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Balancing Ethics And Law: The Application Of Best Interest Theory In Healthcare Decision-Making

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Abstract

The study explores the application of the Best Interest Theory in healthcare decision-making, focusing on its ethical and legal dimensions for vulnerable populations such as minors and incapacitated adults. It examines the theory's jurisprudential foundations, including utilitarianism, Kantian ethics, and virtue ethics, and its integration into legal frameworks like the Mental Capacity Act 2005 (UK), the Patient Self-Determination Act 1991 (US), and the Medical Termination of Pregnancy Act 2021 (India). Key challenges include subjectivity in defining "best interests," conflicts between patient autonomy and medical judgment, and disputes among healthcare providers, families, and courts. The study employs a mixed-method approach, combining doctrinal analysis of legal statutes with qualitative insights to address gaps in practice. Recommendations include standardized guidelines, interdisciplinary ethics committees, and advance care planning to enhance transparency and patient-centered care. The research underscores the need for balancing ethical principles like beneficence, nonmaleficence, and justice while respecting cultural and individual values in healthcare decisions.

Keywords: Autonomy, Best Interest, End-of-life care, Incapacitated adults, Surrogate decision-making, Utalitarianism

Chapter 1: INTRODUCTION

The principle of acting in the "best interests" of individuals who lack decision-making capacity is a cornerstone of medical ethics and legal frameworks, particularly in healthcare settings. This principle emphasizes the need to balance ethical considerations such as autonomy, beneficence, nonmaleficence, and justice when making decisions for vulnerable patients, including adults lacking capacity and children. Tools and guidelines are available to assist healthcare professionals, particularly physicians, in navigating these complex decisions, ensuring that decisions align with the patient's values, preferences, and known intentions, often through substitute decision-makers or surrogates. However, challenges arise when surrogates may misinterpret the patient's wishes or face conflicts of interest, especially in high-stakes scenarios like life-sustaining treatments. Ethical dilemmas also emerge in patient-centered care, where practices intended to prioritize patient autonomy and preferences may inadvertently compromise privacy, medical quality, or professional equality. The concept of altruism further complicates this landscape, as clinicians must balance selflessness with practical realities in medical practice. Legal frameworks, such as the "best interests" test in English law, provide a structured approach to decision-making but require careful application to avoid biases or oversimplification. Case studies in pediatric healthcare, including areas like end-of-life care and genetic testing, highlight the nuanced application of the best interests principle, underscoring the need for a compassionate, multidisciplinary approach that integrates clinical expertise with ethical considerations to uphold patient dignity and rights.

1.1 Research Design

1.1.1 Research Problem:

The application of best interest theory often leads to ethical dilemmas and legal challenges. The problem lies in defining and interpreting the "best interest" standard in diverse healthcare scenarios, balancing autonomy, protection, and medical judgment.

1.1.2 Research Methods

This research employs a combined doctrinal and qualitative methodology to explore the legal and contextual dimensions. The doctrinal approach involves analyzing primary legal sources such as legislation, case law, and regulatory frameworks, alongside secondary sources like scholarly articles and commentaries, to construct a coherent legal framework and identify gaps or trends. This mixed-method approach ensures a holistic understanding of the topic, integrating theoretical legal analysis with real-world perspectives, while addressing ethical considerations such as informed consent and confidentiality. The combination of doctrinal and qualitative methods enhances the research's rigor, depth, and relevance, though limitations such as the availability of legal sources and subjective participant perspectives are acknowledged.

1.1.3 Research Objectives:

1. To explore the application of the Best Interest Theory in decision-making for incapacitated patients in healthcare settings.
2. To analyze how courts interpret and apply the best interest standard in healthcare decisions involving minors and incapacitated adults.
3. To explore the ethical and legal conflicts arising from the best interest theory in medical treatment decisions, especially in end-of-life care and refusal of treatment cases.

1.1.4 Research Questions:

1. How is the Best Interest Theory applied in clinical decision-making for patients who lack capacity?
2. How have courts applied the best interest theory in cases involving minors and incapacitated individuals in healthcare decisions?
3. What are the key legal conflicts and ethical dilemmas associated with the application of the best interest theory in healthcare?

1.1.4 Hypothesis:

The application of the best interest theory in healthcare decisions often leads to a conflict between medical judgment and patient autonomy, resulting in legal and ethical challenges, especially in cases involving vulnerable populations like minors and incapacitated adults.

1.1.5 Review of Literature

1. Best interests decision making for adults who lack capacity: A toolkit for doctors working in England and Wales

In order to assist physicians in making decisions that are best for adults who lack capacity, this toolkit offers helpful advice. It lays out the various elements to take into account, the decision-making process to be followed, and how they should be balanced. It also provides links to additional reading and resources for assistance. Even though this article is primarily intended for physicians, other members of the healthcare team who treat and care for patients who lack capacity will find much of the information helpful. As part of the multidisciplinary team (MDT), they will play a key part in determining what is in the best interests of the team. Only when it has been proven that an adult lacks capacity and is unable to give their own consent or refuse treatment does this toolset come into play.

2. Protecting Incapacitated Patients' Rights and Best Interests, Ercan Avci

In light of the patient's right to privacy and self-determination, modern medical ethics mandate that healthcare services be provided in line with their values, choices, and interests. In light of the best interest standards and substituted judgment, incapacitated patients exercise these rights through substitute decision-makers. The purpose of this article is to provide a brief overview of informed consent in this setting, with an emphasis on safeguarding the rights and best interests of patients who are incapacitated. The article emphasizes how crucial it is to support each patient's autonomy to the greatest extent feasible. However, when a patient lacks the capacity to make decisions or has advance directives, surrogates should make decisions on their behalf based on the patient's best interests and known, recorded, or expressed intentions and preferences. However, in the event of medical procedures with serious consequences, like life-sustaining support, surrogates should be asked to provide convincing evidence that their decisions are in line with the patient's values, preferences, and interests. This is because there is a high chance that surrogates will misinterpret the patient's values, preferences, and interests, and there may be financial and social conflicts between patients and their surrogates.

