Best Interests, Public Interest, and the Power of the Medical Profession

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Published online: 19 July 2008
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Abstract This article provides an understanding and defence of ‘best interests’. The analysis is performed in the context of, and is informed by, English law. The understanding that develops allows for differences in values, and is thus argued to be appropriate in a pluralist liberal system. When understood properly, it is argued, best interests provides the best means of decision-making for people deemed incompetent to decide for themselves. It is accepted that some commentators are cynical of best interests in practice. Following an assessment of some of their principal concerns, it is suggested that best interests in fact provides a construct that is both defensible and desirable.

Keywords Best interests · English law · Value pluralism · Decision-making · Power

Introduction

In this article, I provide a defence of best interests as a construct that assists good decision-making. I concede that it is not *a* concept,¹ but argue that this does not present fundamental problems in practice. I first spell out the proper understanding of best interests, before considering how this works within a model that I think it is in the public interest to preserve. This leads directly to an overview and analysis of English law, and the effect it has given to best interests. I then respond to concerns that some commentators voice regarding the potential for best interests to be used

¹ Or if it is, it is a concept with many mutually exclusive features. I find it analytically clearer to understand it as a construct that entails distinct conceptual aspects.

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cynically to advance wrongful ends by health care professionals.² Finally, I briefly sketch out reasons to keep the term “best interests,” despite its ostensibly misleading emphases.

The Best Understanding of Best Interests

Best interests lacks appeal to many social and ethical theorists, but in this article I wish to defend it. I do not, however, seek to defend it *as a concept*. Rather I defend it as a construct for good decision-making. I hope to demonstrate that when best interests is understood properly, it can be seen as a positive aspect of good health (and social) care. However, this requires us to respond to various aspects of the debate which have led to presumptions being accepted almost as uncontroversial truths.

First, it is proper to emphasise the difference between understanding best interests as a construct and as a single concept. It is no doubt true that best interests could not be one concept, or if it were that it could not really deal with the breadth of cases that it is supposed to.³ In the instruments that provide assistance with understanding of best interests—not least here we might think of the (English) Mental Capacity Act 2005 and its attendant Code of Practice—there is no definition of best interests. Rather, there are questions and processes that are recommended for people in their decision-making, that work to make it legitimate. As a construct, it is a system of action-guiding principles. Because best interests is supposed to govern all decision-making for people who are found to be incompetent, it would be troublesome if it were simply boiled down to one narrow concept; it would be too restrictive. By conceiving of it as a collection of principles, only some of which will be relevant to a decision at hand, we do not need to be concerned about the radically different situations that need to be decided in accordance with best interests.

Even so, we might face two lines of attack: how can we possibly *know* what is in a person’s best interests?⁴; and how can we possibly presume that doing what is best for an individual is the best thing overall?⁵ To the epistemic objection we can give a fairly straightforward response. We need to distinguish between ‘theoretical truth’ and ‘practical truth’.⁶ There are many matters that are subjected to philosophical

² Although I tend to focus in this article on the medical profession, the arguments apply, I think, more broadly to health care professionals.

³ This last can in fact be responded to in two apparently different ways that might in effect amount to the same thing, if not in name: the first is to say that best interests can not be a guiding principle that will be satisfactory in every case, but only in some [16, 35]. The second is to say that best interests is coherently more than one thing [21]. This is not to imply that the authors of these articles are arguing the same thing in their respective articles, but merely to highlight the approach taken by Kopelman, whose commitment to the best interests principle and the need for coherence require this sort of reasoning.

⁴ This line of reasoning, relating to claims about epistemic uncertainties can even be aimed at a person’s ‘knowledge’ of what is best for himself [34].

⁵ For arguments considering how this can play out in a liberal system generally, and principled analysis of the law that might regulate conflicting interests or freedoms, see [2].

