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Guidance and Intervention Principles in Pediatrics: The Need for Pluralism

Mark Christopher Navin and Jason Adam Wasserman

ABSTRACT

Two core questions in pediatric ethics concern when and how physicians are ethically permitted to intervene in parental treatment decisions (intervention principles), and the goals or values that should direct physicians' and parents' decisions about the care of children (guidance principles). Lainie Friedman Ross argues in this issue of *The Journal of Clinical Ethics*[1] that constrained parental autonomy (CPA) simultaneously answers both questions: physicians should *intervene* when parental treatment preferences fail to protect a child's basic needs or primary goods, and both physicians and parents should be *guided* by a commitment to protect a child's basic needs and primary goods. In contrast, we argue that no principle—neither Ross's CPA, nor the best interest standard or the harm threshold—can serve as both an intervention principle and a guidance principle. First, there are as many correct intervention principles as there are different kinds of interventions, since different kinds of interventions can be justified under different conditions. Second, physicians and parents have different guidance principles, because the decisions physicians and parents make for a child should be informed by different values and balanced by different (potentially) conflicting commitments.

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INTRODUCTION

In "Better than Best (Interest Standard) in Pediatric Decision Making," Lainie Friedman Ross argues that the best interest standard (BIS) should be neither the goal parents and physicians pursue in treating a child (guidance principle) nor the threshold for physicians to interfere with parents' treatment decisions (intervention principle).[2] Instead, Ross argues that constrained parental autonomy (CPA) can serve as a principle for both guidance and intervention. The fundamentals of Ross's position should be familiar, since this current article builds on her previous work by engaging with more recent debates about guidance and intervention principles in pediatrics.[3]

Ross argues that the BIS is over-inclusive (physicians would intervene too often), since it grants parents "minimal leeway or discretion if a third party disagrees with the way they calculate their child's best interest."[4] She also argues that the harm threshold (HT) is under-inclusive (physicians would not intervene enough), because the harm threshold "does not capture the breadth of cases in which intervention, at some

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level, is appropriate."[5] In this way, Ross opens up space between the interest-based intervention principles embraced by authors such as Kopelman, Pope, and, more recently, Bester;[6] and the harms-focused intervention principles, like the one embraced by Diekema and recently endorsed in guidance from the American Academy of Pediatrics (AAP) about the limits of parental permission.[7]

We largely agree with Ross's comments about the inadequacies of the interest-based and harm-based intervention principles others have supported. But we part ways with her about how best to move forward. On Ross's view, the solution to inadequacies about other people's intervention principles is to identify a better intervention principle that can also serve as a guidance principle.[8] We do not think this effort can succeed.

DIVERSE INTERVENTIONS

Debates in pediatric ethics about ethically justified interventions in parental decision making often focus on the search for correct principles for such interventions. These "intervention principles" identify justified interventions in terms of thresholds for the amount of good they produce (or harm they avoid). For example, the harm threshold sanctions interventions that "prevent significant risk of serious preventable harm,"[9] while the best interest standard sanctions interventions that prioritize what is best for the child.[10]

Each of these approaches gets *something* right about the ethics of intervening in parental decision making: Whether interventions are justified depends, in part, on the harms those interventions prevent or the benefits they yield. But the good consequences of interventions for patients is just one kind of consideration that matters. We must also consider the morally relevant *costs* of those interventions, for example, to parental freedom, trust, compliance, and to the therapeutic relationship. Importantly, as we will argue below, different kinds of interventions can have widely diverse morally relevant costs.

It follows, from the fact that different kinds of interventions have different morally relevant costs, that we cannot answer questions about ethically justified interventions with a comprehensive intervention principle that has a single outcome threshold for intervention. Instead, we need a set of principles, arranged schematically, that identify different thresholds for the use of interventions that have different kinds of morally relevant costs. We cannot identify or adequately defend a full set of those principles in this commentary. Rather, we hope to outline enough of our view to motivate skepticism about the existence of a single comprehensive intervention principle, such as Ross's CPA.

First, it is necessary to define "intervention." Physicians intervene in parental decision making when they insert themselves somewhere in the chains of reasoning and action that connect parents' prereflective preferences regarding decisions about their child's treatment with the outcomes of those decisions. If we want our child to play football, skip vaccines, or forgo lifesaving surgery, then someone must intervene if he or she wants to change our preferences or prevent them from being actualized.

