

Reversal of Fortune – *Re A (Conjoined Twins)* and Beyond: Who Should Make Treatment Decisions on Behalf of Young Children?

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1. Introduction

The question of who should have the last say in medical treatment decisions on behalf of young children crops up whenever parents and physicians cannot agree on a course of treatment and the courts get involved in the decision-making process. Even though such problems arise frequently, the respective roles of the courts, the medical profession and the parents in the context of treatment decisions on behalf of young children are not clearly defined. While the relevant legal principles seem straightforward, their application in practice is fraught with uncertainty. This is partly because treatment decisions on behalf of young children have to be made in the child's best interests. The best interests analysis is complicated because every course of treatment will normally involve risks as well as benefits, and various treatment alternatives will often be available. Furthermore, it must be decided whether only medical risks and benefits of the suggested treatment should be balanced in a given case, or whether other interests such as the child's psychological well-being, the impact of the medical decision on the life of the child as a whole, and its impact on family relations or on third parties should also be considered.

In the light of these uncertainties, it is evident that the question of who should make treatment decisions on behalf of young children is of the utmost importance, as different decision makers will have different perceptions of the child's best interests.¹ Parents can be expected to take a broad view of the child's best interests and to include non-medical factors in the equation, even though they are likely to attach great significance to medical advice. Physicians will in all likelihood concentrate on the child's medical interests when recommending a certain course of treatment. Courts, once involved, will often be faced with the task of resolving a conflict between the parental and the medical view of the child's interests. They have to decide how much weight to accord to the wishes of the parents, and how much significance to attach to medical opinion. Thus, the issues of *how* to determine the best interests of the child and of *who* should determine the best

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¹See the discussion by J. Fortin, *Children's Rights and the Developing Law* (London: Butterworths, 1998) at 252.

interests of the child, are only at first sight clearly distinguishable, but in fact very closely linked.

The inconsistencies of the current English approach to these problems have been highlighted by the recent case of *Re A (Conjoined Twins)*² regarding the separation of conjoined twins who had been born in a hospital in Manchester. The twins were joined at the lower abdomen and shared a common artery. The lungs and heart of one of the twins, Mary, were too deficient to supply her blood with oxygen, and if she had been born a singleton she would not have survived. Through the common artery her sister, Jodie, supplied her with oxygenated blood. The medical prognosis was that without an operation to separate the twins, Jodie's heart would eventually fail, probably within 3 to 6 months, so that both children would die as a consequence. If, on the other hand, the twins were separated, Mary would die during the operation, as soon as the common artery was clamped off, while Jodie had a good chance to survive and, with several operations, could probably enjoy what Ward L.J. called "a life that will be worthwhile."³ The parents, devout Roman Catholics, refused to give their consent to the operation, as saving one child by allowing the other child to be killed violated their religious beliefs. They also worried about Jodie's quality of life, given that in Gozo, where the family lived, the necessary medical facilities to cope with her disabilities were not easily available. The hospital sought an authorisation from the High Court that the operation could lawfully be performed, which was granted by Johnson J.

On appeal, the Court of Appeal decided that it would have been acceptable for the physicians to comply with the parents' request not to operate. Thus, the parents and the physicians could, without court involvement, have decided that it was in the best interests of the twins to be left to die. However, once the physicians decided to involve the Court, the Court felt free to substitute its own best interests analysis for that of the parents and came to the conclusion that the operation should be carried out, with the consequence that one of the twins was killed during the operation and the life of the other twin saved.

Such a random approach to decisions affecting the health or even life of children is unsatisfactory. The decision in *Re A* clearly confirms the need to reexamine who should make treatment decisions on behalf of children and according to which criteria such decisions should be made. To that effect, this article will examine the question of how courts get involved in the decision-making process. In addition, it will analyse what the role of the courts should be, once involved, and in particular, what weight the courts should accord to the parents' views on the best interests of their child.

²*Re A (Conjoined Twins: Medical Treatment)*, [2001] 1 F.L.R. 1 (C.A.) [hereinafter *Re A*].

³*Ibid.* at 37-38.

2. Court Involvement

Medical treatment without authorisation constitutes an unlawful touching and, therefore, a battery,⁴ and physicians cannot lawfully treat a child without authorisation except in the case of an emergency.⁵ As incompetent children cannot themselves give consent to medical treatment, this power rests in their parents who are entrusted by law with making decisions on their behalf, including decisions regarding their children's medical treatment.⁶ Courts can also authorise medical treatment of minor patients once their jurisdiction has been invoked.⁷ This raises the question of the reasons for which court involvement can be sought, that is whether court involvement is at the discretion of the parents and/or the physicians, or whether at least in some cases it is desirable as a matter of good practice or even mandatory.

2.1. Disagreement between parents and physicians

It has been suggested that in cases of disagreement between physicians and parents over routine medical treatment, physicians should have the right, based on the principles developed in *Re F*⁸ for incompetent adult patients, to treat children without parental consent or court involvement, if that treatment is regarded by agreed medical opinion as necessary in the best interests of the child.⁹ As many cases of routine medical treatment do not have social or moral implications so that the decision of whether or not to treat will be purely medical, it has been argued that medical practitioners are better placed than parents to make such a decision for the child. This approach implies that in cases of routine treatment, parents should not have the right to refuse to give their consent. However, in cases of medical treatment of children, neither is there a need to make the necessity defence available to physicians beyond cases of emergency treatment, nor is this desirable. The decision in *Re F* to allow physicians to rely on the necessity defence to administer any treatment that can be regarded as in the best interests of the patient, including routine medical treatment, must be understood against the background that English law does not provide for a proxy decision maker in cases of incompetent adults. Neither relatives nor the courts have the power to make such decisions.

⁴*F v. West Berkshire Health Authority and another*, [1989] 2 All E.R. 545 (H.L.) at 563-564 per Lord Goff [hereinafter *Re F*].

⁵*Gillick v. West Norfolk And Wisbech Area Health Authority and another*, [1985] 3 All E.R. 402 (H.L.) at 432 per Lord Templeman [hereinafter *Gillick*].

⁶*Ibid.* at 420 per Lord Scarman.

⁷A. Bainham, *Children – The Modern Law*, 2d ed. (Bristol: Jordan Publishing, 1998) at 248-49; J. Munby, "Consent to Treatment: Children and the Incompetent Patient" in I. Kennedy & A. Grubb, eds., *Principles of Medical Law* (Oxford: Oxford University Press, 1998) 179 at 220-21.

