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A Hospital Ethics Review Process for Pediatric Treatment Disputes: On Surrogate Decision-Making in Pediatrics, the Reasonable Exercise of the Authorization Power, and the Harm Principle

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Abstract

Surrogate decision-makers (SDMs) in pediatrics, typically parents, are usually given wide latitude, and the prevailing standards of shared decision-making and the harm principle treat that latitude as limited chiefly by the threshold for state intervention. We argue for a different starting point: the child, who holds a claim to bodily integrity that the child cannot yet waive. Authorization to touch the child is a power held by an SDM for the child's benefit, and its holder must exercise it reasonably. Health care providers, as fiduciaries with positive obligations to the patient, owe the child more than harm prevention. When a provider has a reasonable concern that an SDM is not exercising the authorization power reasonably, review is warranted. We propose a Hospital Pediatric Ethics Review Committee (HPERC), independent of the treating team and modeled on the process of the Texas Advance Directive Act, to conduct such review while preserving SDM choice among reasonable options. Where the committee finds, applying a clear and convincing standard to the factual predicates, that the exercise falls outside the range of reasonable choices and that proceeding is proportionate, we argue that proceeding over objection is ethically permissible and, in some cases, obligatory. Because the harm principle's terms are indeterminate at the margin, such review also offers an alternative to CPS involvement in boundary cases, with lower collateral harm. We acknowledge that proceeding carries legal risk, but argue that its ethical permissibility depends neither on a statutory safe harbor nor on a court order.

Introduction

Disputes between clinicians and parents over a child's treatment fall along a spectrum. At one end, a refusal exposes the child to serious, imminent harm, and the state may intervene. At the other, parents choose among options that reasonable clinicians would accept, and deference is appropriate. Between them lie cases in which a parent's choice is difficult to defend as a reasonable exercise of authority over the child's care, yet falls short of the threshold for state intervention. In such cases health care providers (HCPs) often have little recourse beyond acquiescing or involving child protective services (CPS), and, less commonly, petitioning a court directly; none of these responses fits the problem well.

This paper makes four claims. First, the analysis should begin from the child, who holds a claim to bodily integrity that the child cannot yet waive; authorization to touch the child is a power held by a surrogate decision-maker (SDM), typically a parent, for the child's benefit. Second, that power must be exercised reasonably, which leaves room for choices among reasonable options but not for choices outside that range, even where the harm principle is not met. Third, HCPs, as fiduciaries with positive obligations to the child, should seek review by a body independent of the treating team when they have a reasonable concern that the power is not being exercised reasonably. Fourth, we propose a Hospital Pediatric Ethics Review Committee (HPERC) to conduct that review, and argue that where it finds an unreasonable exercise and proceeding is proportionate, proceeding is ethically permissible and, in some cases, obligatory, though doing so carries legal risk that institutions must weigh.

We begin with the current framework, develop the account of the authorization power and the HCP's role, and explain why institutional review is needed. We then describe the proposed process through its standard, cases, precedents, and procedures, and address its ethical permissibility and legal risk. We do not address in depth the role of religious and cultural values, the decision-making authority of capacitated adolescents, or requests for treatment that clinicians consider potentially nonbeneficial, including disputes about withholding or withdrawing life-sustaining treatment. The standard proposed here addresses refusals of recommended interventions; requests of the latter kind are addressed under the Texas Advance Directive Act (TADA) or comparable processes.

The Current Framework: Best Interest and the Harm Principle

When an adult patient is unable to make medical decisions for him/herself, a surrogate decision-maker (SDM) decides on the patient's behalf. [1] The SDM for an adult patient is tasked with making the decision the patient would have made if capacitated. Pediatric decision-making differs because most pediatric patients never had decision-making capacity or the opportunity to develop values an SDM could attempt to uphold. In pediatrics we use "SDM" to refer to whoever holds the power to authorize treatment for the child, typically but not always the child's parents. The term is not meant to suggest that the SDM's role is to reproduce the patient's wishes, as in the adult case.

Instead, in pediatrics it is widely accepted, as an ethical principle and in the standards applied in many legal settings, that a pediatric patient's SDM should make treatment decisions that are in the patient's best interest. [2, 63] In theory, this means the SDM must consider the treatment options and land on a decision based on the patient's interests, not the SDM's own interests, beliefs, or values. This is a difficult task, with "best interest" often ill-defined or debatable. [3] As such, wide latitude is generally provided to SDMs to determine what is in the patient's best interest, and deference from the health care provider (HCP) is the norm. [4] This is largely because parents are considered best positioned to know the interests of the pediatric patient and have the greatest stake in the patient's wellbeing, besides the patient. [3] Acting on the best interest standard, as the SDM understands it, is thus traditionally treated as the modus operandi for pediatric decision-making.

The best interest standard is not beyond criticism; it has been critiqued as too high a bar, ill-defined, and ultimately inoperable. [5] HCPs tend to focus on optimal medical treatment, while SDMs may also weigh a "normal" life, religious tradition, comfort, and spiritual needs, and SDMs are imperfect and have competing interests. [6–7] A decision that is good but not best, such as transferring a patient closer to home for the family's benefit, may be a reasonable judgment call and not a moral failing. SDMs are therefore, in practice, given greater latitude than the narrow best interest standard might seem to allow, without unlimited license, and other standards have been proposed accordingly, including the "zone of parental discretion." [8–9]

These concepts are implemented through shared decision-making, in which the HCP outlines medically reasonable options and the SDM chooses among them. [11] This respects SDM authority while allowing

HCPs to put forward medically reasonable options, and it may increase parent knowledge and decrease decisional conflict. [12] The American Academy of Pediatrics (AAP) has recommended this approach, and it is increasingly common in pediatric care. [4, 13–15]

When an SDM fails or is unwilling to choose a medically reasonable option, the HCP must determine whether that action or inaction puts the patient at significant risk of serious, imminent harm. [16] When it does, the SDM has violated the "harm principle," the bare minimum responsibility SDMs are required to uphold, and such a decision may constitute abuse or neglect, warranting state intervention. [16] The state has a legitimate interest in children's safety and wellbeing and must seek to prevent abuse or neglect; failure to accept or provide harm-preventing treatment is legitimate grounds to supersede SDM authority. Taken together, SDM authority receives significant deference, but that deference is not unlimited: state intervention is reserved for cases where the decision causes harm to the patient. As we argue below, however, the harm principle answers the question of when the state may intervene, not the question of what those who hold authority over a child owe the child.

