‘Best interests’ in paediatric intensive care: an empirical ethics study

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ABSTRACT
Objective In English paediatric practice, English law requires that parents and clinicians agree the ‘best interests’ of children and, if this is not possible, that the courts decide. Court intervention is rare and the concept of best interests is ambiguous. We report qualitative research exploring how the best interests standard operates in practice, particularly with decisions related to planned non-treatment. We discuss results in the light of accounts of best interests in the medical ethics literature.

Design We conducted 39 qualitative interviews, exploring decision making in the paediatric intensive care unit, with doctors, nurses, clinical ethics committee members and parents whose children had a range of health outcomes. Interviews were audio-recorded and analysed thematically.

Results Parents and clinicians indicated differences in their approaches to deciding the child’s best interests. These were reconciled when parents responded positively to clinicians’ efforts to help parents agree with the clinicians’ view of the child’s best interests. Notably, protracted disagreements about a child’s best interests in non-treatment decisions were resolved when parents’ views were affected by witnessing their child’s physical deterioration. Negotiation was the norm and clinicians believed avoiding the courts was desirable.

Conclusions Sensitivity to the long-term interests of parents of children with life-limiting conditions is defensible but must be exercised proportionately. Current approaches emphasise negotiation but offer few alternatives when decisions are at an impasse. In such situations, the instrumental role played by a child’s deterioration and avoidance of the courts risks giving insufficient weight to the child’s interests. New approaches to decision making are needed.

INTRODUCTION
Between 2004 and 2013, admissions of children to paediatric intensive care units (PICUs) in the UK rose by 13%. This increase was in part due to advances in life-sustaining technology and increasing numbers of children surviving with life-limiting conditions.1 2 Most deaths in the PICU follow decisions to withdraw or limit treatment.3 The majority of PICU patients are ventilated and three-quarters are under 5 years old.2 Such patients are unable to participate in decision making.

‘Best interests’ is the international ethico-legal standard by which decisions are made about children.4 5 Although ‘best interests’ are conceptually ambiguous, English law states that the child’s best interests are the paramount consideration in any decision,6 and holds that best interests go beyond medical interests to encompass ‘medical, emotional and all other welfare issues.’7 Legal and professional guidance states parents and clinicians should share ‘best interests’ decisions8 and in non-emergency situations the courts should be involved if agreement cannot be reached.9 Thus, the current situation resembles shared decision making, a defining (although still ambiguous) feature of contemporary doctor–patient relationships.10

The ambiguities of the decision-making process create the potential for conflict.11 Although legal records indicate lengthy and sometimes acrimonious negotiation between parents and clinicians,12 recourse to the courts appears rare8 and relatively little is known about what happens in practice. This study explores how decisions are made, with a particular focus on decisions about (non-)treatment. Our objective is to critically describe the way in which the best interests standard operates in PICU, with reference to theories of ‘best interests’ from the medical ethics literature.
METHODOLOGIES

The study is a qualitative interview study embedded in a larger ‘empirical ethics’ study. Empirical ethics is a methodology increasingly used in bioethics to ensure that practical experiences inform theoretical analysis. Empirical ethics methodologies arise from concern that philosophical medical ethics has not adequately considered the experiences and social contexts of patients or doctors. Empirical ethics methodologies vary but broadly comprise processes that critically synthesise theoretical and empirical sources. Our study used a method known as ‘reflective equilibrium’ to synthesise a literature review and results of a qualitative study. In this article, we present the qualitative study that was part of this process and interpret the qualitative findings in relation to relevant medical ethics literature.

Participants in the qualitative study comprised key decision makers at three English PICUs. Following practice guidelines, we defined key decision makers as parents, doctors, nurses and members of clinical ethics committees.

Parents were eligible to participate if their child had been admitted to PICU within the past 2 years (to minimise duress), was <4 years old (to ensure the child expressed no antecedent wishes) and was critically ill with length of admission >4 days (to ensure adequate experience of PICU). Parents were sampled purposively to reflect potential health outcomes of a PICU admission. Parents were approached by letter from their treating PICU and were asked to send a reply slip to the study team if they wished to discuss participation. Doctors, nurses and members of clinical ethics committees were approached if they had experience of PICU decisions.

A total of 234 potential participants were approached in writing and 49 people replied. Interviews and analysis took place iteratively until thematic saturation was achieved, which occurred at 39 interviews and recruitment was ceased. The final sample comprised 14 parents, 10 doctors, 8 nurses and 7 members of clinical ethics committees (table 1).

