

What should doctors do when parents request 'second best' treatments for their children?

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What should doctors do when parents request treatments for their children that are less effective than those recommended?

In the *Journal of Medical Ethics* today, leading experts explore the boundaries of parental choice and identify thresholds of acceptable levels of harm and cost.

There has been research into the ethics of parental refusal of [treatment](#), for example, Jehovah's Witness parents who refuse a blood transfusion for their children. In cases where the life of the child is at risk, it is widely accepted that [doctors](#) should over-ride parents' wishes.

But the question of what doctors should do when parents are not refusing treatment, rather requesting a substitute 'second best' treatment, has attracted less attention.

For instance, is it permissible for parents to choose substitute medical treatments that are less effective than those recommended by doctors? If so, how much less effective?

Furthermore, is it permissible in a public healthcare system for parents to choose more expensive medical treatments than those recommended by doctors? If so, what additional cost is acceptable? And third, does the reason behind the parents' choice make a difference?

To explore these questions further, a team led by Tara Nair of Monash University in Australia and Professor Dominic Wilkinson of Oxford University, surveyed 242 US residents about their attitudes towards acceptable levels of harm and expense resulting from parental choice, and the role that religion played in their judgement.

A total of 178 valid responses were assessed. More than half of participants were prepared to provide treatment that would involve a small (less than 5%) absolute increased risk of death for the child and a cost increase of up to US\$500.

Respondents were also more inclined to agree if provided with a religious reason for parents' request compared with a non-religious reason. Responses were not influenced by age, gender, employment status, whether respondents had children, dietary preference or ethnicity.

When the researchers applied a clinical scenario (involving treatment for a seriously ill premature baby) to existing ethical frameworks they found inconsistencies, suggesting that there is no clear theoretical answer to the question of where we should draw the line on parental requests for substitute medical treatment.

"To our knowledge, this is the first study to gauge the attitudes of the general public towards parental refusal of treatment or requests for substitute treatment on behalf of their children," they write.

They outline some study limitations, for example responses may reflect local, cultural and religious values, making it difficult to apply the findings more generally.

They conclude: "Expanding medical possibilities, expanding access to information and increasing diversity of values in society are likely to lead to more situations where [parents](#) request treatment that differs from those recommended by health professionals. It will be important to determine when such requests should be accepted, and when they should not."

More information: Settling for second best: when should doctors agree to parental demands for suboptimal medical treatment? *Journal of Medical Ethics* (2017). heart.bmj.com/lookup/doi/10.1136/medethics-2016-103461

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