

ETHICS MAN Daniel K Sokol

Clarifying best interests

What should doctors consider when determining what's best for their patients?

If from the lamp emerged a bioethics genie who granted me only one wish, I would ask for the ability to determine what is in the best interests of a particular individual. With such insight I would resolve many of the thorniest dilemmas in clinical ethics, discerning immediately what is best for the patient. Should we withhold treatment from this severely disabled neonate? Should we repeatedly inform this woman with Alzheimer's disease that her husband died 10 years ago? Should we respect the confidentiality of this sexually active 14 year old girl?

Nowadays it is almost trite to say that "best interests" is a broader term than "medical best interests." While important, health is one value among others that may, on occasion, be offset by those others. Hence a bon vivant might accept the life shortening effects of eating full fat brie daily in exchange for the pleasure he derives from it. Overall best interests may legitimately differ from medical best interests, and the two should not be confused.

The philosopher Ronald Dworkin makes another useful distinction: between experiential interests and critical interests. Experiential interests concern our sensations of pain and pleasure. I have experiential interests in playing squash, performing magic, and writing my *BMJ* column. Under this conception, it makes no sense to talk of the experiential interests of patients in a persistent vegetative state. They have no such interests. They do, however, have critical interests. These concern the sort of things that give meaning to our lives, that ultimately determine whether our lives are going well or badly. Friendship, the wellbeing of loved ones, and the respect of others are examples of critical interests. These can be frustrated or satisfied even in the absence of consciousness. Spreading malicious rumours behind someone's back can harm their critical interests even if that person never finds out; so too can failing to discharge a

promise to hand over a dead person's savings to her children. Why? Because most people have critical interests in maintaining a good reputation and helping their family to flourish.

The existence of critical interests explains why clinicians should attempt to uncover patients' past and present wishes, either by consulting the patients themselves (or their relatives) or from written documents such as advanced statements. What things are important to this person? How can we respect his or her critical values in our clinical management? To paraphrase Raanan Gillon, professor of medical ethics at Imperial College London, and others, the trick is not to put ourselves in the patient's shoes, but to imagine what it is like for the patient to be in his or her shoes. This requires an appreciation of that person's experiential and critical interests.

When patients are unable to make their own decisions, doctors should, on legal and ethical grounds, act in their best interests. However, even when patients are autonomous most doctors strive to do their best for their patients. In his book *Resolving Ethical Dilemmas* Bernard Lo offers a strategy to promote a competent patient's best interests. Firstly, try to understand the patient's perspective. ("What worries you most about this illness/treatment/operation?") Secondly, address any concerns and misunderstandings. This may be enough to resolve any initial disagreement about treatment. Thirdly, if appropriate, try to persuade the patient to accept medically indicated interventions. If persuasion is unsuccessful, negotiate a plan that is mutually acceptable to both parties. Try to find common ground, a compromise solution; give the patient more time or information to decide; and invite them to speak to a colleague or other patients with similar experiences. If this strategy fails, accept the patient's refusal. This approach aims to protect patients from



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seemingly unwise decisions, while respecting their autonomy.

As we have privileged access to our own interests, respecting a person's autonomy tends to benefit them. One of the greatest tragedies in medicine is when respecting a patient's autonomy has the opposite effect: when it goes against their critical interests. Although formally having capacity, we can sometimes be blind to our own good; thus the seropositive 25 year old declines our outstretched hand at the edge of life's precipice, her judgment clouded by indifferent relatives and the short lived experiential interests of illicit drugs. Her refusal to be treated signals a premature death. Such is the price of our liberal emphasis on respecting autonomy, whatever its undeniable benefits. Although it is legally obligatory in Britain and the United States, respecting a competent refusal of treatment is not always in the patient's best interests.

When there is no indication of a patient's values, how should we determine what is best? Clearly we should consider experiential interests. Yet critical interests also play a part, as all human beings share a common core of critical interests, such as the freedom from pain and indignity. The anencephalic baby with no prospects of a meaningful life has neither experiential nor critical interests in continued life. Where lies that indeterminate threshold below which attempting to prolong survival is no longer in a person's interests? This is where the genie's gift would be most helpful. Respecting a competent refusal of treatment is not always in the patient's best interests

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