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Legal Basis for the Court's Intervention over Medical Treatment of Children

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Abstract
In the medical treatment of children disputes can arise where parents cannot agree with one another, or where the medical treating team and parents cannot agree, this will generally be those situations where the medical team and parents are at loggerheads over what is to be done. This paper focuses on the latter kind of dispute. The paper considers solely on the threshold question: at what stage should the court be permitted to make decisions on behalf of very ill children when parents and the medical treating team cannot agree? It focuses specifically on minors who are not competent to give consent (non- Gillick -competent children), therefore, it does not concern itself with the issues around children who are competent to consent to treatment. It first gives a brief account of the ethical position in peadiatrics treatment. It then reviews the role of the courts, using a number of high-profile cases as examples. There are arguments and concerns about the erosion of what some regarded as the territory of parental authority. That parents have both the primary responsibility and the primary right to make decisions in respect of their sick children. The paper centres on those situations where a court is called upon to intervene in decisions about a child's medical care and how such disputes are resolved. It reveals that disputes come to the courts when there is a serious risk that the parent's decision will result in significant harm to the child. It concludes that the courts have made it clear that courts have the authority to make medical decisions on behalf of children and that the threshold for judicial intervention is the welfare of the child, often referred to as the 'best interests' approach.

Keywords: consent, parental responsibility, medical decision-making, court's involvement, ethics, best interest, children, parental refusals
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1.Introduction

Children have been variously referred to in the law as infants, minors, adolescents, youths, juveniles, and the like. The terms *children* and *child* are adopted throughout this paper for purposes of consistency. For most purposes in this paper, anyone under 18 years of age is considered a child[1] and anyone 18 years of age or older is considered an adult. In the private law context, law has assumed sometimes confusing and often conflicting attitudes towards children. Thus, in private law, children are viewed as lacking the capacity in the areas of contract and property law for example, traditionally under the law, children are viewed as being incapable of entering into binding contracts or disposing of their property or to make a will and in need of protection from adults. The law therefore, has assumed a protective posture in dealing with children in these areas. On the other hand, in the area of tort law, children traditionally have been regarded as liable for their torts where they have caused injury to others or property damage. In contrast to the protective role assumed by the law in other areas of law, in tort, the law here has accorded children a degree of autonomy and has held them accountable for their actions.

The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, parents can and must make those judgments. Children are generally considered incompetent to provide legally binding decisions regarding their health care, and parents or guardians are empowered to make those decisions on their behalf. Depending on the circumstances and the context, children sometimes decide certain matters for themselves, especially if they are emancipated, that is, free from parental authority and living independently. Ss children, however, are treated as adults for some purposes and therefore can make decisions for themselves and engage in certain activities that are denied to children generally.

Medical decision-making for children is an emotion-laden area, rarely do parents make decisions that do not seem to be in the best interests of their children. While there are good reasons to support the decision-making authority of parents in the medical setting, parents' rights in this respect are not absolute. Parental authority is

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[1] Article 1 Convention on the Rights of the Child (Convention on the Rights of the Child (CRC), adopted 20 November 1989 (entered into force 2 September 1990) GA Res. 44/25 (1989), UN Doc A/RES/44/25 (1989), UNTS 1577). See also Article 2 African Charter on the Rights and Welfare of the Child (ACRWC) (1990), OAU/Doc/CAB/LEG/24.9/49 (1990) entered into force Nov 29 1999

however not absolute and when a parent acts contrary to the best interests of a child, the state may intervene. One of the most basic values protected by the state is the sanctity of human life. The doctrine of *parens patriae* holds that the state may act as 'surrogate parent' when necessary to protect the life and health of those who cannot take care of themselves, including children.[1] In general, parental decisions should be accepted except in those rare cases where the decision of a parent places the child at substantial risk of serious harm. In these cases, the state acts *in loco parentis*, in the place of the parents. According to the Supreme Court in *Prince v. Massachusetts*, '*... neither rights of religion nor rights of parenthood are beyond limitation'*.[2] Where parents fail to provide their children with adequate medical care, the state is justified to intervene. However, since the state should usually defer to the wishes of the parents, it has a serious burden of justification before abridging parental autonomy by substituting its judgment for that of the parents.[3] In essence, parental decision-making rights are linked to the duty to promote the child's wellbeing and can be set to one side where the welfare of the child is at risk. Where a disagreement arises between parents and health personnel, further discussion should take place and a second opinion offered, but it may be necessary to seek legal advice. In the interim, only emergency treatment that is essential to preserve life or prevent serious deterioration should be provided.

The best interests' standard is the threshold most frequently employed in challenging a parent's refusal to provide consent for a child's medical care. Providing treatment to children is not usually problematic but occasionally issues do arise, at the same time peadiatricians look at some of the key legal and ethical issues relating to the provision of treatment for this group of patients. The ethical challenge is being able to identify when a concern for children's welfare needs to start giving way to a respect for parent's choices. A doctor would also be concerned to avoid any civil liability by meeting his duty of care. Often when a parent refuses appropriate and necessary treatment for their child, healthcare professionals may be uncertain of their position legally and therefore seek authorisation from the court prior to proceeding. Doctors may still feel some apprehension in making some decisions for sick children, particularly in these litigious times. This, from the point of view of healthcare professionals, shows the importance of consulting the court before acting against a parent's wish if they are to avoid litigation and to ensure that the welfare of the child is upheld.

