inappropriate invocation of Convention and Community law. Moreover, following earlier cases like *R.* v. *Cambridge Health Authority, ex p. B.* [1995] 1 W.L.R. 898, it reaffirms that, subject to the supervisory jurisdiction of the courts, the discretion to allocate resources lies with health authorities, and it provides those authorities with some useful guidance. The case is, however, an unusual example of a successful challenge to the exercise of that discretion, reflecting a greater, and welcome, judicial willingness to scrutinise than has been evident in cases such as *R.* v. *Central Birmingham Health Authority, ex p. Collier* (1988, unreported), where the court declined even to seek the authority's reasons why a life-saving heart operation on a baby had been postponed several times.

Not least in view of the inexorably rising demands on limited resources, the courts are likely to face a growing number of difficult questions about resource allocation. What if the authority in this case had argued, supported by a body of medical opinion, that transsexualism is a mental illness but one for which the *only* appropriate treatment is psychotherapy to bring the mental illness into line with the physical reality rather than surgery to bring the physical reality into line with the mental illness? What if an authority declines to fund gender reassignment, and/or heart transplants, and/or drugs for HIV, so as to increase expenditure on health education and/or chiropody and/or health visitors? What procedures, if any, would it be unreasonable *to* fund? What about the (recently reported) amputation of healthy limbs as a treatment for "body dysmorphic disorder"? Would this procedure pass the criminal law test of "reasonable surgical interference"?

The wide room for disagreement surrounding questions of resource allocation makes it all the more likely that patients will be tempted to seek their resolution judicially. The courts ain't seen nothin' yet.

JOHN KEOWN

BETWEEN THE BABY AND THE BREAST

IN *Re C (A CHILD) (HIV Test)* [1999] 2 F.L.R. 1004, a local authority applied for a specific issue order to test a four-month-old baby girl for HIV. The mother of the child first tested positive for HIV in 1990, but adopted a highly sceptical stance towards generally accepted theories about HIV and AIDS, and refused conventional therapy for herself, preferring to rely on a healthy

lifestyle as a prophylactic. The case arose when the baby's physician became aware not only that the mother was breast-feeding the child (despite the risk of transmission of HIV), but that the parents refused even to have their daughter tested for the virus in the belief that a healthy lifestyle was the optimal treatment even if she were HIV-positive.

In answering the question whether the court could or should require a course of treatment for a child which was in accordance with conventional medical practice, but which was opposed by the parents, the court adopted the conventional view about the transmission and treatment of HIV. In addition, the court noted the parents' unequivocal testimony that they would not alter their care of their baby no matter what the test results showed.

Despite these facts, Wilson J. in the Family Division refused to do more than order the single HIV test requested by the local authority, expressing a perhaps over-optimistic belief that disclosure of the baby's true status would inspire the parents to embrace conventional medicine. Admittedly, there was little else the court could do, since its ability to impose a treatment plan different from the plans suggested by the parties is severely limited: *Re S and D (Children: Powers of Court)* [1995] 2 F.L.R. 456, 463–464 (Balcombe L.J.). The Court of Appeal refused permission to appeal: [1999] 2 F.L.R. 1017.

However, and more problematically, Wilson J. did not stop with the single order at issue. He strongly suggested that if the child tested positive for HIV and went into decline, the court would order conventional drug therapy if the parents did not initiate such treatment voluntarily. He was less inclined to propose prophylactic drug therapy, but expressly left the issue open for later debate. These conclusions appear proper. However, a problem would arise if the child were to test negative for HIV. In that event, the court would in all likelihood *not* order the mother to cease breast-feeding, since Wilson J. stated that if she "cannot be persuaded by rational argument that she must curb her instinct to feed, I doubt she would comply with a court order" to do so. The Court of Appeal accepted Wilson J.'s position regarding breast-feeding, noting that a prohibitory order "would be ineffective".

Although these statements are technically obiter, it is absurd to suggest that the court may act to prolong an infected child's life but not to save him or her from contracting HIV in the first place. In making his order, Wilson J. recognised that the Children Act 1989 required the court to give paramount consideration to the baby's welfare and cited two cases in support of his decision. In *Re T (A Minor) (Wardship: Medical Treatment)* [1997] 1 All E.R. 906,

the Court of Appeal refused to order a child to return from a Commonwealth country and undergo a liver transplant in England that would, in all likelihood, save his life, focusing largely on the mother's refusal of consent. The mother's wishes were persuasive because there was room for disagreement as to what was in the best interest of the child. Wilson J. also cited *Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 W.L.R. 1421, in which the Court of Appeal overruled parental wishes and required a Down's syndrome baby to have a life-saving operation to remove an intestinal blockage. The court in *Re T* distinguished *Re B* on the grounds that the Down's syndrome baby needed only a single operation, whereas the child in *Re T* would have needed long-term care after the liver transplant.

