

ARTICLE

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In Defence of the Best Interest Standard: A Fiduciary Duty

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Abstract

Looking at Canadian provincial pediatric health care policies and laws, the best interest standard (BIS) enjoys support. Within philosophy, however, the BIS faces serious opposition. Granted, there remain a few fervent defenders of the BIS in the contemporary literature; however, I argue that while some authors nominally defend the BIS, my analysis reveals that what they really defend is at best a watered down version of it. In this article, I argue that not only must the BIS be understood narrowly, but a substitute decision-maker (SDM) must satisfy the BIS — for an SDM is her patient's fiduciary.

Résumé

En examinant les politiques et lois provinciales canadiennes relatives à la santé pédiatrique, on constate que le principe du meilleur intérêt (PMI) bénéficie d'un soutien généralisé. Cependant, dans le domaine de la philosophie, le PMI est confronté à une opposition sérieuse. Certes, il reste quelques défenseurs fervents du PMI dans la littérature contemporaine ; cependant, je soutiens que tandis que certains auteurs défendent nominalement le PMI, mon analyse révèle que ce qu'ils défendent réellement est au mieux une version édulcorée de celui-ci. Dans cet article, je soutiens que non seulement le PMI doit être compris de manière restrictive, mais qu'un preneur de décision substitut (PDS) doit satisfaire au PMI — car un PDS est le fiduciaire de son patient.

Keywords: bioethics; best interest standard; parents; substitute decision-maker; children; fiduciary relationship

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1. Introduction

My primary concern in this article is the *best interest standard* (BIS) — specifically, qua the principle of substitute health care decision-making for incapable minor patients.¹ If a patient is incapable of providing his health care team with his informed consent (or refusal) with respect to the present health care treatment decision, then a *substitute* (i.e., replacement) health care *decision-maker* (SDM) must be appointed in order to provide that informed consent *instead* — on the incapable patient’s behalf. The BIS asserts that this appointed SDM is to endorse *only* that treatment option which maximally promotes the (incapable) patient’s *well-being*.² If the patient is a *child* — an incapable minor — then it is (normally) his parents that are appointed as his SDM. This is because his parents are his closest *family*,³ and, as such, are assumed to be the persons most concerned about his well-being; that is, his parents are appointed to the role of his SDM because they are the persons most likely to satisfy the preceding demand that the SDM follow the BIS,⁴ and, hence, are appointed because they are the persons most likely to do a better job than anyone else in deciding for him.⁵ Thus, the BIS entails that parents, when making substituted health care decisions on behalf of their child, must act exclusively in his best interest.

Looking at Canadian provincial paediatric health care policies and laws, the BIS enjoys widespread support. For example, Ontario’s *Health Care Consent Act* (HCCA) states that the SDM of an incapable child-patient “shall act in the incapable [patient’s] best interests” (HCCA, 1996, s. 21.1), and that, in deciding what is in his best interests, the SDM must consider his well-being (HCCA, 1996, s. 21.2).⁶ Similarly, British Columbia’s *Family Law Act* (FLA) states that “a child’s guardian

¹ The BIS applies to cases where there is no valid advance directive, and in which substituted judgement is inapplicable.

² Explication and defence of this definition of the BIS is given in §2. Well-being is what is good for the person in question — i.e., the incapable patient. In regards to the nature of well-being (either for children or in general), the central argument of this article should not presume a particular view; that being said, well-being must be more than just health.

³ Following Buchanan and Brock, the patient’s *family* is defined as whomever the patient is most closely associated with (Buchanan & Brock, 1990, p. 136).

⁴ Thus, the BIS is not presumed by the rule of having parents be the default SDM; rather, the rule of having parents be the default SDM is inferred from the demand that the SDM satisfy the BIS.

⁵ There are three further reasons mentioned by Buchanan and Brock as to why parents are (generally) the persons who ought to be appointed as their child’s SDM. First, parents are held financially responsible for the costs of treatment and bear some (if not all) of the longer-term consequences (financial and otherwise) of the particular treatment choice made (Buchanan & Brock, 1990, p. 233). Second, within limits, parents have the right to raise their children according to their own standards and values (Buchanan & Brock, 1990, p. 233). Finally, third, the family is a valuable social institution — providing the most significant source of intimacy for many adults, as well as the context in which the children’s own capacities for intimacy are developed — and the family must have some significant freedom from oversight, control, and intrusion in order to achieve that intimacy, including the freedom to make important decisions about the welfare of its incompetent members (Buchanan & Brock, 1990, p. 233). For reasons largely not explicitly discussed here, I find these alternative justifications wanting. Hence, the original justification — that parents ought to be their child’s SDM if and when they are the most likely to best fulfill the role of SDM — is superior, for “[t]his argument accords to parents *no* independent interests or right to decide for their children and to enforce their choice when the choice may *not* best serve their children’s welfare” (Buchanan & Brock, 1990, p. 233).

⁶ The SDM must consider the patient’s “condition or well-being” (HCCA, 1996, s. 21.1).

must exercise [her] *parental responsibilities* in the best interests of [her] child” (FLA, 2011, s. 43, emphasis added), responsibilities including the “giving, refusing, or withdrawing [of] consent to medical, dental, and [any] other health-related treatments for the child” (FLA, 2011, s. 41). In this way, parents qua SDMs must follow the BIS.

In philosophy, however, the BIS faces serious opposition.⁷ Granted, there remain a few fervent defenders of the BIS in the contemporary literature — most notably, Johan Bester, Allen Buchanan and Dan W. Brock, and Loretta M. Kopelman; however, as I demonstrate later in §3, these philosophers defend the BIS in name only. Hence, very few (if any) philosophers actually defend the BIS as even a merely *plausible* standard of substitute health care decision-making.⁸ In this article, I argue against this vast majority: I argue that not only is the BIS (when properly understood) a plausible standard of substitute health care decision-making, but, further, that it *must* be the standard, for the satisfaction of the BIS is required by virtue of the *fiduciary nature* of the relationship between an SDM and her incapable patient.

Thus, in §2 and §3, I argue that the BIS should be understood *narrowly* — requiring that the SDM act exclusively in her patient’s best interest. In §4 and §5, I demonstrate that the common defenders of the BIS do not *really* defend the BIS (but, rather, defend something like Douglas S. Diekema’s harm principle). In §6 and §7, I argue that not only *must* the BIS be understood narrowly, but an SDM *must* satisfy the BIS — for an SDM is her patient’s fiduciary and, as such, she must act exclusively in her patient’s best interest. In §8 and §9, I explain how this fiduciary understanding of the BIS resolves the worry that it is too *demanding* on account of its being too *individualistic* — requiring that parents intrinsically consider only their child’s interests, even where the harm to the child is relatively minor, and the stakes for the parents large. Finally, §10 concludes the argument.

2. The Best Interest Standard

The BIS asserts that an SDM is to *act* exclusively in her patient’s best interest. However, given that an SDM’s authority is simply that of *consenting to* substitutively *for* — on behalf of — her patient, then that act which the BIS requires of an SDM is simply that of *choosing* the available treatment option which maximizes her patient’s well-being.

To say that an SDM’s decision ought to *maximize* her patient’s well-being is just to say that she must *weigh* each of the available treatment options according to her patient’s interests (balanced against each option’s inherent risks, burdens, and costs), and then *choose* that option which looks to provide him with the greatest net benefit overall. Similar descriptions of the BIS are given by most of the philosophers who discuss the BIS, the most notable of these being Buchanan and Brock, who write,

The best interest principle states that a surrogate [SDM] is to choose what will best serve the patient’s interests, in other words, that which will maximally promote the patient’s good. (Buchanan & Brock, 1990, p. 94)

⁷ See, for example, Diekema (2004), Rosamond Rhodes and Ian R. Holzman (2014), Lainie Friedman Ross (1998), and Winters (2018).