Treatment refusal is an important issue that threatens the ongoing therapeutic relationship between the health-care team and families. Fortunately, most disagreements between clinicians and parents regarding treatment decisions for children are resolved within the health-care team/family dyad or with the objective advice of other clinicians or clinical ethics services. In some situations, conflict may arise if the values and beliefs of parents differs from those of the health care team or even from each other. Although most conflicts involve a remediable breakdown in communication, sometimes a genuine clash in values exists. Although many parental decisions differ from the recommendations of the health care team, it is argued that parental decision-making ought to be accepted unless it is obvious that the decision is patently not in the best interest of the child. Nonetheless, parental authority should be critically scrutinised whenever there is strong disagreement about medical facts, prognosis, risks and benefits of ongoing treatment, and if the child is likely to suffer harm as a result. If disagreement persists, the physician should provide the opportunity for a second opinion, either within his or her own centre or from another centre. Practitioners may not withdraw from a patient's care without providing a referral. In the case, *Re Green*, court ruled as follows; '*…We are of the opinion that as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition.'*[4] A well-settled exception to the parental consent requirement is the life-threatening scenario in which the child requires immediate medical attention in order to preserve his life. In such cases, courts have supported intervention on the child's behalf, over parental objection. The court found the life-threatening/non-life-threatening distinction a useful tool, particularly in cases invoking a claim of religious freedom. A locus classicus case is *People ex rel. Wallace v. Labrenz*, in which the parents, Jehovah's Witnesses, refused to consent to a blood transfusion for their child based on Biblical teachings that blood is the life of the flesh and that it should not be consumed in any way, which they read as an admonition against any injection of blood into the body. The court upheld the trial court's finding that the child was a dependent child and it ordered placing the child in the custody of a guardian for the purpose of the guardian giving consent to the transfusion.[5] Similarly, in *State v. Hamilton*,[6] in which the court upheld a trial court's finding that a 12-year-old child with a cancerous tumor in her leg was a neglected child because her parents had rejected medical treatment based on their belief that God alone can cure illness.[7] On the

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[1] Yolanda V. Vorys, (1981) 'The Outer Limits of Parental Autonomy: Withholding Medical Treatment from Children,' *Ohio State Law Journal* 42: 815–816. See also Kathleen Knepper, (1994) 'Withholding Medical Treatment from Infants: When Is It Child Neglect?' *University of Louisville Journal of Family Law* 33: 1–2.

[2] *Prince v. Massachusetts*, U.S. 321: 158 (1944).

[3] per Justice Thomas W. Caldecott: In *re Phillip* B. 92 Cal. App. 3d 796, 801

[4] *Re Greene* 448 Pa. at 348, 292 A.2d at 392.

[5] *People ex rel. Wallace v. Labrenz*, 411 ill.618 104 NE 2d 769

[6] *State v. Hamilton,* 657 S.W.2d 424 (Tenn. Ct. App. 1983)

[7] The background of the case can be found in *NEWSWEEK*, Oct. 3, 1983, at 57

other hand, the life-threatening exception is best summarised in In *re Green*:[1]

> We are of the opinion that as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition.[2]

A life-threatening emergency may arise when consultation with a person with parental responsibility is impossible, or the person with parental responsibility refuses consent despite such emergency treatment appearing to be in the best interests of the child. In such cases the courts have stated that dispute should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health. But, nontherapeutic procedures, such as immunisation and treatments of doubtful benefit, consent is required and should be given by all those who are in a position to do so therefore health practitioners must not give such procedures or treatment to children without obtaining consent. Many physicians believe strongly that parental decisions to refuse immunisation are contrary to the best interest of a child, and a few would argue that state intervention is justified on that basis. Most who feel this way appeal to the best interest standard. But parents may also use the best interest standard in refusing immunisation on behalf of their children. While most mandatory vaccines are effective and safe, a small possibility of adverse reactions exists. For example, a parent might reasonably conclude that refusing the measles vaccine is in the best interests of a child living in a community with a high immunization rate. In such a community, the prevalence of measles is sufficiently low that an unimmunized child would be unlikely to contract measles and therefore, could be safely spared any possible risks associated with the vaccine. Under such circumstance, the absence of agreement of those with parental responsibility, treatment ought not to be carried out.[3] At the same time the harm principle could also be used here under very restrictive conditions (such as an ongoing epidemic) to justify state intervention to force immunisation of children for the good of others in the community. In these cases, the unimmunised child represents a risk to others in the community, thus justifying state interference with parental decisions to withhold vaccination from their children.[4] In sum nontherapeutic procedures, such as immunisation and treatments of doubtful benefit need consent given by all those who are in a position to do so, it is only in an emergency, that health professionals must act promptly to avoid serious harm or death.

2.Consent

Consent is a basic requirement for medical treatment. Medical treatment without consent constitutes a trespass, an actionable tort. The failure to obtain informed consent constitutes a battery under the law, for which a physician might be either criminally or civilly liable. To be valid, consent must be informed—that is, the person giving it must have been apprised of and understand the risks entailed in the medical procedure and given freely by someone with the legal capacity to do so. Under the law, children are generally considered incompetent to provide legally binding consent regarding their health care, parents or guardians are generally empowered to make those decisions on their behalf, and the law has respected those decisions except where they place the child's health, well-being, or life in jeopardy. Hence, children, unless they are emancipated or an emergency exists and the parent is unavailable, cannot consent for themselves; rather, a parent's consent is required. Whether or not a child is competent to give their consent to medical treatment, there are usually others who can consent on their behalf. Such a proxy consent must be taken in the child's best interests to be valid. The right to such a proxy consent is usually part of being a parent and of having parental responsibility. Where a child lacks capacity to consent (that is, not Gillick competent),[5] consent can be given on their behalf by any one person with parental responsibility. Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent. Usually only one consent is required; it is then legally unnecessary to seek the involvement of others. So even though a number of people can consent, only one is required. This leads to the question that who has/ can have parental responsibility to consent? It is the following members of the child's family, namely; child's biological mother, child's biological father, if parents are married at the time of the child's birth or where the father is named on the child's birth certificate. Other relatives for

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[1] *Re Greene* 448 Pa. at 348, 292 A.2d

[2] Ibid at 392

[3] Within that group is included sterilisation and nontherapeutic circumcision. See *Re J (Specific Issue Orders:Child's Religious Upbringing and Circumcision)*[2000] 1 FLR 571. See also, Thorpe LJ's dictum in *Re C (Welfare of child: immunisation)*[2003] EWCA Civ 1148 [2003] 2 FLR 1095 CA , where immunisation is added to the list. In these cases, when irrevocable disagreement exists between those with parental responsibility, it is best to seek the guidance of the courts.

[4] Diekema, Douglas S. and Marcuse, Edgar K., (1998) 'Ethical Issues in the Vaccination of Children,' in *Primum Non Nocere Today*, eds., G.R. Burgio and J.D. Lantos (Amsterdam: Elsevier), pp. 37–48.