The highly individualistic analysis required under the Children Act 1989's welfare principle means that earlier cases cannot be considered as binding precedents, but they are persuasive. Therefore, to the extent that *Re C* is about a single blood test, it is analogous to *Re B* rather than *Re T*. Even if *Re C* is interpreted as dealing with a child requiring long-term care, however, Wilson J. did not adopt the approach used in *Re T*. This result suggests either that he believed the long-term burden of care to be less than the burden in *Re T* or that C's parents had not demonstrated that there was room for disagreement about what was in the best interest of the child. However, neither of these grounds explains his view of the position should the baby be found to be HIV-negative. To support his conclusion on this point, Wilson J. referred to the mother's "instinct to feed". However, such language is patently out of place when the parents have undertaken a long-standing, considered course of treatment. It is not "instinct" that is at issue; it is the parents' belief about conventional medicine, the same belief that the court was prepared to overrule in the event that the child tested positive for HIV.

Although one cannot draw direct comparisons between the criminal and civil law, there are times when it is, or should be, appropriate to analogise. For example, the court in *Re C* should, perhaps, have taken into account the fact that parental beliefs about medical treatment cannot be used as a defence to charges of child neglect or harm. In *R.* v. *Senior* [1899] 1 Q.B. 283, a father was convicted of manslaughter for refusing to provide his child with medical treatment. There, as in *Re C*, the father believed that his method of care (prayer) was superior to conventional medicine. Although the father acted out of religious scruples, the court looked only at whether he had refrained from taking "such steps as a reasonable parent would take, such as are usually taken in the

ordinary experience of mankind". Although the "reasonable parent" standard was rejected in *Re T, R.* v. *Senior* still illustrates the "clear case" for judicial intervention identified by Waite L.J. in *Re T*, and adopted by Wilson J. in *Re C*, wherein "parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind".

Although the parents in *Re C* were not claiming to act out of religious belief, they did argue that their beliefs about the nature and treatment of HIV and AIDS should prevail. However, if religious beliefs (which are greatly respected in law and society) cannot negate a charge of manslaughter, why should controversial beliefs about medical treatment be allowed to prevail here? Must one wait until the child dies to demonstrate that the parents' beliefs were not sufficient as a matter of law to justify their actions? Surely not.

A more recent case, *R.* v. *Sheppard* [1981] A.C. 394, construes *Senior* as not creating an absolute offence. Instead, the question is whether the parent's "failure to provide medical care is due to inability, through stupidity or ignorance, to appreciate the need for it". "[A] parent who knows that his child needs medical care and deliberately, that is by conscious decision, refrains from calling a doctor, is guilty" of neglect.

Were the parents in *Re C* acting improperly under *Sheppard?* They knew of the possible need for medical care, since they had researched conventional medical practices extensively. One could say that they had "wilfully shut [their] eyes to the need for medical care", not only with respect to the need for an HIV test but with respect to continued breast-feeding as well.

Not every principle of criminal law is transferable to the civil law. However, when courts contemplate the possibility of the future death of a child due to the beliefs of the parents, they should at least consider analogous criminal cases. Both *Senior* and *Sheppard* provide useful information about what types of parental beliefs can and "cannot stand against the right of the child to be properly cared for in every sense", to quote Butler-Sloss L.J. in *Re C*. Belief patterns that are "patently irreconcilable with principles of child health and welfare" cannot be allowed to prevail under either the criminal or civil law, particularly when such beliefs are overruled in one instance (such as when a child is HIV-positive) but not in another (such as when a child is HIV-negative). In suggesting that "the law cannot come between the baby and the breast", Wilson J. effectively conceded the law's inability to protect this child in the

event that she was HIV-negative, a concession that need not and should not have been made.

S.I. STRONG

A DUTY TO GIVE REASONS?

IN *Flannery* v. *Halifax Estate Agencies Ltd.* [2000] 1 W.L.R. 377, the purchasers of a flat in Manchester sued a valuer, on whose report they had relied, for negligence. At the trial there was a conflict of expert evidence. The judge preferred the evidence of the defendant's experts and dismissed the claim. It was accepted that the judge's conclusion was one that was open to him on the evidence. The Court of Appeal set aside the judgment and ordered a new trial.

The trouble, according to Henry L.J., giving the judgment of the court, was that the trial judge had not given his reasons for preferring the defendant's evidence. All he had said on that was that he had heard the witnesses and seen the way in which they reacted to the questions they were asked; this was not enough to satisfy his duty to give reasons. It was by now too late to call upon the judge to reconstitute his reasons and there were no transcripts of the experts' oral evidence. A new trial was necessary.

In the past, the reasons given by judges for their decisions were often short and unhelpful. Goodhart, in his famous essay on the *ratio decidendi* of a case, clearly contemplated that a case might be a precedent even if no reasons at all were given (*Essays in Jurisprudence and the Common Law* (Cambridge 1931), p. 1, at p. 6). Things are different now, and Henry L.J. thought it clear that "today's professional judge owes a general duty to give reasons", but the case on which he principally relied (*R.* v. *Crown Ct., ex p. International Club* [1982] 2 Q.B. 304) was an application for judicial review of a decision of the Crown Court on appeal from a licensing committee, and reasons have been required of licensing justices since at least 1892: *R.* v. *Thomas* [1892] 1 Q.B. 426 (mandamus). *Flannery*, on the other hand, was an ordinary civil appeal, and in such cases the appeal is "by way of rehearing", which means that it is not restricted to questions of law alone: in principle, an appellate court makes its own finding of facts.

It has, of course, frequently been stressed that appellate judges, when considering questions of fact, must bear in mind that the trial judge does, and they do not, have the advantage of seeing and hearing the witnesses. This is rarely of importance, however, in