⁸*Re F*, *supra* note 4.

⁹R. Lavery, "Routine medical treatment of children" (1990) *J. Soc. Welfare L.* 375 at 383; see also the discussion of this issue by Bainham, *supra* note 7 at 258.

However, in the case of minor patients, parents can make treatment decisions on their behalf. As children lack the maturity to accept or reject medical treatment, it is the function of the parental consent requirement to allow the parents to exercise this right on behalf of the child. Thus, the parental right to make medical decisions includes the right to refuse medical treatment if the parent believes that the refusal of treatment best protects the child's interests, for example because they fundamentally disagree with the approach of orthodox medicine and prefer to resort to complementary medicine for routine treatment, because they want to seek a second opinion, or because they think that it is best to reject treatment altogether.¹⁰ If physicians could treat the child against the parents' refusal outside of emergency situations, this right would be undermined and reduced to a right to agree with the medical recommendation. In cases of children, the necessity defence is thus not available to the physician outside of emergency situations, that is, unless the physician believes that without treatment there would be an immediate or imminent risk to the child's life or health.

While the physician cannot administer treatment without parental consent unless the delay in securing consent puts the child's life or health at risk, it does not follow that where a child's parents refuse to consent to non-urgent but nevertheless medically necessary treatment, the physician has to wait until an emergency arises so that he/she can then treat the child based on necessity. Given that the physician is under a duty of care towards the child, he/she can seek a court order authorising the recommended treatment.¹¹ Thus, in cases of parental non-compliance with medical advice, the physician can involve a new decision maker in the process. The parents can do the same where the physician refuses to provide the course of treatment the parents think best for their child, for example where the physician wants to withhold life-prolonging treatment because he/she regards it as futile, or refuses to treat the child because he/she thinks that the treatment is too burdensome and therefore not in the child's best interests.¹²

In cases of a disagreement between a child's parents and physician, it is left at the discretion of the parents and the medical profession whether or not to resort to the courts. If in those cases in which the parents refuse to consent to treatment or the physicians refuse to administer treatment, it is decided not to invoke the court's jurisdiction, the child will not receive treatment. This will only have legal consequences if, exceptionally, non-treatment must be regarded as a breach of either the parental or the medical profession's duty of care towards the child.¹³

¹⁰*Gillick*, *supra* note 5 at 432 per Lord Templeman.

¹¹*Ibid.* at 432 per Lord Templeman; *Re A*, *supra* note 2 at 27 per Ward L.J.

¹²See, for example, *Re C (Medical Treatment)*, [1998] 1 F.L.R. 384 (Fam. Div.); *NHS Trust v. D*, [2000] 2 F.C.R. 577 (Fam. Div.).

¹³This point will be discussed in detail under 2.3. below.

2.2. Non-therapeutic treatment

In exceptional cases, court involvement in the decision-making process might be regarded as desirable, or might even be mandatory, in spite of an agreement between parents and physicians as to the right course of treatment. Court involvement can only be mandatory if without it, the treatment in question cannot lawfully be performed, that is, if in the relevant group of cases, parents cannot validly consent to the treatment in question because the decision is not encompassed by their parental powers. If parents can validly consent to the treatment in question, it would only be possible to declare court involvement desirable to encourage the parents and the medical profession to seek the opinion of the court before carrying out the treatment decision.

2.2.1. Sterilisation

Court pronouncements on this issue mainly stem from the area of sterilisation. In the Australian decision of *Secretary, Department of Health and Community Services v. JWB and SMB*,¹⁴ a case that concerned the non-therapeutic sterilisation of a minor girl, McHugh J., giving one of the minority speeches, was of the opinion that parents had the power validly to consent to non-therapeutic sterilisations. As such operations were not regarded as running counter to public policy, and as competent persons could validly consent thereto, he thought that the same power must be invested in parents where the operation was necessary in the best interests of the child.¹⁵ However, the public policy considerations justifying non-therapeutic sterilisations where a competent person has decided that sterilisation is the appropriate form of contraception cannot easily be applied to parental decisions on behalf of incompetent minor girls. Non-therapeutic sterilisations of minors or mentally incompetent adult women are regarded as particularly sensitive because of concerns that these decisions might be based on eugenic policies and, even more importantly, because these operations have irreversible consequences in taking away from the woman concerned the chance of ever exercising reproductive autonomy.¹⁶ In the case of minor girls, there is the additional worry that a sterilisation might be sought before she reaches the age of consent to prevent her from making her own decision.¹⁷

A sterilisation may have significant psychological effects and may influence the whole life of the patient. At the same time, no medical benefits clearly outweigh

¹⁴(1992) 66 A.L.J.R. 300 (Austr. H.C.).

¹⁵*Ibid.* at 340-43.

¹⁶*Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.) at 29 per La Forest J.; R. Lee & D. Morgan, "Sterilisation and Mental Handicap: Sapping the Strength of the State?" (1988) 15 J. L. & Society 229.

¹⁷This seems to have happened in *Re P (A Minor) (Wardship: Sterilisation)*, [1989] 1 F.L.R. 182 (Fam. Div.); see the critical discussion by M. Brazier, "Sterilisation: Down the Slippery Slope?" (1990) 6 Prof. Negl. 25.

the risks and adverse consequences of the operation. Therefore, as the majority pointed out in *Secretary, Department of Health and Community Services v. JWB and SMB*, the problematic issue that might justify mandatory court involvement is the question of how to determine whether or not such treatment is in the child's best interests. According to the majority opinion, the significant risk of making a wrong decision, the serious consequences of a wrong decision, the fact that such a decision had social and psychological dimensions which parents and medical practitioners were not necessarily competent to address, and the possibility that the parents as the girl's carers might have their own interests in the outcome of the decision made court involvement essential.¹⁸ Equally, in *Re B*, Lord Templeman argued that a sterilisation was such a "drastic step" that it should only be performed after a full and informed investigation into the risks and consequences of pregnancy and sterilisation and into possible alternatives. This could best be achieved in court proceedings in which the girl was represented by a guardian. As there was no better method of reaching a "decision which vitally concerns an individual but also involves principles of law, ethics and medical practice," the High Court should be the only authority empowered to authorise such treatment.¹⁹ Even if the parents consented to the sterilisation because they agreed with the physicians that the sterilisation was in the best interests of the girl, this did not automatically exempt the physicians from criminal, civil or professional liability. Lord Templeman thus expressed the opinion that consent to a sterilisation lies outside the scope of parental powers and that court involvement is mandatory in such cases.