⁸ Here, I restrict myself to those within bioethics who have written on the BIS.

Thus, the best interest principle instructs us [the SDM] to determine the *net* benefit for the patient of each option, assigning different weights to [each of] the options to reflect the relative importance of the various interests [of the patient] they further or thwart, then subtracting costs or “disbenefits” from the benefits for each option. The course of action to be followed, then, is the one with the greatest net benefit to the patient. (Buchanan & Brock, 1990, p. 123)

Most everyone else in the literature simply references (either implicitly or explicitly) the above description given by Buchanan and Brock; for example, Tom L. Beauchamp and James F. Childress write,

Under the best interest standard, a surrogate decision-maker must [...] determine the highest probable net benefit [from] among the available [treatment] options, assigning different weights to [the] interests [that] the patient has in each option, balanced against their inherent risks, burdens, [and] costs. The term *best* applies because of the surrogate’s obligation to act beneficently by maximizing benefit [to the patient] through a comparative assessment that locates the highest probable net benefit. (Beauchamp & Childress, 2019, p. 140)

The two descriptions are essentially the same. Hence, on an essential or fundamental level, the BIS asserts that an SDM is to choose only that treatment option which maximally promotes her patient’s well-being, which requires, first, that she *weigh* (according to her patient’s interests) each of the treatment options available to her patient, and then *choose* that treatment option which looks to provide him with the greatest net benefit overall. That being said, notice that this conclusion does not entail (as some assume it does) that there is a single “objectively best” treatment, which the SDM must select; rather, the BIS requires merely that the SDM choose that treatment option which *she herself* believes is in the best interest of her patient, for her decision depends entirely on how *she herself* identifies, and subsequently weighs, her patient’s interests. Hence, any reference to a patient’s best interest must always be understood as being *subjective* to the decision-maker, never truly objective. Of course, there are limits to this subjectivity; however, I leave that discussion until later (see §7).

It follows from the above description of the BIS that an SDM *maximally promotes* her patient’s well-being just in case, during her deliberations (about which treatment is best for her patient), that she *intrinsically values* — and, therefore, *ultimately considers* — only her *patient’s* interests, and then chooses accordingly. For given that the BIS asserts that the SDM is to weigh each of the (available) treatment options according to her *patient’s* interests and then choose that treatment option which looks to provide him with greatest net benefit overall, then should she intrinsically consider either her own well-being or that of another person other than her patient, then she won’t have chosen that treatment option with the greatest net benefit to her patient.⁹ Consequently, if an SDM instils any intrinsic value in either her own well-being or in

⁹ What about in order to break a tie between two options that are deemed equally good for the patient? Perhaps. However, the worry is that such consideration of the SDM’s own interests may render the SDM’s decision suspect.

that of another person other than her patient, then she is guilty of either abusing or *neglecting* (where that abuse is accidental) the authority placed in her as her patient's SDM; accordingly, she is guilty of doing wrong to her patient, for, by definition, an SDM is supposed to *maximize her patient's* well-being. In such cases, the state has the moral authority (and sometimes, too, the responsibility) to intervene. Hence, an SDM cannot balance her duty to act in her patient's best interest against competing obligations, for then she need not choose *only* that treatment option with the greatest net benefit to her patient: either she must act exclusively in her patient's best interest, or she must not act as the SDM at all, thereby ceding that authority (to make the decision) to someone else.

However, this is not to say that an SDM cannot consider the interests of persons other than her patient *whatsoever*, for the interests of others may still be *instrumentally* relevant to the patient's well-being. For example, if an incapable patient is dependent upon another person — such as how a child-patient is dependent upon his parents — then maximizing the child's well-being requires being mindful of the parents' interests and obligations too; for given that burdening the parents will likely also negatively affect the child, then considerations of the parents' interests are, thereby, *instrumentally* relevant to the consideration of the child's own well-being. Accordingly, it is important to realize that the BIS does not, and in fact *cannot*, require (as is oftentimes mistakenly alleged) that an SDM refrain absolutely from considering the interests of persons other than her patient.¹⁰ For all that the BIS demands of an SDM is that she abstain from considering non-patient interests as being *intrinsically valuable* — as ends in themselves; that is, the interests and obligations belonging to, say, the patient's family (whom ought to serve as the patient's SDM) can and should still sometimes be considered by the SDM, but only insofar as their fulfilment contributes *instrumentally* to maximizing the patient's well-being. Thus, if an SDM fails to intrinsically value only her patient's well-being, then the state (presumably) has the moral responsibility to intervene, since the SDM would not be maximizing her patient's well-being. This conclusion follows quite naturally from our starting definition of the BIS — that the SDM must endorse only that treatment option which maximally promotes her patient's well-being.

3. A Common First Assessment

Unsurprisingly, then, insofar as most philosophers accept our starting definition of the BIS, I am not alone in arriving at such a strong and *literal* first assessment of it. For example, Buchanan and Brock argue that an SDM ought to be disqualified from occupying the role of an SDM if she stands in a (serious) *conflict of interest* that is likely to bias her substitutive decision against her patient's interests; accordingly, if a health care provider (or anyone else involved in the patient's care) believes that this (or another) disqualifying condition is satisfied, then “she should [...] seek the [necessary] court intervention [to have the SDM replaced, and] to see that a suitable guardian [of the patient's interests] is [then] appointed” (Buchanan & Brock, 1990, p. 142).¹¹ A conflict of interest is a situation in which

¹⁰ This point is at least partially realized by Bester (2019b, p. 119).

¹¹ The conflict of interest must be serious because parents naturally stand in a conflict of interest.

some person P (1) is in a relationship with another that requires P to exercise judgement on that other's behalf (as an SDM must), and (2) P has knowledge of either a private interest or *another duty* that is sufficient to interfere with the proper exercise of her judgement in that relationship.¹² The problem with standing in a conflict of interest is that it becomes impossible to know for sure whether, and to what extent, one's judgement has been affected by it (Smith, 2020a, p. 156).¹³ Hence, if an SDM stands in a (serious) conflict of interest, then she must be replaced, for her competing interest or obligation renders her decision suspect. This conclusion by Buchanan and Brock mirrors my own, for it too suggests that if an SDM is *not* motivated in her substitutive decision-making by only her patient's well-being, then that decision-maker ought to be divested of her authority as an SDM.

Similarly, Beauchamp and Childress endorse a criterion of *partiality*; they argue that an SDM must be *committed* to her patient's interests — free of any conflicts of interest, as well as the controlling influence of those who might not act in her patient's best interest (Beauchamp & Childress, 2019, p. 195). Thus, Beauchamp and Childress too arrive at the familiar conclusion that health care providers should seek to disqualify an SDM if she is acting in bad faith or stands in a (serious) conflict of interest (Beauchamp & Childress, 2019, p. 196), or if she has made a decision that is, evidently, not in her patient's best interest (Beauchamp & Childress, 2019, p. 141). Hence, as stated in §2, if an SDM is either unable or unwilling to consent to only that treatment option which maximizes her patient's well-being, then she ought to relinquish her authority as an SDM, or else be intervened upon by the state for abusing her patient, for the BIS demands that the SDM act exclusively in her patient's best interest, or not act at all.

Even the philosophers who argue against the BIS presume a literal understanding of it, for they object to the BIS (in part) on the grounds that it is too *individualistic*; that is, they argue that the interests of persons *other* than the child-patient can and should matter intrinsically to the decision-making process of the family.¹⁴ Arguments of this sort are of two kinds: those that appeal to the interests of *parents* (i.e., the decision-makers),¹⁵ and those that appeal to the interests of the *family as a unit* — concern for which may be thought of as a duty that is owed by the parents, who may be thought of as representing the family.¹⁶ In this way, the objectors challenge the BIS's demand that the SDM consider only her patient's well-being.