The Child's Claim and the Authorization Power

From the child's claim to the authorization power

We begin our discussion starting from the child and their interests, not the parent. A child, like an adult, holds a claim to bodily integrity, and the claim does not depend on the capacity to assert it. Because the child cannot presently waive that claim, someone else must hold the power to authorize touching, by which we mean any physical examination or intervention, on the child's behalf. We develop this account, and the structural argument that the person who authorizes treatment should not be the person who performs it, elsewhere. [17] Three conclusions matter here. First, the moral and social order assigns the authorization power, because of the child's incapacity, presumptively to the child's parents or other legally recognized decision-makers, for reasons of relationship and epistemic position. That assignment has limits, and we argue that in certain cases an institutional process should determine where they are crossed. Second, the power is held for the child's benefit, so it is fiduciary-like and purpose-limited: SDMs need not make the best decision in every case, but they must exercise the power reasonably. Third, the power does not simply pass to the physician when an SDM exercises it unreasonably; an independent process should review such an exercise, and the HPERC proposed below is that process.

A natural objection is that authorization is redundant when treatment is clearly beneficial. If the physician already owes the child a fiduciary duty to provide beneficial care and to avoid harmful interventions, a parent's authorization seems to add nothing, since any refusal would be harmful and the physician is already bound to provide what benefits the child. The reply is structural. Even where the physician is likely to be right, a rule that lets the actor authorize their own act removes the independent check that authorization provides against error, institutional pressure, and conflicts of interest, and medical expertise, though indispensable, does not establish an exclusive epistemic position on the

child's non-medical interests. Authorization therefore serves functions that fiduciary duty does not replace, and it should be held by someone other than the performing physician.

The strongest justification for decision-making latitude in medicine is autonomy, the right of competent adults to govern their own lives and bodies, and the competent adult patient is both decider and recipient of the decision's outcomes. [18, 19] In pediatrics, SDMs hold no autonomy-based right to choose what happens to another; instead, the SDM holds a power to authorize treatment on the child's behalf, assigned by the moral and social order because of the child's incapacity, held for the child's benefit, and conditional on its reasonable exercise. SDMs are therefore not mini-autonomous agents entitled to the wide latitude competent adults enjoy over their own care. They are decision-makers holding a power for another's benefit, as is typical of fiduciary agents: bound to exercise it reasonably in the child's interest, with discretion among reasonable options but without authority to choose outside that range.

Because SDM authority is conditional and fiduciary rather than autonomy-based, informed permission in pediatrics serves different functions than informed consent in adult medicine. It does not protect the child's autonomy. It is, rather, the means by which the power-holder exercises the authorization power over the child's claim to bodily integrity; it supplies an independent check by separating the person who authorizes treatment from the person who performs it; and it brings to the decision knowledge of the child, the family, and the child's non-medical interests that the clinical team may lack. These functions are why the authorization requirement is not redundant even when an intervention is clearly beneficial, and why it should not be set aside lightly.

Sources and limits of parental authority

By assuming the role of parent, the parent incurs a positive moral obligation to the child, which arguably flows from several sources: the voluntary act of creating or raising a dependent being; a special relationship of trust and intimacy, with Feinberg grounding parental duties in stewardship and a child's right to an open future; the child's uniquely vulnerable and dependent position, which Brennan and Noggle argue makes parental obligations fiduciary in nature; and a social contract in which society entrusts parents with authority in exchange for promoting the child's best interest. [20–28] Notably, we argue, parental authority thus flows from parental obligation and should not be understood as absolute.

A competing tradition centers parental rights, emphasizing family discretion, pluralism, and the freedom to raise children according to one's own values. [29–34] Its strongest version holds that family self-determination is intrinsically valuable, not merely a proxy for good outcomes, because the family is the setting for cultural transmission and intimate association. That view has genuine force for religious upbringing, education, and values transmission, but a discrete medical decision bearing on the child's survival or wellbeing is different in kind. Adult autonomy is compelling because the person choosing and the person living with the consequences are the same; here they are not. Even traditions that weight liberties such as religious free exercise accept limits where a third party's survival or bodily integrity is at stake, as Prince v. Massachusetts makes explicit. [35] The framework defended here is compatible with

the intrinsic value of family self-determination where it properly operates; it denies only that this value extends to choices outside the reasonable exercise of a power held for a separate person who cannot yet speak for themselves.

The ethical question, then, is not whether parents possess rights but how those rights should be understood in medical decision-making and what limits exist. Considered from the standpoint of parental duty, parents bear a fiduciary duty to the children in their care. [36] This framing centers the child's interests, rather than family privacy or parental rights. [37] As Lord Scarman concluded in Gillick v West Norfolk and Wisbech AHA, an English House of Lords decision, "parental rights are derived from parental duty...exist only so long as they are needed for the protection of...the child." [38] We argue, parental authority is thus best understood as derivative of responsibility rather than primarily an independent right: it is important insofar as it advances the child's interests, and secondary when the two conflict. Understood this way, parental rights are reconceptualized as a role-based power that enables parents to discharge their fiduciary duties, oriented toward the child's interest but limited when that interest is seriously threatened.

Reasonable exercise

The SDM's authority is therefore not unlimited. It is exercised appropriately when it is exercised reasonably. We do not require SDMs to select the best option in every case: the best option is the aspiration, but a reasonable option is permissible. Where several options fall within the range of reasonable choices, including where one is somewhat more beneficial than another, the SDM chooses among them, and the HCP's disagreement with the choice is not itself a reason for review. Where only one option is reasonable, refusing it falls outside the range. Reasonableness is not satisfied merely by avoiding harm. The range of reasonable choices narrows as the magnitude, probability, and irreversibility of the risk to the child increase. Values-based decisions deserve serious engagement and may be reasonable, but a sincere value does not make an otherwise unreasonable option reasonable.

