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PERSPECTIVE

Best interests and the raison d'être of health care

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The report of the expert group on the review of the Mental Health Act has recommended that the requirement to consider the best interests of the person be replaced by a list of guiding principles, which focus on the autonomy of the individual. The implied rationale for this is that acting in our patients' best interests may be a violation of their human rights. Dignity is being proposed as an alternative way of capturing 'the positive aspects associated with best interests', but it is not clear how dignity is preferable to best interests. Both approaches may help protect the most vulnerable from exploitation. However, unlike best interests, dignity can be used as a synonym for autonomy. Valuing autonomy as a means to an end (instrumental value) should be distinguished from valuing autonomy as an end in itself (intrinsic value). As the ultimate end of instrumental autonomy is invariably the person's best interests, abandoning that principle renders instrumental autonomy obsolete, leaving intrinsic autonomy as the supreme value. As best interest, dignity and autonomy rarely conflict, the proposed changes may appear minor, but they are not. When such values do conflict, acting against our patients' interests may become inevitable.

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Introduction

The recently published report of the expert group on the review of the Mental Health Act (Department of Health, 2015) recommends that section 4(1) of the act be amended such that the requirement to consider 'the best interests of the person' be replaced by a list of guiding principles, which focus on the autonomy of the individual. These include 'autonomy and self-determination' as well as 'dignity'. The implied rationale for this seems to be that the best interests principle may be incompatible with our international human rights obligations, including, among others, those contained in the UN convention on the Rights of Persons with Disabilities (UN, 2006).

In other words, we are being asked to accept that acting in our patients' best interests is somehow a violation of their human rights. Not only is this counter intuitive, it is a challenge to the core ethos of health care. Acting in the patient's best interests has been a principle of medicine since ancient times and is still regarded as the primary responsibility of a modern doctor (Medical Council, 2009). Yet this beneficence motive, arguably the *raison d'être* of the profession, is now being presented as a problem and a limitation. 'Dignity' is being suggested as a way by which 'the positive aspects associated with best interests could be captured'. This redefining of the values and language of health care requires closer scrutiny.

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Best interests versus dignity

Admittedly, a contentious aspect of the best interests principle is that it is not clear how such interests are to be defined, nor by whom (Slade, 2009). It is, however, difficult to see how this proposed alternative, dignity, is preferable in this regard.

The everyday meaning of the word 'dignity' refers to being worthy of honour or having a sense of self-importance, but the term also has a long history of use in both religious and secular ethics as well as in human rights law (Rosen, 2012). Although difficult to define precisely, dignity (in the ethical/legal context) tends to be conceived of as that which is inherently human, common to and equal in all humans and from which all human rights are derived (Andorno, 2009). With a few exceptions, such as Macklin (2003), there is almost universal agreement that human dignity is something, which ought to be valued. However, despite this consensus, determining what constitutes dignity in any specific instance ultimately relies, as in the case of best interests, on subjective interpretations.

For instance, both sides in the debate on assisted suicide cite respect for human dignity to justify their respective (opposing) positions (John Paul II, 1995; Dignitas, 1998). Horton (2004), while arguing that respecting human dignity may be 'an over-riding requirement for a decent society', also acknowledges that the word can be 'a linguistic currency that will buy a basketful of extraordinary meanings'. Caulfield & Chapman (2005) expressed the concern that dignity could be used as 'mere rhetorical dressing' and Orwell (1945) alluded to the word's propaganda potential.

Dignity therefore would appear to be at least as subjective, and thus potentially contentious, a concept as 'best interests' is, if not more so, and thus seems a somewhat dubious alternative.

Perhaps dignity should be thought of as a nuanced concept, which combines aspects of the traditional Christian idea of the human soul with modern ideas of individual human rights, and thus provides a common focus for both religious and secular altruism. As such, its inclusion in any piece of legislation might be regarded as welcome. However, the simple inclusion of dignity (as a consideration when making decisions under the act) is not what is being proposed. Rather it is the *replacement* of best interests by dignity.

Context

Removing the principle of best interests needs to be seen in the context of the paternalism – autonomy debate, in which the traditional paternalistic beneficence motive is challenged by libertarian ideas, which prioritise freedom of personal choice. This is a debate, which extends beyond medical ethics and into politics, as it addresses the question of how much society should do in order to protect the weak from exploitation by the strong.