It seems as if the decisive factor in favour of court involvement in sterilisation cases is the non-therapeutic nature of the treatment with its specific ethical and psychological implications. The difference between therapeutic and non-therapeutic treatment is important for the best interests analysis. As every form of medical treatment constitutes an infringement of the patient's integrity, parental consent based on the parents' assessment of the child's best interests is required to protect the child from non-beneficial intrusions. In cases of therapeutic treatment, the intrusion will normally be outweighed by medical and other benefits derived from the suggested treatment. However, the situation changes when non-therapeutic treatment is at stake, as no medical benefits will then outweigh the risks and the intrusiveness of the treatment. Accordingly, there should be a presumption that in principle, non-therapeutic treatment is not in the best interests of the child.²⁰ Such a presumption can be rebutted if it can be demonstrated that the risks and harm inherent in the treatment are, exceptionally, outweighed by its benefits. With regard to non-therapeutic sterilisations, this could be the case if the sterilisation were the only way to avoid a pregnancy which might adversely affect the physical and/or psychological well-being of the patient. In cases of non-therapeutic sterilisations, there is an increased risk that the sterilisation might be the most convenient option

¹⁸*Supra* note 14 at 310-12 per Mason C.J., Dawson, Tooley and Gaudron JJ.

¹⁹*Re B (A Minor) (Wardship: Sterilisation)*, [1987] 2 All E.R. 206 (H.L.) at 214-15.

²⁰I. Kennedy & A. Grubb, *Medical Law*, 3d ed. (London: Butterworths, 2000) at 859.

for the carer, which is an important reason for requiring the involvement of the court. Only if the decision is made by an independent and objective decision maker, based on a full investigation of the relevant evidence, can the interests of the child be adequately protected.²¹

The best interests analysis is different where sterilisation is suggested for therapeutic purposes, for example to remove a cancerous uterus. Such cases do not differ from other cases of medical treatment and can therefore be decided without involving the courts.²² The distinction between therapeutic and non-therapeutic sterilisations which was rejected both in *Re B*²³ and in *Re F*²⁴ is thus important when deciding whether or not court involvement is required. This was the approach adopted by Stephen Brown P in *Re E*.²⁵ In that case, he argued that parents can validly consent to therapeutic sterilisations and implied that in cases of non-therapeutic sterilisations, the parents did not have such powers.²⁶

2.2.2. Other forms of non-therapeutic treatment

It remains to be seen whether the principles derived from the sterilisation cases can be applied to other cases of non-therapeutic treatment. The other important category of cases of non-therapeutic treatment is that of tissue or organ donation. In those cases, the treatment does not have any direct medical benefits for the donor and, depending on the type of donation, will create slight (for example in cases of bone marrow donation) to very serious (for example in cases of kidney donation) risks and side-effects. If at all, these risks can only exceptionally be outweighed if the child derives a psychological benefit from the treatment, for example if it is the only possibility to save the life of a person very close to the child.²⁷ In such cases, a particularly careful best interests analysis is required to

²¹But see *Re Eve*, *supra* note 16 at 32 where La Forest J. rejected the idea that a non-therapeutic sterilisation could ever be in the best interests of an incompetent patient.

²²Arguably, the distinction is sometimes difficult to make, for example in cases of sterilisation for menstrual problems.

²³*Supra* note 19.

²⁴*Re F*, *supra* note 4.

²⁵*Re E (A Minor) (Medical Treatment)*, [1991] 2 F.L.R. 585 (Fam. Div.) at 587; see also *Re GF (Medical Treatment)*, [1992] 1 F.L.R. 293 (Fam. Div.) at 294, and *Re S (Adult Patient: Sterilisation)*, [2001] Fam. 15 (C.A.) at 29 per Butler-Sloss L.J. regarding an incompetent adult. In the last two decisions, the courts have qualified this statement by adding that the sterilisation has to be in the patient's best interests and must be the least intrusive means to achieve the therapeutic purpose.

²⁶This is also the position of the Law Commission regarding the sterilisation of mentally incompetent adults, see Law Commission Report No. 231, *Mental Incapacity* (1995), 6.4.

²⁷See the rather questionable decision of *Re Y (Mental Patient: Bone Marrow Donations)*, [1996] 2 F.L.R. 787 (Fam. Div.) and the discussion by Kennedy and Grubb in *Medical Law*, *supra* note 20 at 788-90; D. Feenan, "A Good Harvest? *Re Y (Mental Incapacity: Bone Marrow Transplant)*" (1997) 9 Child & Fam. L.Q. 305; see also *Curran v. Bosze*, 566 N.E. 2d 1319 (Illinois Sup. Ct. 1990); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. C.A. 1969).

protect the interests of the child. These decisions very clearly benefit a third party, in fact the benefits for the recipient are much more direct than any benefits for the minor. In cases of a donation by a minor, the beneficiary will always have to be a close relative to justify the donation in the best interests of the minor, and the parents will then frequently have their own interest in the outcome of the decision. Furthermore, given the presumption that non-therapeutic treatment is not in the best interests of the minor, the involvement of the court as independent decision maker seems necessary to ensure that the decision really reflects the best interests of the child.²⁸ The same principles should be applied to other forms of non-therapeutic treatment.²⁹

2.2.3. Court involvement mandatory or desirable?

A last issue to be addressed in this context is whether court involvement in cases of non-therapeutic treatment should be mandatory or merely desirable. Given that the parents are in principle entrusted with making treatment decisions on behalf of their children, most treatment decisions lie within their powers and there is no reason to make court involvement either mandatory or desirable. If, exceptionally, it is thought that the courts are better placed than the parents to make a particular decision, this seems to suggest that the decision in question should not be within the ambit of parental powers.³⁰ It follows that court involvement should be mandatory in such cases, as only the courts, not the parents, can then authorise this particular form of treatment. Only the requirement of mandatory court involvement adequately protects the interests of the child, as this ensures that the non-therapeutic treatment cannot lawfully be performed on the child unless the court as an objective decision maker has authorised it in proceedings in which the child was represented. If the involvement of the court were solely desirable, the focus would lie on the interests of the medical profession to protect itself against potential liability,³¹ as the physician, if in doubt about the lawfulness of the procedure, could, but would not have to, get a court decision. Given that the interests of the child are paramount in

