% of the estimated 5-year-old children) by 15,528 teachers from 7,423 Government, Catholic and Independent schools (95.6% of schools with eligible children) [28].

The ethical requirements for consent, privacy and confidentiality

Ethical Requirements of Consent

The Australian National Statement of Ethical Conduct in Human Research (National Statement) generally applies to human research; however, it contains information pertaining to consent and ethical conduct that would be relevant to establishing an obesity monitoring system. According to the National Statement, ethical conduct involves acting with respect and concern for fellow human beings [25]. In turn, respect for others ‘involves giving due scope to people’s capacity to make their own decisions’ (page 19 in [25]). Consent should be a voluntary choice, and it must be based on sufficient information and adequate understanding of what the project entails and the implications of participation [25]. Although the National Statement does not explicitly address passive consent, it has been argued by some that this form of consent maintains informed individual decision making in line with the respect and concern for fellow humans necessary for ethical conduct [4].

According to the National Statement, in projects that involve children, the child’s level of maturity and capacity to understand what the project entails must be considered when deciding whether the child’s consent is necessary for participation in research [25]. In particular, the National Statement states that the consent of young people of developing maturity is required when those young people are able to understand information relevant to consent [25]. However, this consent is not sufficient and must accompany the consent of parents or guardians [25]. Although the National Statement does not attach fixed ages to this group of people, it would be reasonable to assume that most of the children involved in an obesity monitoring system would fall into this category. Therefore, consent from children should be sought in addition to parental consent.
The ethical requirements of privacy and confidentiality

In Australia, federal government agencies must uphold the Information Privacy Principles (IPPs) of the ‘Privacy Act 1988’ when collecting personal information. The IPPs regulate how federal government agencies collect, store, use and disclose personal information [34]. The first three principles are particularly relevant to the collection of obesity monitoring data. In brief, these principles stipulate that personal information should be collected fairly and lawfully, persons from whom information is collected should be informed of the purpose of data collection and personal information should not be collected in an intrusive manner [34]. The Privacy Act, in conjunction with the Census Act, also protects the confidentiality of personal information as it lawfully binds government agencies, such as the ABS, from providing to anyone information that may be used to identify an individual [16].

With anthropometric data collection in schools, children sometimes have the tendency to share their results and discuss them amongst one and other, which could lead to bullying, stigmatisation or low self esteem [35]. This could also diminish the privacy of students, as they may feel pressured to disclose their results. Likewise, the confidentiality of students could be at risk as students may pass along information about peers to others. The confidentiality and privacy of measurements should be addressed with children in order to prevent discussion of results [35].

Information

The ethical requirements of consent involve the provision of information and ensuring the capacity to make a voluntary choice [25]. Parents (or guardians) and children should always receive enough information to know what is involved in the process and feel empowered to voluntarily participate [24]. If opt-out consent were to be used, then this information should be provided in a plain language statement which must clearly detail the mechanisms in which parents can opt out on behalf of their children, how their children can opt out on the day of measurements, for what and how long the data will be used, and who will be measuring the children (personal communication with NHMRC). Parents must be made aware of the option to opt out and the details of how and by when this should be done (for example, by writing to the school) (personal communication with NHMRC). Children must also be clearly informed that their participation is voluntary and they may verbally withdraw before or at the time of measuring [25]. It is essential that information that is given to parents and children is easy to read and understand [30], so plain language statements should be provided to parents and children in the language spoken at home.

A plain language statement could be complimented with an information session to ensure that potential participants understand the measurement process and can make their own informed decision [24, 25]. Previous research has indicated that using the standard consent process and complementing it with an extra education session with a qualified person is the most reliable way to improve participants’ understanding [31]. An information session would also provide an opportunity for prospective participants to ask questions and discuss information and their decision, which is an important aim of the process of seeking consent [25].

In a monitoring system that operates on an annual basis, it would be expected that each year parents and children are re-informed of the measurement process and given the opportunity to opt out, as is the case in the US state of Arkansas [32]. It has previously been recommended [25] that parents are continually educated and reminded of the monitoring protocol, allowing for informed and continued permission for long-term projects.
Ethical Considerations Related to Measurement Personnel

School Nurses or Other School Personnel

It has been recommended that an obesity monitoring system in Australia be school-based and that height and weight measurements should be performed by school nurses whenever possible. However, the relationship between a school nurse, or other member of school personnel, and a student would constitute a dependent or unequal relationship, which may impair the student’s ability to voluntarily consent [25]. A dependent or unequal relationship may also compromise the voluntary character of a student’s decision to participate even if the adult is not the one taking the measurements, but is involved in facilitating or implementing the project [25]. In the event that a dependant relationship exists, it is required that the data collector reassures the participant ‘that refusal to participant in, or withdrawal from, the research will not result in any discrimination, reduction in the level of care or penalty’ [25].

