

The best interests of mentally incapacitated patients without a living will

Introduction

I have previously suggested that doctors' moral duty to respect mentally incapacitated patients' autonomy during decision-making can be fulfilled by helping them prepare a written living will before they become incapacitated.¹ Mentally incapacitated patients fall into two categories: 'formerly-competent' and 'never-competent' and only the former are capable of preparing living wills. For those with living wills, the ethical standard of informed consent applies and in those without, two other ethical standards are available: the substituted judgement standard and the best interests standard. Both standards are potentially applicable to 'formerly-competent' patients, but in 'never-competent' patients, medical decisions can only be guided by the best interests standard, one that should be narrowly and medically defined. In this paper, I will evaluate the best interests standard as it is used in Part IVC of the Hong Kong Mental Health Ordinance (MHO) and also discuss the substituted judgement standard and the Mental Capacity Act (2005) for England and Wales (MCA).

Substituted judgement standard

In some countries, eg the US, a mentally incapacitated patient's next of kin may use the substituted judgement standard to make a decision the patient would make, based on his/her known prior wishes and preferences. As in a living will, the moral principle underpinning this approach is respect for patient autonomy. Nonetheless, the substituted judgement standard is less efficient than a living will because the patient's prior wishes and preferences are only known indirectly through surrogate decision-makers who have to produce clear and convincing evidence that the information is true. The recent US case regarding the withdrawal of life-sustaining treatments from Terri Schiavo, where different courts took almost a decade to decide which substituted judgements were the more reliable, illustrates how complicated and time-consuming this can become. In the UK and Hong Kong, substituted judgement has never been accepted as a legal standard partly because it is considered difficult to use and partly because the next of kin or close relatives—the people who are most likely to know a patient's prior wishes and preferences—are not legally empowered to make surrogate decisions. Hence, in those who are 'formerly-competent' but lack a living will, the best interests standard is the only practical one available

to surrogate decision-makers.

The 'medical best interests standard' and 'expanded best interests standard'

The MHO empowers judges, legal guardians, or doctors to make medical decisions or provide urgent and necessary treatments for mentally incapacitated patients, provided that the patient's best interests are being served (Sect. 59ZB, 59ZF). According to Sect. 59ZA, 'in the best interests' "means ... to (a) save the life of the [patient]; (b) prevent damage or deterioration to the physical or mental health and well-being of that person; or (c) bring about an improvement in the physical or mental health and well-being of that person." When doctors provide urgent and necessary medical treatments for mentally incapacitated patients, eg in the Accident and Emergency Department, without any instructions from judges or guardians, they are driven primarily by the duty to provide what a reasonable person would want in similar circumstances: scientifically proven treatments for that medical condition. Prior preferences and wishes are not usually considered since they are mostly unknown, and many doctors believe their actions are guided by the best interests standard, narrowly considered a 'medical best interests standard'.

Sect. 59ZA has, apparently, more than a narrow 'medical best interests standard' in mind when it defines the best interests standard as improving on or preventing damage to the 'well-being' of the patient. 'Well-being' is a value-laden term and includes subjective factors such as patients' wishes, values, preferences, beliefs etc. Expansion of this standard beyond medical interests is done to increase patients' autonomy since competent patients usually include non-medical interests when they consider their best interests. This intention is confirmed by the strong 'pro-autonomy' statement in Sect. 59ZK that treatments based on the best interests standard should be provided "as if" the patient "had been capable of giving such consent" and treatments "had been carried out with [their] consent." Given the importance of patient autonomy in western bioethics, it is not surprising that the MCA has also adopted an 'expanded best interests standard' for mentally incapacitated patients. Sect 4 (6) of the MCA stresses that a "best interests" judgement should consider "(a) the person's past and present wishes and feelings...; (b) His or her beliefs and values where

they would have an impact on the decision.” Hence, both the MHO and MCA have extended patients’ autonomy using an ‘expanded best interests standard’ that includes personal preferences and values—considerations that are manifestly more explicit in living wills or substituted judgement standards.

‘Expanded best interests standard’ shortcomings

There are several problems with the ‘expanded best interests standard’. Firstly, its application is limited to ‘formerly-competent’ patients who have provided readily accessible evidence of their prior wishes and preferences. It cannot be used for ‘never-competent’ patients who never had morally significant interests or preferences, and whose treatment can only be guided by circumscribed ‘medical best interests’ standards.

Secondly, since doctors are only permitted to provide urgent and necessary medical treatments for mentally incapacitated patients, it is neither sensible nor practical to expect doctors working under pressure to use an ‘expanded best interests standard’ necessitating extensive information about the ‘formerly-competent’ patient. Doctors are often forced to forgo respecting autonomy in favour of providing beneficial care. The Hong Kong MHO appears to have anticipated this problem and put in Sect. 59ZS the proviso: “... under this Ordinance, the guardian shall ensure ... that the views and wishes of the MIP [mentally incapacitated patient] are, *in so far as they may be ascertained*, respected.” (Italics added) Just as the ethically more desirable substituted judgement standard is too complex to be of use, the laudable ‘expanded best interests standard’ is often displaced by the practical ‘medical best interests standard’ because patients’ views and wishes are not readily ascertainable. But it seems hypocritical to give the morally lofty ‘expanded best interests standard’ statutory status and simultaneously provide an ‘escape clause’ so that the standard need not be met.

