

IN THE BEST INTEREST OF THE PATIENT

*Applying This Standard to Healthcare Decision Making
Must Be Done in a Community Context*

BY JANE MARY TRAU,
PhD, & REV. JAMES J.
McCARTNEY, OSA, PhD



Dr. Trau is vice president, ethics, St. Joseph's Health System, Atlanta; and Fr. McCartney is associate professor, Department of Philosophy, Villanova University, Villanova, PA.

Whether a medical treatment is in the "best interest of the patient" is an important basis for healthcare decision making, especially in situations where the patient's values, preferences, and wishes are unknown to care givers and family. Because this concept of "best interest" is an accepted ethical standard—and usually an accepted legal standard as well—those involved in healthcare decision making should understand the term and its implications before putting it to use. They should consider the following:

- A broad definition of the term
- Its relationship to individuals and to communities
- The possibilities for conflicts between individual and communal "best interests" and the attempted resolution of these conflicts within the Catholic tradition

Summary Acting in the "best interest" of another implies taking certain steps or following certain rules so that the person and his or her concrete human community will survive and potentially flourish. The long-term understanding of best interest refers to the balance of benefits and burdens with respect to the ultimate goals or purposes of a community within which an individual is situated; short-term best interest refers to that balance with respect to a specific healthcare decision, without reference to the overall situation. However, considering only short-term best interest is unsatisfactory in the final analysis.

Any decision to sacrifice individual preference for communal best interest should include three crucial aspects: (1) The individual must be a willing (or potentially willing, in the case of a child) member of the community, (2) individuals never lose

GENERAL SCOPE OF "BEST INTEREST"

Acting in the "best interest" of another implies taking certain steps or following certain rules so that the person and his or her concrete human community will survive and potentially flourish. "Survival" is a minimal yet essential consideration. It requires no vision beyond maintaining the existence of the person and his or her specific community of shared value or good. "Flourishing" is the fulfillment of a person's potential for purposeful existence within a community of choice. "Human flourishing" is more complex than survival because it implies movement beyond mere existence and thus requires some shared purpose, or *telos*, as a standard or direction for the individual and his or her community to pursue.² To flourish is to pass from mere survival to active participation in and enjoyment of the goods and values of at least one specific social group—that is, to move from merely

their moral standing in the community, and (3) society can justify failure to accept the autonomous decisions of some individuals only (a) if it is impossible, (b) that failure is necessitated by attempts to meet the needs of other individuals, and (c) that decision is not based on unfair or unjust practices.

Applying the concept of best interest to nontherapeutic research on children, one can conclude that the indirect benefit to the child is in his or her best interest only when the long-term benefit to the community, in terms of both survival and flourishing, is adequately considered. In addition, healthcare surrogate decision makers, acting in the best interest of a person who cannot make decisions and has not previously expressed his or her wishes, must take into account the long-term interests of the community.

being alive as an individual to creatively living within a community.

But human life, characterized by freedom, necessitates choice, and choice requires reflection and valuation. Thus, if human existence within a concrete community has shared values and goals, then adult members of that community will flourish by affirming a substantial portion of the community's goals.

In addition, acceptance of those values and goals requires that people reflect on and evaluate themselves and their meanings. This process of reflection and affirmation of human values is the foundation for the concept of "best interest."

To flourish is to reflect on, choose, and realize purposeful human existence within the context of a suitable communal existence.³ Philosophies of rights that highlight individual autonomy often neglect the importance of flourishing and forget that we are born into a web of relationships and responsibilities that we can either value and accept or purposefully change, but never ignore.

Survival interests may entail healthcare inter-

ventions or goods required to sustain human life (e.g., food and water, shelter, clothing, treatment of serious injuries and pathologies). Flourishing interests may include education, relationships with family and friends, just conditions in the workplace and within government, spiritual activity, and aesthetic recreational activities. Obviously, survival interests are generally more compelling and urgent than flourishing interests because, to flourish, one must first exist. However, in cases where the potential for human flourishing is weak or nonexistent (e.g., persons in a persistent vegetative state), one can argue that the patient's best interests would best be served by minimizing survival interests.

To serve the best interest is to act in ways that promote the individual's survival and/or flourishing within the framework of his or her communal relationships and responsibilities. The calculation of benefits and burdens in healthcare decision making, as in other spheres of life, implies a reference to the best interest of the person. When burdens and benefits of a specific

Any consideration of personal best interest can be distinguished but not separated from community best interest.



