# **CHILDREN UNDER THE KNIFE: CURRENT INTERESTS, FUTURE INTERESTS OR PARENTAL INTERESTS?**

## **Introduction**

It is both natural and essential to take a paternalistic approach to raising a child.[[1]](#footnote-1) This is in order to protect the child’s long-term interests from their immature judgement. Parents have a right to shape their child by raising them in accordance with their religion and values, choosing their diet, education and accommodation. However, it is a parent’s duty to preserve their child’s right to an open future and to not take irreversible actions which may deprive the child of future life choices.[[2]](#footnote-2) There is a potential adult in every child and it is this potential adult’s autonomy which must be protected while the child is young.[[3]](#footnote-3)

In the context of health care decisions, the law supports a parents right to make medical decisions on the behalf of his children. The general presumption are that a parent will make a decision on medical treatment with the child’s best interests in mind.[[4]](#footnote-4) Parental rights, however, tend to only be invoked where a decision is controversial.[[5]](#footnote-5) Where there is an agreement on medical treatment between parents and doctors, it is presumed that the best-interests standard has been satisfied. This parent-doctor presumption allows doctors to recommend, and parents to give consent to, medically unnecessary treatments. This leaves gaps in the law which potentially lead to a failure in protecting a child’s right to a open future.[[6]](#footnote-6)

This article will examine the adequacy of the law in protecting the open future principle. As will be discussed the law protects children against some non-therapeutic procedures but not others. It will be claimed that the malleability of the best interests standard leads to gaps in the law for three reasons. Firstly, if the surgery is not life-threatening it can often be justified through the harm principle. Secondly there is a presumption that the parent will make a decision with their child’s best interests at heart, even though this is not always the case. Thirdly, the medical profession is afforded too much scope when applying the best interests standard. The arguments in this paper will focus on young minors who are not yet Gillick competent.[[7]](#footnote-7)

## **The best interests standard**

Parental authority over healthcare decisions is not unlimited. For example, all UK blood transfusion refusals have been overridden on the basis that necessary transfusions represent the child’s best interests, even if this conflicts with the religious views of the family.[[8]](#footnote-8) The restrictions to a parent’s power over their child’s body applied not only to refusals of treatment but also to consent. This can be seen through the criminalisation of non-therapeutic surgery such as female genital mutilation (FGM) and sterilisation of children without Court approval. In these situations, the law acknowledges and protects a child’s right to an open future. In view of this, the law appears to agree with the claim that parents plays a fiduciary role in a child’s life rather than a property-owning one.[[9]](#footnote-9) They are legally bound to hold their child’s future rights on trust until they are old enough to exercise them. However, the Laws limiting parental authority are only procedure specific and therefore do not protect children from being inflicted with other non-therapeutic treatment.

In regards to other non-therapeutic decisions, a parent-doctor presumption is applied. Parents may provide consent to procedures of a cosmetic nature such as ear-pinning, circumcision, limb-lengthening and genital normalising surgery by arguing that the procedure is in the child’s best interests. The legality of such procedures raise questions concerning the adequacy of the best-interests standard applied by the courts and medical practitioners in guarding the concept of an open future

The best-interests standard has been criticised for its inherent vagueness and lack of explicit normative guidance.[[10]](#footnote-10) It has been described as an ‘empty rhetoric’.[[11]](#footnote-11) The ambiguity of the phrase raises concerns that the standard can be manipulated in order to justify questionable treatments[[12]](#footnote-12). Despite this, supporters of the best-interests standard agrees that the concept is subjective but also highlight that, as a society, we have a general consensus about what a ‘good’ life entails[[13]](#footnote-13). The standard is easily applied where the child’s life is at jeopardy and parental autonomy rights are overridden.[[14]](#footnote-14) However, in situations where a proposal for treatment lacks therapeutic intent, an application of best interests standard is not so straightforward.

1. **The Court’s Approach to Non-therapeutic Procedures**

The malleability of the best-interests standard becomes obvious in its application to ritual male circumcision, a procedure which has no proven medical benefits. When weighing the benefits and the harms of the procedure in terms of the child’s well-being, it is apparent that the surgery is not to the child’s best interests. Irrespective of this, it was held as obiter dicta in R v Brown[[15]](#footnote-15) that ritual male circumcision is lawful.[[16]](#footnote-16) The best-interests standard is inherently centred on values[[17]](#footnote-17) and, therefore, a multitude of reasons can justify a procedure if more weight is attached to cultural values than to the physical harm caused. Bridge, for instance, claims that circumcision is justification under the best-interests principle as it is important for the welfare of the child that he conforms to family traditions.[[18]](#footnote-18) Such reasoning is also listed as a justification in the British Medical Association guidelines.[[19]](#footnote-19) However, it is debatable whether cultural benefits justify impinging a child’s right to an open future.