In bioethics, attention has often focused on coercive interventions; these are usually the most controversial and sensational. In pediatrics, *forcible treatment* can take place when a physician triggers state coercion (for example, guardianship, child protective services) aimed at ensuring treatment that parents refuse. But there are many ways to intervene other than through force. For example, Blumenthal-Barby argues that there are morally important differences between forcible treatments, omissions (of choices or information), reason-countering influences (including uses of social norms and affect), reason-bypassing influences (including framing and default nudges), and reason and argument.[11] The traditional view has been to group all nonrational noncoercive influences—everything between forcible treatments and reason and argument—under the banner of *manipulation*.[12] But these kinds of influences can be very different from each other, from a moral point of view in particular, with respect to their effect on autonomy. And these differences matter for questions about when different kinds of interventions can be justified.

Physicians who invoke social norms to overcome parents' hesitancy to agree to treatment intervene with a reason-*countering* nudge. The same is true of physicians who attempt to invoke guilt, shame, or other emotional states to get otherwise recalcitrant parents to accede to physicians' recommendations. In these cases, physicians are intervening to influence parents' decisions in ways that parents likely are aware of, and against preferences parents have previ-

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ously identified. These kinds of reason-countering nudges are less of an attack on parental freedom than forcible treatment (or omitting choice and information), but nonetheless may undermine autonomy to a significant degree.

In contrast, consider physicians who intentionally present statistical data in terms of positive outcomes, rather than adverse ones, in order to knowingly push otherwise skeptical parents toward a treatment that the physicians believe is in the best interest of the child. This use of a framing nudge likely *bypasses* parents' reasoning in ways that undermine their ability to make autonomous choices.[13] But this kind of intervention likely does less to undermine parental freedom than does a reason-*countering* nudge.

Finally, we think that physicians also perform an intervention when they provide *information* and engage in *reasoning* with parents about how to treat their child. Such efforts surely have the potential to affect the chains of reasoning and action that connect parents' prereflective preferences regarding decisions about their child's treatment with the outcomes of those decisions. While such efforts do not undermine parental liberty and can even support parents' autonomy, they nonetheless *intervene* in parental decision making.

Someone might object to our pluralistic account of interventions (and their moral costs) by asserting that only forcible acts qualify as interventions. This kind of belief may be a background assumption for some proponents of the HT, according to which physicians should intervene in parental decision making only to prevent a child from experiencing "significant risk of serious preventable harm." But this is clearly an *ad hoc* conception of what counts as an *intervention*, and not even Diekema seems committed to it.[14] Some interventions can block, redirect, delay, or mitigate parental preferences or their bad consequences for a child's health without being coercive or forcible. Importantly, Ross acknowledges—following Buchanan and Brock—that interventions in parental decision making can take forms other than forcible treatment sanctioned by judicial authorities.[15] We think she is correct to embrace a broader conception of interventions, but, as we discuss below, this actually pushes away from the possibility of not only a single principle for both guidance and intervention, but for a single principle for intervention itself.

Another objection may claim that an act is an intervention only if it confronts parents' *explicit refusal*. This would rule out anticipatory or preventive efforts to change parents' preferences, on the grounds that an intervention must respond to conflict, rather than prevent it. However, this also seems like an *ad hoc* constraint on what counts as an intervention. Consider that the AAP has recently recommended that physicians consider using "presumptive communication" (rather than open-ended conversations) to forestall vaccine hesitancy.[16] This kind of default nudge (a reason-*bypassing* intervention) prevents conflict; it does not overcome it.[17] But it is surely an intervention, and the AAP explicitly identifies it as such.[18]

MORALLY RELEVANT COSTS AND BENEFITS OF DIFFERENT INTERVENTIONS

Different interventions—in different contexts—can implicate parental freedom to different magnitudes (by undermining autonomy, liberty, or both), as we note above. Furthermore, different kinds of interventions can also have differing impacts on other values such as trust, respect, compliance, et cetera. For example, coercive interventions likely sever trust between physicians and parents, while merely providing information is much less likely to do so.[19] A reason-bypassing nudge—like the provaccination "presumptive communication" identified by Opel and colleagues—seems to fall somewhere in between on this score.[20] Arguably, the most important value for justifying pediatric intervention in parental decision making is the impact that interventions have on protecting or promoting a child's medical interests. In some contexts, an intervention may prevent parents from placing a child at a "significant risk of serious harm." In other contexts, an intervention may protect some of a child's basic needs or primary goods, but without rising to the level of preventing "significant risk of serious preventable harm." And in still other contexts, an intervention may promote a child's interests, even when the child's basic needs or primary goods are not at stake.

When we give appropriate attention to how different kinds of interventions can implicate different kinds of values to different degrees, we may sketch the following rough schema for justifying interventions with parents' decision making in pediatrics (see table 1). Each line of this

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schema identifies a minimum magnitude of positive consequences a child patient would have to experience from a kind of intervention for the costs associated with that kind of intervention to be outweighed by its benefits. This schema can also be read hierarchically, such that one ethically may use a less "costly" intervention in contexts in which more "costly" interventions would be justified. For example, autonomy-preserving interventions are justified to promote patients' medical best interests (3C), but also to prevent significant risk of serious harm (3A), or to protect a child's basic needs or primary goods (3B). In contrast, state-mediated coercion is not justified to promote a child's best interests (1C).