Thirdly, different surrogate decision-makers have different interpretations of the patient’s best interests partly because best interests permits wide-ranging discretion² and partly because the patient’s personal information is not equally accessible to all decision-makers due to unequal availability of time, unequal proximity to the patient etc. This gives rise to conflicts between them. Even the law courts have not reached a consensus on the definition of the best interests standard: “Neither the precise nor the general nature of best interests is defined by the United Kingdom courts.”³ If the ‘expanded best interests standard’ can give rise to more than one standard, then it ceases to perform its function as a standard. For this and other reasons, the Scottish Parliament and its Law Commission rejected the best interests standard as a guiding principle.²

Lastly, the ‘expanded best interests standard’ is conceptually muddled as it conflates the best interests standard with the substituted judgement standard. The drive to include items that usually fall under the substituted judgement standard in the best interests standard arises from abuse of the best interests standard as a moral standard. In Hong Kong and England, treatment guided by the best interests standard often amounts to nothing more than providing non-negligent medical treatment,⁴ and there is a strong demand to create a statutory ‘expanded best interests standard’ that “would no longer conflate best interests with non-negligent care.”⁵ Yet, whenever surrogate decision-makers consider patients’ prior wishes, values, beliefs etc, both substituted judgement standards and best interests standards are being used. Surrogate decision-makers are trying to determine what the patients would decide if they were competent, and include it. This inevitably conflates the best interests standard with the substituted judgement standard, creating considerable confusion with interpretation and implementation. Consider Sect. 59ZK: “treatment... in respect of a [patient]...has effect for all purposes *as if* (a) that person had been capable of giving such consent...and (b) that treatment...had been carried out with the consent of that person.” (Italics added) The ‘*as if*’ language used is more reminiscent of the substituted judgement than the best interests standard. The English Law Commission and the House of Lords insisted that the ‘expanded best interests standard’ is not a substituted judgement because it is not trying to determine what the person would have wanted, and called it an ‘objective test’ that considers all relevant factors in order to determine “the person’s actual best interests”. But scholars have disagreed: “English courts ... have consistently rejected ... [the substituted judgement standard] in favour of a best interest test, but like it or not, an element of substituted judgement pervades many of the relevant cases”,⁶ and “Substituted judgement becomes an integral part of best interests where such judgement can be discerned.”⁵

Conclusion

It is important to make a clear distinction between the substituted judgement standard and the best interests standard and not conflate the two because they operate at different levels of the moral hierarchy, according to the degree to which they faithfully adhere to patient autonomy. The living will is the most faithful, followed by the substituted judgement standard, then the best interests standard. The substituted judgement standard is closer to an ‘autonomy-based standard’, and is ethically preferable to the best interests standard, which is more paternalistic.⁶ Consider Sect 59S(3) of the Hong Kong MHO which

states that "...under this Ordinance, the guardian shall ensure (a) that the interests of the...[patient]... are promoted, including overriding the views and wishes of that person where... such action is in the best interests of that person; (b) despite paragraph (a), that the views and wishes of the MIP [patient] are, in so far as they may be ascertained, respected." This section is difficult to interpret and implement since it asks decision-makers to both respect and override the views and wishes of the patient. Clause (a) can be interpreted to endorse a paternalistic best interests standard by recommending "overriding the views and wishes of that person" if such action promotes the patient's best interests; yet clause (b) approximates a substituted judgement standard by insisting on respecting the patient's prior views and wishes. If this interpretation is correct, the MHO incorporates both standards as an 'expanded best interests standard' and gives primacy to the substituted judgement standard.

Doctors treating mentally incapacitated patients rarely have time to wrestle with the complexities of the 'expanded best interests standard'. Most use the 'medical best interests standard', relieving their consciences with the 'escape clause' in Sect. 59ZS. This is unfair to doctors. A clear distinction should be made between the 'medical best interests standard' and 'expanded best interests standard'. In most clinical situations doctors should be expected to use only the 'medical best interests standard', leaving the rest for the legal guardians and courts. The 'expanded best interests standard' is intended for judges but not doctors; it is better used in courts rather than wards. If by default it is done by the doctors, it cannot be done well.

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References

1. Hui EC. The living will—pitfalls, benefits and a way forward. *Hong Kong Med J* 2007;13:493-5.
2. Mason JK, McCall Smith RA, Laurie GT. Law and medical ethics. 6th edition. UK: LexisNexis (UK) Ltd; 2003:324.
3. Mason JK, McCall Smith RA, Laurie GT. Law and medical ethics. 6th edition. UK: LexisNexis (UK) Ltd; 2003:333.
4. Brazier M. Medicine, patients and the law. 3rd ed. London: Penguin Books; 2003:117-9.
5. Brazier M. Medicine, patients and the law. 3rd ed. London: Penguin Books; 2003:132.
6. Mason JK, McCall Smith RA, Laurie GT. Law and medical ethics. 6th edition. UK: LexisNexis (UK) Ltd; 2003:519.