Parents were given the option to be interviewed alone or with a partner (table 2). Interviews explored participants’ experiences of decision making. Interview topics, including scope of parental discretion and acceptable quality of life, were developed from existing literature. Interviews lasted 40–180 min and consent was provided immediately before each interview.

**Table 1** Recruitment

<table>
<thead>
<tr>
<th>Group</th>
<th>Study site</th>
<th>Approaches</th>
<th>Responses</th>
<th>Consents</th>
<th>Interviews</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>Site 1</td>
<td>71</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
<td>40</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Site 3</td>
<td>20</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Doctors</td>
<td>Site 1</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Site 3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Nurses</td>
<td>Site 1</td>
<td>20</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinical ethics committee</td>
<td>Site 1</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
<td>(44)*</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

*At site 2, the committee chair circulated the details of the study to members and invited them to respond directly to the chief investigator.

**Table 2** Characteristics of parents

<table>
<thead>
<tr>
<th>ID*</th>
<th>Participant(s) in interview</th>
<th>Age of child</th>
<th>Admission type</th>
<th>Length of admission†</th>
<th>LLC‡</th>
<th>Outcome of admission§</th>
</tr>
</thead>
<tbody>
<tr>
<td>P40</td>
<td>Both parents</td>
<td>&lt;1 month</td>
<td>Emergency</td>
<td>&gt;1 month⁴</td>
<td>Yes</td>
<td>Ongoing ill health</td>
</tr>
<tr>
<td>P41</td>
<td>Both parents</td>
<td>&lt;1 month</td>
<td>Emergency</td>
<td>&gt;1 month⁴</td>
<td>Yes</td>
<td>Death</td>
</tr>
<tr>
<td>P42</td>
<td>Mother**</td>
<td>1–12 months</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>Yes</td>
<td>Death</td>
</tr>
<tr>
<td>P45</td>
<td>Both parents</td>
<td>1–4 years</td>
<td>Emergency</td>
<td>2–4 weeks</td>
<td>No</td>
<td>Ongoing ill health</td>
</tr>
<tr>
<td>P55</td>
<td>Mother</td>
<td>1–4 years</td>
<td>Emergency</td>
<td>2–4 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P56</td>
<td>Both parents</td>
<td>1–12 months</td>
<td>Elective</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P58</td>
<td>Mother</td>
<td>1–4 years</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Ongoing ill health</td>
</tr>
<tr>
<td>P59</td>
<td>Both parents</td>
<td>1–4 years</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>Yes</td>
<td>Ongoing ill health</td>
</tr>
<tr>
<td>P60</td>
<td>Mother</td>
<td>&lt;1 month</td>
<td>Emergency</td>
<td>2–4 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P61</td>
<td>Mother</td>
<td>1–4 years</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Ongoing ill health</td>
</tr>
<tr>
<td>P62</td>
<td>Mother</td>
<td>1–4 years</td>
<td>Elective</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P63</td>
<td>Mother**</td>
<td>1–4 years</td>
<td>Elective</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P64</td>
<td>Mother</td>
<td>&lt;1 month</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
<tr>
<td>P65</td>
<td>Both parents</td>
<td>1–12 months</td>
<td>Emergency</td>
<td>&lt;2 weeks</td>
<td>No</td>
<td>Recovery</td>
</tr>
</tbody>
</table>

*Participant identifier.
†Period of time given to aid anonymity.
‡Outcome of admission §
§Includes time on ward due to multiple readmissions to PICU during hospital stay.
**A supportive other was also present but did not participate in the interview.
¶Total length of stay on ward plus PICU as times were unclear.

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Interviews were transcribed, anonymised and analysed thematically. The first author assigned codes to the data, with codes derived inductively. Data were then grouped into broader themes. Ten per cent of transcripts were second coded independently by members of the study team, and this process was used to refine codes and theme development.

**Ethics**

The study was funded by the Wellcome Trust (grant number WT077725MF) and received Research Ethics approval from the Southwest NHS Research Ethics Committee (reference 12/SW/0210). All participants gave written, informed consent, including to audio-recording and publication of anonymised quotations.

**RESULTS**

Analysis of interviews with study participants gave rise to three central themes that covered the ideal principles and practical processes of decision making and the role of the courts:

**How should decisions be made?**

Most participants thought that decisions should be shared between clinicians and parents but did not necessarily agree how this should occur. Parents were unanimous that the child alone should be the focus of the decision but felt that families should be allowed to make independent decisions where the life of their child was at stake. Doctors considered collaboration with families to be standard practice but voiced concerns about the impact on parents of sharing life or death decisions. Some clinicians explicitly conflated child and parent interests or emphasised the interests of the parents where prognosis was poor (Box 1).

