

When Parents and Clinicians Disagree

Odette Hutchinson considers the balance being struck by the courts between medical paternalism and parental wishes

NHS Trust v. A [2007] EWHC 1696 (Fam)

Most decisions made by parents on behalf of their children are benign and without controversy. One area in which real and potential conflicts between parental autonomy and the interests of children are exposed, with unsettling frequency, is in the realm of contested medical consent cases.

A parent who has 'parental responsibility' under the Children Act 1989 may consent to medical treatment on behalf of that child, where the child lacks Gillick¹ competence. The exercise of this parental autonomy is governed by the best interests test; parental choice must then be exercised in accordance with this test and parental decisions inconsistent with this principle are at risk of legal challenge.

In circumstances where parents withhold their consent to treatment, which is deemed by doctors to be in the child's best interests; approval can be sought from the courts. The court's power to authorise the medical treatment of children derives from its inherent jurisdiction, wardship and more recently from statute.

The issue of contested medical treatment was addressed again in July 2007 in NHS Trust v. A. This case is unusual because despite the very grave consequences for the child if she did not undergo the recommended treatment, no positive order was sought to compel the parents to take their child to hospital for treatment and no suggestion was made in the instant case that she should be taken from them to facilitate this. Holman J preferred instead to rely on indications by the parents of their respect for the 'inherent objectivity and wisdom of the court'. In selecting the path of least resistance, Holman J perhaps sought to repair the damaged relationship of trust between the parents and clinicians.

The facts

The Trust in this case sought a declaration to the effect that it would be lawful for doctors to perform a bone marrow transplant (BMT) on the seven-month-old child suffering from a terminal genetic defect. The proposed treatment, whilst potentially offering a cure for the child, would be prolonged, painful and distressing and carried with it significant risks. A's parents contended that she should enjoy the quality of life that she had remaining to her and withheld their consent to the treatment.

The parents in this case were well educated, practicing Christians with a detailed grasp of the medical issues surrounding their child's condition

and treatment. Their approach to A's illness and prognosis was reasoned and analytical and both parents had co-operated fully with the medical advice and treatment up until the point of the instant case. A's parents accepted as medically certain that their child would die without the BMT, however their strong religious convictions were manifested in a belief that God has the ability to heal their child and a fervent hope that this would be the case.

Unlike most contested medical consent cases the child in this case was well and in remission. Crucially, she was living at home with her family in a loving and caring environment at the time of the application. Regrettably, by this point A had already endured a period of serious illness in hospital, where she had received protracted and damaging treatment, during which she was in obvious pain and distress.

There was no dispute in this case as to the medical evidence, thus it was medically certain (as acknowledged by the parents), that without a BMT, A would die within a year. If a BMT was to be carried out, it was crucial that it was undertaken whilst A remained well and before the disease became active again.

In the circumstances of this case, the doctors estimated that the BMT had a 50 per cent chance of effecting a lasting cure, so that A would enjoy a normal life expectancy. There remained, however, a 10 per cent prospect that she would die during and as a direct result of the treatment; a 30 per cent chance that the treatment would not be successful and she would die from her underlying HLH; and a 10 per cent prospect that although she may survive the treatment it would cause some significant impairment. In the event of a successful BMT, it was highly probable that A would be left infertile.

Holman J concluded that the religious views of the parents were not to be taken into consideration, as an objective balancing of A's best interests was not affected by whether her parents adhered to one particular belief or another. The case was decided on the basis of medical knowledge, the evidence, and reason. The central principle in this case was, with all the relevant factors considered, what was in the objective best interests of the child? In granting the application by the Trust, Holman J held that a 50 per cent prospect of a full and normal life (albeit an infertile one) when set against the certainty of death outweighed all other considerations and disadvantages.

Comment

It is now settled law that parents do not have a right to demand specific medical treatment for their child. Following the decision in *Re T*² however, judicial strength was given to the argument that scope exists for a 'genuine difference of opinion between the judge and parents, enabling parents to legitimately refuse treatment on behalf of their child in circumstances where the decision is not founded in 'scruple or dogma'. *Re T* was refreshing not simply because of the courts willingness to look beyond the medical evidence, which unanimously concluded that the treatment was in the child's best interests; but additionally because of its consideration of 'broader considerations' as important determinants in the best interests test. *NHS v. A* is instructive because it does not appear to be a case in which such 'genuine scope' existed and in which the 'broader considerations' were clearly not as compelling. In the light of this decision, it would seem that the decision in *Re T* is truly exceptional.

In our society, with its unprecedented life expectancy, we tend to deny death all together and instead celebrate new forms of medical technology designed to forestall death. In this context it is perhaps unsurprising that the decision in *NHS Trust v. A*, eschewed overt deference to parental know-how; and of course candour towards death and the limitations of modern medicine.

Yet in practical terms Holman J's judgement maintained that it is the parents of A, who retain ultimate control over whether or not their child undergoes the BMT. Of course a cynic would comment that this power or choice is illusory in nature, given the legal armoury poised in the wings, in the event that A's parents decline to 'respect the inherent wisdom and objectivity of the court'. n

¹ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)

² [1997] 1 All ER