²⁸*Re Y (Mental Patient: Bone Marrow Donations)*, *ibid.*

²⁹But see *Re J (Specific Issue Orders: Muslim Upbringing and Circumcision)*, [1999] 2 F.L.R. 678 (F.D.) per Wall J., [2000] 1 F.C.R. 307 (C.A.), where it has been held that in cases of male circumcision, court involvement is only necessary where the parents are not agreed on the treatment given that the procedure is widely practised and only of minor intrusiveness. Equally, in Canada, following La Forest J.'s analysis in *B. (R.) v. Children's Aid Society of Metropolitan Toronto* (1995), 122 D.L.R. (4th) 1 (S.C.C.) at 42 that parents can make decisions against their children's rights as long as they do not exceed the threshold dictated by public policy, it has been argued that parents can validly consent to minor non-therapeutic interventions such as blood donations or male circumcision: see J. Gilmour, "Minors" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 179 at 197.

³⁰*Re B (A Minor) (Wardship: Sterilisation)*, *supra* note 19 at 214-15 per Lord Templeman. However, see Munby, *supra* note 7 at 217, who argues that court involvement can never be mandatory, but merely in some cases desirable as a matter of good practice.

³¹Brazier, *supra* note 17 at 27.

these cases, the better view would be that which puts those interests first by requiring mandatory court involvement.

2.3. *Re A*: life-and-death decisions

One question arising in *Re A*,³² the conjoined twins case, was whether it would have been lawful for the physicians to follow the parents' wishes to leave both children to die without involving the courts, or whether court involvement was mandatory to decide whether or not the separation operation that would have saved the life of one of the twins but killed the other should be performed. Ward L.J. argued that court involvement was not mandatory in that case. According to him:

it would ... have been a perfectly acceptable response for the hospital to bow to the weight of the parental wish ... Had St Mary's done so, there could not have been the slightest criticism of them for letting nature take its course in accordance with the parents' wishes. ... The hospital have care of the children and whilst I would not go so far as to endorse a faint suggestion made in the course of the hearing that in fulfilment of that duty of care, the hospital were under a further duty to refer this impasse to the court, there can be no doubt that the hospital is entitled in its discretion to seek the court's ruling.³³

Ward L.J. thus took the stance that this was a case in which it was at the physicians' or the hospital's discretion whether or not to involve the court and therefore a case falling into the category of cases discussed under 2.1. above. Looking at the consequences of the decision to accept the parents' wishes not to operate, this is surprising. According to the medical prognosis, without an operation both twins would have died, while an operation would have saved Jodie. Medical opinion recommended such an operation and there was evidence that after some follow-up operations, Jodie would be able to lead a relatively normal life with a normal life expectancy. Thus, there were clear indicators that the operation was in Jodie's best interests,³⁴ and that a decision not to operate would have violated her best interests.

It could be argued that the irreversible nature of non-treatment decisions inevitably leading to the preventable death of the patient, and the severe consequences of non-treatment, the loss of life itself, put such cases into the same category as cases of non-therapeutic treatment and justify a requirement of mandatory court involvement. However, there is a decisive difference between non-treatment and non-therapeutic treatment. In cases of non-therapeutic treatment, court involvement serves the purpose of providing the medical profession with the consent needed to treat a child lawfully in situations in which the parents do not

³²*Re A*, *supra* note 2.

³³*Ibid.* at 27.

³⁴*Ibid.* at 37-38.

have the power to consent to the procedure in question. In cases of non-treatment, that is cases in which physicians decide to respect the parents' wishes not to treat a child, physicians decide not to act, a behaviour for which a court authorisation can, in principle, not be required. It would also not be practicable to make court involvement mandatory in every case in which physicians want to withhold or withdraw life-saving or life-prolonging treatment, because of the consequences of such a decision.

However, support for the view that court involvement can be necessary in the context of certain types of life-and-death decisions can be found in *Bland*,³⁵ a case in which the House of Lords decided that decisions to withdraw life-prolonging treatment, in that case artificial nutrition and hydration, from a patient who was in a permanent vegetative state, needed to be brought before the courts. Given that the physician is under a duty of care towards the patient, and given that there is a presumption that it is in the patient's best interests that his or her life be preserved,³⁶ court involvement in those cases serves the purpose of establishing the scope and content of the physician's duty of care towards the patient. The determination of the scope and limits of a physician's duty of care is even more complex in cases of life-saving treatment of children, as these cases also raise the problem of the relationship between the parents' and the physicians' duty towards the child. Parents have the right to refuse to give consent to medical treatment of their children, and physicians cannot lawfully treat a child without parental consent. Where the refusal is in the best interests of the child, the parents do not breach their duty of care towards the child by refusing to give consent, and the physicians do not breach their duty of care by following the parents' decision without involving the courts. However, given that parental decisions are valid only as long as they conform with the best interests of the child,³⁷ the situation changes where the refusal to consent to a child's medical treatment violates the best interests of the child, thus constituting a breach of the parents' duty of care.³⁸

Can it really be said, as Ward L.J. suggested, that in such a case physicians can fulfil their duty of care towards the patient by respecting the parents' wishes that run counter to the best interests of the child and lead to the child's death? This

³⁵*Airedale NHS Trust v. Bland*, [1993] 1 All E.R. 821 (H.L.).

³⁶*Re T (A Minor) (Wardship: Medical Treatment)*, [1997] 1 W.L.R. 242 (C.A.) at 252 per Butler-Sloss L.J.

³⁷*Re J (A Minor) (Wardship: Medical Treatment)*, [1991] Fam. 33 (C.A.) at 41 per Lord Donaldson M.R.