However, following Buchanan and Brock, I am suspicious of appeals to the interests of the family as a unit. For Buchanan and Brock argue that talk of a group's

¹² The definition given here is derived from Smith's discussion of the subject (see, Smith, 2020a, p. 157). More specifically, it is a combination of the definition given by Smith and that given by The Honourable W. D. Parker (1987), which Smith discusses. However, technically, the definition I give is not a proper definition of a *conflict of interest* proper (which is a conflict between one's self-interest and the duty that is owed), for the definition given here includes also a reference to a conflict between the duty that is owed and another duty (which is technically a conflict of duty and duty; see Smith, 2020a, p. 160).

¹³ A parent is allowed to serve as SDM despite the conflict of interest because of the involvement of the patient's health care team (see §6d).

¹⁴ While there are other objections against the BIS, the narrowness problem discussed here is by far the most prevalent.

¹⁵ See, for example, Rhodes and Holzman (2014).

¹⁶ See, for example, Diekema (2004), Ross (1998), Erica K. Salter (2012), and Winters (2018).

interests is warranted only if (1) the group has expressed some preference through a collective decision, or (2) the thing reportedly in the group's interest is something held in the interest of each member individually (Buchanan & Brock, 1990, p. 237); and the first cannot apply in cases regarding child-patients (for they cannot make a decision), and the second is already accommodated by the BIS. Thus, the alleged problem with the BIS must not be that maximizing the child-patient's interests conflicts with the *family's* interests, but, rather, that it conflicts with the legitimate interests of other individuals *within* the family (such as other children), to whom the parents owe a similar duty to intrinsically consider and protect. Indeed, while both Diekema (2004, p. 247) and Janine Penfield Winters (2018, p. 22) object to the BIS on the grounds that a parent may rightly compromise her child's interests in favour of those of the family, the examples which they provide indicate an issue more reductive to the *individual*: for example, Diekema argues that while driving with his children in his car so that he may get his morning coffee is certainly not in their best interest (because of the risks of driving), few would object that he has the obligation to forgo this opportunity simply because it puts his children at some measurable risk of harm (Diekema 2004, p. 247). Here, the relevant competing interest is not that of the family, but Diekema's own interest; that is, Diekema may compromise his children's well-being because *his own* interests matter intrinsically too.

Hence, those philosophers who argue *against* the BIS typically do so on the grounds that, in making decisions about their children, parents are able to intrinsically value both their own interests and the interests of other persons (other than the patient) to whom they owe a like duty to protect; and this seems inconsistent with the BIS. Regardless of whether such an argument succeeds, the argument presumes a *literal* understanding of the BIS; otherwise, the objection makes no sense. Hence, the BIS ought to be understood as demanding that an SDM intrinsically value only her patient's interests and, thus, that she maximize his well-being.

4. Abandoned

Given how the BIS is to be understood, then, it requires just that the SDM consent to only that treatment option which maximizes her patient's well-being. However, no one in the contemporary literature actually defends this view — neither as an understanding of the BIS itself, nor even as a *plausible* standard of substitute decision-making. Those who allegedly *do* defend the BIS defend, instead, the much weaker thesis that the BIS is merely a *supererogatory* or *ideal* standard that need not be enforced; that is, contemporary defenders of the BIS concede to the objectors that an SDM need not intrinsically consider only her patient's interests and, thus, that she need not maximize his well-being.

Now, writers on both sides of this debate distinguish between *guidance* principles and *intervention* principles. A guidance principle provides substantive direction as to *how* an SDM is to make her substituted decisions on behalf of her patient — for example, whether she is to follow an advance directive, choose as the patient would have chosen, or act in the patient's best interest; in contrast, an intervention principle specifies the conditions under which others — specifically, the state — can and should *intervene* with those decisions and take the decision-making authority

away from the SDM (Buchanan & Brock, 1990, p. 88). However, despite the general acceptance of this distinction, I find it to be painfully inaccurate, for a guidance principle *is also* an intervention principle: if a guidance principle really is how an SDM *is to make* her substituted decision on behalf of her patient — whether it be following an advance directive, choosing as the patient would have chosen, or acting in the patient’s best interest — then *if* she fails to make her decision according to that standard, then, surely, she is acting in a morally inappropriate manner that (in principle) requires correction. Guidance principles (as defined) do not assert how an SDM (ideally) *ought* to act, but how she *is* to act. When an SDM acts substitutively for her incapable patient, she is to (or must) act according to a particular standard, for acting in such a way was the purpose for which she was empowered to act; thus, if she fails to act according to that standard, then, she ought not to have acted at all (see Smith, 2020b, p. 428). In this way, the distinction between guidance principles and intervention principles is inaccurate, for, in this case, the two are essentially the same: acting in a manner contrary to the guidance principle warrants intervention.

Therefore, rather than talk of guidance principles and intervention principles, we ought to, instead, talk about *supererogatory standards* of substitute decision-making and *obligatory standards* of substitute decision-making. Indeed, this seems to be the real distinction at play in these debates, for Buchanan and Brock — in their argument *against* the BIS’s being an intervention principle — explain that, “within special relationships, [such as the relationship between an incapable patient and his SDM,] which generate especially stringent *obligations*, we still can and ought to distinguish between *duty* [i.e., *obligation*] and *supererogation*” (Buchanan & Brock, 1990, p. 259, emphasis added).

Now, the BIS (as summarized above) is an *obligatory* standard of substitute decision-making (i.e., an intervention principle), for an SDM (who ought to follow the BIS) is to choose only that (available) treatment option which maximizes her patient’s well-being, and if she fails to do *this* — consider only her patient’s well-being — then the state has the moral authority to intervene. As mentioned previously, no one in the contemporary literature defends this view. For example, Buchanan and Brock do not endorse the BIS as an intervention principle; they argue explicitly that while,

there are many cases in which the best interest principle is appropriate to *guide* a surrogate’s decision, [...] this same principle would be wholly inappropriate if taken as specifying the conditions under which others may rightfully *intervene* and wrest [the] decision-making [authority] from the surrogate. (Buchanan & Brock, 1990, p. 88, emphasis added)

Furthermore, while Beauchamp and Childress, Kopelman, Bester, and Thaddeus Mason Pope all *do* claim to defend the BIS qua intervention principle, they do not *actually* do so.

Beauchamp and Childress, and Kopelman argue that intervention is determined entirely by the harm principle: intervention is warranted just in case the SDM’s chosen treatment falls below a threshold of acceptable care (Beauchamp & Childress,

2019, p. 178; Kopelman, 2009, p. 26). However, this intervention principle is clearly not the BIS: for the BIS requires that the SDM intrinsically consider only her patient's interests; here, however, that requirement is dismissed as supererogatory — for so long as the SDM's decision is above the threshold, then, presumably she may intrinsically consider both her own interests and those of other persons aside from her patient. Indeed, Kopelman even argues that an SDM ought to intrinsically consider the interests of persons other than the patient (Kopelman, 1997, pp. 283–284).

Pope's view seems similar, albeit, ultimately unclear: he argues that an SDM has a zone of discretion, and it is only when she exceeds this zone and abuses her discretion that clinicians and courts have grounds for intervention (Pope, 2018, p. 37). For example, Pope (comparing a parent-SDM's discretion to the colours of light refracted by a prism) states, “[a] parent may have discretion to choose all but the extremes of red and violet. While a healthcare provider may disagree with [the] parent's decision among orange, yellow, green, blue, and indigo, those are within the range of discretion,” and, therefore, are allowed (Pope, 2011, p. 138, n 5). Hence, Pope too seems to allow for an SDM to intrinsically consider the interests of persons other than her patient, for it seems that so long as her final decision is among orange, yellow, green, blue, and indigo, then intervention is unwarranted.