[5] Gillick competence – In United Kingdom, people aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances. Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. The standard is based on the decision of the House of Lords in Gillick *v. West Norfolk and Wisbech Area Health Authority*. The test was proposed by Lord Scarman. Cited as; *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

example, grandparent can also apply for special guardianship which also confers parental responsibility, also adoptive parents have parental responsibility and so are in the position to give consent for treatment of the child. There is no hierarchy of parental consent. It is therefore not usually necessary to seek the opinion of all those who hold parental responsibility. If both parents cannot be won round to the physician's point of view, or reach a satisfactory compromise, treatment can be proceeded with the consent of the one parent. It is then for the dissenting parent to seek the intervention of the courts. It is advisable to bring in an experienced colleague or others who know the family, such as their health visitor, to ensure that everything has been done to seek agreement, and that the doctor's actions are clearly in the child's best interests. In a non –emergency but essential case: consent is only required from a single parent. Medical care should proceed on that basis and is the responsibility of the disagreeing parent to seek judicial review if they choose. Consent must be informed, and given freely by someone with the capacity to do so. When those with the capacity to consent refuse to do so and the matter involves serious consequences for the child, then arises the need seek the guidance of the courts.[1]

A well-settled exception to the parental consent requirement is the life-threatening scenario in which the child requires immediate medical attention in order to preserve his life. In such cases, courts have supported intervention on the child's behalf, over parental objection.[2] For example, in a situation where there is a genuine emergency, and it is not possible to contact the parents in the available time; here, the law allows a doctor to provide life-saving treatment without consent on the basis of ' necessity.'[3] There are times when it may be acceptable to examine the child without consent: when the child's injuries necessitate prompt medical intervention, when seeking consent might put the patient in serious danger, or when it might hamper a police investigation. If none of these pertain, health professionals do not proceed without consent. Lord Denning described consent as a 'flak jacket'- *only one was required to protect the doctor from the 'claims by the litigious' in matters of consent*.[4] Where persons with parental responsibility disagree as to whether certain procedures are in the child's best interests, it is advisable to refer the decision to the courts. The Supreme Court affirmed this notion in *Cruzan v. Director, Missouri Department of Health*[5], ruling that '…a *competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment'*.[6]

3.Parental responsibility

Parental responsibility is a legal concept relating to the authority to make decisions on behalf of children. Although parents have the right to raise their children according to their own values, common law dictates that these rights are present to be of benefit to the child and should be concerned primarily with the child's best interests. In both domestic and international law parental rights are subsumed into the broader concept of parental responsibility. As John Eekelaar has observed, parental responsibility '*can represent two ideas: one that parents must behave dutifully towards their children; the other that responsibility for child care belongs to parents, not the state* '.[7] These meaning can be found in the UN Convention on the Rights of the Child (CRC).[8] The first important principle of parental responsibility is that the parental role is one of responsibility to children rather than proprietary rights over them.[9] This fundamental principle is also recognised as a right and guiding principle of international children's rights law in the CRC.[10] The interests of children provided both the normative justification for parental authority and the limits on its acceptable use. This point was expressed by Lord Fraser:

> [P]arental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child, and towards other children in the family.[11]

Lord Scarman emphasised the role of welfare in providing the limits of that parental authority:

> [W]hen a court has before it a question as to the care and upbringing of a child it must treat the welfare of the child as the paramount consideration in determining the order to be made. There is here a

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[1] Ross-Trevor J. (1996) 'Informed consent and the treatment of children'. *Nurs Stand*: 10:46-8.

[2] Lainie Friedman Ross, (1998) *Children, Families, and Health Care Decision-Making* (New York: Oxford University Press, p. 135 see also Yolanda V. Vorys, 'The Outer Limits of Parental Autonomy: Withholding Medical Treatment from Children,' *Ohio State Law Journal* 42 (1981): 815–816.

[3] *Re R (Wardship: Consent to Treatment)* [1992] Fam 11 (CA).

[4] *Re W (A Minor) (Medical Treatment)* [1992] All ER 627,CA

[5] *Cruzan v. Director, Missouri Department of Health* 497 U.S 261 (1990)

[6] ib

[7] Eekelaar, J. (1991) ' Parental Responsibility: State of Nature or Nature of the State ? ' *13 Journal of Social Welfare and Family* Law 37

[8] Convention on the Rights of the Child Article 18(1): 'Parents … have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern '.

[9] Taylor, Rachel.(2019) "Parental Decisions and Court Jurisdiction: Best Interests or Significant Harm?." Parental Rights, Best Interests and Significant Harms: -*Great Ormond Street Hospital v Gard*. Ed. Imogen Goold, Jonathan Herring and Cressida Auckland. Oxford: Hart Publishing, 2019. 49–66, at 51.

[10] Art. 3 CRC

[11] *Gillick v. West Norfolk and Wisbech Area Health Authority* (Gillick) [1986] AC 112 at 170;

> principle which limits and governs the exercise of parental rights of custody, care and control. It is a principle perfectly consistent with the law's recognition of the parent as the natural guardian of the child: but it is also a warning that parental right must be exercised in accordance with the welfare principle and can be challenged, even overridden, if it be not.[1]

The implication is that a parent who exercises parental decision making in a manner that does not further the interests of the child is acting outside of the proper scope of their authority and is vulnerable to court intervention to restrain that excess. The second important principle of parental responsibility is that responsibility for children upbringing lies primarily with parents rather than with the state. The legal concept of parental responsibility is well elucidated by Baroness Hale in her well-known explanation of the law in *Williamson:*

> Children have the right to be properly cared for and brought up so that they can fulfil their potential and play their part in society. Their parents have both the primary responsibility and the primary right to do this. **The state steps in to regulate the exercise of that responsibility in the interests of children and society as a whole.**[2] But 'the child is not the child of the state' and it is important in a free society that parents should be allowed a large measure of autonomy in the way in which they discharge their parental responsibilities.[3]

As Baroness Hale observes, although parents have the primary role, the state also has a legitimate role in regulating parental decisions in the interests of children and society. Rarely, parents make decisions that do not seem to be in the best interests of their children. In an emergency, if the child cannot give consent and nobody with parental responsibility is available, legal and ethical treatment that is necessary to preserve the life, health or wellbeing of the child can be given. An emergency can probably best be described as a situation where the requirement to provide treatment is so pressing that there is not time to seek alternative sources of consent. Lord Scarman in *Gillick v West Norfolk and Wisbech Area Health Authority* explained this as follows:

> Emergency, parental neglect, abandonment of the child, or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent.[4]

There is full support from the law with respect to family autonomy and for those with parental responsibility to bestow their chosen values of their children. Parental decision-making is supported by the constitutional right of privacy in the family. Rights to privacy and family life are constitutionally protected and they are the foundation cases for an entire constitutional theory of family.[5] There are arguments and concerns about the erosion of what some regarded as the territory of parental authority. It is further argued that children have the right to be properly cared for and brought up so that they can fulfil their potential and play their part in society and it is their parents that have both the primary responsibility and the primary right to do this. There are good reasons for this presumption to respect parental autonomy and family privacy. First, it is the presumed that because most parents care about their children, they will usually be better situated than others to understand the unique needs of their children, desire what's best for their children, and make decisions that are beneficial to their children. Second, parents are often in a better position to weigh the competing interests in making a final decision for their child than outsiders. Third, parents should be allowed to raise their children according to their own chosen standards and values and to transmit those to their children. Lastly, in order for family relationships to flourish, the family must have sufficient space and freedom from intrusion by others.[6] Without some decision-making autonomy, families would not flourish, and the important function served by families in society would suffer. For all of these reasons, the assumption is that parents are the persons best suited and are most inclined to act in the best interests of their children, and that in most cases they will do so. In view of the words of Baker J's dictum in *Re King*:

> [I]t is a fundamental principle of family law in this jurisdiction that responsibility for making decisions about a child rest [sic] with his parents. In most cases, the parents are the best people to make decisions about a child and the state – whether it be the court, or any other public authority – has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child not being what it would be reasonable to expect a parent to give.[7]

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[1] Ibid, 184

[2] Emphasis mine

[3] *R (on the application of Williamson and others) v. Secretary of State for Education and Employment and others* [2005] UKHL 15 ; [2005] 2 All ER 1, [72];

[4] *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (Gillick) at 185

[5] S.23 1999 Constitution of the Federal Republic of Nigeria. Right to private and family life is a fundamental right in the constitution of Nigeria.

[6] Joseph Goldstein, "Medical Care for the Child at Risk: On State Supervision of Parental Autonomy," in *Who Speaks for the Child: The Problems of Proxy Consent,* eds. Willard Gaylin and Ruth Macklin (New York: Plenum Press, 1982), pp. 153–190, here pp. 158–162. See the cases; *Meyer v. Nebraska*, US 262: 390 (1923), *Pierce v. Society of Sisters*, U.S. 268: 510 (1925).

[7] *Re Ashya King* [2014] EWHC 2964 (fam); [2014] 2 FLR 855.

This dictum captures the general principle of the primacy of the parental role and describes the ordinary experience of most parents. It is, however, not intended as a complete statement of the law and it would be a fallacy to treat it as such. Although the law generally operates to inhibit unwarranted intervention in family life, the court retains a protective jurisdiction. So, while there are good reasons to support the decision-making authority of parents, in the medical setting, parents' rights in this respect are not absolute. Certainly, there are good motives for granting parents significant freedom in making health care decisions for their children, but then there are certain decisions that are sufficiently harmful that they ought not to be allowed.[1] The best interest standard has long been used to identify the threshold at which the state is justified in interfering with parental decision-making. Parental authority is not absolute and when a parent acts contrary to the best interest of a child, the state may intervene. Apart from best interest standard, harm principle provides a more appropriate threshold for state intervention. The harm principle may assist pediatricians in the difficult task of determining when it is justifiable to refer a case for judicial intervention.[2] The harm principle provides a basis for identifying the threshold for state action. The characteristic of parental decision-making that justifies interference is not that it is contrary to the child's best interest, but rather that the decision poses some harm to the child.[3]

Indeed, court recognises the fundamental right of parents to make child-raising decisions, in accordance with the principles of constitutional law, at the same time, the Court will apply strict scrutiny to determine whether the state can intervene in family decisions. This occurs where there is a collision between the parents' constitutional rights of privacy and free exercise of religion and the state's interest in protecting the child. In general, courts have gone against parents when the life of a child is endangered, but have typically given great discretion to parents in situations that are not imminently life-threatening.[4] In *Maine Medical Center v. Houle*[5] the Supreme Court of the state of Maine ruled that parents did not have the right to withhold consent for lifesaving treatment and that doing so constituted neglect. This ruling included two other important points. First, a guardian cannot withhold consent for lifesaving medical measures. Second, the ruling affirmed that children with physical or mental impairments have the same right to life as other children.[6] In sum, if the child faces high risk of loss of life or permanent injury without medical treatment, the court may intervene. If such a risk is not present, the court may not intervene.

4.Disputes between parents and healthcare professionals

Normally in a non-emergency situation, treatment cannot be given a child without consent. If the family decline consent for necessary treatment, they can seek judicial review of the case. Best practice in either case is to get second opinion before referral. If case goes to judicial review, court has to consider what is in child's best interests. Treatment can only proceed against parental wishes when a court order is in place. Medical emergencies- Doctors and healthcare staff have a duty to act in the best interest of their patients in medical emergencies. Best practice is always to attempt to gain consent, but if consent is refused then treatment should proceed. In general, parental decisions should be accepted except in those rare cases where the decision of a parent places the child at substantial risk of serious harm. In these cases, the state acts *in loco parentis*, in the place of the parents, this role of the state is recognised as constitutionally valid.[7]

4.1Treatment disagreement situations when parents and doctors disagree.

Court proceedings over a child's medical treatment almost inevitably indicate that the relationship between the parents and healthcare professionals has already seriously broken down. -The possible scenarios can be grouped into any of the following three: First, situation when health professionals withhold treatment of the sick child. Second, situation where the child is removed from hospital by the parents and the parents are seeking the alternative therapies. Third, non-emergency but life affecting treatment.

4.1.1Situation when health professionals withhold treatment of the sick child.

When it comes to a decision about medical treatment for a child the question is- should it or shouldn't it be provided? These are situations where doctors feel further active medical intervention will not change the outcome and death is inevitable, but parents disagree. A further dilemma includes those cases where, although

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[1] Strong, Carson., (1993) 'Patients Should Not Always Come First in Treatment Decisions,' *The Journal of Clinical Ethics* 4: 63–65. see also, Schoeman, Ferdinand., (1985) 'Parental Discretion and Children's Rights: Background and Implications for Medical Decision-Making,' *The Journal of Medicine and Philosophy* 10: 45–61.