³⁸In *R v. Lowe*, [1973] Q.B. 702 (C.A.), and *R v. Sheppard*, [1981] A.C. 394 (H.L.), the Courts decided that a failure to provide the child with medical care might constitute a criminal offence under s. 1 of the *Children and Young Persons Act, 1933* (U.K.); see also the Canadian case of *R. v. Tutton*, [1989] 1 S.C.R. 1392, in which parents who had caused the death of their diabetic child by withholding insulin because they believed in faith-healing were charged under the *Criminal Code*, R.S.C. 1985, c. C-46, s.215(1)(c) with failure to provide the necessities of life.

could only be the case if the parents' refusal of consent relieved the physicians from their duty to preserve the life and health of the child patient. As the parents cannot lawfully do anything to harm the child, it can hardly be maintained that the parents can exempt the physicians from their duty to act in the best interests of the child. However, the physician cannot lawfully treat the child without parental consent, even if the treatment promotes the child's best interests.³⁹ Where the parents refuse to give consent to life-saving treatment that would be in the best interests of the child, the physician can therefore not be under a duty to treat the child. What the physician can lawfully do, though, is involve the court to seek an authorisation to treat the child against the wishes of the parents. The physician can thus fulfil his or her duty of care towards the patient by involving the court. In such cases court involvement serves the dual function of delineating the content of the physicians' duty of care and of authorising treatment if the court thinks that such treatment is in the best interests of the child.

It is conceded that it is no more practicable in cases of children than in cases of adult patients to involve the courts in every decision which might affect the patient's life. However, at least in cases in which the child's life could easily be saved, for example in cases in which a child is in need of a blood transfusion, physicians should be regarded as being under a duty to involve the courts if the parents refuse to give their consent to such treatment. The same should apply to cases in which treatment would have a good chance of improving the child's health and of considerably prolonging the child's life expectancy, even if this treatment might potentially involve serious side-effects. Given the importance of the child's right to life, it can hardly be argued that physicians can in such cases fulfil their duty of care by letting the child die without initiating a further exploration of the child's best interests and a potential authorisation of treatment by a court. For example, in cases such as those of *Saskatchewan (Minister of Social Services) v. P. (F.)*⁴⁰ and *Re T*,⁴¹ two cases in which a child was in need of a life-saving liver transplantation to which the parents were opposed because they thought that it was better for their child to have a short life without the invasive procedure, it is submitted that the physicians could only discharge their duty of care towards the child by seeking court involvement.

Coming back to the case of Jodie, to respect the parental decision would inevitably have resulted in Jodie's death and could have potentially amounted to an unlawful killing by omission. Jodie's death could have been prevented by obtaining a court order authorising the medically recommended operation and by carrying out the operation. By giving the physicians discretion as to whether or not to involve the court, Ward L.J. empowered them to make decisions that clearly go against the best interests of the child patient and gave them the choice as to whether or not to

³⁹*Gillick*, *supra* note 5 at 432 per Lord Templeman.

⁴⁰(1990) 69 D.L.R. (4th) 134 (Sask. Prov. Ct.).

⁴¹*Re T (A Minor) (Wardship: Medical Treatment)*, *supra* note 36.

let a child die whose life could have been saved and towards whom they were under a duty of care.

In order to protect the interests of the child, the more convincing solution would have been to hold that court involvement was, in fact, necessary here, as parents and physicians cannot lawfully decide to sacrifice the life of the child under such circumstances. It is thus submitted that contrary to Ward L.J.'s opinion, if the physicians had not involved the courts, they would have breached their duty of care towards Jodie, as the parents' refusal to consent to the operation violated Jodie's best interests and was therefore not valid. On the other hand, the parents could not have given valid consent to an operation which would have ended Mary's life. The operation violated Mary's best interests⁴² and her right to life, and Mary's death during the operation would have amounted to an active killing to which consent cannot validly be given.⁴³ Consequently, the physicians could neither operate lawfully without court involvement, as the parents' consent would have been void, nor could they decide not to operate without court involvement, as they would thereby have violated their duty of care towards Jodie.

3. Role of the Courts Once Involved

So far, the analysis has focused on the reasons for which courts will get involved in medical treatment decisions regarding child patients. What remains to be determined is the role of the court in the decision-making process. Thus, in the context of *Re A*, the question of whether or not the operation should have been authorised is not answered by the statement that court involvement should have been mandatory. Mandatory court involvement merely determines the decision maker, not the outcome of the decision or the criteria according to which it should be made.

3.1. De novo decision making or control of parental decisions?

Once involved, the courts can control and in certain circumstances override parental decisions where this is necessary in the best interests of the child. This seems logical, as parental decisions must be made in the child's best interests⁴⁴ and there is no basis to uphold decisions that do not meet this criterion. In *Re Z*, Lord Bingham M.R. described the role of the courts in such cases as follows:

the decision of a devoted and responsible parent should be treated with respect. It should certainly not be disregarded or lightly set aside. But the role of the court is to exercise an independent and objective judgment. If that judgment is in accord with that of the devoted and

⁴²*Re A*, *supra* note 2 at 46 per Ward LJ.

⁴³*Airedale NHS Trust v. Bland*, *supra* note 35 at 890 per Lord Mustill.

⁴⁴S. 1(1) of the *Children Act 1989* (U.K.), 1989, c. 41.

responsible parent, well and good. If it is not, then it is the duty of the court, after giving due weight to the view of a devoted and responsible parent, to give effect to its own judgment. That is what it is there for. Its judgment may of course be wrong. So may that of the parent. But once the jurisdiction of the court is invoked its clear duty is to reach and express the best judgment it can.⁴⁵

The position of English courts is thus clear. It is the role of the court to exercise an independent and objective judgment, which means that the role of the courts is not reduced to a review of the parents' decision. Instead, the courts have to make their own assessment of the child's best interests and they cannot uncritically accept medical opinion or parental views.⁴⁶ The courts thus assume the role of a self-appointed *de novo* decision maker, which suggests that once involved, the courts think that they are in a better position than the parents to determine the best interests of the child. This makes sense in cases of mandatory court involvement based on the nature of the procedure, that is in cases of non-therapeutic treatment. In such cases, the court gets involved because the parents are not regarded as the best decision makers for the child, given the severity and complexity of the issue, the potential for conflicts of interests between child and parents, and the ethical and public policy issues some of these cases raise. As the matters dealt with in those cases are not within the parents' decision making powers, and the parents might have their own interests to protect, it makes sense that the court defines its role as that of a *de novo* decision maker.