We cannot elaborate a full justification for our schema in this short commentary, but we hope to have illustrated our main idea: Different kinds of interventions in parental decision making can be justified in response to different kinds of threats to a child's interests. This is not an entirely new idea. For example, Brock and Buchanan suggest that no one intervention principle is sufficient for pediatric ethics, because parental choices can be suboptimal in different ways. So, for example, when parents are abusive, incompetent, or have a conflict of interest, they can be *disqualified* from decision making. In contrast, when a child is especially vulnerable, a decision is especially momentous, or there is a high likelihood of a conflict of interest, parents can be subject to *special scrutiny*.[21]

Our arguments in this commentary have amplified this pluralistic orientation towards pediatric intervention principles, by focusing on differences in the morally relevant costs of different kinds of interventions. We conclude, *contra* Ross, that it is not possible to justify all justifiable pediatric interventions in terms of a single threshold of good outcomes for a child. This insight has significant upshot for debates about intervention principles in pediatric ethics, and for debates about the relationship between intervention and guidance principles.

First, the existing literature may reflect less disagreement about the conditions in which interventions are justified than is generally supposed. For example, suppose that Diekema is right that physicians may trigger state coercion to prevent parents from allowing their child to suffer "significant risk of serious harm" (1A in table 1). This does not contradict Ross's claim that physicians may use nonforcible means to restrict parental autonomy in ways that protect a child's basic needs or primary goods (2B). And neither of those claims is contradicted by the idea that it can be ethically permissible to use minimally intrusive interventions to promote a child's best interests (3C), even when the child's basic needs or primary goods are not at stake. Ultimately, much of the supposed disagreement about intervention principles disappears if one focuses on the conditions in which particular kinds of interventions can be justified.

Relatedly, it follows from our arguments that there cannot be a single comprehensive intervention principle. Diekema, Ross, Bester, Kopelman, and Pope each may correctly identify a context in which *some* kinds of interventions are justified. But none of them has identified the contexts in which *all* kinds of justifiable interventions are justified.

GUIDANCE PRINCIPLES AND DIFFERENTLY POSITIONED AGENTS

We have so far argued that there cannot be a single comprehensive intervention principle. But what about guidance principles?

If there is not a *single* comprehensive intervention principle, then it follows (as a trivially true point of logic) that there is no single comprehensive intervention principle that is iden-

TABLE 1. A Schema for intervention principles in parental decisions about pediatric treatment

Kind of intervention	Context of justification
1. State-mediated forcible treatment	A. Prevent significant risk of serious harm
2. Manipulation (omitting information/choices; reason-countering nudges)	B. Protect basic needs or primary goods
3. Autonomy preserving or promoting (reason-bypassing nudges; reason and argument)	C. Promote best interests

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tical to the correct guidance principle. More substantively, the same attention to context-specific moral facts that motivates Ross's critical response to harm-based and interest-based intervention principles can also be targeted at attempts to identify a single comprehensive guidance principle for pediatrics.

Parents and physicians are responsible for different sets of people, and even for the same person (the child patient) in very different ways. For example, parents are responsible for all of their children, not just the patient under the pediatrician's care; physicians are responsible for all of their patients, not just the parent's child. Also, parents are responsible for raising their child in accordance with their best judgment about how the child may function well in the world, in light of the family's values. In contrast, physicians are responsible for protecting and promoting the child's medical best interests.

We have argued elsewhere that there are good reasons for physicians to sometimes defer to parental preferences, even when those seem suboptimal from the point of view of the child's medical best interest.[22] It does not follow from the fact that physicians should sometimes not interfere with parents' preferences—for example, to allow families to pursue their religious or cultural values—that physicians should internalize those values into their practice guidelines. This would blur important lines in the division of responsibilities between physicians and patients/families. Ultimately, the divergent sets of people to which they have ethical obligations, and the fundamentally different positions they have vis-à-vis a particular child patient, suggest that the stakeholders involved in the care of children—primarily parents and physicians, but perhaps others as well—cannot be identified by the same principle. This is analogous to the animating idea behind our criticism of intervention principles: Just as the existence of diverse kinds of interventions (with different morally relevant costs) rules out a single comprehensive intervention principle, the diverse moral commitments of engaged stakeholders in pediatrics rules out a single comprehensive guidance principle.

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CONFLICTS OF INTEREST

The authors have no conflicts to declare.