3. Principles of Clinical Ethics and Their Application to Practice, Basil Varkey

This review provides an overview of ethics and clinical ethics. The definition and explanation of the four primary ethical principles—beneficence, nonmaleficence, autonomy, and justice—are provided. The autonomy concept underpins informed consent, honesty, and confidentiality, all of which are covered. Conflicts between ethical principles—particularly between beneficence and autonomy—occur frequently in patient care contexts. A four-step methodical approach to ethical problem-solving is offered, along with a number of conflict examples. The ethical concepts involved are highlighted in the comments that follow the examples, which also provide clarification on how these conflicts are resolved. A patient care model with compassion at its core that combines the clinical and technical knowledge that a doctor should possess with ethical considerations (entwined with professionalism) is demonstrated.

4. Ethical conflicts in patient-centred care, Sven Ove Hansson and Barbro Froding

There is no denying that patient-centered healthcare is the way to go. Some of the procedures that are frequently referred to as patient-centered treatment, however, could have unethical repercussions. The adoption of (certain variations of) person-centered care may give rise to twelve ethical problems, which are identified and discussed in this article. These conflicts include, but are not limited to, privacy, autonomy in decision-making, protecting medical quality, and upholding professional equality and equality in treatment. Understanding these possible conflicts can assist choose the best strategy to guarantee that patient demands and interests are the main focus of healthcare. Depending on the type of sickness, the patient's circumstances, and the financial, organizational, and technological resources the healthcare facility has at its disposal, patient-centered care may need to take on many shapes.

5. **The best interest of patients, not self interest': how clinicians understand altruism, Madiha Sajjad, Shazia Qayyum1, Samina Iltaf and Rehan Ahmed Khan**

Acting in "the best interest of patients, not self-interest" is referred to as altruism. The function of altruism in modern medical care is muddled due to the apparent discrepancy between the notion and practice of altruism and the growing focus on "pathologic altruism." In light of this, it is necessary to make clear the proper balance of altruism that medical students must be taught. The practicing clinicians may be the most qualified to handle this issue. The study's goals were to find out how clinicians understood altruism in a therapeutic setting and to pinpoint the essential altruistic ideas that they believed should be incorporated into clinical practice.

6. **Best Interests in the MCA 2005—What can Healthcare Law Learn from Family Law?, Shazia Choudhry**

In English law, the "best interests" test is a very alluring one. In addition to seeming to be pretty uncontroversial, it also presents itself as the most logical, impartial, and "fair" way to handle decision-making on behalf of those who are thought to be the most vulnerable members of society. This article's objectives are to critically evaluate the standard's application in family law, describe how it should be applied in healthcare law, and, lastly, determine how applicable the best interests standard's family law experience is to the standards' operation as intended by the MCA.

7. **What does the best interests principle of the convention on the rights of the child mean for paediatric healthcare?, Julian W. Marz**

One of the most frequently discussed medical ethics and human rights principles, the best interests of the child principle, is examined in this paper along with its consequences for pediatric healthcare. It begins by outlining how the United Nations Committee on the Rights of the Child interprets the best interests principle. Based on this, it identifies potential areas in which the best interests principle could be applied in relation to pediatric healthcare and talks about potential challenges in doing so. Based on this, four case studies that examine moral conundrums in pediatric gynecology, end-of-life care, HIV care, and genetic testing are used to demonstrate the implications of the best interests principle for pediatric healthcare.

1.1.6 Research Scope & Limitations:

The research focuses on the legal framework surrounding the best interest theory in healthcare, with a particular emphasis on its application in cases involving minors, incapacitated individuals, and end-of-life care decisions. The study will analyze case law, legal principles, and ethical considerations from common law jurisdictions, particularly India, the United States, and the UK.

The study will not delve into non-healthcare contexts where the best interest standard is applied & will primarily focus on legal perspectives, with limited exploration of purely medical or bioethical viewpoints.

Chapter 2: MEANING AND EVOLUTION OF THE BEST INTEREST THEORY IN HEALTHCARE

2.1 Overview of the best interest theory

In the healthcare industry, the best interest theory serves as a framework for decisions made on behalf of people who are unable of making their own decisions, such as children, patients who are unconscious, or those who have cognitive disabilities. According to this theory, decision-makers and healthcare professionals must behave in a way that maximizes the patient's well-being while taking into account their social, emotional, and medical needs[1]. It is frequently used in situations where the patient's previous desires or preferences are not readily apparent. In actuality, the best interest criterion entails a comprehensive evaluation of the patient's health, quality of life, possible treatment advantages and disadvantages, and any known values or beliefs the patient may have had.

For instance, the theory directs choices on end-of-life care or stopping life-sustaining therapy to guarantee that the patient's comfort and dignity are given first priority. Applying this theory, however, might be challenging because it calls for striking a balance between conflicting moral precepts like autonomy, beneficence, and nonmaleficence. Courts and medical ethics committees frequently assist in settling conflicts, especially when surrogates or family members cannot agree on what is in the patient's best interests. Although the idea seeks to safeguard those who are most in need, it also presents moral dilemmas, including the possibility of paternalism and biases in judging what is "best." All things considered, the best interest criterion continues to be a pillar of moral judgment in the medical field, guaranteeing that the well-being of patients who are unable to care for themselves is the primary concern.