Chris Haney

medical treatment are calculated against the background of basic goals and values held by persons and communities involved, best interest may be directed toward an ultimate goal such as religious salvation and hence may seem to appeal to long-term concerns. Often, however, the decision about what is in a patient's best interest is determined by balancing benefits and burdens of a particular therapy in the short term.

For example, in the case of an impaired newborn, long-term interpretation of the infant's best interest may suggest the inappropriateness of multiple operations when the prognosis is a life of protracted pain, diminished capacity, and repeated and costly medical treatments. These long-term considerations encompass the interests of the infant, the family, and the larger community within which they hope to flourish. On the other hand, a short-term consideration of best interest may support a particular surgical procedure that, as an isolated procedure, is likely to accomplish its limited goal with manageable human and material costs.

We can summarize this distinction as follows: The long-term understanding of best interest refers to the balance of benefits and burdens with respect to the ultimate goals or purposes of a community within which an individual is situated; short-term best interest refers to that balance with respect to a specific healthcare decision, without reference to the overall situation. However, considering only short-term best interest is unsatisfactory in the final analysis. A complete decision-making process must transcend the short term and progress to long-term values and beliefs of the community within which the person could survive and flourish.

INDIVIDUALS AND COMMUNITIES

Any consideration of personal best interest can be distinguished but not separated from community best interest. At the same time, a community exists by virtue of its individual members. The reciprocal exchange between the good of the individual and the good of the community is the moral justification for the existence of the community, though neither exists at the expense of the other.⁴ But the fact that we can warn against

Considering
only short-term
best interest is
unsatisfactory.

fulfillment of one at the expense of the other indicates there are some boundaries between the two.

Philosophers and theologians have argued that persons are most adequately fulfilled in the context of their relationships and responsibilities to others.⁵ Thus the individual does not emerge in isolation but as relational. Historical narrative, cultural values, and the present and

future community all serve as the referents from which individual meaning is shaped.⁶ Thus it is in the individual's best interest—both for survival and flourishing—to actively participate in community life.

The individual is characterized by a freedom that encompasses communally shared values or goals and courses of action that will realize them. Individual freedom is limited primarily to prevent individuals from harming others, secondarily to promote significant goals (such as building highways and bridges and improving the quality of life), and, in some cases, to prevent individuals from harming themselves. Given our culture and its method of distributing goods, individual choices regarding treatment are often influenced by the perceived best interest of society.

Additionally, public policy decisions that control access to the healthcare system usually demand that individuals conform to society's perception of its best interest. For example, although an individual decision to have a kidney transplant might not be prohibited, society may believe that it is in its best interest to deny funds for a kidney transplant to people under age 65 with no history of alcohol abuse or secondary complicating conditions because the money is needed to fund prenatal clinics instead. Unless individuals have access to private means, individual choice is constrained by what society perceives as being in its best interest. The community seeks the survival and flourishing of a plurality of its members, and, unless this is done in an arbitrary or prejudiced way, sometimes individual choice must yield to the common good.

Although this may seem to be a utilitarian approach—namely, that the community may act to bring about the greatest balance of good over evil for the greatest number of people—this need not be the case. We could argue that a deonto-

logical approach demands that society always act in accordance with the most compelling duty. In this case, the duty to respect individual autonomy may be balanced against duties to promote justice. In some cases the former is more compelling; in others the latter prevails. In our culture the individual is so sacrosanct that duties revolving around autonomy are taken as prima facie obligations and are overridden only with great caution.

SACRIFICING INDIVIDUAL PREFERENCE

Any decision to sacrifice individual preference for communal best interest should include three crucial aspects.

A Choice to Belong The individual must be a willing member (or a potentially willing member in the case of a child) of the community. The basic principle operative here is: If communities sacrifice the interests of individuals against their will, those communities are immoral. Persons may disagree with the policies of their community, but if they accept the benefits of the society as a means of achieving individual good, then they make an implicit or explicit agreement to further the good of the whole as well. The just distribution of goods within that group may demand some inequalities, such as the use of scarce resources only for those most likely to benefit from them. If a person agrees to live in a community that adopts this rule, then the community may fairly agree to deny him or her specific goods.