However, it is not obvious that the same considerations apply in cases in which the court only gets involved because the physician disagrees with the best interests analysis performed by the parents. In those cases, treatment decisions clearly lie within the scope of parental powers, and it is then not at all evident that the courts are better placed than the parents to determine the child's best interests. The position of the courts that they need to make their own decision of what is in the best interests of the child even in cases of discretionary court involvement seems to reflect the view that there is always only one possible answer as to where the child's best interests lie. If that were true, then the courts, being asked to safeguard the child's best interests, would need to override the parents' decision whenever they disagree with it, as, according to the court's interpretation, the parents' decision would then not promote the best interests of the child. It may be both logical and attractive to think that only one treatment option can be best at any given time.⁴⁷ However, given that the best interests analysis is based on a variety of factors, including an assessment of "medical, emotional and all other welfare

⁴⁵*Re Z (A Minor) (Identification: Restrictions on Publication)*, [1997] Fam. 1 (C.A.) at 32.

⁴⁶See also, for example, *Re B (A Minor) (Wardship: Medical Treatment)*, [1981] 1 W.L.R. 1421 (C.A.) at 1424 per Dunn LJ.

⁴⁷*Re S (Adult Patient: Sterilisation)*, *supra* note 25 at 28 per Butler-Sloss L.J., and at 32 per Thorpe L.J.

issues,”⁴⁸ it is evident that the evaluation of which of different options should be regarded as best can give rise to controversy, and that the parents, the physicians and the court can all have a different perception of the child’s best interests in a given case.⁴⁹

In principle the law entrusts the parents, not the courts or the medical profession, with making medical treatment decisions for their children. It could even be said that the best interests test itself to some extent embraces the notion that it is, in principle, in the best interests of the child that decisions be made by his or her parents.⁵⁰ Consequently, as long as the subject matter to which the decision refers lies within the scope of parental powers, there should be a presumption that the parents, not the courts, are the best decision makers. This thought is, to some extent, reflected in Waite L.J.’s statement in *Re T* that:

It can only safely be said that there is a scale at one end of which lies the clear case where a parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations it is the duty of the judge to allow the court’s own opinion to prevail in the perceived paramount interests of the child concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course a certainty) that the greater the scope for genuine debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parents to whom its care has been entrusted by nature.⁵¹

Thus, Waite L.J. acknowledges that there may be cases in which there is genuine scope for debate with respect to the definition of the child’s best interests and that in such cases, there is a presumption that the parents are the most competent

⁴⁸*Re A (Male Sterilisation)*, [2000] 1 F.L.R. 549 (C.A.) at 555 per Butler-Sloss L.J.

⁴⁹For a good example of such a case see *Couture-Jacquet v. Montreal Children’s Hospital* (1986), D.L.R. (4th) 22 (Que. C.A.).

⁵⁰*J v. C*, [1969] 1 All E.R. 788 (H.L.) at 824 per Lord MacDermott; see also the discussion by B. Clucas & K. O’Donnell, “*Re A (Children): A hard case is no excuse*” (Health Law and our Children, Nottingham Trent University, 10 May 2001) [unpublished; available from the authors upon request].

⁵¹*Re T (A Minor) (Wardship: Medical Treatment)*, *supra* note 36 at 513-14; for a Canadian decision regarding the best interests analysis in the context of a life-saving liver transplant where the parents refused to consent to the transplantation see *Saskatchewan (Minister of Social Services) v. P. (F.)*, *supra* note 40.

decision maker. This raises the question of how to determine whether or not there is genuine scope for debate in a given case so that several treatment options may be regarded as being in the best interests of the child. When promoting the view that the courts will easily override parental views which they perceive as based on scruple and dogma rather than in line with generally accepted majority views, Waite L.J. seems to suggest that this question should be decided based on the parents' motives for the decision. This consideration appears to be directed at cases such as those in which Jehovah's Witnesses oppose life-saving blood transfusions for their children.⁵²

However, it is submitted that the reason for which the parental refusal can be overridden in those cases is not that the decision was based on religious views that are not shared by the majority, but rather that the child's life can easily be saved by the administration of treatment that does not have any serious side effects, while no alternative life-saving treatment is available. Thus, there are no different treatment options and the one available option is clearly in the best interests of the child, unless spiritual interests are regarded as more important than the child's life, which cannot be sustained given the overriding importance of the child's right to life.⁵³ Accordingly, in such cases there is no genuine scope for debate regarding the best interest analysis and the courts can override the parents' views regardless of their motives. On the other hand, if the parental refusal of treatment were based on religious views, but the blood transfusion were controversial given the medical condition of the child, the parents' refusal should be respected, even though it was not based on the same reasons for which the court might consider non-treatment as compatible with the best interests of the child. The same considerations apply to cases in which the refusal of treatment was not based on religious views. In cases in which parents reject the recommended medical treatment in favour of alternative treatment methods, the parents' view should not be dismissed because it deviates from that of the majority as was done in *Re C (HIV Test)*.⁵⁴

Conversely, the perceived reasonableness of the parental decision should not be sufficient to uphold a parental decision not to authorise the administration of life-saving treatment for their child.⁵⁵ Instead, it needs to be examined whether the treatment favoured by the parents or the parental preference for non-treatment can be regarded as lying within the range of options that promote the child's best interests.⁵⁶ This suggestion is also in line with the Canadian approach as developed

⁵²See, for example, *Re S (A Minor) (Medical Treatment)*, [1993] 1 F.L.R. 376 (Fam. Div.); *Re R (A Minor) (Blood Transfusion)*, [1993] 2 F.L.R. 757 (Fam. Div.).

⁵³Fortin, *supra* note 1 at 260; see also *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, *supra* note 29 at 50-52 per La Forest J.

⁵⁴*Re C (HIV Test)*, [1999] 2 F.L.R. 1004 (C.A.) at 1021 per Butler-Sloss L.J.

⁵⁵But see *Couture-Jacquet v. Montreal Children's Hospital*, *supra* note 49, in which the court put a lot of emphasis on the reasonableness of the parental decision.