⁶ Based on the claim in [5], where the authors say that the claim that best interests are unknowable, “while theoretically true, is practically false ...”, p. 482.

discourse on which we can not be certain: the very existence of morality is beyond empirical demonstration. And other matters, such as a person's intention, can never be known to an absolute certainty. Outside of the ivory tower, however, is a world where presumptions—some of them rebuttable—must be made, and, from these, truths taken for granted. Thus, a society with a criminal law system is interested in theoretically unknowable matters (such as intention) being proven beyond reasonable doubt, not to a complete certainty. Equally, in our treatment of each other, it is better (practically, if not philosophically) to work as if there is some notion of the good, of better, and best, that we take to be true, rather than to plump for some enduring and universal paralysis as a default measure in the face of empirical imperfections and epistemic uncertainty.

The objection that doing the best for the individual may not be best overall is hard to refute. As a non-ideal construct, however, best interests is capable of accommodating this (and further consideration is given below). When we allow tacitly for 'real world' limitations we see that it is not blind to the needs of others, despite its ostensible focus on the individual directly in question at any time.

So, we do well to think of best interests not as a single thing that will be met in each case, but as a goal to aim towards in all cases, however distinct they are. But still some further clarification is in order. Best interests is often described as objective. If this is the case, it might be asked, who says what goes onto the implicit objective scale to assess the interests? This, however, represents too narrow an understanding of what is meant by objectivity in this context. When, for example, a judge seeks knowledge of the best interests of a patient in a case, what he is looking for (or should be looking for) is (reasonably) objective knowledge of factors relevant to the assessment. Subjective perspectives will necessarily and appropriately form part of this. For example, a previously competent patient's subjective values can be taken to have existed objectively, and are appropriately brought into consideration. If a now incapacitated Jehovah's Witness has a medical need for a blood transfusion, a court can properly find that it is in his objective best interests not to receive it. This is not because the Jehovah's Witness' beliefs are found to be objectively true, but because it is objectively true that he had them, and they bear on his current interests.⁷

Best Interests and the Public Interest

In this section, I will argue in favour of a pluralist, liberal social system. This will allow us to see the various issues at play, and go on in the next section to demonstrate the way that best interests works within the system. My contention is that there is a positive good to be derived from being a part of a society that recognises genuine moral and cultural pluralism. If this is true, it is desirable that the recognition carries through to our treatment of people unable to decide for themselves. A commitment to value-pluralism ought to apply to everyone, not

⁷ For an example of such an investigation, albeit one where the views were found not to inhere in the patient, see [15].

simply to those able to make a contemporaneous statement of their values. Although there are more practical bars to discerning the value systems of incompetent than competent individuals, the principled commitment to pluralist liberalism implies a need to have a construct of best-interests that can vary in its application depending on the specific patient under consideration.

However, there are various bars to a sound defence of pluralist liberalism, which require consideration. In a system that acknowledges the validity of conflicting values, strong conceptions of the good will potentially be controversial, especially if they impose positive obligations on unwilling citizens. Thus, I suggest that whilst the pluralist liberal must concede some core conception of harm (or some such means of assessing the legitimacy of actions),⁸ he can still advocate a system that is broadly respectful of differing value systems. And in such a system, we do well to promote this variation, and have it known that such variation exists.

The Public Interest and Positive Obligations

We are familiar with strongly made arguments within bioethical discourse, many claiming to provide us with the right answer, or the most rational answer given some intuitively sound belief. John Harris's 'survival lottery' is a good example [14]. If Harris could convince everyone to become a conscript, that is all well and good. But absent their consent, what if a Government sought to make participation in such a lottery obligatory?⁹ Overall, the Government could point to a great harm being avoided, but how would we feel about the legitimacy of such a system? There are many ways that people could quite plausibly claim to be harmed by living in a system that did not allow them freedom to dissent from such a regime. The 'harm principle' that the Government might be citing in justification of its measure would be too rigid. There are physical and metaphysical aspects to harm, and the interests of each of us are bound up in both of them. To point to an intuitively plausible harm (e.g., a high chance of physical injury) and then to pose positive obligations on people to diminish that harm without considering other possible benefits (derived, for example, from the freedom to choose to enjoy activities that present a level of physical risk) that might be lost, is not an appealing way to administer a society. Of course, this does not mean that we can not or should not make any bold claims about harm, but we must be aware that harm itself is a malleable concept. One man's harm can legitimately be another man's happiness. Indeed, a qualitatively identical act on the same person may in some instances be considered to be a harm, in some instances not to be a harm, and in some instances to be a justified harm. For example, pulling someone against his will is a harm, but may cease to be once consent is given (perhaps as part of a dance routine), and may be justified if it is not possible to infer consent or dissent, and some higher good is served by it (such as pulling an unconscious individual from a burning car in an emergency).

