VIEWPOINT

The Value of Parental Permission in Pediatric Practice

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The American Academy of Pediatrics (AAP) Committee on Bioethics recently released guidelines stating that physicians may challenge parental authority to make medical decisions for their children only when failing to do so would result in "significant risk of serious harm."[1(pe6),2(p3)] Drawing heavily on the work of Diekema,[3] these new guidelines superseded the 1995 AAP Committee on Bioethics statement,[4] which implied that a parent's failure to comply with options that would promote their child's best interests could undermine a parent's moral right to make decisions for his or her child. Recently, Navin and Wasserman[5] applauded this move, but argued that there were numerous additional reasons to support the expansion of parental latitude in decision making up to the threshold of harm. This position was heavily criticized by commentators, particularly those in clinical practice, and important questions were raised about the value and limits of parental decision making.

In this commentary, we provide clinical illustrations of how taking parental permission seriously can help clinicians deliver better care to pediatric patients and may ameliorate some frustrations with parent requests for (what may appear to be) suboptimal interventions.

The AAP's 2016 documents that address parental permission better align AAP guidance with legal restrictions and clinical prudence, which both favor deferring to parents who request nonharmful options that fall short of the medical best interests of their children.[1,2] More important, these new statements underscore the positive value of parental participation in pediatric decision making, noting that "parental permission and childhood assent is an active process that engages patients, both adults and children, in their health care."[1(pe13),2(p1)] In a nod to the importance of shared decision making, the new guidelines identify the importance of engaging parents in the assessment of diagnostically relevant facts and values "by balancing health care needs with social and emotional needs within the context of overall family goals, cultural beliefs, and values."[1(pe13),2(p5)]

Pediatricians aim to promote the best interests of their patients. Therefore, they may be frustrated when parents disagree with their expert judgments in ways that fall short of that goal. It is our hope that focusing on some of the positive implications of parental permission can help ameliorate such frustrations.[5] In the following 2 clinical illustrations, although the parental decisions may not seem to align with the patients' best interests, it may nonetheless be valuable to respect the responsibility of parents to make decisions about their children's treatment.

Encouraging Resistance to Suboptimal Default Practices

Consider the following hypothetical case:

A woman was delivering her first child at a hospital birthing center. After parturition, the baby was placed skin-to-skin on the mother, where she cried softly, latched, and fell asleep. When a nurse later entered the room to administer a first dose of the infant's hepatitis B vaccine, the couple demurred. They were not asked their reasons, but were perceived as noncompliant by the health care team. However, the parents' refusal arose not from opposition to vaccines, but from a desire not to disturb the mother-child bonding process, and because they knew that vaccination could occur at the 2-week well-baby visit. In addition, risk to the infant was low because the mother had negative test results for the hepatitis B virus surface antigen.

Like all institutions, hospitals follow rules and procedures that aim for the best aggregate results, but may be inattentive to the needs of outliers. Ideally, physicians can mediate the needs of particular patients and the standard protocols of their institutions. However, clinicians are only human, and the routines of practice may sometimes obscure idiosyncratic patient needs. However, parents are concerned primarily with their individual child's needs in the context of their family values.

Although parental indifference to standardized protocols can generate frustration, it can also highlight moments when institutional goals and practices may not be in the best interests of a child patient or family. Because the parents in this case were solely focused on the best interests of their child, via mother-infant bonding, they were able to resist a default practice that was good in the aggregate, but suboptimal in their particular situation, and whose shortcoming went unnoticed by habituated health care professionals. When we expand the latitude for parental participation in pediatric decision making, we promote parents' ability to resist these sorts of suboptimal default routines.

Nurturing Children's Health Care Autonomy

Consider the following hypothetical case:

A woman emigrated from the Inner Mongolia region of northern China. She brought her 7-year-old daughter to a local free clinic because the child was experiencing left ear pain. The girl had a fever of 39.1°C, but was otherwise well appearing. A middle ear infection was diagnosed. Amoxicillin was recommended, which would be provided free of charge. The mother was reluctant about this course of treatment, noting that an herbalist in her neighborhood differentiated the daughter's condition as "wind-warm" and suggested a Chinese herb called "he zi." This herb appeared to have few, mild

adverse effects, typically short-term. The pediatrician responded, "Okay, I've heard about that herb and its potential for reducing inflammation, but that is only one part of the problem with an ear infection. So if her fever persists beyond 48 hours, will you bring her back so we can try something else?" The mother smiled, nodded her head, and replied, "Okay," before leaving the clinic.

In this clinical scenario, the pediatrician agreed to a treatment plan that was not his preference and did not follow the AAP's strong recommendation for antibiotic therapy in otitis media when the child has a fever above 39.0°C.[6] Arguably, then, the physician's decision was not in the medical best interests of the patient. At the same time, this decision does not appear to place the child at significant risk of serious harm. Diekema[3] has suggested that the value of family integrity justifies acceding to parental preferences when doing so does not cross the threshold of harm. We would add that taking parental permission seriously in this sort of case resists detrimental forms of social power that can result in unhelpful parental deference or even resentment. Moreover, such encounters represent potential moments of socialization for child patients, as they observe parent-physician interactions. Children can learn about the possibility for shared decision making about health care when they see health care professionals model that practice with their parents.[7]

Conclusions

In some ways, there may appear to be a trend toward offering less latitude for parental permission. For example, consider the AAP's similarly recent determination that it is "an acceptable option"[8(pe9)] for pediatric clinicians to dismiss families who refuse vaccines. However, we applaud the AAP's recent statements on parental permission, and we think that there are even more reasons to value parental permission than those statements identify. In particular, we have illustrated how taking parental permission seriously can allow reasonable resistance to suboptimal default practices and can nurture the development of future autonomous patients. These benefits are often worth minimal risks. It may frustrate physicians to permit parents to make medical decisions that seem to fall short of the child's best interests. We hope to have provided reasons for clinicians to be flexible in this regard.

ARTICLE INFORMATION

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