2.2 Historical development of the best interest principle in healthcare law

1. Early Origins in Common Law: The concept of acting in someone's "best interest" has roots in English common law, particularly in cases involving guardianship and the care of minors or incapacitated individuals[2]. Courts historically acted as parens patriae (parent of the nation), making decisions to protect vulnerable individuals who could not care for themselves.

2. Influence of Medical Ethics: The Hippocratic Oath, one of the earliest ethical codes in medicine, emphasized acting for the benefit of the patient, laying the groundwork for the best interest principle. Over time, medical ethics evolved to prioritize patient welfare, influencing legal frameworks.

3. Legal Recognition in 20th Century: In the early 20th century, the best interest principle began to gain formal recognition in healthcare law. Courts increasingly applied the principle in cases involving minors, mentally ill patients, and those unable to make decisions for themselves. Landmark cases, such as **Prince v.**

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[1] Helen J Taylor, "What are 'best interests' Decision making in clinical practice" *Med Law Rev.* (2016)

[2] *supra note 1 at 6*

Massachusetts[3] in the U.S., reinforced the idea that the state could intervene to protect a child's best interests, even against parental wishes.

4. Mid-20th Century- Expansion in Pediatric and Geriatric Care: The principle became central in pediatric care, with courts and healthcare systems emphasizing the need to prioritize a child's welfare in medical decisions. In geriatric care, the principle was applied to decisions involving elderly patients with cognitive impairments, such as dementia.

5. Advancements in Patient Rights during 1970s-1980s: The rise of the patient rights movement in the 1970s brought attention to autonomy and informed consent. While autonomy became a key focus, the best interest principle remained relevant for individuals unable to make decisions, such as comatose patients or those with severe disabilities.

6. Codification in International Law in 1990s: The best interest principle was formally codified in international instruments, such as the United Nations Convention on the Rights of the Child (1989)[4]. Article 3 of the Convention explicitly states that the best interests of the child must be a primary consideration in all actions concerning children.

7. 21st Century: Integration into Healthcare Policies: The principle has been integrated into national healthcare laws and policies worldwide. For example, the **Mental Capacity Act 2005**[5] in the UK explicitly requires decisions made on behalf of incapacitated adults to be in their best interests.

2.3 Statutory Definitions of "Best Interest"

2.3.1 The Mental Capacity Act 2005[6] (England and Wales) defines "best interest" as a decision that considers the patient's past and present wishes, beliefs, and values, as well as the opinions of family members and caregivers. It also requires an assessment of whether the patient might regain capacity in the future.

2.3.2 Health Care Consent Act 1996[7] outlines that decisions must be made in the patient's best interest, considering their current condition, the potential benefits and risks of treatment, and any previously expressed wishes.

2.3.3 United Nations Convention on the Rights of the Child (UNCRC) 1989[8]**:** The United Nations Convention on the Rights of the Child (UNCRC) defines the "best interests of the child" as a primary

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[3] 321 U.S. 158 (1944)

[4] United Nations Convention on the Rights of the Child,1989, Art. 3

[5] Mental Capacity Act 2005 (Act no. 9 of 2005)

[6] Mental Capacity Act 2005 (Act no. 9 of 2005)

[7] Health Care Consent Act 1996

[8] United Nations Convention on the Rights of the Child (UNCRC) 1989

consideration in all actions concerning children, encompassing decisions made by public or private social welfare institutions, courts of law, administrative authorities, and legislative bodies.

2.3.4 Child Welfare Committee (CWC), "best interest of the child" involves making decisions that prioritize the child's basic rights, needs, identity, social well-being, and physical, emotional, and intellectual development, all while ensuring their safety and well-being.

Chapter 3: PRINCIPLES BEHIND THE THEORY & ITS APPLICATION

3.1 Jurisprudential Foundations of the Best Interest Theory

3.1.1 Utilitarianism: This school of thought encourages deeds that minimize damage and increase well-being for all. According to the best interest theory, choices are made with the patient's physical, emotional, and social requirements in mind in order to maximize their benefit.

3.1.2 Kantian Ethics: The best interest theory's emphasis on upholding the patient's intrinsic dignity and value is consistent with Immanuel Kant's view that people should be treated as ends in and of themselves rather than as means to an end.

Consequentialism: Ethical theories such as consequentialism, including utilitarianism, evaluate actions based on their results rather than intentions. These approaches define morality by how much an action increases a desired "good" or reduces harm. The idea of "best interests" is often tied to consequentialist thinking because making decisions in someone's best interest requires forecasting outcomes such as ensuring greater benefits than drawbacks[9].

Some scholars explicitly connect best interests to utilitarianism, noting that both rely on balancing positive and negative effects to promote well-being. Others suggest that best-interest decisions mirror utilitarian principles by aiming for the most favorable overall result[10]. However, interpretations differ some believe "maximizing good" means strictly prioritizing one key value, while others take a broader view, considering various factors before deciding what's best.

3.1.3 Virtue ethics: This method places a strong emphasis on how moral character influences choices. When deciding what is best for the patient, healthcare professionals and surrogates are supposed to operate with empathy, discernment, and honesty.

3.2 Application of this theory in healthcare

When making decisions for patients who are unable of making their own decisions, such as minors, people in chronic vegetative states, or those with significant cognitive disabilities, the best interest hypothesis is

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[9] Giles Birchley, "The theorisation of 'best interests' in bioethical accounts of decision-making" BMC Med Ethics (2021)

[10] *ibid*

frequently used in the healthcare industry. Its use guarantees that choices put the patient's health, dignity, and general quality of life first. The following are important healthcare domains where this theory is used:

3.2.1 End-of-Life Care and Treatment Withdrawal: When deciding whether to continue, withhold, or stop life-sustaining treatments like artificial nutrition, hydration, or mechanical ventilation for patients who are terminally ill or permanently unconscious, healthcare professionals and surrogates apply the best interest standard[11].