⁸ Note the analysis in [6].

⁹ Not something that Harris is committed to advocating, it should be stressed.

Circumstances can affect whether the pulling is a harm, and the individual's perception of it can too. The individual's freedom to decide what harms to accept, or risk, is crucial to the acceptability of harms remaining legitimate in society.

The Public Interest and Individual Freedom

A society is well served by having some narrow commitment to harms, although there will almost certainly be arguments concerning the extent to which the harm is properly defined or understood at law. If we look to John Gray's analysis of the work of Isaiah Berlin we gain some useful insights into the way that this could work as an appealing social model [13]. The thesis Gray develops is premised on the idea of "agnostic liberalism" [13, Chap. 1]. This agnostic liberalism is not committed to a strong metaphysical or specific moral truth. Rather, it acknowledges that there are conflicting accounts of good and evil, and these are "rationally incomparable". However, there will be times, given the competing understandings of the good, that state actors have to make "radical choices" between them [13, Chap. 2]: that is, choices that necessarily offend against some understandings will have to be made because of fundamental conflicts presented that must be resolved. Such choices are the product of a necessary political (and legal) compromise. Thus we have our harm principle [13, p. 144]¹⁰:

[I]f the radical value-pluralist thesis of the rational incomparability of goods and evils is true, then the state can never have sufficient rational justification for imposing any particular ranking of values on people (*save that involved in securing the possibility for any sort of worthwhile life*). And, because imposing any such ranking would result in the suppression or incomplete realization of some genuine values, the state has good reason *not* to engage in authoritarian or illiberal policies of this kind.

Whenever a measure limits a person's freedom, it must do so justifiably. When we are placing positive obligations on people this is especially true. Generally, I suggest, the public interest is served by a situation where people are able to lead lives in accordance with the values that are theirs. This affords people the right to refuse or accept medical treatment for any reason or no reason at all. The state's business is not in holding up the decision against some apparently objective yardstick. Although the state should not be obliged to adhere to every positive demand made by an individual—especially if this involves unwilling complicity by state actors, or would require the diversion of public funds from others with an equal or stronger claim to them—the negative freedom of the individual should be left as unfettered as possible.¹¹ To advocate a distinct system is to advocate oppression and political and moral homogeneity. This, I suggest, is best resisted. And a sound

¹⁰ The first set of italics in this quote is mine.

¹¹ Gray's work strikes me as the most plausible expression of the type of liberalism the law should seek to respect. An alternative, non-agnostic liberal account of the interplay between individual choice and the public interest is found in Joseph Raz's work, e.g., [25]. See especially pages 52–55, for a convincing argument that works in parallel with the one advanced here, for analysts unsatisfied with the notion of agnostic liberalism.

understanding of best interests is needed as a part of this resistance. I suggest in the following section that under English law best interests is properly understood in the way I presented it above. The focus then is on the question of when we concern ourselves with best interests judgments.

The Relevance of Best Interests at Law

The short (and thus rather question-begging) answer to the question of where best interests is *relevant* at law, is in cases where we find a level of paternalism to be necessary, or at least justified, for an individual's own good. We can distinguish this in principle from coercive measures designed to protect the good of others, although in practice somewhat inventive reasoning can be used with best interests, making it work to the effect of benefiting others. Probably the most famous example at common law is the case of *Re Y* [31], where a severely mentally incapacitated woman was found to benefit from donating bone marrow to her sister who was dying of leukaemia, notwithstanding the fact that they did not have the close relationship that might be supposed to support the altruism involved.