To be fair, Pope does suggest that an SDM *really* ought to intrinsically consider only her patient's interests. For example, Pope claims that another basis for intervention is that the SDM is selfishly prioritizing her own interests, rather than selflessly choosing the treatment option in her patient's best interest (Pope, 2011, p. 137). Furthermore, Pope states that, “the surrogate must choose (within broad limits) [that] option [which] produces the greatest net benefit or the smallest net burdens to the patient as the surrogate [SDM] herself identifies and weighs those benefits and burdens” (Pope, 2018, p. 37). If this is right, then Pope is wrong in claiming that intervention is only justified when the SDM exceeds her zone of discretion. For that reason, we may read Pope as ultimately arguing for a view similar to that which Bester defends (even though Pope explicitly dismisses Bester's view as unnecessarily complex; see Pope, 2018, p. 37).

Bester states that intervention is warranted either if (1) a reasonable argument cannot be given that the decision is best for the patient, all things considered (from the SDM's view of the good), or (2) the SDM's decision exposes the patient to an obvious risk of (net) harm (Bester, 2018, p. 17). Here, we can see Pope's view that the SDM must choose (within the broad limits set by the second condition) that option which produces the greatest net benefit or the smallest net burdens to the patient as the SDM herself identifies and weighs those benefits and burdens. The issue here is that the first condition includes competing obligations; that is, Bester argues that the SDM's obligation to choose that treatment option which maximizes her patient's well-being can and should be *weighed against* competing obligations (Bester, 2019a, p. 225). However, this is not the BIS, for the BIS requires that the SDM intrinsically consider only her patient's interests, and, here, the SDM need not do this. Consequently, on Bester's model, the BIS is relegated to a merely supererogatory standard of substitute decision-making. Hence, no philosopher in the literature actually defends the BIS as an obligatory standard of substitute decision-making. In the next section, I examine why this might be the case.

5. The Problem

Why do the supposed defenders of the BIS not truly defend it? The issue here is when it is the *parents* who serve as their child's SDM: it is argued that, in making decisions about their children, parents may intrinsically consider both their own interests and the interests of other persons other than their patient (such as their other children) to whom they also owe a special duty to protect. Hence, philosophers argue that the BIS is too individualistic — that it imposes morally excessive demands on the patient's family, who, remember, typically serve as the patient's SDM.

References to the parent-SDM motivate most exceptions to the BIS. For example, Buchanan and Brock argue that since neither the law nor common sense morality dictates that society ought to intervene whenever the family's treatment of its dependent member merely fails to maximize his interests (say, in education) and since the fact that a decision concerns the child's medical treatment does not, in itself, prove an exception to this general rule (Buchanan & Brock, 1990, p. 144), then parents cannot be expected to choose that treatment option which is optimal (as opposed to that which is merely good or just acceptable) *if* that option requires them to expend resources (either emotional or financial) that would ultimately destroy their marriage or thwart the basic interests of their other children (Buchanan & Brock, 1990, p. 259). Hence, Buchanan and Brock conclude that the BIS is to serve merely as a regulative ideal, not as a strict and literal requirement, for "parents' obligations towards their other children as well as their own legitimate self-interests can [sometimes] conflict with doing what maximizes the child's well-being, and sometimes may take precedence over it" (Buchanan & Brock, 1990, p. 236). Likewise, Kopelman argues that a family cannot be required to migrate from, say, Utah to New York in order for their child to receive a marginally more effective treatment, *if* that would cause the rest of the family to suffer from the disruption of the relocation and possible bankruptcy; hence, a family is not, and should not, be required to ignore *all of their interests* in order to provide what is narrowly *ideal* for just one member (Kopelman, 2009, p. 25). Bester appeals to the fact that parents cannot neglect their other children, nor their other obligations to the detriment to the family (Bester, 2018, p. 16). Even Beauchamp and Childress appeal to the fact that parents are typically given fairly wide discretion about how to educate their children, and whether to allow them to engage in risky sports (Beauchamp & Childress, 2019, p. 178) — suggesting, in lines with Bester, Buchanan and Brock, and Kopelman above, that just as parents need not maximize their child's well-being in decisions concerning education and sports, neither need they maximize their child's well-being in decisions concerning health care. Notice that these criticisms mirror the objections raised by the philosophers typically characterized as arguing *against* the BIS: in making decisions about their children, parents are able to intrinsically value both their own interests and the interests of persons other than their patient to whom they owe a similar duty to protect; consequentially, the BIS cannot be right.

Thus, the problem with the BIS is that the family's other interests ought to have *intrinsic* value, and since this seems wholly at odds with the BIS, we ought to, then, abandon the literal, strict sense of the BIS. Thus, as everyone else in the

literature has concluded, the BIS cannot be our obligatory standard of substitute decision-making. Philosophers argue that the BIS is merely a supererogatory standard which merely suggests how the SDM ought to act; they then defend what is essentially Diekema's harm principle as the obligatory standard that must be met. For Bester, Beauchamp and Childress, Buchanan and Brock, Kopelman, and Pope all argue that an SDM need not do what is best for her patient, but that she *must* avoid doing what falls below some threshold of acceptable care. This view is essentially the same as that which is defended by Diekema and many other opponents of the BIS. Accordingly,

there is actually widespread agreement that intervention is justified [only] when harm to the child is projected to cross some threshold. The disagreement is primarily about whether this threshold is best described under the best-interest paradigm or under the harm principle. (MacDougall, 2019 p. 282)

Hence, the BIS qua obligatory standard of substitute decision-making has been essentially dismissed from the contemporary debate.

In what remains of this article, I argue that this is a mistake, for how the BIS has been understood in the literature is fundamentally flawed. First, I argue that the BIS is *essentially* an obligatory standard of substitute decision-making, for the relationship between an SDM and her incapable child-patient — which is characterized by the SDM's obligation to act exclusively in her patient's best interest — is a *fiduciary relationship*. Accordingly, an SDM's obligation to follow the BIS is her *fiduciary duty*. Second, I argue that, properly understood, the BIS entails *neither* that a child-patient's parental guardian may only maximize her child-ward's interests *nor* that she cannot intrinsically value her own interests in the process of making her decisions.

6. The Fiduciary Relationship

In this and the next section (§7), I argue that the BIS is an SDM's *fiduciary duty* to her patient — her duty to act solely in his best interest. In order for there to be a fiduciary duty, there must first exist a *fiduciary relationship*. Because the fiduciary relationship is normally a distinctive kind of *legal* relationship, I appeal to the legal scholars in order to define it — specifically, Paul B. Miller, for he has most clearly captured what is most essential to it.

Miller defines the fiduciary relationship as that in which one person — the fiduciary — possesses *discretionary power* over the *significant practical interests* of another person — the beneficiary (Miller, 2014, p. 69). Three terms in this definition require further clarification: our *practical interests*; their *significance*; and the nature of our fiduciary's *discretionary power* over them.

6a. Practical Interests

Miller distinguishes *practical* interests from other, *non-practical* interests on the basis of (1) their character, and (2) their susceptibility to influence under authority by

another (Miller, 2011, p. 276). On this basis, Miller states that an interest is *practical* just in case, “it connotes a real, ascertainable *matter of personality, welfare, or right* in relation to which one person [the beneficiary] may be uniquely and materially *susceptible to the exercise of authority by another* [the fiduciary]” (Miller, 2011, p. 276, emphasis added). Accordingly, practical interests concern matters of personality, welfare, or right; this is their character. However, in order for a practical interest — a matter of personality, welfare, or right — to be uniquely and materially susceptible to the exercise of authority by another, it must encompass a *range of options* (about a matter of personality, welfare, or right) over which authority is to be exercised; that is, fiduciary power must be the authority to *make a decision*, namely, about some matter of personality, welfare, or right.¹⁷ Consequently, Miller states that matters of personality include (but are not limited to) the *determination* of the interests of incapable persons; that matters of welfare include *decisions* bearing upon the specific aspects of the welfare of persons, including their physical and mental health; and that matters of right include *decisions* relating to the (legal) rights, obligations, powers, and liabilities of persons, including those in relation to contract and property (Miller, 2011, p. 276). Hence, the fiduciary relationship is that in which “one person is empowered to exercise decision-making authority [which must be discretionary] on behalf of another” (Smith, 2014, p. 608). For example, consider the following case provided by Lionel Smith:

Albert and Belinda are playing backgammon, and Belinda is called away to the telephone. The call takes longer than expected; Albert becomes impatient; Belinda calls out: “Play my turn for me.” Albert rolls the dice and, *like a fiduciary*, is presented with a range of possible moves. (Smith, 2014, p. 613, emphasis added)

Here, Albert possesses discretionary power over a matter of Belinda’s *right* — her capacity to move her pieces according to the numbers rolled on the dice; as such, Albert *morally* stands in a fiduciary relationship with Belinda.

