ETHICAL AND LEGAL ISSUES IN HEALTHCARE

Standards of care and the 'Best Interests' principle

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"The Irish government believed that it needed to... [guarantee the banking system] in the best interests of the Irish banks and the Irish people."

As I listened to Áine Lawlor[1] talk about the *"government bailout legislation due to be signed into law by lunchtime"*, I realised that she had, indeed, used the term 'best interests' in reference to the financial 'lifeblood' of our capitalist system.

'Duty of care to act in the patient's best interests' is a phrase so fundamental to every healthcare code of ethics that I had begun to think of the phrase as peculiar to the professions, in general, and to healthcare professions in particular. It seemed that the 'best interests' principle merited review.

'Best interests', in particular 'best interests of the child', is the terminology used by most courts to determine a wide range of issues relating to the wellbeing of children. It is a doctrine used as an aspect of parens patriae[2], which rested on the basis that children are not resilient and almost any change in a child's living situation would be detrimental to their wellbeing. In simple terms, it might be considered to refer to the age-old belief that a civilised society will protect the vulnerable.

In medicolegal terms the principle is considered to apply not just to children but also to incompetent[3] adults, and generally refers to best medical interests. It facilitates the intervention by a medical practitioner in the care of a patient where the patient is not in a position to give his/her consent. In legal terms it protects the practitioner from a charge of assault or being sued for battery or infringement of rights. The BMA (British Medical Association) recommends that a number of factors should be taken into account when considering what is in a patient's best interests, including:

- the patient's own wishes and values (where these can be ascertained),
- clinical judgment about the effectiveness of the proposed treatment, particularly in relation to other options,
- where there is more than one option, whichever option is least restrictive of the patient's future choices,
- the likelihood and extent of any degree of improvement in the patient's condition if treatment is provided,
- the views of the parents, if the patient is a child,
- the views of people close to the patient, especially close relatives, partners, carers or proxy decision-makers about what the patient is likely to see as beneficial, and
- any knowledge of the patient's religious, cultural and other non-medical views that might have an impact on the patient's wishes.

While the legal terms focus on children and incompetent adults, the reality is that the ethical principle of 'duty of care to act in a patient's best interests' applies to all practitioner: patient interactions. Regardless of whether or not the patient has provided consent to the intervention, the practitioner must provide a 'standard of reasonable care'. Otherwise he/she will be open to a criminal charge of negligence. The Bolam test[4] serves to differentiate medical negligence from other negligence actions, i.e. when deciding whether a driver, for example, has been negligent, the standard of care is set by the court using the device of the 'reasonable man'. When the defendant is a doctor, however, the standard of care has tended to be set by other doctors, via the Bolam test. "If a practitioner is unable to meet this standard, then he/she will be negligent for undertaking treatment beyond his/her competence" (Jackson, 2006). Hence we must assume that acting in a patient's best interests is inherently linked with having the recognised competence to provide such a service.

However, the Dunne case,[5] taken against the National Maternity Hospital following birth injuries to a child born at the hospital, challenged the perspective that once practitioners followed 'custom and practice' they could not be found negligent. In this case the foetal monitoring protocols accepted by the profession were deemed to be inherently deficient and 'blindly following' such protocols was found to have been negligent. Simon Mills (2007) summarises the relevant five elements of the Dunne test (as a measure of whether appropriate standards of care had been adhered to) as follows:

- Comparison with a professional of equal specialisation
- Deviation from accepted practice is not negligence
- Blindly following the standard course of action may nonetheless be negligent
- An honest difference of opinion between two medical practitioners does not mean that one of them must be guilty of negligence
- A jury or judge is not there to decide whether one course of action is preferable to another

To further develop our understanding of the best interests principle, a case involving the sterilisation of a mentally incapacitated patient (Re F)[6] merits consideration. In this case, the court of appeal took a slightly different view to that of Bolam, in that it points out that "there are in fact two duties: first doctors must act in accordance with proper professional standards, that is, they must satisfy the Bolam test; and, second, they must act in the best interests of the particular patient. The Bolam test may approve several different courses of action as being within the reasonable range of clinical judgment, but, logically, the best interests test should give only one answer".

This distils the difficulty met when trying to legislate for a healthcare professional's 'Duty of Care'. The law can adjudicate on whether a standard of care has been met, and therefore adjudicate whether or not a charge of negligence should be upheld, but the courts will not adjudicate on which of a number of acceptable options is actually the 'best'.

Once a patient presents at the pharmacy and the pharmacist offers advice, a service, and/or supplies a medicine, a duty of care is established wherein the pharmacist is obliged to prioritise the patient's best interests. The question of who decides what is in a patient's best interests may well be outside the jurisdiction of the court of law. The question therefore becomes an internal one for the practitioner deliberating on what he/she believes to be in the patient's best interests, and what it is he/she must do to demonstrate that any action was, indeed, in the best interests of the patient. As a minimum he/she ought to be able to demonstrate competency, as assessed, against recognised standards for the particular service delivery. The question of competency, while absolutely relevant, is a separate discussion. Indeed 'competency', with respect to the processes governing the supply of product in which the pharmacist can have full confidence, also raises matters for debate. Inevitably there will be competing interests at play, as professional, commercial and personal factors pressurise both the patient and pharmacist in the decision-making process. The pharmacist's intentions and ability to manage these factors will most likely be the determining factor in the ultimate promotion of the 'patient's best interests'.

The question I ask myself is whether my reaction to Áine Lawlor's use of the 'best interests' principle with reference to our banking system was a betrayal of an underlying belief that competing interests in healthcare systems are different to those in the financial world? Or was it the niggling belief that it is hard enough to contemplate honouring the 'best interests' principle in the socially focussed world of healthcare, never mind the capitalist world of finance? The fact is that "most people's motives are a confusing mix of self interest, altruism, and other influences" (Stark, 1993). In banking, as in healthcare, appropriate standards of care can be determined, regulated and enforced. In banking, as in healthcare, the vast majority of employees are decent people who want to care for the customer, while progressing along their career path in an honest manner, balancing the demands of customer, employer, regulator and share-holder/HSE. Mixed influences, and mixed motives, prevail.

In healthcare we provide irreversible care and treatment to individuals who, whether or not they consent to the care, are often in a vulnerable position. Community pharmacy

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represents an environment where the care provided is not 'overseen' by others on a team and the patient absolutely depends on the practitioner's 'duty of care to act in the patient's best interests'. Healthcare codes of ethics aim to constantly nudge the practitioner towards this ideal. This is absolutely appropriate. However, it seems to me that the 'best interests' principle will remain forever open to question and probably unattainable. Nevertheless, it is something to which we in pharmacy practice (as well as our colleagues in other professions) must continue to aspire.

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References ~

1 Morning Ireland October 2nd 2008: Áine Lawlor introducing Vince Cable of the UK liberal democrats.

2 A doctrine that grants the inherent power and authority of the state to protect persons who are legally unable to act on their own behalf.

3 The term 'substituted judgement' may be considered to apply to adults now incompetent but having been competent.

4 Bolam v Friern Hospital management Committee [1957] 2 A11 ER 118.

5 Dunne v National Maternity Hospital [1989] IR 91.

6 Re F [Mental patient: Sterilisation] [1990] 2 AC 1.

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