In fact, I would contend that best interests is a principle that is legally presumed to pervade all decision-making, or at the very least all considered decision-making. Of course, we generally do not consider the question of best interests as *relevant* when a competent adult is giving or refusing consent. However, the basis of this liberal outlook is not that people are free to ignore any construction of “objective” best interests, but rather that it is not appropriate for the state to declare what those interests are: it is proper, at least in cases concerning competent adults, to allow people to define (or infer) their own best interests. The GMC guidance on consent has acknowledged this [12],¹² and it accords with a straightforward analysis of English law as stated in the courts, and now in the Mental Capacity Act 2005, which has a guiding principle that a “person is not to be treated as unable to make a decision merely because he makes an unwise decision.”¹³ The Code of Practice that accompanies the Act reinforces this position, saying that:

People with capacity are able to decide for themselves what they want to do. When they do this, they might choose an option that other people don't think is in their best interests. That is their choice and does not, in itself, mean that they lack capacity to make those decisions.¹⁴

This is best interpreted not as meaning that people are entitled to act against their interests. Rather it means that having capacity means that presumptions about best interests do not have to be acted upon, because the individual best understands his

¹² It states in paragraph 15: “It is for the patient, not the doctor, to determine what is in the patient's own best interests”.

¹³ Mental Capacity Act 2005, s 1(4).

¹⁴ Mental Capacity Act Code of Practice, available at <http://www.dca.gov.uk/menincap/legis.htm#codeofpractice> (accessed 14/03/07), p. 67.

own best interests.¹⁵ There are, of course, legal limits to a person's freedom to *act* in accordance with his best interests, even if he is able to define them for himself. These limits apply to those with and without capacity. There are obvious civil, criminal, and public law limitations. And within a health care context, we might say that whilst a person's negative liberty is secured, his positive liberty is not: the Court of Appeal decision in the *Burke* case confirmed that there is no claim right—at least at present—to define your best *medical* interests for yourself and then insist that the state serve these no matter what [24].¹⁶

In our analysis, however, we generally become concerned with best interests when considering decision-making for others. The ideal presented in the case of *re F* [17], that treatment that a person can not consent to must be in his best interests, has been developed at law, and it is possible to give an account of what best interests is taken to mean. I reiterate, though, that this is really a bundle of guiding factors rather than an expression of one concept. The courts have decided that best interests can not be boiled down to a single test [23, 24], and the Mental Capacity Act purposefully does not provide a definition of best interests:¹⁷ as with the case law, we instead see guidance on how to make the assessment.¹⁸ It is important to stress that best interests includes not only straightforward welfare issues, but also arguable metaphysical interests. So, a patient in a persistent vegetative state has been found by a court to be best treated at home, in accordance with her religious beliefs, even though she would not be aware of it [1].

Best interests serves as a legally necessary consideration in any decision-making on behalf of an incompetent individual: what clothes to dress him in; where he should live; whether he should receive medical treatment. But how wide is this scope? How far does the law take an interest in ensuring that best interests are being served? There are three areas we might look at.

The first is the law as it relates to children. In health care law, we could think of cases such as those concerning Charlotte Wyatt, in which the Court of Appeal confirmed that intolerability is not the touchstone of best interests [23]. We might also think of 'mature minors' who seek to act against their medical interests in favour of some overall best interests that they consider to be of more importance. In cases concerning medical treatment, we have seen judges maintaining a more stringent ("objective"?) code of values than may be applied to adults. A common example is provided by the cases involving older children who are Jehovah's Witnesses [27–30]. There is a sceptical approach in the judiciary, legitimised ostensibly by the need for children to achieve majority before they can make profound choices based on unusual metaphysical convictions. With regard to

¹⁵ This point speaks against an apparent asymmetry that some may perceive in health care provision—namely that those without capacity are entitled to have their interests better protected than those with capacity. In fact, everyone (subject to the various qualifications that apply universally) is entitled to treatment in accordance with his best interests.