[2] Diekama, Douglas S., (2004) 'Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention', *Theoretical Medicine and Bioethics* 25,243-264 at 243.

[3] ibid

[4] Holder, Angela., (1980) 'Circumstances Warranting Court-Ordered Medical Treatment of Minors,' 24 *POF 2d*: 175–177.

[5] Civil Action Docket (1974) No. 74 -145 Opinion and Order. February 14. See also *L & Med* 237 (1986-1987) 237 .

[6] Issues Law Med. 1986 Nov; 2(3):237-9. See also, Weir, Robert F,. (1977)' 14. *Maine Medical Centre v. Houle'. Ethical Issues in Death and Dying*, New York ChiChester, West Sussex: Columbia University Press,185-6. https//doi.org/10.73`12/weir91040-016 accessed 12 Feb 2022.

[7] Note 6, *People ex rel. Wallace v. Labrenz* supra

death is not inevitable, treatment is futile as the child's life is so severely impaired.[1] There are often situations where parents wish for treatment to continue, but health professionals believe that this offers no benefit to the child and may be harmful. The assessment of best interests in such cases involves weighing up the benefits of life (including an assessment of the quality of a child's life) against the harms of invasive medical treatment.[2] This is a profoundly difficult assessment to make, partly because of uncertainty about what might lie ahead for the child. Courts in these cases may authorise the withdrawal of care or agree that aggressive resuscitation would not be appropriate, at the same time prohibiting withholding of "food or nutrients, water, oxygen, or comfort care" in the case of newborn infants.[3] Exceptions are allowed also where the infant suffers from a terminal and irreversible condition that cannot, in the exercise of sound medical judgment, be corrected or where the potential risks to the child's health or life as a result of surgery or treatment outweigh the potential benefits for survival.[4]
The treatment or non-treatment of critically ill children has long generated problems and disagreement. As these dilemmas typically involve life-or-death questions, legal questions inevitably arise. Failing to meet a duty to care for a dependent, which results in that dependent's death, can amount to murder or manslaughter, depending on the accused's intention or knowledge. In *R v Arthur*[5], after the mother rejected the new-born, who had Down's syndrome, Dr. Arthur prescribed a painkiller and ordered 'nursing care only'. The child died 69 hours later. In his direction to the jury, Farquharson J noted there was no 'special law' protecting doctors, but he also pointed to the lawfulness of some omissions and of symptom relief, plus the good character and motives of the defendant, who had allegedly been following accepted practice. [6] Dr. Arthur, the paediatrician, was acquitted of attempting to murder baby John Pearson. Whereas in Re B , the Court of Appeal authorised the provision of life-saving surgery in the ' best interests ' of another new-born with Down 's syndrome, as the court found it was not the case that ' the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die '.[7] As life-sustaining technology becomes increasingly available, parents of children with severe disabilities have begun to demand medical treatments that doctors believe will have no beneficial effect. The concept of 'medical futility' encompasses treatments that may do no harm, but also are thought to do no good. It does insist that patient or parent demand does not mean that a physician has a duty to treat. No physician is obligated to administer treatment that he or she believes does not benefit the patient.[8] Life prolonging treatment is not always in the child's best interests if it increases their suffering. Treatment decisions regarding an infant should be based on the judgment that the infant will derive net benefit, and that medical treatment that is judged to be of no benefit, or futile is inappropriate and should not be offered or provided. Although decisions about withholding or withdrawing treatments when death is at hand are difficult, a broad consensus has emerged that decisions to withhold or withdraw medical interventions are ethically and legally acceptable in limited circumstances, and these decisions fall within the authority of parents or guardians in consultation with the child's physician.[9] Courts have traditionally been loath to impose on health professionals an obligation to provide medical treatment. For example, a court order may provide permission to withdraw treatment, although professionals are not obliged to do so. Professionals may feel that continuing treatment would be contrary to their professional role, and conscientiously object to providing the treatment.[10] At times, it would be permissible to withdraw life-prolonging treatment and allow the child to die, and health professionals may also decline to provide treatment on the basis that they do not consider it to be in the child's best interests. The English courts nevertheless confirmed that there would be no violation of the Human Rights Act 1998[11] if a decision not to offer life-supporting treatment was made in the best interests of the child.[12]

There are certain circumstances in which treatment is not considered to certain disabled infants three of these situations are as follows: First, when the infant is chronically and irreversibly comatose.[13] Second, when

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[1] *Portsmouth Hospitals NHS Trust v Wyatt* [2005] EWCA Civ 1181 (Wyatt).
[2] Huxtable ,R., (2012) Law, Ethics and Compromise at the Limits of Life: To Treat or Not to Treat ? (London), Routledge, 39 – 49. See British Medical Association, Withholding and Withdrawing Life-Prolonging Medical Treatment (BMA, 1999). Royal College of Paediatrics and Child Health, Making Decisions to Limit Treatment in Life Limiting and Life-Threatening Conditions in Children: A Framework for Practice (RCPCH, 2014).
[3] *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984).
[4] *In re Doe*, 262 Ga. 389, 418 S.E.2d 3 (1992).
[5] *R v Arthur* [1981] 12 BMLR 1
[6] Ibid 5
[7] *Re B (a minor) (wardship: medical treatment)* [1990] 3 All ER 927, 929 (Re B
[8] Jordan and LeBlanc, (2001) *Index Medicus* 2001; 48(4): 921-33
[9] Diekema, D.S., Botkin, J.R.(2009), 'Clinical Report- Forgoing medically provided nutrition and hydration in children', *Pediatrics*. 2009 Aug 124 (2):813-22
[10] Wilkinson, D., 'Conscientious Non-Objection in Intensive Care ' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 132 .
[11] Article 2, the right to life
[12] *A National Health Service Trust v D* [2000] 2 FLR 677. See also, General Medical Council, ' Withholding and Withdrawing – Guidance for Doctors ' (2002) www. gmc-uk.org/-/media/documents/withholding-or-withdrawing-life-prolonging-treatments-2002--- 2010-55677704.pdf accessed 23 March 2022.
[13] Ellis, T.S., (1982) Letting Defective Babies Die: Who Decides, 7 *Am. J. L. & Med*. 393; see also, Field, Martha A. (1993) Killing 'The Handicapped'—Before and After Birth, 16 *Harv. Women's L. Rev*. 79.

the provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.[1] Third, when the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.[2] This is extensively analysed in The U.S. Commission on Civil Rights Report.[3] The Commission further dismissed withholding treatment from severely disabled babies for economic reasons, stating;

> …the real economic costs associated with disability are less a function of the disability or its severity than of a policy that tends to segregate and isolate, at enormous public cost, persons considered most severely disabled.[4]

The assumption has been that the severity of the disability is the major determinant of lifetime cost and, consequently, that the more severely disabled a child may appear to be at birth, the less likely it is that the child will be able to contribute as an adult to his or her own economic sufficiency.[5] This assumption according to the Commission is a self-fulfilling prophecy: a diagnosis of severe disability leads to placement of a person in an institutional and non-work environment that significantly limits that person's capability and entails far more expense than necessary.[6] The Commission emphatically rejects the view that lifesaving medical services should be provided or denied to any group of people based on their estimated economic worth to society.[7] Much has changed, major developments in the field of prenatal diagnosis have improved medical care and outcomes for infants born with disabilities. It is now possible for parents to know if their children would be born with severe disabilities. Today, most severe disabilities are identified before the child is born, thanks to advances in prenatal screenings and diagnostic tests. In some cases, the parents may opt to terminate the pregnancy based on the results of the prenatal screening. Regarding medical decision-making for newborns with severe disabilities, it is still an ongoing debate that is likely to continue for years. Because it touches on the most basic human ardor and the social institution of the family, emotion enters into the picture as well, especially in the defective newborn cases. Until the drama is played out, the eventual outcome can only be speculated and how this medico/legal/ethical dilemma will be resolved is unclear. In spite of modern technology developments, the controversy continues. On balance, it is important to note that the Court cannot mandate any single, fixed formula for deciding when discontinuance of medical treatment might be appropriate in these situations.

4.1.2Situation where the child is removed from hospital by the parents.

There are situations where parents have identified alternative health professionals who are prepared to provide treatment, or they want to try experimental treatment which they have read about, and in some cases, parents might want traditional therapy instead. In any of these situations, the parents had removed their sick child from hospital where the child was being treated and this had in most cases resorted to intervention by the court and have generated headlines which have made high-profile legal cases circulated in the media internationally. In this section, four of the cases both in the United States of America (USA) and United Kingdom (UK) will be briefly discussed here.

The first, Chad Green case in Massachusetts.[8]

Chad Green was diagnosed at age 20 months with acute lymphocytic leukemia. His doctors recommended a program of chemotherapy, and their prognosis was that with such therapy he had a substantial chance for a cure and a normal life. His parents refused to consent to the chemotherapy and instead expressed interest in pursuing a treatment program using laetrile. A trial judge ordered them to consent to the chemotherapy treatment, and this decision was upheld on appeal.[9] The appellate court did not view this as a case in which parents wished to elect one course of treatment over another but rather as one in which the parents, contrary to the child's best interests, were refusing traditional medical treatment with promise of success while proposing no alternative treatment "consistent with good medical practice." His parents had petitioned for review and redetermination of the original order declaring him a child in need of care and protection. The trial court continued in effect the prior order and further ordered the parents to cease the laetrile treatments they had commenced since the prior court appearance. By the time the case reached the appellate court, the parents had removed Chad from the state and taken him to Mexico for further laetrile treatments at a clinic there. Nevertheless, the court decided the case in the absence of parents and child. Once again, the court upheld the trial court's order on the basis that the parents,

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[1] Phillips, Patricia M. (1992) 'Comment, Treatment Decisions for Seriously Ill Newborns: Who Should Decide?' 21 *Capital U.L. Rev.* 919.

[2] U.S. Commission on Civil Rights Report 1989. In September 1989, the issued a report, Medical Discrimination against Children with Disabilities. The Commission summarised the standard of care as follows: First, all such disabled infants must under all circumstances receive appropriate nutrition, hydration and medication. Second, all such disabled infants must be given medically indicated treatment.

[3] ibid

[4] Ibid p.3

[5] ibid

[6] Ibid p.4

[7] ibid

[8] *Custody of a Minor*, 378 Mass. 732, 393 N.E.2d 836 (1979).

[9] *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978).

against the overwhelming weight of medical evidence, were pursuing a course of treatment for their child that, aside from being useless, was actually dangerous. Because the parents had failed their child, the state had the authority to intervene in the child's best interests.[1] Chad Green died in Mexico in October 1979. When his parents returned to Massachusetts, a trial court held them in contempt for removing Chad from the state but did not impose any punishment on them on the premise that they had suffered enough.[2] What stands out in this case is how strongly each side believed in its opinion. The conflict moved from hospital rooms to court rooms where health practitioners and the parents stood against each other in fierce combat to prove their own positions as right. The case ended up making headlines on the pages of newspapers throughout United States and beyond.

The second case also concerned removal of child from the hospital and opting for treatment elsewhere. The case of Joey Hofbauer in New York.[3] Joey Hofbauer was diagnosed with Hodgkin's disease at age seven. His doctor recommended traditional radiation therapy and chemotherapy. His parents, however, elected to pursue a course of nutritional or metabolic therapy, including injections of laetrile. They traveled to Jamaica for the initial treatment but eventually found a licensed physician in New York who used metabolic therapy. A petition was filed by the local child protection service agency seeking to have Joey declared a neglected child. Medical testimony offered by both sides at the hearing was in sharp conflict. Physicians testifying for the agency advocated radiation and chemotherapy as the accepted treatment for Hodgkin's disease and denounced nutritional therapy as inadequate and ineffective. Doctors testifying for the parents, however, testified that they had used nutritional therapy in treating cancer patients and described it as beneficial and effective. The Hofbauers' physician testified that he used both traditional and nontraditional treatment with his patients and that he would not rule out traditional therapy if Joey's condition worsened under nutritional therapy. The trial court here ruled in favor of the parents, and the appellate division unanimously affirmed the trial court's decision. The appellate court later noted, Joey's father testified that he would allow Joey to be treated by traditional means if his physician recommended it. When the case reached the New York Court of Appeals, the court narrowed the issue:

> [T]he issue presented for our determination is whether the parents of a child afflicted with Hodgkin's disease have failed to exercise a minimum degree of care in supplying their child with adequate medical care by entrusting the child's physical well-being to a duly licensed physician who advocates a treatment not widely embraced by the medical community.[4] 'What constitutes adequate medical care,' the court stated, 'cannot be judged in a vacuum free from external influences, but rather, each case must be decided on its own particular facts.'[5]

On the facts in this case, the court affirmed the lower court's conclusion that Joey was not a neglected child, that his parents were concerned and loving, parents looking out for his best interests. Two principal factors seem to have guided the New York court's decision. First, the parents based their choice of treatment on competent medical advice. Second, the particular mode of treatment chosen by the parents was not itself without credit or recognition. Arguably, the New York court gave deference to parental authority. It did so as the facts of the case warranted such deference. In the Hofbauer case, the parents had some medical professionals on their side, and the mode of treatment they proposed to follow was, while unconventional, endorsed and used by those professionals. Joey Hofbauer died in 1980 at the age of ten. Following Joey's death, his father told a reporter that Joey had been '*a pioneer whose purpose was to establish the right of parents to make these decisions for their children and to keep Governor Carey and his faceless bureaucrats out of the family.'* [6]Here the father is strongly of the opinion that parents should have the final say about a child's medical care. Hofbauer's case also encompasses situations where parents seek to opt for one medical professional ' s approach over another 's, here the court hold the ultimate authority to intervene in such situations once the child ' s welfare was engaged.

The third and fourth cases involved medical treatment of children in the United Kingdom that have generated headline and wide international reach. Third is the Ashya King's case.[7] It involved five-year old Ashya King, who had undergone surgical removal of a brain tumour. His doctors thereafter proposed chemotherapy and radiotherapy, but his parents favoured proton beam therapy (PBT). NHS funding for PBT was refused but Ashya's parents had identified a willing centre in Prague and had the requisite funding available. Believing the hospital would seek a Child Protection Order to prevent this (which the hospital denied), Ashya's parents removed him from the hospital and took him to Spain. Ashya was subsequently made a ward of court and a court hearing convened to determine whether he was at risk of significant harm from the plan to take him

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[1] *Custody of a Minor*, 378 Mass. 732, 393 N.E.2d 836 (1979).
[2] N.Y. TIMES, Dec. 9, 1980, § 2, at 21, col. 1.
[3] *In re Hofbauer*, 47 N.Y.2d 648, 652, 393 N.E.2d 1009, 1011, 419 N.Y.S.2d 936, 938 (1979). See also N.Y. TIMES, July. 18, 1980, at D13, col. 5.
[4] In *re Hofbauer*, 47 N.Y.2d 648, 652, 393 N.E.2d 1009, 1011, 419 N.Y.S.2d 936, 938 (1979).
[5] Ibid. at 655, 393 N.E.2d at 1013, 419 N.Y.S.2d at 940.
[6] N.Y. TIMES, July 18, 1980, at D13, col. 5.
[7] *Portsmouth City Council v Nagmeh King, Brett King, Southampton Hospital Trust, Ashya King (by his Children's Guardian)* [2014] EWHC 2964 (Fam).

to Prague for PBT. Baker J referred to the 'fundamental principle of family law' that the 'responsibility for making decisions about a child rest with his parents'.[1] Drawing on the medical evidence, he concluded that the proposed treatment was reasonable, in Ashya 's best interests and Ashya was not at risk of harm, so he could be transferred to the unit in Prague, at which point he would no longer be a ward of court.[2] The parent's action offer an example of the lengths parents will go to present the best possible treatment for their child; researching alternative treatments, finding a treatment centre, travelling abroad, selling their properties to fund their child's treatment. Also, the internet now provides access to a host of information, including alternative treatments available across the world and stories of their successes.

The fourth case is *Charlie Gard* .[3] Charlie, who was eight months old, had a form of mitochondrial DNA depletion syndrome and was being treated in Great Ormond Street Hospital (GOSH). His treating clinicians judged his quality of life to be poor, with no hope of recovery, such that continued ventilation would be futile. His parents opposed withdrawal of ventilation on the basis that an experimental treatment was available in the United States, which might help their son. The parents raised funds for him to travel to the US where a medical specialist had offered to provide treatment. The hospital was initially prepared to consider such treatment but, following Charlie's deterioration, his treating clinicians concluded that this too would be futile. Charlie's parents maintained that he should be transferred to the United States.[4] In the first substantive ruling, Francis J looked particularly to the (UK) medical evidence, deciding that mechanical ventilation was not in Charlie's best interests.[5] The Court of Appeal permitted an appeal on certain grounds,[6] but the Supreme Court refused permission to appeal, finding there was no arguable point of law. [7] The European Court of Human Rights also declared inadmissible the parents' attempt to have the case heard in Strasbourg.[8] The case did, however, return to the High Court, on the basis (inter alia) of new evidence from a US clinician. However, during this hearing, the US clinician met with the treating clinicians and reviewed up-to-date scans, which led him to conclude that there was no possibility of the nucleoside therapy having any effect that Charlie's condition was now too far advanced for experimental treatment to work. Charlie's parents thereafter withdrew their opposition to the proposal to withdraw life support. Francis J confirmed his earlier declaration, adding that Charlie would continue to be treated at GOSH, before being transferred to an agreed hospice.[9] Charlie's case yielded global attention and an outpouring of sympathy from around the world notably the Pope and the then US President Donald Trump.

In all these four cases discussed above, all the cases drew substantial public attention, in part due to the issues around parental authority it raised. Concerns about the erosion of what some regarded as the territory of parental authority were aired. And it was that it should be for parents, rather than the medical profession or the courts, to have final decision making authority about a child's health and there should be a shift in the law's position on when the court should legitimately intervene. Much of the public concern around these cases (based on comments in the social media) centred around the rights of parents to make decisions for their children, with many objecting to the role of the state in what some consider to be private, familial decisions. Truly, there is also the fact that it is parents, along with the child, who will ultimately bear the burdens that flow from the decision. It is they who will carry the care burdens that may result. This would seem to be quite a strong reason for them to want to have a considerable say over what treatment the child receives. These reasons do not, of course, hold in all situations. There are parents who make unwise, irrational decisions, without doubt the courts are very much mindful of this.