6b. Significance

Of course, this relationship between Albert and Belinda is a *morally* significant fiduciary relationship, not a *legally* significant fiduciary relationship — wherein breach of fiduciary duty has legal consequence. The difference here concerns the *significance* of the practical interest, which grounds the fiduciary relationship. Following Miller, the *significance* of a practical interest is, “a matter of the *objective subsistence* of [the] interest, such that the law can recognize it as such” (Miller, 2014, p. 73). To explain: if authority over a practical interest (i.e., a matter of personality, welfare, or right) is a capacity intrinsic to persons by virtue of their humanity, then the practical interest *objectively subsists* and, therefore, can (and ought to) be legally protected. Accordingly, if the authority possessed (substitutively) by the fiduciary is

¹⁷ Of course, the decision will usually be subject to conditions that define its scope or constrain its exercise (Miller, 2014, p. 72). Accordingly, fiduciary power is the authority to make a decision from among a range of *authorized* options (Smith, 2014, p. 610).

an authority ordinarily within the exclusive, *legally protected* capacity of the beneficiary, then any misuse of that authority by the fiduciary has legal consequence. Accordingly, Miller's definition of the fiduciary relationship is a definition of the *legally* significant fiduciary relationship: fiduciary authority consists in the discretionary exercise of a *legally protected* capacity of the beneficiary.

6c. Discretion

However, it is worth clarifying that fiduciary power is technically not *discretionary*, for, as mentioned previously, it must be used exclusively in the beneficiary's best interest; if not, then that misuse of authority is *voidable* — meaning that the decision can be set aside at the insistence of the beneficiary (Smith, 2020b, p. 428). Accordingly, fiduciary authority is more accurately described as *substitutive authority*, for it is the *substitutive* use of the beneficiary's own inherent discretionary power. Indeed, as Miller asserts, "fiduciary power consists in the substitutive exercise of legal capacity" (Miller, 2014, p. 71). However, as Smith clarifies, when one person acquires substitutive authority — to act on behalf of another — she is not just authorized to act in new ways that affect this other person, but is authorized to act *for* him; and it is part of the logic of acting *for* another person that there is only one right way to do it: one must act exclusively in the way one thinks is best for that other person (Smith, 2014, p. 613). For example, Smith argues that the only way to make sense of the idea that Albert is playing Belinda's turn *for* her is that he must be playing her turn in the way that he thinks is in her best interest; if he deliberately makes what he thinks is a bad move, then this would not count as playing her turn for her (but perhaps, for himself; Smith, 2014, p. 613). Of course, this is not to say that Albert is to maximize Belinda's interests by any means, for there are limits on Belinda (in virtue of playing the game) as to how she can make her move and pursue winning the game — for example, she cannot cheat. In this sense, it might be said that Belinda has certain obligations when it comes to making her move. Consequently, when Albert acts for Belinda he, so-to-speak, "inherits" the duties of Belinda not to cheat and so must act in her best interest within the confines of the (legal) play-options that were available to her.¹⁸

It is this acting *for* another person (which makes fiduciary authority discretionary) that also grounds the fiduciary duties of *loyalty* and *care* — which together represent the fiduciary's duty to act *only* in her beneficiary's best interest. Consequently, a legally significant fiduciary relationship is where the fiduciary exercises the legally protected decision-making authority of the beneficiary *substitutively* — consistently with loyalty and care.

6d. Loyalty, and the Best Interest Standard

The fiduciary duty of loyalty is the duty to avoid misuses of power; that is, it is the duty to act (*qua* fiduciary) only in the beneficiary's best interest. Hence, when a

¹⁸ Hasko von Kriegstein makes this argument in the context of what managers may do on behalf of shareholders if we understand the former as the fiduciaries of the latter (von Kriegstein, 2016, pp. 454–456). Many thanks to von Kriegstein himself for making this point clear to me.

fiduciary exercises discretionary decision-making authority *substitutively* for — on behalf of — her beneficiary, she must, then, intrinsically consider only her patient's well-being, and then *choose* accordingly. Thus, if a fiduciary, say, possesses substitutive decision-making authority over her beneficiary's legally protected capacity to determine his own health care treatment, then she must choose only that option which is in her beneficiary's best interest.

However, notice that this means that an SDM is just her patient's fiduciary — possessing substitutive (discretionary) authority over her patient's significant practical interest in choosing and consenting to his own medical treatment. Indeed, both Miller (2013, p. 1014, n 153) and Smith (2020b, p. 452) state that the relationship between an SDM and her patient is a fiduciary one. Accordingly, an SDM, much like a fiduciary, must act (qua SDM) exclusively in her patient's best interest; and if she considers the interests of persons other than her patient, then she has violated her duty of loyalty and thereby harms her patient.

Of course, an incapable child-patient cannot himself oversee his fiduciary's conduct. Hence, responsibility for that oversight falls to another — a public official, specifically, the child-patient's health care team (or anyone else involved in his care; Smith, 2020b, p. 430). This point is actually realized by Buchanan and Brock. Realizing that parents stand in a conflict of interest in regards to their children, Buchanan and Brock argue that parents may still serve as fiduciary in such cases because the oversight of health care practitioners provide significant safeguards against misuses of authority (Buchanan & Brock, 1990, p. 137). Thus, if the patient's health care team believes that the SDM is acting inappropriately, then they must either refer the case to the state, or (in some cases) to the institutional ethics committee (Buchanan & Brock, 1990, p. 148). Now, here, the state (or institutional ethics committee) is to judge merely whether the SDM has exercised her judgement in what she *subjectively believed* was in the best interest of the beneficiary, not whether the decision she made was contrary to that which the state itself would have made were it the SDM (Smith, 2014, p. 611); for fiduciary accountability is fault based, not outcome dependent (Miller, 2011, p. 285). Thus, the role of the state is to insist upon, and facilitate, *sound* decision-making, not to make the substituted health care decision for itself (Buchanan & Brock, 1990, pp. 148–150). Therefore, if an SDM intrinsically considers the interests of persons other than her patient, then she has violated her duty of loyalty — a fault — and the state, thereby, has the duty to intervene.

7. Reasonableness, and the Duty of Care

However, the fiduciary duty of loyalty does not (by itself) entail that the fiduciary must act in her patient's *best* interest, but merely that she act in his *interest*. For example, suppose that in acting for Belinda, Albert rightly does intrinsically consider only her interests, but fails to give his acting for her much thought (far less than he would were acting for himself); consequently, Albert acts sub-optimally for Belinda. We can imagine, then, that when Belinda returns from her call, that she becomes angry at Albert (or at least disappointed in him), for he knew (or should have known, at least) that there was a far better move available to her that he could

have made for her. This example illustrates that, in a fiduciary relationship, if the fiduciary acts lazily on behalf of her beneficiary, then even if she acts exclusively in his interest, she wrongs him no less than if she had not acted in his interest at all. Of course, a fiduciary cannot be expected to act in her beneficiary's literal best interest in every case, for this simply might not be possible: for example, suppose that Albert tried his best in acting for Belinda, but just is not a very good backgammon player; here, surely, he cannot be blamed for his not having acted optimally for Belinda. In other words, where Albert is acting for Belinda in her best interest, he can only be expected to do so within the limits of his own ability.