Why not require the best? The answer lies in the structure of fiduciary obligations. Fiduciary duties have two components. The duty of loyalty concerns whose interests the fiduciary serves: it requires that the child's interests, and not the fiduciary's own, guide the decision, and the reasonableness standard does not dilute it. The duty of care concerns how well the fiduciary serves those interests: it requires reasonable prudence, not the best possible decision in every case. That is true of both SDMs and HCPs. Because neither is required to do the best, the duties of both are satisfied by reasonable exercise, and an HCP's view that another reasonable option would be better is not itself a ground for review. Requiring more of SDMs than we require of HCPs, or of either than fiduciary duties ordinarily demand, would need a justification the account does not supply.

In assessing reasonableness, the HPERC considers at least whether (1) the SDM understood the material medical facts and uncertainties; (2) the SDM gave appropriate consideration to the child's interests, including non-medical interests; (3) the decision rests on a defensible interpretation of the

available evidence rather than a materially false or recklessly disregarded premise; (4) the burden imposed on the child is proportionate to the interests the SDM sought to protect; and (5) a reasonable SDM, given the circumstances and information available, could reach the same decision. These factors are not a scoring system. Refusals grounded in genuinely contested evidence fall within the range. Where the evidence is mixed, uncertain, or disputed within the relevant scientific and clinical communities, or where professional guidelines differ, an SDM may reasonably choose among the supported positions; a decision is unreasonable on factual grounds only where it rests on a materially false understanding of settled information, disregards relevant evidence without a defensible reason, or refuses to engage with information a reasonable decision-maker would have considered. A finding that a decision falls outside the range concerns that decision, not the SDM's character, love for the child, or commitment to the child's welfare, and the process should be explained to families in those terms.

Reasonableness standards are common in law and are workable for the same reasons: they are familiar, applied in context, and given content over time. The federal foster-care statute, for example, defines a reasonable and prudent parent standard ("the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child…") for caregiver decisions about activities, and we borrow its language though not its scope. [39] We do recognize the term 'best interest' is included in this definition, and we think it apt even while recognizing it might be difficult to consistently and clearly determine in all cases. A committee, unlike a court, has no body of precedent, so the five considerations, the illustrative cases below, and the annual case log noted in Table 1 serve to give the standard content. The standard differs from Kopelman's threshold, the zone of parental discretion, and Ross's constrained parental autonomy in being grounded, first and foremost, in the child's claim and the conditional authorization power rather than in parental rights limited from outside, in being paired with a fiduciary duty that triggers review, and in being embedded in a process with a record and written findings. [2, 8–10]

When an SDM's choice falls outside the range of reasonable exercise, the power has not been exercised in a way that meets the duty attached to it. This does not abolish the child's claim or eliminate the need for authorization; it raises the question of who should exercise the power. That question calls for an independent process, and we propose the HPERC as that process. Where it finds that the SDM's exercise falls outside the reasonable range and that proceeding is proportionate, we argue that proceeding is ethically permissible and, in some cases, obligatory for the HCP.

The Role of the Health Care Provider

SDMs are not the only ones with fiduciary obligations to the pediatric patient. HCPs also have a fiduciary duty to use their specialized knowledge to promote the patient's welfare, reflected in the Hippocratic Oath, the AMA Code of Ethics, and AAP guidance. [15, 40, 41] Given the vulnerability of pediatric patients and the specialized knowledge HCPs possess, HCPs must prioritize patient welfare above competing

interests, which is the duty of loyalty; the duty of care requires reasonable care in advancing that welfare, not necessarily the best possible decision in every case. [42, 43]

These obligations require HCPs to do more than avoid harm; they carry a positive duty to promote the patient's interests, including providing clearly beneficial care. This duty is more pronounced in pediatrics than in adult medicine: there, the HCP's fiduciary duty is discharged once a competent adult makes an informed decision, because autonomy considerations can override the HCP's own assessment of welfare. That justification is absent in pediatrics, so the HCP's fiduciary duty is not discharged merely by the SDM's informed decision; it requires the HCP to exercise reasonable care in advancing the patient's interests, making it primary rather than secondary to autonomy in pediatric medicine.

Both SDMs and HCPs thus hold fiduciary obligations to the pediatric patient: SDMs by relationship, HCPs by specialized knowledge and professional obligation. [36] HCPs are therefore not neutral executors of SDM wishes but co-fiduciaries who must also advocate for the course of action most likely to benefit the patient. Because the SDM's authority is contingent on its reasonable exercise, that authority does not discharge the HCP's duty to seek review when the HCP has a reasonable concern that it is not being exercised appropriately.

These duties explain why HCPs may and should seek review when they have a reasonable concern about the exercise of the authorization power, and why the bar for that review is not the state's harm threshold. They do not, by themselves, give the treating physician authority to act over an SDM's refusal. Allowing the physician who believes an intervention is warranted to supply the missing authorization would collapse the roles of deciding that an intervention is warranted and performing it, removing the independent check that authorization provides. [17] The question is therefore what independent body should exercise the authorization power when an SDM's exercise of it is found to fall outside the reasonable range. The HPERC proposed below is such a body.

Diekema, by contrast, asks when state authority may permissibly override parental authority and sets the harm principle as that threshold. [16] That threshold is appropriate for state intervention, since the state has no special relationship, specialized knowledge, or fiduciary obligation to the patient, only the authority to protect children's welfare (parens patriae), an authority courts have limited out of respect for parental rights. [15, 35] The HCP is in a different position: HCPs owe fiduciary duties to the patient, which include positive obligations to act in the patient's interests and not merely to prevent harm. Those duties ground a different bar for review than the state's. The harm principle is calibrated to the costs of state coercion; it tells us when the state may intervene, not what those who hold authority over a child's claim owe the child. The two standards overlap at the extreme, since refusal of chemotherapy for a curable childhood cancer is both unreasonable and sufficiently dangerous to justify state intervention, and the HCP's duty to report suspected abuse or neglect remains in every case. They diverge where an exercise of the power is unreasonable but does not meet the harm threshold.

Why an Institutional Review Process Is Needed

How SDMs decide

If SDMs reliably exercised the authorization power in the child's interests, there would be little cause for review. Emotion, hope, trust in the physician, and the SDM's sense of ownership over the parental role shape SDMs' reasoning, though the evidence focuses on requests for treatment as much as refusals. [44–48] The point is not that SDMs frequently fail, but that unreasonable exercise is possible enough to warrant a mechanism for review. HCPs are also not neutral, error-free decision-makers, which is why the mechanism weighs both positions before a body independent of the treating team.