All nurses in Australia are required to follow the ‘Code of Ethics for Nurses in Australia’ [36]. The code details a number of things that are relevant to a school-based obesity monitoring system. For instance, Value Statement 5 stipulates that nurses value informed decision making. The code states: Nurses value the legal and moral right of people, including children, to participate whenever possible in decision making concerning their nursing and health care and treatment, and assist them to determine their care on the basis of informed decision making [26]. Value Statement 7 says that nurses value ethical management of information. The code states: Nurses respect each person’s wishes about with whom information may be shared and preserve each person’s privacy to the extent this does not significantly compromise or disadvantage the health or safety of the person or others. Nurses comply with mandated reporting requirements and conform to relevant privacy and other legislation. Ethical information management also requires nurses to maintain information and records needed in order to provide quality nursing care. Nurses do not divulge information about any particular person to anyone not authorised to have that information [26].

These two value statements cover material relevant to decision making, privacy and confidentiality relevant to obesity monitoring systems.

Primary Healthcare

It has been recommended that if height and weight data are to be collected on children who are not of school-age, then these data should be collected through the coordinated efforts of state-wide primary healthcare organisations. Like nurses, physicians would also be considered to be in dependent or unequal relationships with participants. However, in this case, it would be the relationship between the physician and the parent (rather than that between the physician and the young child) that would potentially influence a parent’s decision to consent to monitoring. Physicians also have a code of ethics, which is set forth by the Australian Medical Association (AMA) [37]. This code includes several elements that refer to patients participating in research.

While monitoring is not technically research, these elements of the code could still be relevant to an obesity monitoring system incorporating passive parental consent. Relevant elements of the code include [37]:

• Consider first the well-being of your patient...
• Treat your patient with compassion and respect...
• Make sure that all research participants or their agents are fully informed and have consented to participate in the study. Refrain from using coercion or unconscionable inducements as a means of obtaining consent...
• Respect the participant’s right to withdraw from a study at any time without prejudice to medical treatment...
• Make sure that the patient’s decision not to participate in a study does not compromise the doctor-patient relationship or appropriate treatment and care.

Under this code of ethics, physicians may also be required to offer feedback and suggestions to parents if a weight problem is identified in order to improve the well-being of the child. Therefore, if a monitoring system was designed to be carried out within doctors’ offices in Australia, those doctors would be given the responsibility of judging the situation and the patient’s wellbeing and in providing feedback if they deem it appropriate.

External Personnel
Though it has been recommended that school nurses be utilised in a school-based obesity monitoring system, external personnel could be utilised to measure and weigh children. These could be parents or hired data collection personnel. Even though they would be external in terms of being employed by the school, these people, especially parents, could potentially be in dependent or unequal relationships with some of the students. They could be the parents of some students or the parents of the friends of some students. Considering this possibility, in terms of avoiding dependent or unequal relationships, it could potentially be more ethical for children to be measured and weighed by personnel unknown to them or their parents.

An additional consideration is the confidentiality obligations of external personnel who may collect data. As these people may not be bound by ethical guidelines set by their professions, they may need to sign a Deed of Confidentiality.

To further minimise potential harm to participants, under law, it is essential that individuals who will be measuring children in Australian schools have appropriate checks: ‘Working with Children’s’ checks in Victoria, New South Wales and Western Australia; police checks Northern Territory and South Australia or a ‘Blue card’ in Queensland [38]. The Australian Capital Territory and Tasmania currently have no requirements, but local organisations (such as schools) may have adopted their own requirements.

Summary and conclusions
This report provides an examination of the ethical considerations relevant to Australia for using a passive consent method within an obesity monitoring system. Passive consent has several advantages to its use and is already being utilised when collecting nationally representative data in Australia. Properly informed passive consent should meet the ethical guidelines applicable to consent in Australia. Other ethical issues raised by the proposed design of an Australian childhood obesity monitoring system are also addressed in this report, including those of privacy, confidentiality and dependent relationships.

References

Crowther, K., C. McIntosh, and M. Kristiansen, Developing and piloting a web-based tool to facilitate the informed consent process. Nurs Instruct J Nurs Instruct, 2008. 28(2): p. 59-64.