A right to an open future places value on self-fulfilment and liberty.[[20]](#footnote-20) If actions are taken in childhood which later leave an adult unable to make future choices, the opportunity for self-fulfilment and liberty will be diminished. Although a child’s relational background will influence his decisions later in life, the child may grow up to challenge the values of his parents. As circumcision involves permanently altering the body, the child’s freedom of religious choice may be restricted by their parents’ decisions.[[21]](#footnote-21) On the other hand, Mills claims that providing children with an open future is both impossible and undesirable.[[22]](#footnote-22) She argues that the idea of raising a child in a way which provides the ability to pursue all options are superficial and it is impossible to rear a child without encouraging him down one path or another.[[23]](#footnote-23) However, this does not take into account that a child can be raised in a way which makes him aware of other ways of life so that, if he chooses to, he have the option of living their life differently.

In the context of circumcision, Mills’ thoughts can be applied to debate that, while Muslim parents may be viewed as closing off the right to religious freedom through circumcision, state intervention could also be seen as closing off a child’s option of living in accordance with his family’s values and belonging to a religion. In this way, it can be argued that state intervention will influence religious freedom. It is highly debatable where the line should be drawn between morally acceptable and unacceptable decisions.[[24]](#footnote-24) Feinberg contends that state-neutrality is impossible.[[25]](#footnote-25) In refusing to intervene, the state is still playing a part in closing off the child’s options. With that being said, the state’s decision to intervene may not have such a drastic effect as the child has the option of being circumcised as an adult. Increasing or reducing the likelihood of a child’s faith will not close off their options. The child will still have the ability to rejected or accept the faith they have been raised to follow when they become autonomous.

1. Joel Feinberg, *Freedom and Fulfilment* (Princeton University Press 1992), 76. [↑](#footnote-ref-1)
2. Robert Darby, ‘The Child’s Right to an Open Future: Is the Principle Applicable to Non-therapeutic Circumcision?’ (2013) 39 Journal of Medical Ethics 463, 464. [↑](#footnote-ref-2)
3. Ibid. [↑](#footnote-ref-3)
4. Alicia Ouellette, ‘Eyes Wide Open: Surgery to Westernize the Eyes of an Asian Child’ (2009) 39 The Hastings Centre Report 15, 16. [↑](#footnote-ref-4)
5. Robert van Howes, ‘Infant circumcision: the last stand for the dead dogma of parental (sovereignal) rights’ (2013) 39 Journal of medical ethics 475, 475. [↑](#footnote-ref-5)
6. Anne Tamar-Mattis, ‘Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants’ (2006) 21 Berkeley Journal of Gender Law and Justice 39, 89. [↑](#footnote-ref-6)
7. Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security[1986] 1 FLR 224. [↑](#footnote-ref-7)
8. *Re S (A Minor)* [1993] 1 FLR 376; *Re O (A Minor) (Medical Treatment)* [1993] 1 FCR 925; Re S (A Minor) (Consent to Medical Treatment)[1995] 1 FCR 604. [↑](#footnote-ref-8)
9. Alicia Ouellette, ‘Eyes Wide Open: Surgery to Westernize the Eyes of an Asian Child’ (2009) 39 The Hastings Centre Report 15, 17. [↑](#footnote-ref-9)
10. Mary Donnelly, Health Care Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism (CUP 2010) 176. [↑](#footnote-ref-10)
11. Ian Kennedy, *Treat Me Right: Essays in Medical Ethics* (Clarendon Press 1991) 90 [↑](#footnote-ref-11)
12. Jonathan Herring, *Vulnerable Adults and the Law* (OUP 2016) 208 [↑](#footnote-ref-12)
13. Ibid [↑](#footnote-ref-13)
14. *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 193. [↑](#footnote-ref-14)
15. *R v Brown* [1993] 2 All ER 75. [↑](#footnote-ref-15)
16. *R v Brown* [1993] 2 All ER 75, 79. [↑](#footnote-ref-16)
17. Douglas Diekma, ‘Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention’ (2004) 25 Theoretical Medicine and Bioethics 243, 246. [↑](#footnote-ref-17)
18. Caroline Bridge, ‘*Religion, Culture and Conviction: The Medical Treatment of Young Children*’ (1996) 11 Child and Family Law Quarterly 1, 5 [↑](#footnote-ref-18)
19. British Medical Association, “The Law and Ethics of Male Circumcision: Guidance for Doctors” [2004] 30 Journal of Medial Ethics 259 [↑](#footnote-ref-19)
20. Jonathan Morgan, ‘Religious Upbringing, Religious Diversity and a Child’s Right to an Open Future’ (2005) 24 Studies in Philosophy and Education 367, 370. [↑](#footnote-ref-20)
21. Robert Darby, ‘The Child’s Right to an Open Future: Is the Principle Applicable to Non-therapeutic Circumcision?’ (2013) 39 Journal of Medical Ethics 463, 465. [↑](#footnote-ref-21)
22. Claudia Mills, ‘The Child’s Right to an Open Future?’ (2003) 34 Journal of Social Philosophy 499, 499. [↑](#footnote-ref-22)
23. Ibid, 500. [↑](#footnote-ref-23)
24. Ibid, 503. [↑](#footnote-ref-24)
25. Feinberg (n 1) 85. [↑](#footnote-ref-25)