That is what the fiduciary duty of care requires: that the SDM act for her beneficiary to the best of her ability. Indeed, as Julian Velasco explains,

[o]f primary importance [to the fiduciary relationship] is that the fiduciary does a good job [in their fiduciary role] — exercising all [of] their skill with the appropriate diligence. This is the domain of the duty of care, which protects beneficiaries from fiduciary shirking. (Velasco, 2015, p. 690)

Thus, the fiduciary possesses substitutive (discretionary) decision-making authority on behalf of her beneficiary; and in virtue of possessing this substitutive authority, the fiduciary must act exclusively in her beneficiary's best interest: she must *weigh* each of the available treatment options according to her patient's interests (balanced against each option's inherent risks, burdens, and costs), and then *choose* that option which looks to provide him with the greatest net benefit overall; and she must do so *carefully*, with the appropriate diligence. These are the main conditions on the subjective nature of best interest decision calculations.

In regards to the BIS, the duty of care is usually conceived of in relation to what (most) *reasonable persons* would regard as acceptable treatment. For example, Kopelman argues that (minimally) acceptable care is what reasonable and informed persons of goodwill would regard as acceptable were they in the SDM's position (Kopelman, 2007, pp. 188–189). Buchanan and Brock argue that acceptable care is (in part) what most reasonable and informed persons would have chosen themselves (Buchanan & Brock, 1990, p. 145). And Pope argues that acceptable care is what a reasonable person *could* have chosen based on the relevant facts (Pope, 2011, p. 135). Indeed, even Diekema (who focuses on state intervention) argues that intervention must pass a measure of *reasonableness*, based on whether most other (reasonable and informed) persons would agree that the intervention is required (Diekema, 2004, p. 254).

This standard of care is unsurprising, given that most legal appeals to diligence similarly make use of appeals to the reasonable person (Moran, 2007, p. 149). However, as Mayo Moran argues, appeals to the reasonable person risks catering to the *ordinary* or *common person*, for “the reasonable person [...] is [often] simply a stand in for the common or ordinary man” (Moran, 2007, p. 149). Accordingly, appeals to the reasonable person cannot be a true test of the reasonableness of a decision; indeed, what makes a decision *reasonable* is not, technically, that a reasonable person would have made the same decision — which is not really a property of the decision itself — but whether the decision itself is reasonable.

Thus, I agree with Bester in arguing that what makes an SDM's decision *reasonable* is that a *reasonable* argument can be offered (from the SDM's point-of-view) that the decision is best for the child. Bester clarifies that a reasonable argument is,

a logically valid argument showing the decision to promote the child's interests best. There should be no internal contradictions, the argument should not be self-defeating, [its] factual premises should not be untrue, and it should be obviously connected to furthering the child's interests. (Bester, 2018, p. 17)

Indeed, this is further supported by what Buchanan and Brock say about our duty to ensure the soundness of an SDM's decision (see Buchanan & Brock, 1990, p. 149). Thus, if the reasoning behind an SDM's decision is not reasonable, then she was not diligent in her decision-making and her duty of care has been violated — a fault; consequently, the state thereby has the moral obligation to intervene.

Thus, the BIS can be properly described as follows. If a patient is incapable of making his own informed health care decisions, then a fiduciary must be appointed to exercise *substitutive* decision-making authority on his behalf. In most such cases, the fiduciary relationship must be established by means of *unilateral undertaking* by the SDM, and the patient's family is the best to do this. As her patient's fiduciary, the SDM has discretionary authority on the matter of the patient's treatment, but must exercise her fiduciary authority exclusively in her patient's best interest — satisfying the fiduciary duties of loyalty and of care. Hence, if the SDM intrinsically considers the interests of persons other than her patient, then she misuses her fiduciary power, and the state, thereby, has the moral obligation to intervene, in order to protect the patient from his SDM's abuse. This is the BIS proper, and it is grounded in the intrinsic fiduciary nature of the relationship between an SDM and her patient.

8. Distinguishing Parents From Fiduciaries

In the above, I have demonstrated that, insofar as the SDM is the person authorized to exercise health care decision-making authority on behalf of her patient, she is, then, her patient's fiduciary; and, like a fiduciary, she must act (in her capacity as SDM) exclusively in her patient's best interest. Consequently, the BIS is just an SDM's fiduciary duty to her beneficiary; and, as such, her failing to satisfy it — by failing to satisfy either loyalty or care — is sufficient for state intervention. Hence, not only *must* the BIS be understood narrowly, but an SDM *must* satisfy the BIS.

However, what should be said about the narrowness problem? How do we resolve the worry that the BIS demands too much — that parents qua SDMs cannot intrinsically consider their own interests nor those of their other children, and, thus, may only choose for their child-patient that treatment option which maximizes his well-being? My response to this worry is simply that the problem is the result of a *confusion* — the failure to properly distinguish the role played by the child-patient's SDM in the health care decision-making process from that played by his parental guardian(s).

Now, given that the nature of a fiduciary's authority is simply that of being able to *make a decision* on behalf of her beneficiary, then a fiduciary is not required to

expend her own personal resources to *bring about* her beneficiary's best interest (Smith, 2020b, p. 400).¹⁹ In other words, the role she plays is merely that of settling some decision that is (already) open to the beneficiary, on his behalf. Accordingly, as Smith states, “[n]o one has ever heard of a trustee [the fiduciary in charge of trust assets] being obligated to spend [...] her own money to send the beneficiaries to a private school” (Smith, 2020b, p. 400).

However, while parents are (presumably) also not obligated to spend their own money to send their child to a private school, they *are* obligated to spend their own money to send him to *a* school; that is, parents are obligated to expend *some* of their personal resources in order to promote the interests of their children — presumably, enough to ensure that each receives at least some minimally decent standard of care.²⁰ Indeed, this is the entire basis behind the harm principle: parents have discretion in raising their children, just so long as they meet what is minimally required of them. What this means, however, is that the parent-child relationship is not strictly a fiduciary relationship, for a fiduciary is to *decide for* her beneficiary from amongst those options available to him, whereas a parental guardian must *provide for* her child-ward — to ensure that there is at least some minimally decent selection of options made available to him. Of course, parental guardians may still stand in a fiduciary relationship with their child-wards and, thus, owe them a fiduciary duty to act (in that capacity) in their best interest, for example, in offering them advice. However, the fiduciary relationship here is *in addition to* (i.e., other than) that underlying parent-child relationship. Hence, the role of a parent may, in some instances, be dual.

Scott Altman considers something like this view: “fiduciary duties apply [to parents] only when parents’ power derives exclusively from [their] children’s incapacity” (Altman, 2023, p. 421); that is, parents owe a fiduciary duty to their children just in case they stand in a fiduciary relationship with them — when the authority that they exercise is *substitutive* decision-making authority over their children’s legally protected capacity. This explains why parents must focus only on their child’s well-being when they make his medical decisions, but may balance self-interest when, say, they make spending decisions: the authority to make medical decisions is a (significant) practical interest of the child, whereas the authority to make decisions about their own money is a (significant) practical interest of the parent. Thus, using Altman’s terminology, purely *parental* decisions (i.e., where decision-making authority is possessed substitutively, on behalf of the child) must intrinsically value only the child’s well-being, whereas *mixed-power decisions* (i.e., where decision-making authority is not possessed substitutively) need not be so restricted.