¹⁶ For an overview of the freedoms upheld by law, see [4, pp 236–240].

¹⁷ See Mental Capacity Act Code of Practice, p. 68: "The term 'best interests' is not actually defined in the Act. This is because so many different types of decisions and actions are covered by the Act, and so many different people and circumstances are affected by it".

¹⁸ Mental Capacity Act 2005, section 4.

children, then, the law has a role whenever there is a serious disagreement about how the interests of a child are best served, or if the child is seeming to be treated harmfully, even if he consents. This represents a special sort of paternalism, that implies an account of harm and benefit that is stronger than would generally be permissible in a pluralist, liberal society, legitimised (ostensibly at least) because children are considered to be a special group. If we revert to Gray's version of the harm principle, we see that potentially this is justified. Arguably it is necessary in order to give children "the possibility for any sort of worthwhile life". There are difficult cases, as the law's definition of becoming an adult is rather more rigid than some philosophers' understanding of a person becoming "his own agent". For older children, we may perhaps be cynical of the courts' approach, whilst also being sympathetic to the reasons for taking it.

Secondly, we might look to the Mental Capacity Act. Section 2(1) of the Act says that a person lacks capacity—and thus best interests becomes relevant:

if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Section 3 states that a person is unable to make a decision for himself if he is unable:

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).

This approach in the Mental Capacity Act is subtly different from that developed at common law for adults (though in effect, it is arguably the same) [26]. When making decisions for those without capacity, the course of action least restrictive of a person's rights and freedoms is always to be preferred.¹⁹ The Act says that it is important to consider anything that may be relevant, but there are things of especial importance laid out, including regard to the likelihood that the person will at some time have capacity to make the decision himself, and, if so, when that might be.²⁰ Section 4(6) instructs the decision-maker to take into account, so far as is possible, the person's past and present wishes and feelings, as well as any of his beliefs and values that might affect his decision were he making it. If there is doubt, it is possible to apply to a court to determine a person's best interests.

Finally, we should look at the 2005 case of *SA* [18]. In this case, Munby J. looked at the inherent jurisdiction of the High Court of the Family Division in relation to vulnerable adults. He held that incompetent adults are protected by the courts in a way that is practically indistinguishable from the protection afforded to children

¹⁹ Mental Capacity Act 2005, section 1(6).

²⁰ *Ibid.*, section 4 (3).

[18, paragraph 37]. This means quite a strong position for the courts. He tells us at paragraph 45 that:

[T]he jurisdiction must evolve in accordance with social needs and social values... [T]here is probably no theoretical limit to the jurisdiction... [T]he court can regulate everything that conduces to the incompetent adult's welfare and happiness, including companionship and his domestic and social environment.

This seems a pretty broad scope. But more surprising, Munby J. goes on to argue that the inherent jurisdiction extends to a wider class of individuals than merely the mentally incapacitated and those unable to communicate their decisions. He holds at paragraph 77 that:²¹

[T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, *or is reasonably believed to be*, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.

The judge at paragraph 82 gives us a very loose description of what it means to be a vulnerable adult:²²

In the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is *or may be* unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity.

And in the following paragraph he cites what is possibly the strongest available authority in support of his position (namely, himself giving an earlier judgment), which demonstrates that there is “no doubt” that:

The court has jurisdiction to grant whatever relief in declaratory form is necessary to safeguard and promote the incapable adult's welfare and interests.

Thus the position at law is that best interests may have an incredibly wide scope. Suffice to say here, analysts of English health care and social policy should think seriously about the very troubling implications of Munby J.'s judgment. I am very uncomfortable with the breadth of vulnerability as described by Munby J.