⁵⁶*Saskatchewan (Minister of Social Services) v. P. (F.)*, *supra* note 40 at 140-43 per Arnot Prov. Ct. J.

in *B. (R.) v. Children's Aid Society of Metropolitan Toronto*.⁵⁷ In that case the majority of the Supreme Court of Canada decided that as the parents have a right under section 7 of the Canadian Charter of Rights and Freedoms to make treatment decisions for their children, any state intervention must be justified, so that the burden is on the courts to show that it was in fact necessary in the best interests of the child to override the parental decision. As La Forest J. put it, the state can intervene, but only "in situations where parental conduct falls below the socially acceptable threshold." Parents may not, in the exercise of their parental rights, refuse their child medical treatment that is necessary and for which there is no reasonable alternative.⁵⁸

Thus, the focus of judicial control should lie on the effect of the parental decision on the child, not on judicial control of the parents' motives. Parents can make their decision according to the dictates of their conscience or religion, or based on intuition. If parents make a choice that is compatible with the best interests of the child, it does not matter on what reasons that decision was based. Only if the outcome of such a decision violates the best interests of the child can it be justified that courts intervene to protect these interests. This is why the suggestion that the courts should review parental decisions according to the principles of judicial review in public law⁵⁹ is not convincing, even though it would lead to a welcome restriction of the role of the court. Public bodies must make rational decisions based on a proper consideration of all relevant facts,⁶⁰ while parents are under no such obligation, as long as they do not violate the best interests of their children.

If a court comes to the conclusion that there was genuine scope for debate regarding the choice of treatment options, for example because several treatment options are available and there is no clear answer as to which would best serve the interests of the child, there is no reason why the court would be better placed than the parents to make the final decision. As long as the parents' decision is within the range of options that are compatible with the best interests of the child, there is no reason for the court to override their views.⁶¹ Only in cases in which there is either no room for genuine debate, for example if there is only one form of treatment available to save the child's life or to preserve the child's health, and the benefits of that treatment are not outweighed by its burdens, or if, on the balance, regardless of serious side-effects, the presumption in favour of life still clearly prevails, should the court intervene and substitute its own decision for that of the parents. Given that

⁵⁷*Supra* note 29 at 42 per La Forest J.

⁵⁸*Ibid.* at 52.

⁵⁹*Medical Law, supra* note 20 at 793.

⁶⁰*North West Lancashire HA v. A, D and G*, [2000] 1 W.L.R. 977 (C.A.) at 997 per Buxton L.J.

⁶¹See the American decision in *Re Hofbauer*, 395 N.E. 2d 1109 (N.Y. C.A. 1979) and the Canadian decision in *Saskatchewan (Minister of Social Services) v. P. (F.)*, *supra* note 40 at 140-43 per Arnot Prov. Ct. J.

court involvement in these cases is discretionary, it seems more consistent for the court to do no more than to make sure that the parents' decision is within a range of options that could be regarded as promoting the child's best interests.

3.2. Parents, physicians and the court in *Re A*

In *Re A*, in line with previous cases, the Court of Appeal held that while court involvement was not mandatory, once involved, the court had to make its own assessment of the best interests of the children. With regard to the weight to be given to the views of the parents, Ward L.J. went to some length to profess sympathy for their situation before stating that to uphold their views would not be in the children's best interests. He implied that their worries that they might not be able to meet Jodie's special needs, given the lack of medical facilities at Gozo and the limits of their own financial resources reflected their concern that they might not be able to cope with her disabilities, thus concentrating on their own best interests rather than Jodie's.⁶² He also suggested that the parents had "in their natural repugnance of the idea of killing Mary ... fail[ed] to recognise their conflicting duty to save Jodie,"⁶³ thereby not according sufficient weight to Jodie's interests. This seems to suggest that Ward L.J. was of the opinion that the parents' decision was highly influenced by their religious conviction and that that disqualified them from making an objective assessment of their children's best interests. Based on his view that on the balance, Jodie's best interests should prevail over Mary's, and that to operate would be to choose the lesser of two evils, he came to the conclusion that the parents' views should be disregarded in this case. He even went as far as expressing the opinion that:

If a family at the gates of a concentration camp were told they might free one of their children but if no choice were made both would die, compassionate parents with equal love for their twins would elect to save the stronger and see the weak one destined for death pass through the gates.⁶⁴

Ward L.J.'s discussion of the weight to be given to the decision of the parents seems to suggest that the perceived reasonableness or unreasonableness of the parental choice, though officially rejected as a criterion for the court's decision, nevertheless plays an important role. This becomes clear when comparing *Re A* with *Re T*.⁶⁵ In the case of *Re T*, the parents were both health professionals and managed to convince the Court that their refusal was well thought through and not based on minority views. In *Re A*, on the other hand, the parents were peasants from Gozo whose life choices were primarily based on their adherence to the tenets of

⁶²*Re A*, *supra* note 2 at 52-53.

⁶³*Ibid.* at 53.

⁶⁴*Ibid.*

⁶⁵*Re T (A Minor) (Wardship: Medical Treatment)*, *supra* note 36.

Catholicism. Their values were not shared by the English Court and it was therefore easy for the Court to dismiss them as unreasonable and to disregard them accordingly. It seems as if the courts regard the parents' motives, values and background to be at least as important as, if not more important than, the impact of their decision on their children when deciding whether or not to override or to respect parental wishes.

Both Robert Walker L.J. and Ward L.J. confirmed that the parental decision in *Re A* was not based on "scruple and dogma." Given that Waite L.J.'s statement in *Re T* was quoted as authority, before overriding the parents' decision because it differed from the view of the judges, it should at least have been discussed whether or not there was "genuine scope for debate" in this case. This depends on the focus of the best interests analysis. The determination of Jodie's and of Mary's best interests was not particularly controversial. While the operation was clearly in Jodie's best interests, it as clearly violated the best interests of Mary. The controversy thus did not consist of how to determine the best interests of each twin, but of how to resolve the dilemma that the interests of the two children were diametrically opposed.

Ward L.J. suggested that the solution would be to balance the interests of the two children,⁶⁶ which he did by focussing on the question of which course of treatment would constitute the lesser of the two evils. The parents had done just that when they considered the interests of both children and arrived at the conclusion which was shared by many that it was better for both children to be left to die a natural death than for Mary to be sacrificed to save Jodie. If the dilemma is to be resolved by balancing the best interests of both children against each other, it seems that, given the wide controversy over the issue, this is a question that should have been left to the parents to decide.⁶⁷ If a balancing of the conflicting interests of the children is not regarded as necessary,⁶⁸ it is the court's role to clarify the complex legal issues raised by this case and to declare which course of action can lawfully be taken.⁶⁹ If that analysis shows that alternative actions could be lawful, then it should be left to the parents to decide which alternative to choose.⁷⁰

While the choice of the parents was disregarded easily in *Re A*, a right to choose was conferred on the medical profession. To that effect, Ward L.J. held that:

⁶⁶*Re A*, *supra* note 2 at 53-54.