The limits of CPS and the harm principle

When SDM decision-making falls short, HCPs with a reasonable suspicion of abuse or neglect, including medical neglect, are statutorily required to report to the appropriate state agency, such as CPS, which investigates and decides whether to seek a court order to permit intervention over SDM refusal. [49] CPS's guiding philosophy centers on family engagement, child safety, and family integrity, a focus that may differ from an HCP narrowly concerned with a single patient's interests, and one study found that 63% of providers felt their patient did not benefit from a CPS report. [50–54]

CPS involvement, though protective in intent, is not benign. [55–57] High-profile cases, including Kowalski v. Johns Hopkins All Children's Hospital and Bright v. Texas Department of Family and Protective Services, involved aggressive state intervention in suspected maltreatment later found unsubstantiated, causing significant distress, including a parent's suicide in one case. [58, 59] These cases are anecdotal, but there are documented concerns about bias in reporting and investigation, and uncertainty remains about whether CPS actually prevents future maltreatment. [60–62]

There is broad agreement among HCPs and SDMs that avoiding state intervention is desirable where possible. [61] At present, however, HCPs facing an intractable dispute have little recourse beyond acquiescing to the SDM, referring the case to CPS, or, less commonly, petitioning a court directly. Where an SDM's exercise of the authorization power is unreasonable but does not rise to medical neglect, review within the institution offers an intermediate pathway that can precede, and sometimes avoid, a CPS report or court petition.

The harm principle's terms, namely significant risk, serious harm, and imminence, are indeterminate at the margin. Cases such as the tracheostomy case discussed below show that reasonable clinicians can disagree about whether the principle is met, so an HCP facing such a case has little guidance on whether it belongs on the CPS side or the discretion side. The HPERC offers a response suited to boundary cases. It is not less coercive at the level of the decision, since an authorization over objection is coercive in the same way a court order would be. Its advantage is lower collateral harm: no investigation of the family, no risk to custody, and a determination confined to a single intervention. Nor does it displace mandatory reporting. Where an HCP has reasonable cause to suspect medical neglect, the reporting duty applies regardless of HPERC review. The HPERC is therefore the pathway for cases in which the

HCP concludes that the reporting threshold is not met, and its findings may inform a report where one is required.

How the HPERC differs from existing ethics consultation

Hospital ethics committees and consultation services already assist in pediatric disputes, and nothing in the proposal displaces them. Ethics consultation is typically advisory: it clarifies the ethical issues, facilitates communication, and offers recommendations that the treating team and SDM may accept or decline, without a defined standard of decision, burden of proof, evidentiary record, or stated consequence for the SDM's refusal. The HPERC differs in four respects. It applies a defined standard, namely whether the SDM's exercise of the authorization power falls outside the reasonable range. It assigns the burden of proof to the HCP. It requires a record and written findings. And it specifies what follows from the determination, including a review period for a second opinion, court review, or appropriate transfer, and the option of proceeding over objection. Institutions may house the HPERC function within an existing ethics committee, provided those features are present.

The Proposed Process: A Hospital Pediatric Ethics Review Committee

An HCP may come to have a reasonable concern that an SDM is not exercising the authorization power appropriately, and where that concern arises, the parties should first attempt negotiation and compromise, including a second opinion and engagement of institutional resources. If the disagreement proves irreconcilable, the question whether the SDM's exercise falls outside the reasonable range is one on which each party is entitled to a fair process. Because this is not a matter of state intervention, that process need not be judicial; it should be conducted by a hospital ethics review committee independent of the treating team, modeled on the process used under the Texas Advance Directive Act, discussed below. [63] The HPERC is a process analogue, though its subject differs from TADA's: TADA addresses decisions to withdraw life-sustaining treatment over objection, whereas the HPERC addresses authorizing an intervention the SDM has refused. Where the recommended course is to withhold or withdraw life-sustaining or potentially nonbeneficial treatment over the SDM's request, the dispute is instead reviewed under TADA in Texas, or under a process of the kind described by the AAP elsewhere. [64] We use TADA here for brevity, but it should be noted the AAP’s recommended review process is quite similar and functions in hospitals across the country, though it does not entail a statutory safe harbor.

Each party should have an opportunity to state why their position is justified, with the review committee weighing all pertinent information. The burden remains on the HCP, since the HCP seeks to implement a plan against the SDM's refusal: the HCP must establish by clear and convincing evidence the factual predicates of unreasonableness, namely the relevant medical facts, the strength of the evidence, the SDM's understanding of the information, and the basis for the SDM's decision. The committee's conclusion that the SDM's exercise falls outside the range of reasonable exercise, and its conclusion that

authorizing the specific intervention over objection is proportionate, each require a two-thirds majority. Where an exercise falls within the reasonable range, including where one option is on par even if not equal to the other, the SDM's choice stands. The aim of the review is agreement: the committee should explore whether a plan acceptable to both the SDM and the HCP can be reached. If the SDM declines every reasonable option, the starting point is the option that is most reversible and life-preserving.

Review can err in either direction. Wrongful deference leaves a child without a clearly beneficial intervention, and wrongful override coerces a family on a mistaken judgment and may damage the relationship and trust on which the child's care depends. We do not treat the two as symmetric. The standards favor the SDM, through a demanding burden on the factual predicates and two-thirds majorities, for two reasons: humility about the committee's own judgment, particularly on non-medical interests where parents are better placed; and the fact that authorization over objection requires coercion, whose costs fall on the family even when the decision is right. The standards are therefore set to make wrongful override less likely than wrongful deference, although the range of reasonable choices narrows as the stakes for the child rise.

A finding that an SDM's exercise is unreasonable establishes that the power has not been exercised reasonably in this decision; it does not by itself settle the response. Before authorizing, the committee asks whether the specific intervention, and the degree of coercion required to carry it out, is proportionate and feasible for this patient, including this patient's particular risks and burdens. This is not a harm threshold. It asks whether the means are fit for the ends, as any fiduciary acting for a principal would, and it prevents the standard from licensing coercion for modest or distant benefits. In making this determination the committee considers at least the invasiveness and burden of the intervention, including any restraint, sedation, or anesthesia required; its reversibility; the magnitude and certainty of its expected benefit; the time sensitivity of the decision; the availability of less coercive alternatives; and the likely effect of coercion on the child's relationship with the family and the health care team.

