Can mediation avoid litigation in conflicts about medical treatment for children? An analysis of previous litigation in England and Wales

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ABSTRACT
Objective To investigate the reasons why parents disagree with their clinicians in cases reaching the court and to estimate the number of cases in which mediation might have avoided litigation.

Design Analysis of 83 published cases regarding medical treatment decisions for children initiated either by an NHS Trust or Local Authority between 1990 and 1 July 2022.

Results The analysis found that the main areas of contention are different value judgements, different interpretations of observable events such as the health of the child, their quality of life or burden of treatment and relational issues (ie, loss of trust). More than half of the cases are estimated not to have been preventable by mediation because either no conflict existed (n=13) or the parental decision was based on strongly held, mostly faith-based, views unlikely to be open for discussion (n=31).

Conclusion The potential of mediation to avoid future litigation may be more limited than hoped for.

WHAT IS ALREADY KNOWN ON THIS TOPIC
⇒ There appears to be an increase in contentious cases regarding medical treatment decisions for children litigated in the courts of England and Wales.
⇒ Mediation has been suggested as a way to avoid future litigation.
⇒ No data are available that confirm mediation can play this role.

WHAT THIS STUDY ADDS
⇒ An analysis of judgements shows that mediation might have avoided just under half of cases heard since 1990.
⇒ Mediation as a tool is thus not suitable for all conflicts about medical treatment for children.

WHAT THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY
⇒ The role of mediation in avoidance of litigation may be more limited than hoped for.

INTRODUCTION
Conflicts about medical treatment for seriously ill children have been litigated in the courts of England and Wales for many years. The exact number of such cases reaching the courts is not known but there is a noticeable increase in the number of published cases. While 10 and 11 cases were published in the decades between 1990–1999 and 2000–2009, respectively, the number of published cases almost quadrupled (n=39) between 2010–2019 and the 2½ years since 2020 has seen the publication of 24 cases already. Should litigation continue at this pace the current decade will see the publication of 10 cases per year rather than per decade. The marked increase in published cases does not necessarily mean that either conflict or litigation is now more frequent than before. While prior to 2014 cases were published when the judge decided that was in the public interest, since 2014 practice guidance states that any case about the giving or withholding of serious medical treatment should be published.3

To what extent that has been achieved is unknown as, due to workforce pressure, the overall number of published judgements in the Family Court has actually fallen.2

While the value of applying to the court lies in the resolution of an otherwise intractable conflict, litigation does have disadvantages such as the length of time before a final conclusion is reached,3 the financial costs4 and the adverse effects of an adversarial process on the relationship between parents and clinicians.5 It is not surprising therefore that especially after highly contentious cases questions are asked how to avoid such litigation in future.5 6 7

Judges, clinicians, academics and parents agree that improved communication between clinicians and parents could avoid future litigation5 6 12 but research outlining if and to what extent better communication will avoid future litigation is lacking.11 It is important to define what is here meant by ‘improved communication’. In the context of conflicts about medical treatment for children the term most often refers to mediation. Mediation is a form of dispute resolution in which parties try to resolve their dispute in facilitated meetings11 and is used as a substitute to court interventions in other family disputes such as divorce.14

Successful mediation requires the ability and willingness of both parties to compromise. Whether a compromise is possible depends, at least in part, on the arguments that underpin the conflict.

Based on an analysis of parental arguments as described in judgements this paper attempts to (1) investigate the reasons why parents disagree with the clinicians in conflicts escalated to the courts and (2) estimate the number of cases that potentially could have been avoided by mediation.
METHODS
To evaluate cases in which parents are in conflict with their treating team about medical treatment for children a search was performed in LexisLibrary (www.lexisnexis.com) and BAILII (www.bailii.org) using the search terms ‘medical treatment’, ‘child’ and ‘minor’. Cases were included when they fulfilled the eligibility criteria: (1) the case was heard in court between 1 January 1990 and 1 July 2022, (2) the court process was initiated by an NHS Trust/Health Board or Local Authority and litigated medical treatment for a child, defined as a person under the age of 18 years, (3) the judicial decision is based on best interests and (4) the judgement describes a conflict in which the parents are the sole decision makers. The fourth criterion excludes conflicts between children and their clinical team because these cases often turn on issues of capacity and understanding, both issues unsuitable for mediation. To avoid duplication of parental arguments only the first published judgement in any conflict was included. For cases about individual children that returned to court more than once for decisions on different aspects of their care, the first published judgement of each new case was included. Where a partial consensus was reached during the trial, only parental arguments about the still contentious issues were included. For cases in which parents disagreed among themselves only the arguments of the not consenting parent were included.