3.2.2 Pediatric Care: Parents and medical professionals must decide what is best for children and minors, especially when the child is unable to give consent for treatment. This covers choices on experimental therapies, life-saving procedures, and surgeries. If the wishes of the parents and the welfare of the child are at odds, the courts may step in[12].

3.2.3 Mental diseases or cognitive impairments: Patients with serious mental diseases or cognitive impairments, like advanced dementia, frequently need surrogate decision-makers to make decisions about their treatment[13]. According to the best interest criterion, interventions or treatments are designed to enhance their quality of life, lessen their suffering, and uphold their dignity.

3.2.4 Emergency Situations: When a patient is unconscious or incapable of communicating, medical professionals use the best interest theory to quickly decide whether to perform life-saving procedures like resuscitation or surgery.

3.2.5 Ethical Conundrums and Conflicts: The best interest norm offers a framework for settling disagreements between surrogates or family members on a patient's treatment. The patient's condition, possible treatment outcomes, and any known preferences or values may be assessed by ethical committees or courts.

3.2.6 Advance Directives and Decision-Making by Surrogates: Surrogates are supposed to act in the patient's best interests when there are no living wills or advance directives[14]. This entails taking into account the patient's present health and prognosis in addition to their prior declarations, convictions, and values.

3.3 Application Of Best Interest Theory In Public Health Law

The Best Interest Theory plays a significant role in public health law, particularly when policies and interventions impact vulnerable populations, including children, the elderly, or individuals with disabilities.

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[11] Julian W. Marz, “What does the best interests principle of the convention on the rights of the child mean for paediatric healthcare?” *European Journal of Pediatrics* (2022)

[12] *ibid*

[13] Ercan Avci, “Protecting Incapacitated Patients’ Rights and Best Interests”, Indian Journal of Palliative Care

[14] Derick T Wade, Celia Kitzinger, “Making healthcare decisions in a person’s best interests when they lack capacity: clinical guidance based on a review of evidence”, Clinical Rehabilitation, Vol. 33(10) 1571 –1585 (2019)

In this context, the theory ensures that public health decisions prioritize the well-being, safety, and long-term health outcomes of individuals and communities. For instance, during public health crises such as pandemics, laws mandating vaccinations, quarantine measures, or resource allocation must balance collective health goals with the rights and needs of individuals.

A well-functioning society strives to support every individual but must balance personal and collective needs. If a community fails to provide for its members, it risks collapse as seen in post-Soviet Eastern Europe. At the same time, individuals must recognize that their own interests may sometimes be restrained for the common good[15]. This compromise ensures that both individuals and communities thrive together. In healthcare decisions such as whether to continue or withdraw treatment decision-makers (like family members) must weigh both survival and quality of life. For instance, prolonging the life of a severely disabled child might sustain biological life but place extreme strain on the family. Likewise, maintaining life support for an unconscious patient with no recovery prospects could be viewed as unjust if those resources could save someone else. In the end, determining a person’s "best interest" requires looking beyond immediate survival to their long-term well-being. However, these judgments are always influenced by the social and familial context in which a person lives.

The Best Interest Theory guides policymakers to consider the disproportionate impacts of such measures on marginalized groups and to design interventions that minimize harm while maximizing benefits. For example, in cases involving children, public health laws related to school closures, immunization programs, or access to healthcare services are evaluated based on how they affect children's physical, emotional, and educational development. By applying the Best Interest Theory, public health law ensures that ethical principles are integrated into decision-making, fostering trust, equity, and the protection of individual rights while advancing the broader goals of public health.

3.4 Ethical Principles

3.4.1 Beneficence[16]: This principle highlights the duty to behave in a way that advances the welfare and well-being of other people. Beneficence in healthcare demands that decisions for patients who are incapacitated be made with their health, comfort, and quality of life in mind.

3.4.2 Nonmaleficence[17]: The principle of nonmaleficence, which is closely linked to beneficence, requires healthcare workers to refrain from doing harm. The best interest theory makes sure that procedures or therapies don't cause needless pain or danger.

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[15] Dr. Trau, “Health progress in the best interest of the patient”, *Journal of the catholic health association of the United States* (1993)

[16] Common Ethical Issues In Healthcare: Identifying & Navigating Them, *available at:* https://www.sermo.com/ (last visited on 30th March 2024

[17] *ibid*

3.4.3 Respect for Dignity: According to the principle, every person has inherent worth and dignity, thus decisions should respect the patient's humanity even if they are unable to communicate their desires.

3.5 Legal Principles

3.5.1 Parens Patriae Doctrine: The legal principle known as the Parens Patriae Doctrine gives the state the power to act as a guardian for people who are incapable of taking care of themselves, such as children or adults who are incapacitated. This theory is frequently used by courts to decide cases in the best interests of those who are most in need. It allows the state to act as a protector for individuals who cannot care for themselves, such as children, the mentally ill, or incapacitated adults. Rooted in the idea that society has a responsibility to safeguard vulnerable populations, this doctrine empowers courts and government agencies to intervene when necessary. Under the Best Interest Theory, decisions made under Parens Patriae must prioritize the well-being of the individual rather than personal preferences or external pressures. For example, in child custody cases, courts may override parental rights if evidence shows abuse or neglect, ensuring the child's safety and development. Similarly, in cases involving severe mental illness, judges may authorize involuntary treatment if it is deemed essential for the person's health and safety. The doctrine balances state authority with ethical obligations, ensuring that interventions are justified, proportionate, and truly in the individual's best interest.