HCPs should be cautious about concluding that an SDM's choice is unreasonable when that conclusion rests solely on medical interests, and should be slow to dismiss non-medical interests and values, which deserve serious engagement even though a sincere value does not make an unreasonable option reasonable.

A full treatment of adolescent decision-making is beyond the scope of this discussion. Our account concerns the authorization power as held for children who lack decision-making capacity, and where an adolescent has capacity the question of who should hold that power changes, since capacity and authority are distinct questions. [66] The AAP and others argue that capacitated adolescents should be included in decision-making to the greatest extent possible and that their informed refusal should carry significant weight. [67] The HPERC should therefore assess capacity, elicit and document the adolescent's views, and give them weight in proportion to the adolescent's capacity. Nothing in the

process proposed here is intended to authorize treatment over the informed refusal of a capacitated adolescent without further argument. [68–73]

Models for Institutional Review: TADA and AAP Guidance

In the mid-1990s, a group of healthcare systems grew concerned about requests for "futile" medical care, viewing both the definition of futility and the absence of a well-justified review process as significant shortcomings. [74] These systems developed a review process they believed could fairly and ethically justify withdrawing life-sustaining treatment over an SDM's objection. In 1999, this process inspired the Texas Advance Directive Act (TADA), which provides a statutory safe harbor for HCPs who withdraw such treatment over objection, provided they complete the review process and satisfy due process. [75, 76]

TADA's history demonstrates that healthcare systems can and have created institutionally based review practices, before any statutory process existed, to address major disagreements between HCPs and decision-makers about a patient's interests, and that such practices can subsequently influence and inform statutory law. The mere creation of a process, however, is not sufficient; as TADA's history of revision illustrates, it must be a due process. [77] TADA's initial version had significant due-process shortcomings, yet it remains a broadly positive model, in part because it may resolve conflicts within the medical system, where familiarity with the salient facts is greater. [78–80] One limitation is that TADA's arbitrators are largely institutional employees, a potential source of bias.

We draw on TADA as a process analogy, not as a precedent for the act the HPERC would authorize. TADA concerns decisions not to continue life-sustaining treatment over an SDM's objection, whereas the HPERC concerns authorizing an intervention the SDM has refused. Disputes of the first kind belong to TADA in Texas; elsewhere, the AAP has recommended a defined institutional resolution process for parental requests for potentially nonbeneficial treatment, including second opinions, mobilization of institutional resources, and options for transfer and appeal, which is analogous to TADA without a safe harbor or statutory codification. [64] These developments suggest that institutional practice can precede and shape policy and statute, and that the absence of a statutory safe harbor today is not a reason to reject a process that is ethically justified.

Process Design

Procedural fairness

Because the HPERC may supersede an SDM's exercise of the authorization power, its procedures should meet the standards of fairness we would demand of any body that exercises coercive power. We borrow the vocabulary of due process as an analogy for those protections though we do not claim that constitutional due process applies to a private committee. The protections serve fairness within a collaborative aim and are not intended to convert the review into litigation. A process is "due" when it

involves a fair procedure before depriving someone of a substantive right, and the action itself is fair. [81] No definitive list exists, but proposed criteria include an unbiased tribunal; notice of the proposed action and its grounds; an opportunity to present reasons, evidence, and witnesses and to know and challenge opposing evidence; a decision based on the evidence presented; the opportunity to be represented by counsel; a record; and written findings. [81] These form the minimum baseline for what follows, and the extent to which each is honored may vary with clinical urgency.

In T.L. v. Cook Children's Medical Center, a Texas appellate court found a probable procedural due process violation in a TADA-governed committee review in which the committee applied no defined evidentiary standard and simply "considered" what the physician and family presented, and it held that, as a state actor under the statute, the hospital owed procedural due process. [77] Because the HPERC is an institutionally adopted process, it may avoid the state-action problem, although a court could reason that supervising parental medical decisions is a traditional state function, which would apply here as well. Whether a non-statutory process would be treated as state action remains open. Either way, a committee without a defined evidentiary standard, burden of proof, and record is fragile, which is why the criteria below specify them.

Guiding principles

The HPERC should be guided by five principles: (1) Fiduciary Primacy: the child's claim and interests are the starting point, and all decisions should stem from the fiduciary-like duties attached to the authorization power and to the HCP's role, not from authority or ownership; (2) Proportionality: review should be sensitive to the medical risk, revisability of the intervention, and the degree of coercion required to implement it; (3) Transparency and Accountability: decisions, processes, and rationales should be documented and accessible to involved parties; (4) Non-Adversarial Collaboration: the goal is to clarify whether the authorization power is being exercised reasonably and, where possible, to reach agreement on a plan, not to punish or litigate, with procedural protections serving fairness within that collaborative aim; and (5) Respect for Values: SDM values should be weighed as part of the child's best interest, not displaced by a narrowly medical standard.

Committee composition

Committee composition must satisfy the requirement of an unbiased tribunal: all members must be uninvolved in the patient's care and otherwise disinterested, with any conflicted member recusing, and no member's participation should affect their standing or employment within the institution. Table 1 specifies minimum composition; the range of professional and lay perspectives it requires ensures no decision rests solely on a single profession's standard reasoning, and hospital legal counsel is limited to confirming compliance rather than participating in deliberation. Institutions may house this function within an existing ethics committee rather than a standalone HPERC; either approach is acceptable provided the committee's functions are satisfactorily fulfilled. We acknowledge that members of an

institutional committee are not wholly disinterested, a limitation shared with other hospital committees, including institutional review boards. Where feasible, institutions should include at least one member from outside the institution or from another institution's committee, and counsel's role should remain procedural. Anyone previously involved in the patient's care, including in an earlier ethics consultation on the case, should not participate in the decision, and institutions that house the HPERC within an existing ethics committee should recognize that combining advisory and adjudicative roles may affect families' trust in consultation. Smaller institutions may lack the personnel to constitute such a committee, and may use a regional or cross-institutional committee shared among hospitals, which would also strengthen independence.