After removal of duplicates 83 judgements published between 1 January 1990 and 1 July 2022 were identified. After identification, the judgements were read through several times for familiarisation, and from each judgement data about applicant, defendant, type of treatment proposal under litigation, clinicians’ position, parental position, outcome and outcome(s) of any appeals were collected. To facilitate the analysis the judgements are here divided into three groups depending on type of treatment proposal under litigation: cases in which (1) parents do not consent to proposed medical treatment, (2) parents disagree with a clinician’s proposal to withhold future treatment or (3) parents disagree with a proposal to withdraw currently delivered life-sustaining treatment. Parental positions as described in the judgements were classified according to the likelihood that their reasons were negotiable and the areas of contention. A list of identified cases and classification with regard to type of decision and parental reasons is included in online supplemental data.

RESULTS
The three types of medical treatment decisions have been litigated in almost equal numbers since 1990. In 28 cases the applying NHS Trust or Local Authority sought to obtain consent for proposed treatment, in 26 cases to withhold future treatment and in 29 cases to withdraw life-sustaining treatment. The type of treatment decision under litigation has changed. In the 1990s, the majority of cases were about consent for proposed treatment, in the last decade courts were most frequently asked for permission to withdraw life-sustaining treatment.

A conflict is not always the reason a medical treatment decision is litigated in court. In 13 of 83 cases identified there was no underlying conflict. Instead, the case was decided in court because the child was already in the care of a Local Authority or a ward of court (n=7), no competent party held parental authority (n=2) or the clinicians and parents agreed on a treatment proposal but due to its nature the applicant requested a declaration of lawfulness (n=4). Neither does a court ruling always end the conflict. In 16 of 70 cases the parents appealed at least once. Rulings about withdrawal of life-sustaining treatment are most often appealed (9/29) followed by those about withholding future treatment (4/26) and refusal of proposed treatment (3/28). In addition, the cases of five individual children came to the High Court more than once for decisions about different aspects of their care.

In the analysis below only the 70 judgements in which a conflict between parents and clinicians is the basis for litigation are included.

Non-negotiable arguments
Medical treatment decisions inevitably involve value judgements. Religious arguments are often experienced by families and clinical staff as non-negotiable. Indeed, religious arguments in conflicts escalated to court are relatively frequent. In 22 of the 70 disputes heard in court a faith-based argument is the main or only reason for parents to oppose a treatment proposal and in a further 17 of 70 cases a faith-based argument is part of the reasons (table 1). A parental argument based on religion as only or main reason is most prevalent when refusal of proposed treatment and withdrawal of life-sustaining treatment is litigated. The former mainly entails the transfusion of blood products by Jehovah’s Witnesses (10/11) for reasons specific to this religion, in the latter parents from all religions invoke a sanctity of life argument.

In six additional cases parents use a secular sanctity of life argument. Phrases like ‘no stone left unturned’ or a parental wish for the child ‘to die in their own time’ are here interpreted as secular sanctity of life arguments. Admittedly, a parental wish for their child to die in their own time can also be interpreted as a parental preference for someone else to decide. If so, parents could invite the court to decide on their behalf. As this is rare, an interpretation as a sanctity of life argument seems more probable. It is further assumed that secular sanctity of life arguments like their faith-based counterparts are not negotiable in mediation.

In three cases parents strongly held views that were unlikely to be negotiable. In Re C (a child) (HIV test), parents held that an HIV infection did not cause AIDS and therefore refused an HIV test. In An NHS Trust v BK and others, the parents did not accept the diagnosis of incurable osteosarcoma and thus declined palliative care. In Re C (Baby: withdrawal of medical treatment), the parents’ views on society seemingly prohibited their engagement in both medical decision-making and litigation.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The contribution of faith-based arguments to disputes litigated in court in the period January 1990 to July 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faith-based/type of decision</td>
<td>Only/main reason</td>
</tr>
<tr>
<td>Refusal of treatment</td>
<td>11</td>
</tr>
<tr>
<td>Withholding future treatment</td>
<td>1</td>
</tr>
<tr>
<td>Withdrawing life-sustaining treatment</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

Cases in which there was no underlying conflict have been excluded (n=70).
Potentially negotiable arguments

Besides religious arguments, parental reasons to dispute the clinicians’ treatment proposal show a considerable overlap between the three types of decisions (table 2).

Main areas of contention are the child’s health, their quality of life, and the burden of treatment. The parental arguments in these areas are here placed in the potentially negotiable category as these disputes are based on different interpretations of observable events rather than personal values. Indeed, in five of six cases,16 20–23 in which at least partial consensus was reached during the trial parents and clinicians were able to reach agreement on the child’s health status. That does not mean that these arguments are always negotiable. For example, the family in Re JM (a child)26 left the UK before the court hearing could take place. However, the limited description of the parent’s position in the judgements does not allow for a more precise categorisation.

Another important reason for parents to disagree is about the relationship with the clinicians. Parental loss of trust is expressed in 15 of 70 cases. Two important sources of lost trust are, first, that the child’s health has evolved differently from that previously predicted by clinicians and, second, a parental awareness of divergent medical opinions among clinicians. While loss of trust can be irreparable, trust may be regained in mediation. For other rarer arguments (ie, a belief in a miracle cure), the impact on mediation is more difficult to estimate and is here not classified.