3.5.2 Informed Consent and Autonomy: Although autonomy is a fundamental component of medical ethics, in situations where autonomy is not possible, the best interest theory takes precedence. When patient autonomy is lacking, due to cognitive impairment, unconsciousness, or mental illness, legal frameworks like the Mental Capacity Act[18] (UK) offer principles for surrogate decision-making, ensuring choices align with what the patient would have wanted (substituted judgment) or, if unknown, what is objectively best for them. For instance, if a dementia patient cannot consent to life-saving surgery, doctors and family members must weigh medical benefits, risks, and quality of life to determine the most ethical course of action[19]. While autonomy is respected whenever possible, the Best Interest Theory ensures that vulnerable individuals are not left without protection, upholding both medical ethics and legal accountability.

3.5.3 Guardianship and Surrogate Laws: Under the best interest criteria, several jurisdictions have laws allowing family members or legal guardians to make decisions for incompetent people. When individuals cannot make decisions for themselves, guardianship and surrogate laws allow appointed representatives such as family members, legal guardians, or court-appointed advocates to act on their behalf. These laws operate under the Best Interest standard, requiring decisions to promote the individual's welfare, dignity, and long-term needs. For example, if an adult with a severe intellectual disability requires medical treatment, a guardian

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[18] Mental Capacity Act 2005 (Act no. 9 of 2005)

[19] Basil Varkey, "Principles of Clinical Ethics and Their Application to Practice", Med Princ Pract 30:17–28 (2021)

may consent after consulting doctors and considering the person’s past preferences (if known). Different jurisdictions have varying legal frameworks, but most emphasize safeguards against abuse, such as court oversight for major decisions. The Best Interest Theory ensures that surrogate decisions are not arbitrary but instead grounded in compassion, evidence, and ethical responsibility, protecting the rights of those who cannot advocate for themselves.

3.6 Application of Best Interest Theory by United Nations Convention on the Rights of the Child (UNCRC)

The United Nations Convention on the Rights of the Child (UNCRC) applies the Best Interest Theory as a foundational principle to ensure that all actions concerning children prioritize their rights, well-being, and development. Central to this application is **Article 3**[20], which mandates that the best interests of the child must be a primary consideration in all decisions by governments, courts, administrative bodies, and social institutions. This principle is integrated into various areas, including legal and policy frameworks, where it guides laws and practices affecting children. It also plays a critical role in child-centered decision-making, ensuring that children's safety, education, healthcare, and development are prioritized. The UNCRC emphasizes protection from harm, requiring measures to safeguard children from violence, abuse, and exploitation. Additionally, the Convention highlights the importance of children's participation, as outlined in **Article 12**[21], ensuring that their views are considered in matters affecting them, in line with their age and maturity. The Best Interest Theory is also applied in family and alternative care settings, ensuring that decisions about custody, foster care, and adoption promote the child's emotional and physical well-being. In areas like education, health, and juvenile justice, the principle ensures access to quality services, restorative justice, and opportunities for holistic development. Furthermore, it protects refugee and migrant children, prioritizing their safety and legal status. Through monitoring and accountability mechanisms, the UNCRC ensures that governments uphold this principle, with the Committee on the Rights of the Child providing oversight. Overall, the UNCRC's application of the Best Interest Theory creates a comprehensive framework to protect and promote the rights and welfare of every child.

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[20] United Nations Convention on the Rights of the Child (UNCRC), Art. 3

[21] United Nations Convention on the Rights of the Child (UNCRC), Art. 12

Chapter 4: ANALYSIS OF RELEVANT LEGISLATIONS

4.1 Mental Capacity Act 2005[22]

In order to safeguard and empower people 16 years of age and older who might not have the mental capacity to make their own decisions, the United Kingdom passed the Mental Capacity Act 2005 (MCA). In order to make decisions on behalf of these people and guarantee that their autonomy and rights are upheld, it offers a legal framework. In order to help people with diseases like dementia, learning disabilities, brain injuries, or mental health concerns make decisions, the MCA is frequently utilized in healthcare, social care, and legal settings. It guarantees that choices are made morally, legally, and with consideration for each person's rights and dignity.

4.1.1 Overview:

Presumption of Capacity: Until the contrary is demonstrated, it is necessary to presume that every adult has the capacity to make their own judgments.

Assistance in Making judgments: Before determining that someone lacks capacity, they must be offered every reasonable assistance in making their own judgments.

Freedom to Make Irrational Decisions: Just because someone makes a choice that other people believe to be foolish or illogical does not mean that they lack capacity.

Best Interests: Any choice or action done on behalf of a person who is incapable of making decisions for themselves must be in their best interests.

Least Restrictive Option: Every choice or course of action must minimize the restrictions on a person's liberties and rights.

4.1.2 Key Provisions of the Act:

Definition of Mental Capacity:

A person lacks capacity if, at the time a decision needs to be made, they are unable to:

Understand the information relevant to the decision, Retain that information, Weigh the information as part of the decision-making process, or Communicate their decision (by any means).

Best Interests Checklist:

When making decisions for someone who lacks capacity, decision-makers must:

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[22] Mental Capacity Act 2005 (Act no. 9 of 2005)

Consider the person’s past and present wishes, feelings, beliefs, and values, consult with family members, caregivers, or others interested in the person’s welfare & avoid discrimination and consider all relevant circumstances.

Lasting Power of Attorney (LPA):

The Act allows individuals to appoint an LPA to make decisions on their behalf if they lose capacity in the future. There are two types of LPA:

Property and Financial Affairs: Decisions about money, property, and assets.

Health and Welfare: Decisions about medical treatment, care, and daily life.

Independent Mental Capacity Advocate (IMCA):

For individuals who lack capacity and have no family or friends to consult, an IMCA can be appointed to represent their interests in significant decisions, such as changes in accommodation or serious medical treatment.

Court of Protection:

This specialized court handles disputes or complex decisions regarding individuals who lack capacity. It can:

Make decisions on behalf of the person.