9. Solving the Problem

However, against this dual-role-based view of parental fiduciary duty, Altman objects rather familiarly that applying fiduciary duties to purely parenting decisions is too confining, for sometimes it would require parents to consider only their child’s

¹⁹ Granted, the duty of care does require that the SDM expend some personal resources (her time and energy) in order to diligently make her substituted decision.

²⁰ Indeed, if parents had to provide the best, then there would be no objection to the BIS.

interests, even where the harm to that child is minor, and the stakes for the parents large. To illustrate this worry, Altman provides the following example:

Bob has a young child with special needs. He has adequate income and outside support to care for her well in his home. However, Bob learns about a [boarding] school he thinks could improve her life slightly compared to the good care he [already] provides. He thinks that she would benefit, on net, even though she would miss seeing him. Bob would suffer terribly from her absence. The school is far from his home (and he cannot relocate). He is heartbroken at the thought that he will rarely see his only child. *The loss to Bob here would be terrible, and the benefit to the child might be small. Nevertheless, a fiduciary duty might require Bob to ignore his loss when deciding whether to send his child away for school.* (Altman, 2023, pp. 424–425, emphasis added)

This is a great example, as it perfectly demonstrates, I think, the deep confusion that exists in the debate about the BIS in bioethics. The confusion is this: while Bob's decision whether to send his daughter (call her Elizabeth) to boarding school is indeed a purely parenting decision (and, therefore, requires Bob to ignore his loss when making that decision for her), he may in some sense still intrinsically consider his own loss, despite the fiduciary nature of the decision; and this point is completely overlooked by those in the debate. To explain, a purely parenting decision — one that is fiduciary — is the *substitutive* exercise of authority over a decision (of practical interest) of the child-beneficiary. Accordingly, the purely parenting decision, in this case, is the decision of whether Elizabeth will receive care at home or care at the boarding school. And because it is a *substitutive* (i.e., fiduciary) decision, it must, then, be made only in Elizabeth's best interest; that is, Bob must ignore his own loss when deciding whether to care for Elizabeth in his home or to send her away to be cared for at the boarding school. About this, Altman is right.

However, assume for sake of argument that Elizabeth (in virtue of being a child) has no resources of her own. Given that she has no means to care for herself, someone must provide this care (or means to it) for her. Now, suppose that the state occupies this role and provides Elizabeth with the financial resources necessary to pursue either home care or boarding school care. Here, Elizabeth may choose either home care or boarding school care, as both options are available to her in virtue of the state. Of course, given that Elizabeth is (presumably) incapable of making such a decision for herself, she requires a fiduciary to make that decision substitutively for her. In Altman's example, Bob, as Elizabeth's parental guardian, occupies that fiduciary role; and in making this choice for Elizabeth, Bob qua fiduciary must ignore his loss when deciding whether Elizabeth will receive home care or boarding school care. This outcome seems right to me.

Of course, in Altman's actual example, Bob is expected to provide for Elizabeth himself, since home care (and, presumably, boarding school care too) is only possible given his income. Accordingly, without Bob's assistance, neither home care nor boarding school care are available options for Elizabeth. Now, because Elizabeth depends on Bob — as children generally do depend on their parents — the options available to Elizabeth depend essentially upon how much of a cost Bob is willing to

undertake to make any options available to her. Of course, as Elizabeth's parental guardian, Bob is obligated to provide Elizabeth with a minimally decent standard of care, which requires expanding (in part) some of his own financial resources. However, this choice — about how much of his own financial resources to expend — (above the minimum threshold) is a non-fiduciary, mixed-power decision, for, here, Bob is not acting *substitutively* for Elizabeth, but, rather, for himself *towards* Elizabeth. Hence, his decision is not a fiduciary one, and Bob may consider his own interests in choosing how much of his own financial resources to expend on Elizabeth's care, specifically, on which forms of care are available to her (so long as he meets that minimum threshold which parents owe their children). At this level of the decision-making process, Bob may selfishly choose not to expend the financial resources necessary to make boarding school care an option available for Elizabeth to choose. Consequently, when Bob exercises his substitutive authority to choose on behalf of Elizabeth — which, remember, must be exercised only in her best interest — Bob can (and must) choose home care, since this is the best (and, indeed, only) option that is available to Elizabeth.²¹ Even if both options are assumed to financially cost the same, the added emotional cost for Bob of boarding school care (together with the financial cost) is what allows boarding school care to be excluded from the range of available options. The idea here is similar to that recently proposed by Joe Horton: "If we are willing to make a [supererogatory] sacrifice, [then,] we ought to bring about the best outcome that we can permissibly bring about by making [that] sacrifice" (Horton, 2017, p. 99). In the same way, while Bob must indeed choose the best option for Elizabeth once he has decided on how much he is willing to superfluously sacrifice for her care, that initial decision — about how much to sacrifice — is not fiduciary.

Evidently, applying fiduciary duties to a purely parenting decision is not too confining. In regards to Altman's other objections to the role-based view of parental fiduciary duty, my view of fiduciary duty (or, rather, the view that I describe) preserves the intuition that when doctors or lawyers act in advisory roles that are essentially fiduciary, they have fiduciary duties to their clients, for when doctors and lawyers are acting in advisory roles, they possess *essentially* substitutive power over the decision-making power of their beneficiary. Likewise, the solution is not subject to the worry that purely parenting decisions can transform into mixed-role decisions, for purely parenting decisions concern the act of choosing (the best) from a range of available options, whereas mixed-role decisions concern adding to that range of options. This provides a methodology for resolving the narrowness problem.

10. Conclusion

An incapable child-patient must be provided with an SDM, for the nature of the clinician-patient relationship demands that the clinician receive the patient's informed consent prior to any treatment.²² The individuals best suited for this role

²¹ This also explains why Sue (another of Altman's examples) can consider her interests (see Altman, 2023, p. 425).

²² Unless it is an emergency, of course.

of SDM are usually the child-patient's parents or parental guardian, for they are assumed to be the persons most concerned about the child's well-being. In the specific capacity as their child's SDM, parents replace or *substitute* their child and act on his behalf — i.e., they must serve as their child's fiduciary. In this role as their child's medical fiduciary, parents must in some sense “leave behind” their role as their child's parental guardian (where they are obligated merely to do at least that much which is minimally acceptable) and act in their child best interest. Acting in their child's best interest does not require that parents maximize their child's interests in a *vacuum* (without any consideration of their own interests and situation), for not only does the situation and well-being of the child depend upon the situation and well-being of the child's parents, but the child will usually also depend upon his parents' resources (both financial and otherwise) for his health care. For the health care treatment of a given patient either costs the patient *nothing* (as in the case of non-treatment, or where the cost of treatment is covered by the state) or it costs the patient *something* — think here of a private health care system like that in the United States, or where some portion of the treatment is required to be performed by the patient himself. Assuming (for sake of argument) that the child — the patient — has no resources of his own and that no resources are provided to him by the state (thereby ensuring that the parents assume maximal responsibility), the child, then, must depend entirely upon the resources provided to him by his parents. Hence, the health care treatment of the child depends entirely on the resources given to him by his parents. Thus, in calculating the treatment option that is best for their child-patient, the SDM must consider the resources willing to be provided to the child by his parents. Assuming that, generally, parents do not need to do that which is ideally best for their child but only at least that much which is minimally acceptable, then there is here some minimal amount of resources that parents must provide for their child for his health care. Of course, parents can, of their own free will, provide their children with more than what is morally required, but neither the state, the child, nor the SDM can compel parents to provide more than what they owe. In this sense, we do not demand that parents as *parental guardians* do what is ideally best for their children.