**What happens in practice?**

**Parents’ views**

Parents’ views about what ought to occur did not always equate to what happens in practice. While parents accepted clinical expertise, some acknowledged that deferring to doctors’ advice compromised their stated desire for independence. In order to accept medical opinion, parents had to trust the doctor and relinquish their own authority over their child. Some parents said that a limited range of decision making for critical decisions was left in their hands. Other parents felt they had no real choices in decisions but were given the impression that they had choices, which they found reassuring.

**Clinicians’ views**

Clinicians described distinctive strategies they used in discussions with parents. These encompassed a process of advocacy to advance the clinical view of best interests. Initially they conveyed technical information to allow parents to understand the medical perspective. If a child’s prognosis was poor and parents did not share the clinicians’ view of the child’s ‘best interests,’ clinicians reframed their description of the medical plan in ways that they thought would be more acceptable to the parents. If not effective, starker explanations were offered to parents.

Clinicians felt the success of advocacy required sensitivity to parents’ states of mind. For instance, they explained that if there was no hope of improvement, then they would allow time to pass so parental feelings could adjust. In this context, clinicians described the vital role played by the physical appearance of a child in moving towards a decision, as appearance enabled parents to witness their child’s deterioration and validated the clinical view of ‘best interests.’ While other signs such as frequent admissions to PICU were sometimes cited as corroborators, clinicians thought the physical appearance of the child was most important to parents when considering the child’s best interests. For instance, when the child’s best interests lay in non-treatment, a child’s relatively ‘abnormal’ appearance at admission could help parents understand the prognosis (and thus agree to non-treatment) more easily than when a child appeared to be either visually or behaviourally more ‘normal’ (Box 2).

**Avoiding the courts**

Few participants had direct experience of the courts’ involvement in resolving disputes about best interests. Many parents questioned whether it was appropriate for judges to make decisions about their children. Clinicians believed judicial decisions were inconsistent and felt approaching the courts was arduous, divisive and lengthy. Some clinicians believed the legal framework pressured them to agree to demands from families that they described as ‘unreasonable.’ Others felt that resolving conflicts about a child’s best interests without using the courts was a measure of personal or institutional success (Box 3).

For these participants, shared decision making about the best interests of a child was a process where clinicians encourage parents to adopt their viewpoint. Persuasion was acceptable to most
parents in this study. If the persuasive process stalled over disagreements about whether non-treatment was in the child’s best interests, clinicians interviewed in this study felt they had few options. Parents who firmly refused consent were thought to exert considerable leverage in decisions to continue intensive care even when clinicians regarded that care as too burdensome for the child. If the process reached a ‘stalemate’ there was reluctance to approach the courts to resolve disagreement. Such views arose from doubts regarding the efficacy of the legal processes and judgements.

**DISCUSSION**

Many ethicists accept parental authority as a mechanism to decide the best interests of children although it is usual to impose some limits on this authority. Moreover, some suggest it is acceptable to allow families to take into account considerations of family interests other than those of the child, questioning the validity of best interests as a decision-making standard in this respect. They suggest other approaches including the ‘harm standard’, which allows parental discretion in all cases save those where extreme and irredeemable harm would ensue. Others observe that differences between families’ abilities to benefit children drive inequality, and suggest that children’s vulnerability justifies additional decision-making safeguards. Although the legal position outwardly prioritises the interests of the child, medical interests alone do not determine best interests, resulting in judges sometimes focusing on burdens to parents as well as the child.

Our empirical research suggests that, although all parties were concerned with the child’s welfare, clinicians were sympathetic to perspectives that emphasise family interests. In contrast, parents suggested their focus was solely on their child’s welfare, and aspired to make these decisions themselves, while recognising clinical prerogatives in this area. While parents’ responses may result from their failure to identify their own inherent interests, their perspective may be a barrier to their acceptance of approaches that emphasise parental welfare. More, if this is a case where clinicians know better than parents, clinical expertise in deciding best interests lacks overt recognition in ethical discussion of children’s best interests. Similarly, our finding that clinicians steered reluctant parents towards clinical plans may be unsurprising for practitioners but, again, is not necessarily reflected in current literature.