4.1.3Non-Emergency but life affecting treatment

This scenerio centres on those situations in non-life-threatening cases when the treatment is not life-saving but would enhance the quality of the child's life in some measure. These are circumstances where the medical procedure is risky and there is little or no risk of loss of life or serious injury in the absence of treatment. Some courts, have ruled in favor of state intervention in non-life- threatening cases, principally because the quality-of-life philosophy prevailed.

In *re Sampson*,[10] here, the New York Court of Appeals affirmed the trial court's finding that a 15 year-old boy suffering from neurofibromatosis (also known as Von Recklinghausen's disease) was neglected and its order

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[1] *In the Matter of Ashya King* [2014] EWHC 2964, 31

[2] ibid

[3] *Great Ormond Street Hospital v Constance Yates, Chris Gard, Charles Gard (a Child by his Guardian Ad Litem*) [2017] EWHC 972 (Fam).

[4] ibid

[5] ibid

[6] *Constance Yates, Christopher Gard v Great Ormond Street Hospital for Children NHS Foundation Trust Charles Gard (a Child, by his Guardian)* [2017] EWCA Civ 410 .

[7] *In the matter of Charlie Gard* (8 June 2017), www.supremecourt.uk/news/permission-to-appeal-hearing-in-the-matter-of-charlie-gard.html accessed 12 Feb 2022.

[8] *Gard and Others v UK* (app no 39793-17) [2017] ECHR.

[9] *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates and Others* [2017] EWHC 1909.

[10] *In re Sampson*, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971).

requiring his mother to consent to corrective surgery. Kevin Sampson had suffered from the disease since early childhood. The disease, caused a large growth to envelop one side of his face, making it approximately twice the size of the other side. The abnormal growth caused the cheek, eyelid, and ear on the affected side to droop. Kevin's mother refused to consent to the surgery because of her religious objection to use of the blood transfusions it would require. The corrective surgery, which would improve Kevin's appearance but would not cure his disease, was a lengthy and dangerous process. (Kevin had not attended school in several years, so grotesque was his deformity). The court in effect cast aside the life-threatening/ non-life-threatening distinction as outmoded. The appellate division criticised the life-threatening criterion as '*a much too restricted approach*.'[1] The court of appeals was so in accord with these views. Not a single judge dissented as the case moved through the entire court system in New York.

The case is significant because it is a move by the courts away from the traditional hands-off attitude of courts except in life-threatening cases. The life-threatening exception is best summarised in one of the cases mentioned earlier, In *re Green*:

> We are of the opinion that as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition.[2]

There is no doubt, parents have strong initial control but that control is contingent on how it is exercised, and that contingency is determined by the court's view on the risks posed by their decisions. At the same time, there must be good reasons by the court for taking a different approach in different contexts.

5. Recommendation

The law's approach should be both principled and practical. It should account for clinical realities and have regard for the professional opinion of those who understand the medical aspects of a child's healthcare situation. It must at the same time be sensitive to the parents 'needs as well as those of the child. On the practical aspect, second-opinion experts may be beneficial and reassuring in demonstrating to the family that the clinicians 'proposed course of action is the right one. In other words, there should be provision of independent second opinions to families (and also legal aid).

Considering that there is now a growing support, for mediation as a means of resolving disputes about the healthcare of children which is a welcome development. It should be ensured that all parties have access to mediation. The creation of Medical Mediation means that mediators are available on these cases. To ensure that this is an effective resolution mechanism, the nature of their composition, expertise, training, impact, evaluation should be of standard. With this, courts will be used infrequently and as a last resort for resolving such disputes. In addition, hospitals should have clinical ethics support services with the input of clinical ethics committees which also have the potential to resolve such disputes.

Finally, there should be shift to 'significant harm threshold ', meaning that courts must not intervene to make decisions on behalf of a child unless the parents 'decision poses a serious risk that the child will suffer significant harm as a result. At the same time, courts should not focus on the 'life-threatening' consideration but rather on the child's general welfare, a consideration that may prevail against a parent's claim of inherent parental authority. The Court has a wide discretion to order medical or surgical care and treatment for an infant even over parental objection, if in the court's judgment the child's health, safety or welfare requires it.

6. Conclusion

This paper has offered an insight into the ethical dilemmas facing parents, doctors and courts. It also tried to categorise the situations into the broader context of end-of-life decisions, as well as other cases of disagreement between parents and doctors. The State, (whether it be the court, or any other public authority) generally has no business interfering with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the parents' decision. It is difficult for any regulatory system to balance all the competing needs and demands of those it covers, and the complexity of doing so and walking the line between respecting parental responsibility and protecting those most vulnerable among us is a difficult question that prompts strong feelings. The law imposes an obligation upon both parents and professionals to act in the best interests of the child. The provision of medical treatment to a child depends upon their co-operation in the shared endeavour of care. The co-existent responsibilities of healthcare professionals and public authorities to work together with parents in securing the best possible care for a seriously ill child, irrespective of their distinct perspectives and concerns is important. As in many other areas of life, when there is intractable disagreement between different parties about something important, there is a need for an impartial arbiter - the court is asked to decide. The court is then asked to determine what would be best for the child. Courts must step into the middle

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[1] ibid

[2] *Re Greene* 448 Pa. at 348, 292 A.2d at 392

when relations break down, and when they do so they step into a sphere of life that is otherwise private. The argument over when the courts can intervene in the decisions made in relation to a child is by its nature highly emotive. Parents in such situations will invariably be fighting for their children. Medical personnel will also be fighting to save this child, and also fighting to do their best to ensure that child is not in needless distress. Therein is the dilemma and therefore the need to be very careful to ensure the line is clear and appropriate. Courts are used as a last resort for resolving such disputes, it is likely their input will continue to be necessary. As the current concern for quality of life continues to grow, courts may indeed move more toward the exercise of "wide discretion" in determining a child's best interests. The traditional position that the threshold for judicial intervention in disputes about medical care of children is the welfare of the child, there has been comparatively wider freedom on when the court should legitimately intervene. The trend has been toward greater state involvement in the medical decision-making process even with respect to non-life-threatening medical decisions. In conclusion traditional views of the court's intervention over medical treatment of the child will continue to be tested and with that testing, there will likely arise changes.

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