Bias

The HPERC's judgments about whether an SDM has acted reasonably are open to the same risks of bias that attend CPS reporting and investigation, including bias related to race, ethnicity, language, disability, religion, and socioeconomic status, and we cannot be certain that the safeguards proposed here will prevent them. [60] We counsel caution. The standard limits the committee to factual predicates and to questions on which medical judgment is relevant, requires that values-based reasons receive serious engagement, and gives the SDM an advocate or independent counsel. Institutions should also ensure interpreter services and accessible materials, train members to recognize bias, and record and periodically review the characteristics of the families referred, the decisions reached, and the outcomes, so that disparities can be identified and the process revised or suspended if they appear.

Communication and process

The HPERC must clearly communicate the process, timing, and each party's rights to both SDM and HCP well in advance of review, and provide a written, reasoned decision afterward; Table 1 details the specific notice contents and timing required at each stage. If an SDM declines to participate, the HPERC should document its attempts to involve them rather than proceeding silently. The SDM should have the right to the assistance of an advocate or independent counsel of their choosing; the institution should inform the SDM of this right and, where feasible, help the SDM identify an advocate who is not employed by the institution, such as a patient-family advocate.

Review is triggered when the HCP has a reasonable concern that the SDM is not exercising the authorization power reasonably, or when the SDM disputes a course the HCP proposes, and proceeds through notice, presentation, deliberation, and decision, as outlined in Table 1, including the two-thirds majority required to find that the SDM's exercise falls outside the reasonable range. If the HPERC so finds, concludes that the proposed intervention is proportionate, and the SDM has not sought a second opinion, court review, or an appropriate transfer within the review period, the HCP may proceed with the HPERC-endorsed plan, but this authorizes only the specific question addressed, and HCPs should continue to involve and accommodate the SDM to the extent safely possible. The review period exists to

allow a second opinion, court review, or transfer where appropriate; transfer is appropriate only where the child can be moved safely, a receiving facility is willing and has been informed of the finding, and the move is not simply a means of avoiding a finding while the child remains at risk. If the HPERC instead finds the SDM's exercise within the reasonable range, the HCP should comply as soon as reasonably possible or, if unwilling, invoke institutional conscientious objection policy and transfer the patient to a willing provider. Hospital legal counsel should confirm that the process and decision satisfy applicable criteria, and an SDM who believes the process was flawed retains the right to seek external review by a court.

Procedural checklist

Table 1 presents a procedural checklist spanning case initiation, committee composition, notification, presentation, deliberation, documentation, post-decision procedure, and oversight, for use by the HPERC and institutional counsel.

Table 1
HPERC Procedural Checklist

1. Case Initiation and Pre-Review
● Disagreement persists, and the HCP has a reasonable concern that the SDM is not exercising the authorization power reasonably
● Significant efforts at direct resolution have been attempted and documented in the medical record
● Both parties understand the HPERC's non-adversarial purpose
● Hospital legal counsel has been notified and will oversee procedural integrity
● Reason for initiating review has been documented in the medical record
● Dispute is routed correctly: authorizing a refused intervention (HPERC) versus withholding or withdrawing treatment (TADA or an equivalent process)
● Adolescent capacity assessed and preferences elicited and documented, where applicable
● HCP has considered whether the threshold for mandatory reporting of suspected abuse or neglect is met; if so, reporting duties apply independently of HPERC review
2. Committee Composition
● All members are uninvolved in the patient's care, including any prior ethics consultation on the case, and free of conflicts of interest
● Committee includes ≥ 1 physician, 1 nurse, 1 ethicist, 1 social worker, 2 lay community members (+ spiritual advisor if religious conviction is central)
● Hospital legal counsel present in a non-voting capacity only
3. Notification and Disclosure
● Written notice provided 48 hours–7 full days before review (shortened only if clinically urgent)
● For time-sensitive interventions, the process is expedited and the notice period and standstill shortened, with the rationale documented
● Notice includes: date/time/location; process and decision criteria; participant rights; evidence to be considered; opportunity for written/verbal testimony; rationale if notice is shortened
● SDM informed of the right to an advocate or independent counsel, and given reasonable assistance in arranging one
● Interpreter services and accessible materials provided as needed
4. Presentation Phase
● All required HPERC members, and both parties (if possible), are present
● Meeting is transcribed and attendance recorded
● Each party may present evidence, call witnesses, and question opposing witnesses
● Expert testimony permitted as needed

1. Case Initiation and Pre-Review
● SDM may be accompanied by an advocate or independent counsel
5. Deliberation Phase
● HPERC deliberates privately per the five guiding principles
● Decision based solely on evidence presented; rationale documented
● Finding that the SDM's exercise falls outside the reasonable range requires a two-thirds majority, and the HCP must establish its factual predicates by clear and convincing evidence
● Committee has considered whether the specific intervention and the coercion required are proportionate, including this patient's particular risks and burdens (a second two-thirds determination)
● Written decision (summary of evidence, factual findings, reasoning, vote record) produced within ~ 72 hours
6. Communication and Documentation
● Written decision and reasoning provided to all parties
● Decision, transcript, attendance, and materials added to the medical record
● Institutional legal counsel confirms procedural compliance
● Both parties may review the record for factual accuracy
7. Post-Decision Procedure
● SDM informed of right to appeal to a court of law
● If HPERC finds the SDM's exercise unreasonable and the intervention proportionate: SDM given a defined review period (up to 7 full days, shortened where delay risks harm) to seek a second opinion or court review, or an appropriate transfer where the child can be moved safely and the receiving facility is informed of the finding; facility assists with records and transfer efforts; if none occurs, proceed with HPERC-endorsed plan
● If HPERC finds the SDM's exercise within the reasonable range: HCP complies or invokes conscientious objection and seeks a willing provider; threshold for medical neglect reporting is separately evaluated
● Record whether the institution proceeded on the HPERC record alone or also sought a court order; legal risk assessment documented
● Conscientious-objection protections apply to staff in either direction
8. Oversight
● Maintain an annual case log for institutional review
● Case log records family characteristics, language needs, decisions, and outcomes, and is reviewed for disparities
● Conduct regular audits of procedural adherence

1. Case Initiation and Pre-Review
● Provide HPERC member training on due process, pediatric ethics, and cultural sensitivity
● Periodically review and revise the HPERC process to reflect evolving law

Illustrative Cases

The following four cases illustrate how the standard operates. In each, review is warranted; they differ in whether authorization follows, and why. The analysis has two steps: whether the SDM's exercise of the authorization power falls outside the reasonable range, and whether authorizing the specific intervention over objection, given the coercion it requires, is proportionate and feasible. The cases are stylized, and clinical details are illustrative.

