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.”

A s I listened to Áine Lawlor 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 parents patriae, 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 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 consideration 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 serves to differentiate medical negligence from other negligence actions, i.e. when deciding whether a ‘reasonable’ practitioner, 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, 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 defective 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 FY) 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 be able to adjudicate whether or not a charge of negligence should be upheld, but the courts will

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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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COMMUNITY SPIRIT

Caution and compassion – reducing the need for reliever treatments

Colin Deeny is a community pharmacist based in Donegal. He has an interest in the development of professional pharmacy practice. In addition he has particular interest in respiratory care and the causes and effects of hyperventilation.

T he dispensing of emergency supplies to patients is an important pharmacy service. As long as they have been prescribed the medicine before, need it urgently and cannot access a prescriber, it potentially saves a person considerable inconvenience and expense when they can access emergency supplies of medicines from a pharmacist.

However, I have been concerned for a long time that patients with asthma may be inclined, perhaps inadvertently, to overuse the service. This was brought home to me recently when someone came in to our pharmacy for a ‘blue inhaler for their friend’, who was at work. I knew neither the patient nor their friend personally. So firstly I checked our patient medication records and found out that the patient had previously had an emergency supply of a salbutamol inhaler, a couple of months earlier. Now, following a conversation on the telephone with the patient, I ultimately dispensed another emergency supply of salbutamol. But the rather blase approach of both the patient and their representative, and the fact that they had previously had an emergency supply for the same medication from us made me take note. I made sure that I reinforced a couple of messages to the patient. So what were these messages? Well, firstly, that while reliever medication ‘relieves’ the asthma in the short-term, regular use may actually exacerbate the problem. And secondly, that regular use of reliever medication also suggests poorly controlled asthma and possibly a review of treatment is needed. Let’s look at these two messages in more detail.

So what do I mean when I say that regular use of beta-2 agonists may actually exacerbate the problem? Well, while beta-2 agonists have been used for decades in the management of asthma symptoms, this has been against a backdrop of concern that their regular use may actually increase morbidity, and possibly even mortality. Firstly, there is evidence of tolerance to both the bronchodilator and bronchoprotective effects of beta-2 agonists, particularly with short-acting beta-2 agonists. There is also tolerance to the reliever effects of short-acting beta-2 agonists after the use of long-acting beta-2 agonists. Secondly, there is concern that regular use of beta-2 agonists may actually increase bronchial contractility. This is known as ‘rebound airway hyper-reactivity’ or ‘rebound hyper-reactivity’. In other words, the more the beta-2 agonist is used, the more it may be perceived that it is needed. This could create a vicious circle where a person continues to use the beta-2 agonist unaware that it is the actual drug that is precipitating the problem. Again, although there is some evidence of this with long-acting beta-2 agonists, there is more so with short-acting beta-2 agonists.

Thirdly, there is concern that regular use may increase airway inflammation. The evidence for this is complicated by the fact that some studies suggest inhaled corticosteroids may alleviate this problem, while others do not. Fourthly, there is concern that chronic bronchial inflammation may increase allergen, microbe and irritant deposition in the lungs, thus increasing the chance of an allergic reaction, infection or attack. Fifthly, by artificially maintaining bronchodilation it is possible that beta-2 agonists may mask the underlying disease and delay awareness of airway inflammation. A sixth concern is related to the fact that beta-2 agonists increase ventilation. That is, they increase both the rate and volume of breathing. This is usually measured as the volume inhaled each minute (minute volume). This increase in minute volume can lead to hyperventilation, which by definition leads to reduced arterial carbon dioxide (PaCO2) known as hypocapnia. Hypocapnia causes and can potentiate bronchoconstriction. It can also increase the cooling and drying of the airways, increase allergen and irritant deposition and increase inflammatory factors. Thus an increase in the minute volume could potentially increase airway hyper-reactiveness for a number of reasons.

Much of the evidence, and hence much of the concern expressed, has been directed primarily at short-acting beta-2 agonists rather than long-acting ones. However, a recent Cochrane Review has found an increased risk of serious adverse events with regular salmeterol. All-cause mortality increased with regular salmeterol, but this was not statistically significant. However, non-fatal but serious adverse events increased with salmeterol in comparison with placebo. The study confirmed a “clear increase in risk of asthma-related mortality in patients not using inhaled corticosteroids”, say the authors. In addition, they add, “the confidence interval is wide, so it cannot be concluded that the inhaled corticosteroids abolish the risks of regular salmeterol.” This conclusion must be of concern to all healthcare practitioners involved in respiratory medicine. The authors concluded that “for patients whose asthma is not well-controlled on moderate doses of inhaled corticosteroids, additional salmeterol can give symptomatic benefit but this may be at the expense of an increased risk of serious adverse events and asthma related mortality, risks which are not clearly abolished by inhaled corticosteroids”.

This brings me to the second message that I gave the patient via the telephone. It was that “regular use of reliever medication suggests poorly controlled asthma and possibly a review of treatment”. This is surely common sense and standard with any illness that is not being managed adequately with the patient’s current treatment. If someone is using too much of a medication, possibly in this case a beta-2 agonist, then the regimen needs to be reviewed. The Global Initiative for Asthma (GINA) current guidelines state that “regular use of reliever medication is one of the elements defining uncontrolled asthma”. Both these and other guidelines recommend the introduction of inhaled corticosteroid if there is regular use of reliever medication. Certainly the patient’s treatment, no matter what stage it’s at, warrants review.

References –
1 Morning Ireland October 2nd 2008: Aine Laviorf 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 All ER 118.
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