'Paternalism, Children's Health and Parental Rights' Workshop

Paternalism, Health, and Public Policy Project

https://paternalismhealthpublicpolicy.org/

Day One: 12th September

Location: Penthouse Suite, Collingwood College, South Road, Durham, DH1 3LT

11:00-11:20	Tea and Coffee	
11.20 – 11.30	**Welcome and Introduction**	
11:30 – 12:45	**David Archard** Queen's University, Belfast	*Children, paternalism and respect for their views*
12:45 – 13:30	Lunch	
13:30 – 14:45	**Emma Cave** Durham University	*Medical treatment of children: Paternalism and proxy decision making*
14:45 – 15:15	Tea and Coffee	
15:15 – 16:30	**Ben Davies** University of Oxford	*Best interests, harm and sufficient benefit: Thresholds in paediatric healthcare decision-making*
16:30 – 17:00	Tea and Coffee	
17:00 – 18:15	**Matthew Clayton** University of Warwick	*Children's entitlement to paternalism without perfectionism*
18.30 - onwards	Dinner and Drinks (all welcome!)	*Spice Lounge* *St. Nicholas Cottage, Market Place, Durham, DH1 3NJ*

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Durham University

LSE Department of Philosophy, Logic and Scientific Method

DAY TWO: 13TH SEPTEMBER

Location: Penthouse Suite, Collingwood College, South Road, Durham, DH1 3LT

8:45 – 9:15	Tea and Coffee	
9:15 – 10:30	**Dominic Wilkinson** University of Oxford	*Paternalism and the zone of parental discretion in decisions about treatment for children*
10:30 – 11:00	Tea and Coffee	
11:00 – 12:15	**Anca Gheaus** Central European University	*Beyond anti-perfectionism in upbringing: How should children be paternalised?*
12:15 – 13:00	Lunch	
13:00 – 14:45	**Roundtable** Discussants: **Emma Cave** Durham University **Liam Shields** University of Manchester **Nico Brando** University of Liverpool	*Compulsory Childhood Vaccination*
14:45	End	

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ABSTRACTS

David Archard (Queen's University, Belfast): *Children, paternalism and respect for their views*

The orthodoxy is that children incapable of deciding what is in their interests but capable of expressing a view about what they want may be subject to paternalistic treatment albeit they should be listened to. Article 3 and 12 of UNCRC are canonical statements of, respectively, a best interests requirement and a child's right to express views on self-regarding matters. There are problems in defending a BI standard, understanding how we should balance a child's best interests against their views, and also what it means differentially to weight those views according to the child's maturity. Less discussed is why we should listen to a child. I think accounts of the instrumental value of listening fail to give a satisfactory answer. I want to explore the following thought: just as we owe respect to the voluntary self-regarding choices of adults (mature, reasonably rational individuals) we should respect the views of capable children. I shall try to explain what this means and what justifies the thought.

Emma Cave (Durham University): *Medical treatment of children: Paternalism and proxy decision making*

In this paper paternalism is broadly understood as interference with a person's decisions in order to promote their welfare. This paper starts from the premise that soft paternalism to protect the best interests of a patient who cannot decide for themselves is not only justified but a moral requirement in a society that takes the rights of vulnerable people seriously. In line with a will theory of rights, hard paternalism, on the other hand, is a troublesome incursion of autonomy rights that requires justification. Hard paternalism protects the best interests of a patient notwithstanding their ability to make decisions for themselves. I consider three controversial claims and discuss how the courts in England and Wales react to each one in recent case law. The claims are that the following constitute unwarranted hard paternalism: (1) Judicial override of certain decisions by parents about their child's medical treatment; (2) Judicial override of a child's refusal of life sustaining treatment in circumstances where they are *Gillick* competent or have mental capacity; (3) Judicial endorsement of a requirement that both a child and their parent must consent to a particular medical treatment.

Benjamin Davies (University of Oxford): *Best interests, harm and sufficient benefit: Thresholds in paediatric healthcare decision-making*

Several recent cases have highlighted conflicts between parents and medical professionals over the treatment of young children. The standard framework for

addressing such cases is the Best Interests Standard (BIS). Critics of BIS suggest that it is potentially misleading in its focus on maximising individual value. Parents do not have obligations to maximise children's well-being in other areas of life, such as education or diet. Thus, critics of BIS suggest that parents should have wider latitude for decision-making over their child's health, so long as their decision does not 'harm' their child.