Case 1: Vitamin K prophylaxis (authorization permissible)

A term newborn is born without complications, and the team recommends vitamin K prophylaxis. The parents, who have received accurate information and a second opinion, decline all forms of vitamin K, because they believe it causes childhood cancer. The refusal rests on a materially false premise, while vitamin K deficiency bleeding, though uncommon, can be devastating. Once the factual concern is corrected, no remaining value supports declining every form. The absolute risk is low and not imminent, so the harm principle is unlikely to be met on most readings, though this is contestable. We offer the case because it is a clear example of unreasonable exercise on purely medical grounds, not because it is uncontested. The refusal falls outside the reasonable range, and the intervention is a single low-burden injection with a well-established benefit, so authorization is proportionate. Because the risk window is time-sensitive, the process would be expedited, with notice and standstill shortened and the rationale documented.

Case 2: Tracheostomy, a boundary case (authorization permissible)

A 6-month-old child with a chronic lung condition and significant cognitive delays has been intubated for several months and is stable with no documented airway injury. The team concludes that continued intubation is not sustainable and recommends tracheostomy with home ventilation, and also offers comfort-focused care. The mother declines both, stating that tracheostomy conflicts with her beliefs, and asks that intubation continue. Whether the harm principle is met is itself disputable, which is typical of boundary cases.

The mother's objection is values-based and deserves serious engagement, including spiritual care and extended conversation. But her values support neither reasonable option; they support only continued

intubation, which the team has concluded is not a reasonable course given its cumulative risks and the available alternatives. A sincere value does not make an unreasonable option reasonable, and the benefit analysis does not depend on the child's cognitive status. Because the two reasonable options reflect different goals, the SDM retains the choice between them. If she declines both, the starting point is the more reversible and life-preserving option, here tracheostomy. Both steps are satisfied, and the HPERC may authorize proceeding. Because reasonable clinicians could disagree about whether the harm principle is met, the HPERC offers a response that does not require the HCP to choose between acquiescing and involving CPS. Had the team concluded that withdrawal of life-sustaining treatment was more appropriate, the dispute would proceed under TADA or an equivalent process.

Case 3: Cochlear implantation (review, no authorization)

A 2-week-old child has bilateral profound sensorineural hearing loss and is a candidate for cochlear implantation. The child's parents, who are Deaf and use American Sign Language, decline implantation and plan to raise the child in ASL and the Deaf community. We assume here that deferral would not meaningfully reduce the expected benefit of implantation, so that the parents' choice preserves the child's later options. A sign-language-based upbringing is a recognized alternative with its own developmental case, and the parents' values bear on what counts as benefit to the child: language, identity, community, and the burdens of a lifelong device. Because a reasonable alternative exists and the disagreement turns on contested goods, the choice falls within the reasonable range and the standard does not authorize proceeding over objection. The HPERC should record its finding and recommend continued dialogue. The analysis might change if the window for implantation were narrower, so that deferral would substantially reduce its expected benefit, or if the child were to receive neither implantation nor early exposure to a full language, in which case the risk of language deprivation would bear on reasonableness.

Case 4: Orchiopexy (review, no authorization)

A 20-month-old boy has unilateral undescended testis and is past the age at which surgical correction is recommended. After counseling, the parents decline orchiopexy, citing fear of anesthesia. Watchful waiting does not correct the condition, and the team notes elevated long-term risks to fertility and testicular cancer. The result is sensitive to this patient's particular risks. For a child with ordinary anesthetic risk and a unilateral presentation, we assume that declining falls outside the reasonable range, because the benefit is well established, the burden is low, and the stated fear does not respond to this child's actual risk. Authorization nonetheless does not follow, because the second step is not satisfied: orchiopexy requires general anesthesia and is intrusive, and its benefit is a modest reduction in risks that lie years ahead, so proceeding over objection would require coercion disproportionate to that benefit. The HPERC should record its finding, recommend counseling directed at the specific fear, and revisit the question if circumstances change. The analysis would differ if this patient's risk of malignancy

were higher, which would raise the stakes at both steps, or if this patient's anesthetic risk were elevated, which might bring the refusal within the reasonable range and preclude authorization on that grounds.

The cases show that the standard does not reduce to ranking options by benefit. Where the exercise is plainly unreasonable on medical grounds and authorization is proportionate, as in Case 1, proceeding is ethically permissible. Case 2 is a boundary case in which the harm principle is indeterminate, and the HPERC offers an alternative to the binary choice between acquiescence and CPS referral. Where an SDM chooses among reasonable options, as in Case 3, the choice stands. Where the choice falls outside the reasonable range but authorization would be disproportionate, as in Case 4, review documents the finding without authorizing coercion.

Ethical Permissibility and Legal Risk

We argue that, after an HPERC determination that an SDM's exercise of the authorization power falls outside the reasonable range and that the proposed intervention is proportionate, proceeding is ethically permissible and, in some cases, ethically obligatory for the HCP, and that a court order is not an ethical precondition. The obligation follows from the HCP's fiduciary duty: where an independent process has verified that the SDM's exercise falls outside the reasonable range and that the intervention is proportionate, the HCP's duty to act in the child's interests includes a duty to ensure that the child receives it. The obligation attaches to a good-faith determination reached through a fair process; it does not depend on the determination being infallible, but it does not bind where the HCP has reason to believe the process was flawed or the factual premises mistaken. Where no such process is available, the claim is weaker, and the HCP's duty is to pursue the available alternatives, including a court order. An HCP who disagrees with a finding may invoke conscientious objection and transfer care to another clinician, which does not discharge the institution's duty to ensure that the child receives the intervention. The SDM holds the authorization power conditionally, as a power held for the child's benefit. Where a fair process, independent of the treating team, finds that the power is not being exercised reasonably, the ethical basis for the SDM's control of that decision is lacking, and authorization may be exercised through the process rather than by the treating physician, so that the physician does not authorize their own touching. A court order is a legal instrument that confers legal authority. To make ethical permissibility depend on it would make the ethics of the HCP's duty to the child depend on the threshold at which the state chooses to intervene, which is the very calibration this paper argues is inappropriate as the measure of what is owed to the child. This is not to deny that proceeding carries legal risk, which we address below.