DISCUSSION

As far back as 1990 Lord Donaldson of Lymington summed up the decision-making around medical treatment for children in England and Wales as ‘a joint decision of the doctors and the court or parents’.27 If a child’s medical treatment does fall to the courts to decide the judge will summarise the evidence and give the reasons for their decision in a written judgement. A judgement is thus a summary of the interpretation of the evidence and position of both parties by a third person. Moreover, a trial is a formal process in which both the parents and clinicians give their statements with the aim of convincing the judge. As such, their arguments may not fully represent their opinions. Arguments important to parents but unlikely to be accepted by the courts may be under-reported in the judgements but still inform parental opinions. For example, sometimes faith-based reasons are not used in litigation despite parents being deeply religious.20 28 Such an omission is likely because faith-based arguments are generally unsuccessful in court.

The above considerations are important limitations both to what can be said about parental reasons to disagree with their clinical team and whether mediation could have resolved the conflict without court intervention.

The analysis found that areas of contention include value judgements, of which the faith-based ones are most easily classified, different interpretations of observable events such as the health of the child, their quality of life or burden of treatment and relational issues such as loss of trust. Tables 1 and 2 depict the main areas of contention.

Whether mediation will resolve a conflict depends at least in part on the reasons why parents disagree. Some conflicts cannot be resolved by mediation simply because the viewpoints of the parties are too far apart. A dispute involving parents refusing a blood transfusion because they value their child’s relationship with God more than their earthly existence is an example of a dispute that can only be resolved by arbitration. Most strongly held opinions are unlikely to be resolved through mediation and thus might benefit from an early referral to court.

Overall, for 44 of 83 cases litigated between 1990 and July 2022 mediation is unlikely to have prevented litigation; in 13 cases because conflict was not the reason for litigation, in 22 cases because the parental position was mainly or wholly determined by their faith, in 3 cases because of strongly held parental non-religious views unlikely to be negotiable in mediation and in 6 cases because parents used one or more secular sanctity of life arguments.

This calculation is likely to overestimate the cases in which mediation could avoid a court application for three reasons. First, the calculation assumes that parental arguments that are partially faith based are potentially negotiable. For mediation to successfully avoid litigation all areas in which parents and clinicians disagree must be resolved. It is possible that in some of the 17 of 70 cases in which parental reasons are partly faith based, after mediation their faith-based arguments still prevent a full resolution, hence necessitating a court application. Second, while not described in the judgements it is likely that before a Trust applies to the court considerable efforts have been undertaken to resolve the conflict which might make it less likely for mediation to be successful. Third, for mediation to resolve the conflict clinicians also need to be able to compromise. That may not be possible if, as is suggested elsewhere, for the clinicians involved their position in the conflict is a matter of professional conscience.29

For the avoidance of doubt, the above does not mean to say that there is no role for mediation in clinical practice. Undoubtedly, conflict in clinical practice is costly both within and outside the context of litigation,30 and there is evidence that conflict resolution methods can lead to a resolution thereof.31 However,

| Table 2 Non-religious arguments parents use in court in the three types of decision |
|---|---|---|---|
| Topic of contention | Type of decision | No consent to proposed treatment | Withdrawal of future treatment | Withdrawal of life-sustaining treatment |
| Condition of the child | Health status | 4 | 12 | 12 |
| Quality of life | 2 | 8 | 6 |
| Burden of treatment | 13 | 4 | 1 |
| Alternative treatment option available | 6 | 2 | 5 |
| Treatment successful in the past | 3 |
| Loss of trust | Different evolution of child’s health than predicted | 2 | 3 | 3 |
| Divergent medical views | 2 | 1 |
| Other trust issues | 1 | 1 | 2 |
| Sanctity of life | Child should die in their own time | 1 | 2 |
| No stone left unturned | 2 | 3 |
| Right to life (secular) | 1 |
| Other | Belief in miracle cure or availability of treatment in future | 1 | 2 | 2 |
| Parents should have final say | 1 | – | 1 |
| Impact on family life | 2 | 1 |
| Equity in delivery of healthcare | 2 |

Most parents use a combination of arguments.
the role of mediation in the avoidance of court applications for intractable conflicts may be more limited than currently hoped for.

Limitations
Further limitations should be taken into account in the interpretation of the results of this analysis. It is certain that not all cases heard in court have been included. First, because the search strategy may not have identified all published cases. Second, because not all cases are published. It is likely that after the 2014 practice guidance,¹ the number of unpublished cases is more limited than before, but as unpublished cases are still referred to in judgements² even after 2014 not all judgements are published. To what extent the unpublished cases would have changed the results is impossible to estimate. Third, this analysis is an interpretation of sometimes quite limited information about the parental position in the judgements and as such subjective.

CONCLUSION
This study found that in conflicts about medical treatment for children parents oppose their clinician’s treatment proposal on the basis of value judgements, different interpretation of events and relational arguments. Based on an analysis of the parental arguments only it is estimated that mediation is unlikely to have avoided litigation in just over a half of the court applications. Its role in avoidance of court applications may be more limited than hoped for.

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