Increasingly broad understandings of parental authority risk characterising parent–doctor interactions as a conflict between autonomy and paternalism. Certainly the common language of ‘informed consent’ can draw inappropriate parallels between the authority of a patient and the authority of a parent. The risks of this approach in decisions about non-treatment are evident in our findings; allowing the parent to personally experience the deterioration of their child where they doubt that the best interests of their child lie in non-treatment. Such a strategy appears commonplace. For instance, a recent study of withdrawal of treatment on neonatal intensive care unit (NICU)
Parents:

► P45 (Mother): how do you relay all the facts to that judge, and how do they understand it? Because, yes, there is emotive stuff, and there’s its ethics, and there’s all sorts of other things in there, but at the end of the day there are a lot of medical things in there also which, if the judge isn’t au fait um with those sort of factors then it’s quite—I don’t know—I’d find it a little bit strange that you’d want somebody from a non-medical background sort of making that opinion.

► P59 (Father): [discussing judges] I don’t now how the law can allow anyone to take that decision out of your hands: it’s your child. I think it’s wrong.

Clinicians:

► N38 (Nurse): I do think that maybe sometimes we end up going more favouring towards the parents and what they think is right probably, because we want to avoid that going to court.

► D34 (Doctor): I may have my expertise and opinions as to what to do, but basically somebody with no knowledge, no requirement to be reasonable in any shape or form, can come and demand that I do something … On the whole, that’s not what you’re faced with. But you can be. You can just get an angry, unreasonable family who “know their rights,” you know. And the cards are all stacked in theirhands. It’s very difficult to kind of not treat in that sort of situation.

► D44 (Doctor): But I have never been in a situation where it’s been that far that I’ve had to use a judge. … Some of my colleagues have had to do that, yes, I haven’t. I um please myself in thinking, because I’ve had many cases, in thinking that it’s maybe because I’ve managed to communicate with parents in such a way that they trust me. But that’s just, you know, that’s just pleasing myself in thinking that; I don’t know if it’s true.

This study makes a number of important contributions to our understanding of best interests. While decision making in the NICU has been the focus of numerous empirical studies,30 37–39 few studies specifically consider best interests in decision making in PICU, which has its own unique challenges. The emphasis that parents and clinicians in PICU place on the interests of the family, and the attitudes of PICU decision makers to court advice have never, to our knowledge, been investigated before. Moreover, few studies give empirical evidence of the persuasive strategy used in shared decisions about the best interests of the child. While the instrumentalisation of the child in decision-making practice has been noted elsewhere, ethical critique of this is novel.

This study has a limitation since qualitative research findings are not intended to be generalisable. However, drawing the sample population from multiple sites, using purposive sampling to include a range of individuals and a variety of children’s outcomes, and achieving thematic saturation go some way in providing confidence that the qualitative findings are sound and transferable.

CONCLUSION

Decisions about treatment of children are governed by ambiguous concepts of best interests and shared decision making. Our research indicated differences in the approaches of parents and clinicians to these concepts. Where best interests were disputed, clinicians indicated strategies to encourage parents to adopt the clinical view. Where disputes were protracted, the courts were avoided and the deteriorating physical appearance of the child could play a key role. Parents and children both have important interests at stake in PICU, but these may conflict. Current processes cannot ensure a balance between these conflicting interests is maintained, and new decision-making standards may be needed.

Contributors GB conducted the research (including leading the literature review, collecting, analysing and interpreting data), led the drafting of this paper,

Box 3  Role of the courts

Parents:

► P45 (Mother): how do you relay all the facts to that judge, and how do they understand it? Because, yes, there is emotive stuff, and there’s its ethics, and there’s all sorts of other things in there, but at the end of the day there are a lot of medical things in there also which, if the judge isn’t au fait um with those sort of factors then it’s quite—I don’t know—I’d find it a little bit strange that you’d want somebody from a non-medical background sort of making that opinion.

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Contributors GB conducted the research (including leading the literature review, collecting, analysing and interpreting data), led the drafting of this paper,
contributed to critical revisions and shares accountability for this manuscript. RG-H acted as second supervisor on the research, helped design the project, aided in the interpretation and analysis of data, critically revised this paper and approved and shares accountability for this manuscript. ZD acted as third supervisor on the research, helped design the project, aided in the interpretation and analysis of data, critically revised this paper and approved and shares accountability for this manuscript. JF acted as fourth supervisor on the research, helped design the project, aided in the interpretation and analysis of data, critically revised this paper and approved and shares accountability for this manuscript. RH acted as first supervisor on the research, helped design the project, aided in the interpretation and analysis of data, critically revised this paper and approved and shares accountability for this manuscript. All listed authors are included on a basis compliant with the ICMJE 2013 recommendations.

Competing interests None declared.

Ethics approval Southwest NHS Research Ethics Committee (reference 12/SW0210).

Provenance and peer review Not commissioned; externally peer reviewed.

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