How dignity is interpreted can have significant implications for this debate. Beyleveld & Brownsworth (2001) describe two conceptions of dignity, dignity as constraint (centred on claims of best interests or other social values) and dignity as empowerment (centred on claims of autonomy), mirroring the two poles of the paternalism – autonomy debate. In other words, whereas one of the many possible ways of interpreting the concept of dignity may be to regard it as synonymous with best interests, it can just as easily be used as a synonym for individual autonomy.

By proposing the replacement of best interests by dignity, the expert group are considering dignity as a concept, which contrasts with, and takes precedence over, best interests. This context suggests that it is the 'dignity as empowerment' concept which they have in mind, in effect, the libertarian interpretation. The implications of this for health care seem at odds not only with traditional values of medicine, but with much contemporary opinion also (Matthews, 2007; Medical Council, 2009; Kennedy, 2012; Lepping & Raveeesh, 2014).

The value of autonomy; instrumental or intrinsic?

In order to consider how any two principles differ from each other we need to consider how they might conflict. Overarching principles are statements of values. Fulford (2004) observed that we 'tend to notice values only when they are diverse or conflicting and hence likely to be problematic'.

If we are not usually aware of a conflict between best interests and autonomy, this is probably because there usually is not one. Invariably it *is* in the person's best interests that their autonomy be respected. However, an important question needs to be considered; when we respect a person's autonomy, do we do so because we regard it as an important means to the ultimate end of promoting the person's best interests, or are we doing it as an end in itself? In other words, does autonomy have instrumental value or intrinsic value?

Historically, society has undoubtedly underestimated the instrumental value autonomy. That has now changed and this is to be welcomed. However, in recent years the idea has gained currency, in medical ethics and elsewhere, that autonomy ought to be regarded as being not of instrumental value, but of intrinsic value (Beaucham & Childress, 2001), and even the supreme value (Gillon, 2003).

Why we ought to accept the intrinsic, let alone supreme, value of autonomy is not obvious. A counter argument, that autonomy has instrumental but not intrinsic value, is provided by Varelius (2006). (Indeed, as a historical aside, it is not at all clear that John Stewart Mill (1869), usually regarded as one of the founding fathers of modern libertarianism, regarded autonomy as having anything other than instrumental value either. Mill was, after all, a utilitarian.)

Best interests abandoned

Such is the instrumental value of autonomy that this distinction, between instrumental and intrinsic value, is not usually obvious, and thus may appear unimportant. It takes on importance however, if we were to consider abandoning the principle of best interests. As the ultimate end of instrumental autonomy is invariably the person's best interests, abandoning the principle of best interests renders the instrumental value of autonomy obsolete, leaving intrinsically valued autonomy as the supreme value, superior to best interests. There would then be no escaping the inevitability that on occasions, when the respective values do conflict, we would find ourselves acting *against* our patients' interests.

If a society adopts extreme libertarian values, values that regard individual autonomy and personal choice as supreme, then members of that society with poor decision-making abilities become more vulnerable to manipulation and exploitation. Promoting a person's best interests and respecting their dignity are both ways by which a society might try to protect the vulnerable from such exploitation by the powerful. Dignity is by far the more malleable of the two concepts. It can be conflated with autonomy in a way that best interests cannot, thus undermining its effectiveness in protecting the vulnerable.

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Kelly (2014) anticipates that a legislative approach alone may not be sufficient to ensure adequate care of vulnerable mental health service users. Indeed, it is difficult to see how the cause of the severely mentally ill is advanced by the promotion of a culture, which calls into question the legitimacy of a professional duty to act in their best interests.

Conclusion

The recommended changes are an attempt to realign mental health services towards a culture, which places greater value on individual autonomy, but at the expense of patients' interests. The ambiguous concept of dignity is being proposed, as an alternative to best interests, as a means of mitigating the worst excesses of unfettered libertarianism, but in a way which avoids any challenge to the libertarian world view. We should not allow this undermining of health care values. We should be suspicious of pressure to divorce our professional activities from our patients' best interests. The proposal to do so is profoundly misguided.

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