Although we are born into nations, in our culture citizenship is freely continued or rejected. Any rational adult who is a citizen at some point faces a free choice. Similarly, though we do not choose our families, we do nurture or neglect our relationships. The involvement of families in individual decisions concerning treatment must acknowledge the freely established continuation of natural bonds, or the lack thereof. If one chooses to reap the benefits of a community and accepts the possibility that at some point his or her personal wishes may be sacrificed for the good of the community, then the community may act accordingly. In coercive communities—those in which membership cannot be freely chosen or rejected—the violation of individual interest in favor of communal interest is always suspect.

Inherent Dignity Individuals never lose their moral standing in the community. All persons have inherent dignity that demands recognition of their autonomy, exercised either by themselves or in substituted judgment. Even within the limits of communal best interest, the best interest of the individual is only decided by a third party when it is certain that the individual has not left specific instructions regarding his or her care (which must

be at least considered if not acted on), or when no significant other knows the patient's values and beliefs and would, on the basis of substituted judgment, be able to make a decision that the patient would make if he or she could. Furthermore, the community must ensure that a justified denial of individual preference in a specific case does not in any way diminish its responsibility to respect individual decisions in subsequent cases.

Equal Treatment Society's failure to accept the

GUIDELINES FOR CONSIDERING BEST INTERESTS

DEFINITIONS

Best interest A standard used in healthcare decision making when the wishes of a patient are not known or have never been expressed.

- **Short term:** A specific action (treatment, procedure, intervention) intended to promote the immediate survival or flourishing of an individual or a family or community to which that individual belongs.

- **Long term:** Actions directed toward the attainment of some ultimate value both for the individual and the family or community to which that individual belongs.

- **Ultimate values:** Justifying values or principles that serve as the foundation of and the direction for concrete actions of a family or community and its specific members. Ultimate values have to do with both the survival and flourishing of individuals and families (communities).

NOTE: Short-term interests are in reality a stage in decision making, which must ultimately refer to long-term interests.

Survival The interest of preserving the physical life of an individual and the social, spiritual, and material resources of a family or community.

Flourishing The fulfillment of the potential an individual or a family (community) may possess for meaningful existence beyond mere survival; creative living within a family or community; the capability of family or community development of values beyond mere perpetuation.

NOTE: Survival interests are basic but not absolute; survival derives its value from the possibility of flourishing.

BEST INTERESTS DECISION-MAKING GRID

Catholic healthcare providers can use the following grid to ensure they correctly consider best interests when making treatment decisions.

	ISI	IFI	FCSI	FCFI
Short-term interests				
Long-term interests				

ISI: Individual survival interests

IFI: Individual flourishing interests

FCSI: Family (community) survival interests

FCFI: Family (community) flourishing interests

autonomous decisions of some individuals is justified only if:

1. It is impossible to respect the decisions.
2. That failure is necessitated because of attempts to meet the needs of other individuals.
3. The decision to meet the needs of one group rather than another is not based on unfair or unjust practices such as ageism, sexism, or racism.

For example, a community may decide to treat persons with breast cancer rather than persons with AIDS because the former has a greater chance of success than the latter *and* the community does not have the resources to treat both groups. The community *should not decide to treat one group rather than the other* because it values one group more than another.⁷

Where Best Interests of Individuals and Communities Intersect The underlying assumption of these three points is that society values each individual and would meet all needs if it could. Communities must deliver some benefits to individual members, or these communities will be radically reconstructed and altered, as is happening in Eastern Europe and the former Soviet Union. At the same time, individuals must agree that self-interest will be limited to some extent, and acceptance of that limitation is the point at which individual wishes and communal best interest intersect. Communities need individuals and individuals need community; the best interests of each are met reciprocally.

In the context of decisions to accept or reject treatment for others, legitimate healthcare proxies are concerned with both the survival and the flourishing of the individual, sometimes emphasizing the latter rather than the former, for medical treatment may promise life but not purposeful life. The immediate community of the family can be an overwhelming factor in the decision-making process if, for example, a parent perceives that the flourishing of an impaired newborn would mean a burdensome existence for the rest of the family. Legitimate proxies may believe that, as a matter of social justice, they should not allow someone in a persistent vegetative state whose wishes are unknown to be kept on life support systems, thereby denying those medical resources to a patient for whom the promise of recovery

Society values

 each individual

 and would meet all

 needs if it could.

does exist.

In short, the best interest of each individual as perceived by others should be the long-term view of his or her likelihood for survival and/or flourishing. But these perceptions cannot be separated from the community context within which personal life is fulfilled.