Appoint deputies to manage ongoing decisions about health, welfare, or finances.

Advance Decisions to Refuse Treatment (ADRT): The Act allows individuals to make legally binding decisions in advance about refusing specific medical treatments if they lose capacity in the future.

Deprivation of Liberty Safeguards (DoLS): These safeguards protect individuals who lack capacity and are deprived of their liberty in care homes or hospitals. They ensure that such restrictions are lawful, necessary, and in the person’s best interests.

4.2 Patient Self-Determination Act 1991[23]

A federal law in the United States, the Patient Self-Determination Act (PSDA) was passed in 1991 with the goal of defending and advancing patients' rights to make educated decisions about their medical treatment, especially when it comes to end-of-life circumstances. Healthcare establishments like hospitals, assisted living facilities, and hospice programs that receive federal financing are covered by the PSDA.

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[23] Patient Self-Determination Act 1991

4.2.1 Objectives:

By ensuring that patients are aware of their rights to make decisions regarding their medical treatment, the PSDA seeks to empower them. The act supports patient autonomy and honors personal preferences by promoting the adoption of advance directives, even in cases where the patient is no longer able to communicate. By giving precise instructions about the patient's desires, the act lessens disputes between family members, surrogates, and medical professionals. The PSDA seeks to enhance the standard of care and guarantee that patients receive treatments that are in line with their beliefs and objectives by promoting conversations regarding end-of-life desires.

4.2.2 Key Provisions:

Preliminary Directives: Advance directives are legal agreements that specify a patient's choices for medical treatment in the event that they are unable to communicate or make decisions for themselves. The PSDA mandates that healthcare facilities notify patients of their right to draft these forms.

Living wills, which outline preferred medical procedures, and durable power of attorney for healthcare, which names a surrogate decision-maker, are common forms of advance directives.

Patient Instruction: Healthcare professionals are required by state law to inform patients of their rights to make prior directives and to accept or reject medical treatment. Usually, this information is given when a patient is admitted to a medical facility.

Nondiscrimination: Healthcare facilities are not allowed to treat patients differently because of whether or not they have an advance directive, according to the PSDA.

Patients' choices about advance directives cannot result in them being denied care or receiving altered treatment.

Policies and Procedures: In order to comply with the PSDA, healthcare facilities must create documented policies and procedures that include teaching staff and the public about advance directives.

4.3 Medical Termination of Pregnancy Act 2021[24]

The legal framework in India that regulates the circumstances under which a pregnancy can be lawfully ended is known as the Medical Termination of Pregnancy (MTP) Act. The MTP Act, which was first passed in 1971 and then revised in 2021, attempts to make abortion services safe and lawful. The Act is based on the idea of protecting the pregnant person's best interests by making sure they are healthy, independent, and happy. Pregnancy termination is permitted under the MTP Act up to 24 weeks into the pregnancy. The Act outlines

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[24] Medical Termination of Pregnancy (Amendment) Act 2021, (Act No 8 of 2021)

the circumstances in which a pregnancy may be ended, such as threats to the expectant mother's physical or mental well-being, fetal abnormalities, or pregnancies brought about by rape or unsuccessful contraception.

4.3.1 Alignment with best interest theory

The MTP Act supports the best interest theory, which places the autonomy and well-being of the expectant mother first. It acknowledges that carrying a pregnancy to term may provide serious hazards to one's physical, mental, or social well-being and offers a legal avenue to address these issues. The Act guarantees that choices for pregnancy termination are made with the pregnant person's health, situation, and rights in mind. The pregnant person's consent is required by the Act. A guardian's consent is required for children or people with mental impairments. The Act protects the anonymity and privacy of the person seeking an abortion.

Chapter 5: ETHICAL AND LEGAL CONFLICTS IN THE APPLICATION OF THE BEST INTEREST THEORY IN HEALTHCARE

5.1. Subjectivity in Determining Best Interests: The concept of "best interest" is inherently subjective and can vary based on cultural, religious, and personal values. Healthcare providers may prioritize medical outcomes, while families may focus on quality of life, emotional well-being, or spiritual considerations. This divergence can lead to disagreements over treatment plans, such as life-sustaining interventions versus palliative care. One of the primary ethical and legal challenges in applying the Best Interest Theory is the inherent subjectivity in defining what constitutes a patient’s "best interest." Unlike objective medical diagnoses, best interest assessments often involve value judgments influenced by cultural, religious, familial, and personal biases. For instance, in end-of-life care, one family may prioritize life extension at all costs, while another may prioritize comfort and dignity. Similarly, courts and healthcare providers may interpret "best interest" differently, leading to inconsistent rulings. This subjectivity raises concerns about fairness, transparency, and potential paternalism, where decision-makers impose their own beliefs rather than truly considering the patient’s unique needs. Legal frameworks attempt to mitigate this by requiring multidisciplinary consultations, but disagreements can still arise, highlighting the difficulty of balancing medical, ethical, and personal perspectives.

5.2. Conflicts with Patient Autonomy: The Best Interest Theory may override a patient's autonomy, especially in cases involving incapacitated adults or minors. Previously expressed wishes (e.g., advance directives or living wills) may conflict with what healthcare providers or families deem to be in the patient's best interest. This raises ethical concerns about respecting an individual's right to self-determination[25]. While the Best Interest Theory aims to protect vulnerable individuals, it can sometimes clash with the principle of autonomy, particularly when a patient’s previously expressed wishes conflict with current medical or legal judgments. For example, a Jehovah’s Witness may have clearly refused blood transfusions in advance, but in

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[25] Sven Ove Hansson, Barbro Froding, “Ethical conflicts in patient-centred care”, Clinical Ethics, Vol. 16(2) 55–66 (2021)

an emergency, doctors might argue that administering blood is in their best interest to save their life[26]. Similarly, patients with fluctuating mental capacity (e.g., due to schizophrenia or dementia) may have moments of lucidity where they reject treatment, raising ethical dilemmas about when to override their autonomy. Legal systems often rely on advance directives or substituted judgment to resolve such conflicts, but when these are absent, the tension between respecting autonomy and enforcing "best interest" decisions remains a significant ethical challenge.