Why should an institutional committee, and not a court, exercise the reassigned authority? We offer three reasons. First, the treating physician does not decide. The HCP's fiduciary duties, which extend beyond the state's obligation to prevent harm, ground the duty to seek review, and a committee independent of the treating team decides, so that authorization remains separate from performance. Second, the committee is well placed to decide medical questions: it can draw on knowledge of this child's course and condition, act quickly, and confine its determination to a single decision with less collateral harm

than state involvement. This reason is limited to genuinely medical questions, since parents are better placed on non-medical interests, which is why the authority is reserved for the clearest cases. Third, because the SDM's power is conditional on its reasonable exercise, when the power is exercised unreasonably the decision is reassigned, for that decision only, and the SDM's role otherwise continues. We recognize two limits. A hospital committee is not wholly independent of the institution that employs the treating physician and bears the liability, which the independence measures described below mitigate but do not eliminate. And our claim concerns where the limits of the moral and social assignment of the authorization power lie: the current legal arrangement places the power with parents and the courts, and the histories of TADA and of AAP-recommended processes illustrate how social recognition can follow institutional practice. [64, 74–76]

Alternatives to a committee deserve consideration. A court is the conventional alternative, and it remains available to the SDM and to the institution. But court involvement is often slower and more adversarial, it carries the collateral harms discussed above, and the standard courts apply is calibrated to the costs of state coercion and not to the positive duties of those who hold fiduciary obligations to the child. A guardian ad litem or an independent second physician could supply additional perspective, and the process incorporates second opinions, but a single individual provides neither the range of perspectives nor the record and defined standard that a committee provides, and the concern about separating authorization from performance applies if that individual would also perform the intervention. A committee has its own limits, but it combines medical knowledge, speed, multiple perspectives, and a documented standard in a way the alternatives do not, and the alternatives remain available alongside it.

The committee's authority is also a question of legitimacy. The HPERC does not claim to displace public authority or to define parental rights; it claims that a fiduciary with a duty to the child may, after a fair and accountable process, decline to treat an unreasonable exercise of the authorization power as controlling. That claim is more credible to the extent the process is accountable: the SDM retains the right to seek review by a court, decisions are reasoned and recorded, members recuse for conflicts and include a perspective from outside the institution, the SDM has an advocate or independent counsel, and institutions maintain a case log and audits of adherence that are reviewed by the institution's governing body, with aggregate outcomes made available where feasible. Accountability of this kind does not settle the question of legitimacy, which also depends on public acceptance, but it is of a kind familiar from other institutional review bodies.

Quinlan, although it concerned a different situation, points in the same direction: the court quoted with approval the suggestion that a hospital committee could provide "much needed dialogue," force the exploration of all options, diffuse the responsibility for difficult judgments, and might eventually assume a legal status allowing courses of action not undertaken for fear of liability. [10, 82]

This is an initial proposal, with more work needed to bring it to fruition, as TADA itself developed over time. It may not fully resolve SDM concerns: ideally the SDM would agree to the intervention, and if the family refuses, the refusal should be carefully documented. We recognize that proceeding without

judicial authorization carries legal risk, including exposure to claims of medical battery, a risk similar to that faced by institutions that adopted futility policies before TADA's passage, and unsettled questions about the legal status of such review processes. This risk falls on clinicians and institutions, and the duty to ensure that the child receives the intervention may be discharged by different means: by proceeding on the HPERC record, or by also seeking a court order, depending on the institution's assessment of the legal risk and its tolerance for it. Each institution should assess that risk and decide for itself, but the existence of legal risk does not by itself relieve the HCP of the duty. Our ethical argument does not, however, depend on the HPERC's legal status. The absence of a statutory safe harbor is not evidence that the practice is ethically impermissible: TADA itself began as institutional practice before it became statute, and professional bodies now recommend institutional resolution processes for related disputes, which suggests that practices can precede and shape policy and law. [63–64, 74]

Practical questions remain, such as how to handle a family or child who physically attempts to prevent an intervention. [65] The process may also further strain trust between the public and the medical system. That risk is plausible, though it attends any CPS referral as well, and whether this process would generate more mistrust than existing alternatives is unclear. We must nonetheless work to find solutions that serve pediatric patients while remaining humble about the limits of what we know.

The proposal has limitations beyond those noted above. It has not been tested, and we offer no data on how often disputes of this kind arise or how an HPERC would perform. Evaluation would require tracking outcomes, including family experience and trust, disparities in referrals and findings, and the downstream use of courts and CPS, and we would favor piloting the process at one or more institutions with such evaluation. The proposal also depends on legal questions, including state action and battery, that warrant analysis by legal scholars.

Conclusion

Diekema's harm principle appropriately sets the bar for state intervention, but it answers a different question from the one that governs those who hold authority over a child's claim to bodily integrity. That authority is a power held for the child's benefit, and it must be exercised reasonably. SDMs should aim for the best available care for the child, and choices among reasonable options should stand; but an exercise of the power that falls outside the reasonable range does not meet the duty attached to it, even where the threshold for state intervention has not been met. Because HCPs are fiduciaries with positive obligations to their patients, such exercises warrant review by a process independent of the treating team. We propose the HPERC as that process. Where a committee, applying a clear and convincing standard to the factual predicates and a two-thirds majority to its conclusions, finds that an SDM's exercise falls outside the reasonable range and that proceeding is proportionate, we argue that proceeding is ethically permissible and, in some cases, obligatory, and that a court order is not an ethical precondition. We recognize the legal risks and the early stage of such practices, but institutional processes of this kind have preceded and shaped policy and statute before.

Declarations

Author Contribution

A.G. is responsible for the conceptualization and writing of the main text of this manuscript.

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