NOTES

1. L.F. Ross, "Better than Best (Interest Standard) in Pediatric Decision Making," in this issue of *The Journal of Clinical Ethics*, volume 30, number 3, Fall 2019.

2. Ibid.

3. L.F. Ross, *Children, Families, and Health Care Decision Making* (Oxford, U.K.: Oxford University Press, 1998).

4. Ross, "Better than Best (Interest Standard)," see note 1 above.

5. Ibid.

6. L.M. Kopelman, "The Best-Interests Standard as Threshold, Ideal and Standard of Reasonableness," *Journal of Medicine and Philosophy* 22 (1997): 271-89; T.M. Pope, "The Best Interest Standard: Both Guide and Limit to Medical Decision Making on Behalf of Incapacitated Patients," *The Journal of Clinical Ethics* 22, no. 2 (Summer 2011): 134-18, 135; J.C. Bester, "The Harm Principle Cannot Replace the Best Interest Standard: Problems with Using the Harm Principle for Medical Decision Making for Children," *American Journal of Bioethics* 18, no. 8 (2018): 9-19.

7. D.S. Diekema, "Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention," *Theoretical Medicine and Bioethics* 25, no. 4 (2004): 243-64; D.S. Diekema, "Revisiting the Best Interest Standard: Uses and Misuses," *The Journal of Clinical Ethics* 22, no. 2 (Summer 2011): 128-33; A.L. Katz, S.A. Webb, and AAP Committee on Bioethics, "Informed Consent in Decision-Making in Pediatric Practice," *Pediatrics* 138, no. 2 (1 August 2016): e20161485.

8. Ross, "Better than Best (Interest Standard)," see note 1 above.

9. D.S. Diekema, "Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention," *Theoretical Medicine* 25 (2004): 243-64.

10. Bester, "The Harm Principle," see note 6 above, p. 9.

11. J.S. Blumenthal-Barby, "Between Reason and Coercion: Ethically Permissible Influence in Health Care and Health Policy Contexts," *Kennedy Institute of Ethics Journal* 22, no. 4 (2012): 345-66; see also D. MacKay and A. Robinson, "The Ethics of Organ Donor Registration Policies: Nudges and Respect for Autonomy," *American Journal of Bioethics* 16, no. 11 (1 November 2016): 3-12.

12. R.R. Faden, T.L. Beauchamp, and N.M.P. King.

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A History and Theory of Informed Consent (New York,: Oxford University Press, 1986), 261.

13. M.C. Navin, "The Ethics of Vaccination Nudges in Pediatric Practice," *HEC Forum* 29, no. 1 (1 March 2017): 43-57; J.S. Blumenthal-Barby and D. J. Opel, "Nudge or Grudge? Choice Architecture and Parental Decision-Making," *Hastings Center Report* 48, no. 2 (2018): 33-39.

14. Instead of denying that there are other possible ways for pediatricians to intervene in parental decision making, Diekema seems focused narrowly on forcible interventions that involve state power.

15. Ross, "Better than Best (Interest Standard)," see note 1 above,; A.E. Buchanan and D.W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (New York,: Cambridge University Press, 1990), 147-8.

16. K.M. Edwards, J.M. Hackell, AAP Committee on Infectious Diseases, and AAP Committee on Practice and Ambulatory Medicine, "Countering Vaccine Hesitancy," *Pediatrics* 138, no. 3 (2016): e20162146, e8; D.J. Opel et al., "The Architecture of Provider-Parent Vaccine Discussions at Health Supervision Visits," *Pediatrics* 132, no. 6 (4 November 2013): 1037-46.

17. D.J. Opel and S.B. Omer, "Measles, Mandates, and Making Vaccination the Default Option," *JAMA Pediatrics* 169, no. 4 (1 April 2015): 303-4; Blumenthal-Barby and Opel, "Nudge or Grudge?" see note 11 above.

18. Edwards, Hackell, AAP Committee on Infectious Diseases, and AAP Committee on Practice and Ambulatory Medicine, "Countering Vaccine Hesitancy," see note 14 above.

19. For this reason, the ethical justification for a particular intervention cannot depend solely on a balance between the good outcomes for the patient and the costs to parental freedom. See Blumenthal-Barby, "Between Reason and Coercion," see note 9 above.

20. Opel et al., "The Architecture of Provider-Parent Vaccine Discussions at Health Supervision Visits," see note 14 above.

21. Ross, "Better than Best (Interest Standard)," see note 1 above; Buchanan and Brock, *Deciding for Others*, see note 13 above.

22. M.C. Navin and J.A. Wasserman, "Reasons to Amplify the Role of Parental Permission in Pediatric Treatment," *American Journal of Bioethics* 17, no. 11 (2017): 6-14.