The broader legal picture, however, is largely to be welcomed: a proper understanding of individual decision-making in a pluralist liberal legal system means that it is right that the competent are entitled to decide for themselves what is

²¹ Emphasis added.

²² Emphasis added.

best, and that decisions taken for the incompetent are as compatible as possible with their values. Nevertheless, there is a real danger that the state can rob that decision-making authority from individuals. Were the focus of this article on the courts, there would clearly be much to say about the decision of Munby J. in the case of SA.

The Power of the Medical Profession

Loretta M. Kopelman has developed a defence of best interests, and argues convincingly against many of the charges that critics set against it [20, 21]. There is however an equivocation in a part of this defence that might be the cause of concern. Kopelman says [20, p. 189]:

When the Best Interests Standard is seen in the context of its practical uses, it is... a mistake to suppose that it permits whatever anyone wants it to mean.

The trouble is with the word “permits”. There are many critics of best interests, whose concern is that it leaves too much power with physicians [e.g. 7–11, 22, 34]. This fear will not be allayed if we are told that a doctor who properly applies the principle will not behave in a way that should concern us. The problem is not that best interests does or does not itself permit an excess of power. The problem is that *having the best interests standard* might permit a doctor to do what he wants, unhindered at law (it may be felt) because of the application of the notoriously troublesome *Bolam* test and an excessively deferential judiciary. This does not then mean that best interests permits in the sense of endorses, but permits in the sense of in fact allowing.

So what are we to do to prevent despotic value depositing, or even simple officious moralism, by medical professionals? It is all too easy to castigate without thinking about alternatives. Are patients hostage to the medical profession? Is there a better alternative to best interests?

Patients as Hostages: to an Extent, Yes...

It is easy to draw up strong rhetorical arguments to support the contention that the medical profession needs to be kept in check. Consider the following assertions relating to end-of-life cases, made by Charles Foster [11, p. 1241]:

In the context of end-of-life decision-making, the woolly ‘best interests’ test is too subjective to be safe. It is impossible to police its use. Remember that the vast majority of ‘best interests’ determinations take place not in the Royal Courts of Justice, but on the ward. They are made not by detached judges, but by harassed clinicians and distraught parents. The intolerability test was a clear legal yardstick based on sound ethical arithmetic. It seems to have gone. The judges will be less clear how to approach these crucial cases, and the most vulnerable patients will be less safe.

We might note several difficulties with this approach. First, his preference for the intolerability standard is not unproblematic. In Foster's analysis, the standard is to be preferred because it is the effective test to ensure the law accords with the sanctity of life doctrine. But it has been argued that the courts have failed to understand the sanctity principle [19].²³ It is not clear that physicians can be expected to understand it any better, or that there is a sound basis for making the principle an absolute one at law [3]. Furthermore, in his article he tells us that the intolerability standard admits of exceptions.²⁴ If this is true in the narrow band of end-of-life cases, we surely need something further in a broader context of decision-making for others. Second, if best interests is supposed to focus on the patient, but in practice might not, there is no obvious reason to believe that a similar slip will not happen with a test based on tolerability (or anything else). Third, applied in the right way, subjectivity does not just make decisions safe, it makes them proper and consonant with pluralism.²⁵ Fourth, it is not the best interests standard that makes clinicians "harassed", so presumably that is as relevant to any standard that the law sets. Finally, the empirical claim that judges will be less clear and that greater harm will be done to the vulnerable is given no support. Of course, we should be wary, but not because of claims like that. In fact, the multiple factors that might bear on any decision that would need to be made recommend flexibility, and also give us a *prima facie* reason to be suspicious of any claim that one narrow framework or test can be applied with universally satisfactory effect. So, I do not contest the idea that we need to be concerned about keeping a check on power in a situation where it has the potential to be exercised without great scrutiny. However, I reject the claim that best interests necessarily makes this harder. In fact, I believe that it invites carers to think carefully. The question is, though, can it *make* them do so?