5.3. Disputes Between Healthcare Providers and Families: Families may have different perspectives on what constitutes the patient's best interest, leading to conflicts with healthcare professionals. For example, families may refuse certain treatments due to religious beliefs, while healthcare providers may view those treatments as medically necessary. Another major conflict arises when healthcare providers and family members disagree on what constitutes the patient's best interest[27]. Medical professionals may recommend evidence-based treatments, while families might refuse them due to cultural, religious, or emotional reasons. For instance, parents refusing chemotherapy for a child with cancer in favor of alternative therapies could trigger legal intervention under the Parens Patriae doctrine. Conversely, families may demand aggressive, potentially futile treatments against medical advice, leading to ethical dilemmas about resource allocation and suffering. These disputes often require ethics committees, mediation, or court intervention, prolonging decision-making and sometimes causing distress for all parties involved[28]. The challenge lies in balancing professional medical judgment with familial emotional investment while keeping the patient's welfare central.

5.4. Balancing Collective and Individual Interests: Public health interventions, such as mandatory vaccinations or quarantine measures, may conflict with individual best interests. Balancing public health goals with individual rights can create ethical and legal tensions. The Best Interest Theory primarily focuses on the individual, but healthcare decisions sometimes involve broader societal or institutional considerations, creating ethical tension[29]. For example, during a public health crisis (e.g., a pandemic), treating a critically ill patient with limited resources may conflict with the needs of other patients. Similarly, mental health laws permitting involuntary hospitalization for safety reasons may prioritize public security over personal liberty. Additionally, cost constraints in publicly funded healthcare systems may influence decisions about expensive treatments, raising questions about whether "best interest" should be purely patient-centered or include systemic sustainability. These conflicts highlight the difficulty of reconciling individual rights with collective well-being, requiring transparent policies and ethical guidelines to ensure fairness and accountability.

5.5 Judicial Pronouncements

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[26] *ibid*

[27] *supra note 13 at 19*

[28] *ibid*

[29] *supra note 15 at 12*

Bolam vs Frien hospital management committee[30] [1957] 1 WLR 582

Facts: An epilepsy patient agreed to undergo treatment in the said hospital. There were more than one treatment process but the doctor had communicated only one. The patient was given shock therapy after which he started to suffer more. A suit was filed on the ground of medical negligence.

Issue: Whether the patient gets to decide his process of treatment or the doctor being more qualified should decide the process?

Judgement: It was decided that the hospital cant be held liable since he agreed to go through shock therapy (volenti non fit injuria). If the medical practitioner believes that a particular treatment is best, even if it fails the doctor cant be held liable.

Lee vs Montgomerry[31] 1969 624 So. 2d 850

Facts: A pregnant woman went for delivery with some complications. The doctor was personally against the concept of C section delivery & went on to perform normal delivery. The child's shoulder was unable to come out due to the mother's complicated pregnancy. The baby was born with severe difformity.

Held: The court overruled Bolam's decision & held that the doctor has to inform the patient about all the available choices in the best interest of the patient.

Airedale NHS Trust v Bland[32][1993] AC 789 (UK)

Facts: When Bland was 17 1/2 years old, he was hurt in the Hillsborough Field soccer incident. Since then, he has remained in a permanent vegetative state and shows no prospects of recovering. He is able to breathe on his own, but he needs a feeding tube, a lot of antibiotics, and constant attention to keep him healthy. His parents have urged the doctors to remove the feeding tube in order to end his life since they believe he would not want this. His guardian appealed the lower courts' decision to enable the tube to be removed.

Issues: When a patient is unable to give informed permission, can life support be removed from them?

Judgement: The moral dilemmas raised by this choice trouble the Lords. They assert that Bland's survival is undeniable and that, generally speaking, the principle of self-determination must take precedence over the sanctity of human life. Additionally, physicians typically have an obligation to act in their patients' best interests. However, they assert that doctors do not have an unqualified and absolute obligation to prolong patients' lives, especially when doing so requires intrusive and risky operations. Furthermore, it's critical to distinguish between situations in which medical professionals actively aid in dying (euthanasia) and those in

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[30] [1957] 1 WLR 582

[31] 1969 624 So. 2d 850

[32] [1993] AC 789 (UK)

which they merely refrain from carrying out life-prolonging measures. If the necessary treatment is extremely invasive, doctors are never compelled to do it in order to keep a patient alive.

Aruna Shanbaug v Union of India[33] (2011) 4 SCC 454

The Supreme Court of India addressed the issue of passive euthanasia and the best interests principle in the context of a patient in a persistent vegetative state (PVS). Aruna Shanbaug, a nurse who had been in a PVS for 37 years following a brutal assault, became the focal point of the case when a petition was filed seeking permission to withdraw life support, arguing that her continued existence was undignified and against her best interests. The Court, while rejecting the plea for euthanasia in this specific case, laid down guidelines for passive euthanasia in India. It held that passive euthanasia (withholding or withdrawing life-sustaining treatment) could be permitted in certain circumstances, provided it was in the best interests of the patient and approved by a High Court following due process. The Court emphasized that decisions must be made based on the patient’s best interests, considering their dignity, quality of life, and previously expressed wishes, if any. This landmark judgment recognized the concept of passive euthanasia in India, balancing the right to die with dignity against the need to protect vulnerable individuals.

