The Right to Responsible Parents? Making Decisions about the Healthcare of Young and Dependent Children

Jo Bridgeman*
Sussex Law School, University of Sussex, UK

Introduction

Over the course of his academic career, Michael has critically analysed a wide range of issues concerning the legal regulation of medicine: adolescent decisions about birth control (Freeman, 1983); decisions about the medical treatment of severely disabled newborns (Freeman, 1983); the exercise of responsibility in the planning of parenthood (Freeman, 2008); end of life decisions (Freeman, 2002); Gillick’s ‘false dawn’ (Freeman, 1997a, 2005), the rights of the child born after medically assisted conception (Freeman, 1997a); ‘saviour siblings’ (Freeman, 2006); sterilisation of women with learning disabilities (Freeman, 1988); surrogacy (Freeman, 1999); renouncing maternity (Freeman, 2012). I am sure that is not a comprehensive list! In his examination of these topics, all of which are of enormous significance for the individual and their families, Michael explored the extent to which the rights, and the dignity, of the individual were respected. This chapter explains, and further reflects upon, two aspects of Michael’s work on the rights of young and dependent children and the responsibilities of their parents in relation to healthcare decision-making. First, I explain the context in which Michael argued that important decisions about the healthcare of children require independent and principled review. I examine the extent to which, in recent cases, the courts have fulfilled this responsibility. Then, I take up Michael’s argument, that children have the right to responsible parents, in order to ask what, in the context of decisions about the health of children, it might mean to ‘act in a parentally responsible manner’.

Rights, Interests and Responsibilities

Michael has, as a number of the chapters in this volume amply testify, been both a pioneer and a champion of children’s rights. Michael has also been at the forefront

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in presenting the arguments for conceptualising the parent/child relationship in terms of parental responsibility rather than parental rights (Freeman, 2008: 21). He has argued that, given their particular vulnerabilities, children must be understood as rights-holders if their integrity and dignity is to be protected but that, at the same time, children need to be cared for (Freeman, 1992: 55-6):

[W]e have to recognize the moral integrity of children. We have to treat them as persons entitled to equal concern and respect and entitled to have both their present autonomy recognized and their capacity for future autonomy safeguarded. And this is to recognize that children, particularly younger children, need nurture, care and protection. Children must not... be ‘abandoned’ to their rights (Freeman, 1992: 66 references omitted).

I believe that Michael’s earliest thoughts on the moral and legal responsibilities of parents and of the state in relation to the healthcare of children are to be found in his seminal 1983 book, *The Rights and Wrongs of Children* (Freeman, 1983). In the final chapter, concerned with state intervention into family life, Michael considered the, then recent, cases of *Re D* – in which the court was asked to determine whether the proposed sterilisation of an 11-year old girl who had Sotos Syndrome was in her best interests – and *Re B* – in which the court was asked to authorise an operation on Baby Alexandra to clear an intestinal blockage, Alexandra also had Down’s Syndrome (*Re D (a minor) (wardship: sterilisation)* [1976] Fam 185; *In Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421). In 1983, when Michael wrote and in the preceding years in which these cases were decided, medical law as a discipline was in its infancy. There were very few decided cases in English law and certainly not a body of law, requiring Michael to consider many examples from US case law. It was a time when medical paternalism reigned; when patients were more inclined to defer to the medical profession than challenge them. Respect for patient autonomy had not yet become the guiding principle of the legal regulation of medical practice that it is today. *Gillick*, which would recognise children as rights-holders and parents as under duties to fulfil their responsibilities to their children, had not yet been decided (*Gillick v. West Norfolk and Wisbech AHA* [1986] AC 112). It was from this small but expanding field that these two cases were selected as ‘central’ to the debate around children’s rights. Both offered examples of the imposition of ‘restraints on the power of parents to make decisions on their children’s behalf and, in so doing, control their lifestyles’ (Freeman, 1983: 244).

Furthermore, whilst reflecting upon these cases, Michael offered a critique of the arguments advanced against state intervention into family autonomy by Goldstein, Freud and Solnit in their then recent books, *Beyond – and Before – The Best Interests of the Child* (Goldstein et al., 1979a, 1979b). Presenting the case for non-intervention, they identified six exceptional circumstances when, they considered, state intervention could be justified, the sixth of which was parental failure to obtain medical care.1 But

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1 (Freeman, 1983: 250-255). The others being: where a parent asks the court to determine the residence of a child; adoption or care by non-parental caretakers; where the child’s