...But We have to Work Within some such System

Sometimes resignation to reality is weak and unsatisfactory. If, for example, I took the position that rape is bound to happen no matter what the state does so there is little point in criminalising it, my position would be indefensible. Sometimes, however, it is perfectly legitimate to recommend a situation informed by existing social and institutional norms and practices. Enshrined in strong judicial statement, the Mental Capacity Act, and the guidance that health care practitioners are familiar with, the best interests standard is something that is here to stay. Of course, in any meaningful sense, it is hard to find how it is *a* standard. We decide what to do with a patient in PVS, a neonate with an intestinal blockage, a child whose parents can not agree with the doctors on appropriate treatment, and a demented patient with a

²³ John Finnis levels a similar criticism to Foster in [9]: "The issue is not one of disguise or sincerity, but of the true implications of principles and notions being put into practice by a group of citizens whose medical qualifications, experience and ethos confer no standing to settle for the whole community such issues of meaning, consistency, humanity and justice." p. 334.

²⁴ His recent judicial support comes from a dictum that claims only to apply "Normally", and he says (without elaboration or justification) that patients in a persistent vegetative state "fall into a rather special category".

²⁵ See the section entitled "The Best Understanding of Best Interests", above.

loosely worded advance directive, all according to best interests, yet in each case our decision is informed by very different factors. Is there anything that best interests asks in all cases? I think there is. It asks medical professionals to think. It makes proper contemplation a fundamental aspect of good practice. If it is impossible to police, the standard, whatever it is, is not going to be any use. Instead, we need to see how the safeguards provided in the new legislation, and the exercise the court makes of its inherent jurisdiction, play out. We then need to push for change or better policing if there are not adequate protections.

Alternative Constructions

A problem I highlighted in the section entitled “The Best Understanding of Best Interests”, namely that best interests implies an impossible ideal, remains. In every case we are not really going to do what is best for the patient. Would it be better, then, to advocate the position advanced in this article, but more honestly labelled? There are various alternatives that might be advanced. One, which seemed to underpin the House of Lords decision in *S v S* [32], could be labelled the overall-benefit-and-not-against-the-interests-of-the-individual test. Another would be a reasonable interests test [5, p. 483]. Or perhaps we should focus on the “reasonable decision-maker”, and have a best judgment test. In fact, I suggest that there is good reason to stick with the best interests label. By asking decision-makers to consider the best interests of the individual, with the “real world” limitations to this being tacit, we retain the proper focus that is required if we are to protect the vulnerable. Of course, in the end a name will not alone serve as a safeguard, but best interests does seem to give an appropriately high level of concern to the person for whom we are making a decision. Narrowing this may have the effect of diminishing the protection. Although there is no way to prove this to be the case, it stands as a strong presumptive reason for sticking with the label. (Not to mention the strong pragmatic reason; namely that the term is written in statute and established in case law, and thus will not be substituted in the foreseeable future).

Conclusions

I would urge a tentative but optimistic endorsement of ‘best interests’ as a broad construct that inspires decision-makers to think carefully about the best course of action. In some instances, it is a regrettable terminology, as we rely on stretched reasoning in our construction of how someone’s interests are being served by a course of action, but I think overall it is most prudent to keep the emphasis as it is. There is good reason to believe that policing practice will be hard. I think part of the response to this is to devise strong empirical studies²⁶ and perhaps it is part of the role of academics to help to keep a check on practices. Whilst being wary and vigilant, I think we can, through education and continued assessment, work with

²⁶ Such studies would be possible. See, for example, [33].

what we have. This recognises the power of the medical profession, but also the public interest in maintaining a pluralist system. The idea of best interests is tricky, but practices that are governed by the legal principles of best interests need not be.

Acknowledgements Thanks to participants at the *Workshop on Best Interests*, Cardiff Law School (12/04/07) for helpful discussion and comments on the issues considered here, and to Margot Brazier, Andrew Edgar, Søren Holm, and Sheelagh McGuinness for comments on drafts of this article. I gratefully acknowledge the support of the British Academy Postdoctoral Fellowship Scheme.

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