I suggest that appeals to harm suffer similar worries of indeterminacy between counterfactual and absolute analyses. Many medical interventions harm patients absolutely even if they are counterfactually good for them. When little can be done for a child, the best decision may be one that still leaves them very badly off. Thus, the notion of harm involved in a 'harm principle' must be an all-things-considered, counterfactual principle: preferred interventions must compare favourably to alternatives. But how favourably is unclear. The standard cannot be that interventions are harmful if there are better alternatives—this reduces a harm principle to BIS. So we need some account of the standards below which an intervention is (too?) harmful.

In contrast with a focus on harm I suggest a focus on 'sufficient benefit': does the intervention deliver a level of benefit that is close enough to available alternatives? While such an approach is clearly still open to disagreement, I suggest it better reflects judgements made in such cases.

Matthew Clayton (University of Warwick): *Children's entitlement to paternalism without perfectionism*

I briefly summarise my conception of independence for children, which can be interpreted as defending paternalism without perfectionism: paternalism that protects and promotes young people's interest in freedom and equality rather than their well-being. I then turn to the question of how we ought to understand children's entitlement healthcare if well-being is excluded from consideration. I suggest that that entitlement should be elaborated in a way that is sensitive to (i) a concern for individuals' interest in being free and equal persons, (ii) the health insurance that fairly-situated individuals would purchase, and (iii) increasing respect for the views of the young as they develop in maturity.

Dominic Wilkinson (University of Oxford): *Paternalism and the zone of parental discretion in decisions about treatment for children*

Disputes about medical treatment for children sometimes give rise to claims that UK doctors and courts are unreasonably paternalistic, and unfairly infringe on parental rights to decide. No other country appears to have as many court cases relating to medical treatment in children. In a number of recent high profile case, overseas

hospitals have offered to provide or continue treatment that parents were seeking, but UK courts have prevented transfer of the child.

In this paper, I review the ethical boundaries of decision-making for children, including the justification for constraining parental decisions, and the nature of thresholds for intervention. I explore the concept of ethical dissensus and reasonable (versus unreasonable) disagreement as a way of identifying when it is justified to overrule parents. International variations in approach to parental decision-making reflect both differing values, and the different social contexts of decisions. Finally, I compare the boundaries of adolescent discretion in decision-making with those that apply in adulthood and earlier in childhood.

Anca Gheaus (Central European University): *Beyond anti-perfectionism in upbringing: How should children be paternalised?*

Amongst contemporary political philosophers there is a debate about the proper limits of exercising paternalism over children. The majority view, which Matthew Clayton calls "the liberal consensus," is that parents have a liberty right to raise their children according to controversial conceptions of the good (for instance, parents' own) as long as children also acquire, in due course, a sense of justice and full personal autonomy; the latter is a guarantee that children will be able to reject the ethical, metaphysical and religious values that have guided their upbringing. Against this, anti-perfectionists in upbringing – Clayton and, more recently, others as well – claim that parents and other adults with authority over children are not permitted to foist on children controversial ethical, metaphysical and religious ideals. The exercise of paternalism over children is limited by children's moral status as individuals with developing rationality and the interest of their future selves in not having had their childhood usurped by others, even with the intention of promoting the child's flourishing.

Like anti-perfectionists, I believe that parents lack not only a right but also a permission to foist controversial conceptions of the good on their children. But anti-perfectionism in upbringing comes at too high a cost to wellbeing during childhood and future wellbeing. I propose, and to some extent defend, a third view: children have a weighty interest in being initiated into a variety of reasonable ethical, metaphysical and religious conceptions by people who hold the respective views, so that the child can gain an insider's view into what it means to hold, and live according to, these conceptions. As long as they are protected from monopolies of influence over them, and as long as advocates do not use coercion, deceit, or manipulation, children can greatly benefit without having their rational abilities subverted, or being otherwise disrespected. In a nutshell, children ought to be paternalised by a multitude of individuals, respectfully.

I also examine the limited applicability of these three views when it comes to certain

decisions about children's lives, that cannot be bypassed or postponed, and where any course of action will inevitably be guided by a controversial view of the good life. Prime examples are medical interventions on children too young to decide for themselves, and where all courses of action (or inaction) are compatible with preserving the child's future autonomy, but where the stakes for the child's wellbeing are very high – at least, as seen from the vantage point of the most prevalent conceptions of what it means to lead a flourishing life.