The Catholic tradition has consistently emphasized the importance of the common good and thus has

always made allowance for decisions made in someone's best interest as described above. Realizing that biological survival and human flourishing are basic but not absolute human goals, Catholic theology and teaching have appealed to the use of reason and especially to the virtue of prudence in making third-party decisions supposedly "in the best interest of the person."

APPLICATIONS

Nontherapeutic Research on Children Research involving human subjects was one of the first issues tackled in the field of bioethics, which emerged approximately 20 years ago. Medical researchers began to see the primary ethical imperative of acquiring the informed consent of human research subjects.

In the case of children, researchers could easily justify therapeutic research designed to benefit their young subjects by the proxy consent of their parents, because research that might improve their health and well-being was obviously in the best interest of both children and families. But nontherapeutic research on children was a different matter. As Donald T. Chalkley of the National Institutes of Health put it: "A parent has no legal right to give consent for the involvement of a child not for the benefit of that child. No legal guardian, no person standing *in loco parentis*, has that right."⁸

Paul Ramsey, a leading Protestant ethicist at Princeton University at that time, argued that using children as research subjects in nontherapeutic research was treating them as means rather than as ends in themselves. Thus Ramsey held that "if children are incapable of truly consenting to experiments having unknown hazards for the sake of the good to come, and if no one else should consent for them in cases unrelated to

their own treatment, then medical research and society in general must choose a perhaps more difficult course of action to gain the benefits we seek from medical investigations."⁹

The problem is that nontherapeutic research on children is necessary if children themselves are to benefit from the findings and developments of modern medicine. As Alexander Capron pointed out:

"Children cannot be regarded simply as 'little people' pharmacologically. Their metabolism, enzymatic and excretory systems, skeletal development, and so forth differ so markedly from adults' that drug tests for the latter provide inadequate information about dosage, efficacy, toxicity, side effects, and contraindications for children."¹⁰

A solution to this problem was promoted by the Catholic ethicist Richard A. McCormick, who argued:

To pursue the good that is human life means not only to choose and support this value in one's own case, but also in the case of others when the opportunity arises. In other words, the individual *ought* also to take into account, realize, make efforts in behalf of the lives of others also, for we are social beings and the goods that define our growth and invite to it are goods that reside also in others. . . . Therefore when it factually is good, we may say that one *ought* to do so (as opposed to not doing so). If this is true of all of us up to a point and within limits, it is no less true of an infant. He would choose to do so because he *ought* to do so.¹¹

Since this is the case, McCormick argues that we ought to allow parents to provide consent for nontherapeutic research on children that contains "no discernible risk or undue discomfort for the child."¹² We allow parental consent in the therapeutic situation precisely because we believe the child would want this therapy because of the goods to be achieved through it. McCormick believes that the same can be said of nontherapeutic research in situations where the risk and discomfort to the child are minimal. In short, the family is supporting both existence and human

Life and all
temporal activities
are subordinated
to spiritual ends.

flourishing for the child and itself by this type of decision.

After much debate, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research adopted McCormick's basic approach in their report *Research Involving Children*,¹³ which eventually became the basis of current federal law. The commission argued that even if the

research was not directly beneficial medically, the children would still benefit in terms of personal growth later when they learned they had been involved in altruistic activity that may have saved many lives. The families would benefit by knowing they were educating their children, by example, in their generosity and concern for others.¹⁴

Parental permission for nontherapeutic research on children presents a situation in which the children involved will benefit only indirectly. That indirect benefit, however, is perceived as being in the best interest of the child because the long-term benefit to the community is understood as mutually beneficial to the individual. Thus we have a clear case where the best interest of the individual is apparently served by reference to the community.

Termination of Treatment In other healthcare dilemmas, such as removal of life support systems, we apply the following principle culled from this investigation: Legitimate healthcare surrogates, acting in the best interest of a person who cannot make decisions and has not previously expressed his or her wishes, may rightly take into account the long-term interests of the community within which that person has sought to survive and flourish. If that community is committed to justice and is not coercive, then in some cases, especially where the person may indirectly benefit from a chosen action, "best interest" may rightly allow the interests of the community to prevail even over the survival interests of the individual, as long as the direct intention to end or shorten life is not condoned.

This notion of best interest is implicit in the teaching of Pope Pius XII regarding the termination of treatment:

The rights and duties of the family depend in general upon the presumed will of the

unconscious patient if he is of age and "*sui juris*." *Where the proper and independent duty of the family is concerned* [italics ours], they are usually bound only to the use of ordinary means.

Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it on them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply.¹⁵

This statement may be interpreted as meaning that when the family or legitimate healthcare agent must make best interest decisions on behalf of another whose wishes are unknown, they must take into account not only the degree of burden to the patient but also the degree of burden that they, the community of value and support to the patient, can withstand. Pius XII's "burden for the family" includes not just physical burdens but also emotional, economic, psychological, and spiritual ones.

We believe that this ethic should underlie all relevant decisions at the "edges" of life, including those regarding impaired newborns. Pius XII stresses that life and all temporal activities are subordinated to spiritual ends. If this is the case, a newborn, no matter how precious and innocent, should be allowed to die from natural causes if the burdens associated with healthcare interventions (current and anticipated) are such that the family believes it will be destroyed emotionally, economically, psychologically, and spiritually if the interventions proceed.

This approach does not require the family to judge the quality of the child's life and decide that it is not worth living. Rather, it encourages a judgment on best interest, considering the child not in isolation but within the context of his or her most immediate community of value and good, the natural family. In these types of decisions, issues of survival and the potential flourishing of the individual must be considered, but this has to be done within the context of a specific community that must also survive and flourish.

TIGHT CONNECTIONS

An analysis of the term "best interest" reveals the tight connections between the individual and the community, for the best interest of one cannot be fully understood apart from the other. Although short-term interest may factor into individual and group decisions, that consideration is coherent only in context of the long-term goals of the individual and the community within which he or she hopes to survive and flourish. □

NOTES

1. Our use of the term "human flourishing" differs radically from that of Kai Nielsen in "Autonomy, Equality and a Just Health Care System," *International Journal of Applied Philosophy*, Spring 1989, pp. 39-44. Nielsen's use of "flourish" is equivalent to our use of "survival," which refers to basic physical needs. His discussion of "basic needs connected with our function as social beings" is closer to our concept of human flourishing but does not encompass a value system and lacks our emphasis on communal (shared) goals.
2. We do not intend to establish a strict teleological approach to this issue. It is sufficient to say that value, purpose, or meaning within a community of which an individual is a part is the foundation on which any particular notion of "best interest" is based.
3. Even though one may not accomplish all that one proposes, to realize "a purposeful life" is to set goals, create plans for accomplishing them, and set those plans into action. Hence, even if one realizes none or only a few of her or his plans, a purposeful existence is nonetheless possible.
4. Jacques Maritain, *The Person and the Common Good*, trans. by John J. Fitzgerald, University of Notre Dame Press, Notre Dame, IN, 1966.
5. For a contemporary philosophical analysis, see, for example, Thomas M. Garrett, Harold W. Baillie, and Rosellen M. Garrett, *Ethics for Health Care Professionals: Principles and Problems*, Prentice Hall, New York City, 1989; also see the theological works of H. Richard Niebuhr and Charles Curran for a sustained use of this ethical methodology.
6. Alasdair MacIntyre, *After Virtue*, 2d ed., University of Notre Dame Press, Notre Dame, IN, 1984, especially pp. 216-222; H. Richard Niebuhr, *The Responsible Self: An Essay in Christian Moral Responsibility*, Harper & Row, New York City, 1963, especially pp. 71-72, 97.
7. There has been an ongoing debate on the best means for rationing scarce medical resources. We do not wish to endorse the position that some people are more "valuable" to a society than others. To take that position would require a detailed philosophical justification, which is beyond the scope of this discourse. Moreover, we do not agree on this point.
8. *Medical World News*, June 8, 1973, p. 41.
9. Paul Ramsey, *The Patient as Person*, Yale University Press, New Haven, CT, 1970, p. 17.
10. Alexander Capron, "Legal Considerations Affecting Clinical Pharmacological Studies in Children," *Clinical Research*, February 1973, p. 141.
11. Richard A. McCormick, "Proxy Consent in the Experimentation Situation," in Tom Beauchamp and LeRoy Walters, eds., *Contemporary Issues in Bioethics*, Dickenson Publishing Company, Belmont, CA, 1978, p. 462.
12. McCormick, p. 463.
13. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Report and Recommendations: Research Involving Children*, DHEW Pub. No. (OS) 77-0004, 1977.
14. For further discussion of the *Report and Recommendations*, see James J. McCartney, "Research on Children: National Commission says 'Yes, If . . .'" *Hastings Center Report*, October 1978.
15. Pope Pius XII, "The Prolongation of Life," *The Pope Speaks*, vol. 4, 1958, p. 397.