⁶⁷See also R. Gillon, "Imposed separation of conjoined twins – moral hubris by the English courts?" (2001) 27 J. Med. Ethics 3 at 3-4.

⁶⁸The author would argue that it is not, as the decisive question was one of criminal law, not of family law. See S. Michalowski, "Sanctity of Life - issues across legal boundaries," Legal Studies, forthcoming.

⁶⁹In this case this needs to be determined according to criminal law principles, as the main question was one of the applicability of criminal law defences.

⁷⁰This is also the approach adopted in *Re Hofbauer*, *supra* note 61, and in *Saskatchewan (Minister of Social Services) v. P. (F.)*, *supra* note 40.

Faced as they are with an apparently irreconcilable conflict, the doctors should be in no different position from that in which the court itself was placed in the performance of its duty to give paramount consideration to the welfare of each child. The doctors must be given the same freedom of choice as the court has given itself and the doctors must make the choice along the same lines as the court has done.⁷¹

Medical evidence has been decisive in most English cases regarding the medical treatment of children. Even in *Re T*, while all physicians agreed as to the medical benefits of the treatment, the court could base its decision to accept the parental refusal of consent on medical evidence, as one of the treating physicians had pointed to the importance of the parental attitude for the recovery of the child after the operation. *Re A* goes beyond the existing bias towards medical opinion, as the Court of Appeal seems to have accorded the physicians a quasi-judicial function which stands in sharp contrast to the principle that treatment decisions on behalf of children are to be made either by the parents or the courts. There is no reason to give physicians such far-reaching powers. While the child's medical interests will often be decisive in the context of treatment decisions, other factors such as the child's overall quality of life once the treatment has been administered, including the child's emotional well-being, practical considerations and the child's social situation, are important as well,⁷² and the parents and courts are better placed to balance all relevant considerations than the physicians. If there is a perceived conflict of interests, in that the physician can only fulfil his or her duty of care towards one patient to the detriment of the other patient, it is up to the courts to decide what the physicians can or cannot lawfully do. Where several treatment options would be lawful, it should be left to the parents' decision to decide which course to take, as the parents, not the physicians are entrusted in law to make decisions on behalf of their children.

4. Conclusion

On the surface, it seems as if the law has regulated the decision-making process in the context of medical treatment of children in favour of parental decisions by giving the parents the decisive role of the primary decision maker. Physicians can only make decisions in cases of emergency, and are otherwise reduced to seeking a court decision where the parents have withheld their consent to the recommended course of treatment. Courts can only in exceptional cases substitute their decision for that of the parents, either because the treatment is non-therapeutic and falls outside the parental powers, or because the physicians disagree with the parents' refusal of treatment and use their discretion to resort to the court.

⁷¹*Re A*, *supra* note 2 at 60.

⁷²*Re A (Male Sterilisation)*, *supra* note 48 at 555 per Butler-Sloss L.J.; *Saskatchewan (Minister of Social Services) v. P. (F.)*, *supra* note 40 at 142 per Arnot Prov. Ct. J.

It looks as if at least in cases of agreement between parents and physicians, the parents' wishes are determinative, as it is their consent that enables the physician to treat the child. This would be in line with the important role accorded to parents by the legislator. However, the only reason why these cases never reach the courts is that the medical decision was endorsed by the parents. Thus, the vast majority of cases in which a child needs medical treatment do not reach the courts because the physician's advice is followed by the parent. In cases of disagreement, both parents and physicians can involve the courts in trying to get their way, their positions thus seemingly being equal. However, for a realistic assessment of the roles of the parents and the medical profession it needs to be taken into account how the courts tend to resolve the conflict between parental and medical views. While the courts keep stressing that great weight needs to be given to parental wishes, they are not decisive, and in almost all cases, the courts give medical evidence preference over parental wishes when resolving conflicts between parents and medical practitioners.

This means that the medical profession can influence treatment decisions on behalf of children at two different levels. First, the medical profession decides whether or not to bring certain cases to the attention of the courts. Secondly, medical evidence as to the treatment available to the child will often play a decisive role in court once the medical practitioner decides to invoke the courts' jurisdiction. Thus, in cases of conflict between parents and physicians regarding the medical treatment of a child, the physician holds a powerful tool in being able to involve a new decision maker where the parents disagree with his or her advice, as both parties know that, once involved, the courts tend to follow medical evidence. On the other hand, courts have consistently refused to order treatment which is desired by the parents but rejected by the treating physicians on clinical grounds.⁷³ Thus, if the parents involve the courts because they disagree with the medical decision, the courts will routinely uphold the decision of the medical profession.

When looking more closely at the respective roles of the parents, the physicians and the courts in the context of treatment decisions for minors, it is thus obvious that there is a great disparity between legal principles and reality. The decision in *Re A* demonstrates that the courts' approach to substitute their own decision for that of the parents combined with the tendency to give precedence to medical evidence leads to a shift from parental powers to a more and more influential role for the medical profession. This sits uneasily with the simultaneous trend towards the recognition that best interests are more than medical interests,⁷⁴ which should reemphasise that physicians cannot be the best judges of their child patients' best interests. Courts will have to rely on medical evidence for an

⁷³See, for example, *Re J (A Minor) (Wardship: Medical Treatment)*, *supra* note 37 at 49 per Lord Donaldson M.R.; *Re C (Medical Treatment)*, *supra* note 12; *NHS Trust v. D*, *supra* note 12.

⁷⁴See, for example, *Re MB (Medical Treatment)*, [1997] 2 F.L.R. 426 (C.A.) at 439 per Butler-Sloss L.J.; *Re A (Male Sterilisation)*, *supra* note 48 at 555 per Butler-Sloss L.J.

evaluation of the child's medical interests, and on the evidence of the parents to assess the overall interests of the child. Parents will equally base their determination of the child's best interests on medical advice and on their own perception of the child's interests. There is no reason to believe that outside of cases of non-therapeutic treatment the courts are better placed than the parents to make treatment decisions. Accordingly, courts should restrain themselves to controlling whether or not a parental decision lies within the range of treatment options which can lawfully be performed and promote the best interests of the child. If it does, the parents' decision should be respected, regardless of the parents' motives. Only if this is not the case should the court substitute its own decision of how best to protect the interests of the child for that of the parents.