It is on this foundation that the child's SDM (usually his parents) are obligated to choose that treatment option which is best for their patient. Suppose that there are three possible treatment options for a given child-patient: A, B, and C, where A is ideal, B is good, and C is unacceptable. Further, suppose that the child-patient's parents are obligated to provide only resources enough for B. Now, if the parents are willing to provide resources enough for A, then, *in most cases*, the SDM should, upon calculation, determine that A is in the child-patient's best interest and so thereby consent to option A on behalf of the child-patient.²³ By this same reasoning,

²³ Of course, while the parents might be willing to provide their child with maximal resources — enough resources for treatment option A — treatment A still might not be what is in the child-patient's best interest. For example, we might imagine that the resources would burden the child's parents such that they would neglect their other obligations, such as their jobs and bills, leading to financial hardships and parental and relational stress, which might, in turn, limit the opportunities open to the child and place pressure on the child's attachments, so much so as to not be in his best interest relative to treatment option B.

if the parents are only willing to provide their child with the resources enough for B, then the SDM should endorse option B, since A is unavailable. Likewise, if the parents neglect their duty to their child and are only willing to provide their child with the resources enough for C, then the SDM should, upon calculation, endorse option C, for neither option A nor option B is available to be chosen. However, the SDM's choice of C here will signal to others — namely, the child-patient's health care providers — that something has gone wrong in the process of the SDM's calculation; and as discussed in §6, this is where the institutional bioethics committee has the moral responsibility to become involved. Consequently, the BIS is not too demanding (on account of it being too individualistic), for parental guardians need not only maximize their child-ward's interests *nor* are they prohibited from intrinsically valuing their own interests in the process of making their decisions about his health care.

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References

- Altman, S. (2023). Are parents fiduciaries? *Law and Philosophy*, 42(5), 411–435. <https://doi.org/10.1007/s10982-022-09468-4>
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th Edition). Oxford University Press. <https://global.oup.com/ushe/product/principles-of-biomedical-ethics-9780190640873?cc=ca&lang=en&>
- Bester, J. C. (2018). The harm principle cannot replace the best interest standard: Problems with using the harm principle for medical decision making for children. *The American Journal of Bioethics*, 18(8), 9–19. <https://doi.org/10.1080/15265161.2018.1485757>
- Bester, J. C. (2019a). The best interest standard is the best we have: Why the harm principle and constrained parental autonomy cannot replace the best interest standard in pediatric ethics. *The Journal of Clinical Ethics*, 30(3), 223–231. <https://www.journals.uchicago.edu/doi/10.1086/JCE2019303223>
- Bester, J. C. (2019b). The best interest standard and children: Clarifying a concept and responding to its critics. *Journal of Medical Ethics*, 45(2), 117–124. <https://doi.org/10.1136/medethics-2018-105036>
- Buchanan, A. E., & Brock, D. W. (1990). *Deciding for others: The ethics of surrogate decision making*. Cambridge University Press. <https://doi.org/10.1017/CBO9781139171946>
- Diekema, D. (2004). Parental refusals of medical treatment: The harm principle as threshold for state intervention. *Theoretical Medicine and Bioethics*, 25(4), 243–264. <https://doi.org/10.1007/s11017-004-3146-6>
- Family Law Act, SBC 2011, c 25. <https://www.canlii.org/en/bc/laws/stat/sbc-2011-c-25/217828/sbc-2011-c-25.html>
- Health Care Consent Act, 1996, SO 1996, c 2, Sch A. <https://www.canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/200812/so-1996-c-2-sch-a.html>
- Horton, J. (2017). The all or nothing problem. *The Journal of Philosophy*, 114(2), 94–104. <https://doi.org/10.5840/jphil201711427>
- Kopelman, L. M. (1997). The best-interests standard as threshold, ideal, and standard of reasonableness. *The Journal of Medicine and Philosophy*, 22(3), 271–289. <https://doi.org/10.1093/jmp/22.3.271>
- Kopelman, L. M. (2007). The best interests standard for incompetent or incapacitated persons of all ages. *The Journal of Law, Medicine & Ethics*, 35(1), 187–196. <https://doi.org/10.1111/j.1748-720X.2007.00123.x>

- Kopelman, L. M. (2009). Using the best-interests standard in treatment decisions for young children. In G. Miller (Ed.), *Pediatric bioethics* (pp. 22–37). Cambridge University Press. <https://doi.org/10.1017/CBO9780511642388.004>
- MacDougall, D. R. (2019). Intervention principles in pediatric health care: The difference between physicians and the state. *Theoretical Medicine and Bioethics*, 40(4), 279–297. <https://doi.org/10.1007/s11017-019-09497-6>
- Miller, P. B. (2011). A theory of fiduciary liability. *McGill Law Journal*, 56(2), 235–288. <https://doi.org/10.7202/1002367ar>
- Miller, P. B. (2013). Justifying fiduciary duties. *McGill Law Journal*, 58(4), 969–1023. <https://doi.org/10.7202/1019051ar>
- Miller, P. B. (2014). The fiduciary relationship. In A. S. Gold & P. B. Miller (Eds.), *Philosophical foundations of fiduciary law* (pp. 63–90). Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780198701729.003.0004>
- Moran, M. (2007). The reasonable person and the discrimination inquiry. In S. Tierney (Ed.), *Accommodating cultural diversity* (pp. 147–165). Routledge. <https://www.routledge.com/Accommodating-Cultural-Diversity/Tierney/p/book/9781138264106>
- Parker, W. D. (1987). *Commission of inquiry into the facts of allegations of conflict of interest concerning the honourable Sinclair M. Stevens*. The Commission. <https://publications.gc.ca/site/eng/9.818247/publication.html>
- Pope, T. M. (2011). The best interest standard: Both guide and limit to medical decision making on behalf of incapacitated patients. *The Journal of Clinical Ethics*, 22(2), 134–138. <https://www.journals.uchicago.edu/doi/10.1086/JCE201122205>
- Pope, T. M. (2018). The best interest standard for health care decision making: Definition and defense. *The American Journal of Bioethics*, 18(8), 36–38. <https://doi.org/10.1080/15265161.2018.1485775>
- Rhodes, R., & Holzman, I. R. (2014). Is the best interest standard good for pediatrics? *Pediatrics*, 134(Supplement_2), S121–S129. <https://doi.org/10.1542/peds.2014-1394H>
- Ross, L. F. (1998). *Children, families, and health care decision making*. Oxford University Press. <https://global.oup.com/academic/product/children-families-and-health-care-decision-making-9780198237631?cc=ca&lang=en&>
- Salter, E. K. (2012). Deciding for a child: A comprehensive analysis of the best interest standard. *Theoretical Medicine and Bioethics*, 33(3), 179–198. <https://doi.org/10.1007/s11017-012-9219-z>
- Smith, L. (2014) Fiduciary relationships: Ensuring the loyal exercise of judgement on behalf of another. *Law Quarterly Review*, 130, 608–634. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2559974
- Smith, L. (2020a). Conflict, profit, bias, misuse of power: Dimensions of governance. In P. B. Miller & M. Harding (Eds.), *Fiduciaries and trust* (pp. 149–172). <https://doi.org/10.1017/9781108616225.011>
- Smith, L. (2020b). Parenthood is a fiduciary relationship. *The University of Toronto Law Journal*, 70(4), 395–452. <https://doi.org/10.3138/utlj.2017-0098>
- Velasco, J. (2015). A defense of the corporate law duty of care. *The Journal of Corporation Law*, 40(3), 647–702. https://jcl.law.uiowa.edu/sites/jcl.law.uiowa.edu/files/2021-08/Final%20-%20Velasco_Web.pdf
- von Kriegstein, H. (2016). Professionalism, agency, and market failures. *Business Ethics Quarterly*, 26(4), 445–464. <https://doi.org/10.1017/beq.2016.45>
- Winters, J. P. (2018). When parents refuse: Resolving entrenched disagreements between parents and clinicians in situations of uncertainty and complexity. *American Journal of Bioethics*, 18(8), 20–31. <https://doi.org/10.1080/15265161.2018.1485758>