Gillick v West Norfolk and Wisbech AHA [1986] AC 112 (UK)

Facts: Mrs. Gillick had five daughters, one of whom, when she was too young to legally consent to sexual activity, sought and received contraceptive advice from a local doctor. In accordance with the Department of Health and Social Security's guidelines, this advice was given. Among other reasons, Mrs. Gillick requested that the court declare the Department's guidelines illegal because they negatively impacted parental rights and responsibilities.

Issues: The landmark Gillick ruling brought up several intricate legal questions. First and foremost, the House of Lords was asked to decide how much parental authority there was over a minor child, as well as when and whether the minor may be advised to use contraception or consent to medical treatment against their parents' knowledge or preferences. Ultimately, the question of whether a doctor who gives counsel or contraceptives to patients who are young would be guilty of a crime while performing their therapeutic duties has to be decided.

Judgement: The request for a declaration was turned down. Except inasmuch as it was required to protect a minor's best interests, parental rights did not exist as such. A minor may occasionally be able to offer permission on their own, independent of their parents' knowledge or consent. A minor who exhibits "sufficient understanding and intelligence to understand fully what is proposed" will be allowed to consent to treatment,

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[33] (2011) 4 SCC 454

according to Lord Scarman's test. The test, which is now frequently called "Gillick competence," is essential to family law and medicine.

Re A (Children) (Conjoined Twins: Surgical Separation)[34] [2001] 2 WLR 480 (UK)

Facts: Conjoined twins M and J's parents contested a judgment that would have allowed for their surgical separation, which would have killed M. M needed her sister to give her blood because she had serious brain problems and no lungs. However, J was operating normally in all pertinent areas.

Issues: On the grounds that the judge had erred in concluding that the operation was in the best interests of both children, the parents filed an appeal. In addition to addressing this and the implications of culpability should the operation proceed, the Court of Appeal was asked to determine whether this was the case (if necessity would afford a defense).

Judgement:

(1) The court must decide the case solely in terms of the children's welfare, even though the parents' opinions should be respected.

(2) In this regard, the trial judge erred in implying that since all life had equal value, the separation would be advantageous to both children. In these conditions, M's life was just as precious as J's, hence the operation could not be in her best interests.

(3) After weighing the children's interests against each other, the court determined that J had the better of the two.

Because the three requirements to raise a defense of necessity were met, the operation would not be considered murder: (a) the act was necessary to prevent an irreparable evil; (b) the steps taken were no more than reasonably necessary to accomplish this; and (c) the harm caused was not disproportionate to the harm avoided.

Cruzan v Director, Missouri Department of Health[35], 497 U.S. 261 (1990)

The U.S. Supreme Court addressed the issue of whether a state could require clear and convincing evidence of an incompetent patient's wishes before allowing the withdrawal of life-sustaining treatment. Nancy Cruzan, in a persistent vegetative state after a car accident, had no written directive, and her parents sought to terminate her artificial nutrition and hydration, claiming it aligned with her prior informal statements. The Court held that while a competent person has a constitutional liberty interest under the Due Process Clause to refuse medical treatment, this right does not automatically extend to incompetent individuals. Missouri's requirement

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[34] [2001] 2 WLR 480 (UK)

[35] 497 U.S. 261 (1990)

of clear and convincing evidence to prove an incompetent patient's wishes was deemed constitutional, as the state has a legitimate interest in preserving life, preventing abuse, and ensuring accurate decision-making. The Court emphasized that the risk of error in such cases should favor the preservation of life, as an erroneous decision to withdraw treatment is irreversible. It also ruled that the Due Process Clause does not mandate the acceptance of "substituted judgment" by family members without substantial proof of the patient's wishes. Ultimately, the Court found that Cruzan's prior statements were insufficient to meet the clear and convincing standard, upholding Missouri's strict evidentiary requirements. This case established important precedents regarding end-of-life decisions, balancing individual autonomy with state interests in protecting life and preventing abuse.

Chapter 6: CONCLUSION AND RECOMMENDATIONS

6.1 Suggestions for Maintaining the Application of Best Interest Theory in Public Healthcare

To ensure the effective application of the Best Interest Theory in public healthcare, a multidisciplinary approach is essential. First, standardized guidelines should be developed to define "best interests" clearly, incorporating medical, ethical, and cultural considerations while minimizing subjectivity. Second, training programs for healthcare professionals on ethical decision-making, legal frameworks, and cultural competence can enhance consistency in applying the theory. Third, interdisciplinary ethics committees should be established to review complex cases, ensuring balanced decisions that respect patient autonomy, dignity, and societal interests. Fourth, advance care planning should be promoted to document patient preferences in advance, reducing conflicts in surrogate decision-making. Finally, public awareness campaigns can educate communities about patient rights and the role of the Best Interest Theory, fostering trust and transparency in healthcare systems. By integrating these measures, public healthcare can uphold ethical standards while addressing the diverse needs of vulnerable populations.

6.2 Conclusion

The Best Interest Theory serves as a critical framework in healthcare decision-making, particularly for vulnerable populations such as minors and incapacitated adults, ensuring their well-being is prioritized when they cannot advocate for themselves. However, its application is fraught with ethical and legal complexities, as seen in conflicts between medical judgment, patient autonomy, and surrogate decision-making. Statutory frameworks like the Mental Capacity Act 2005 (UK), the Patient Self-Determination Act 1991 (US), and the Medical Termination of Pregnancy Act 2021 (India) provide structured guidance, yet challenges persist due to the subjectivity of defining "best interests" and balancing competing values. Case studies, such as Aruna Shanbaug v. Union of India and Cruzan v. Missouri Department of Health, highlight the delicate interplay between dignity, autonomy, and state interests. To address these challenges, recommendations include enhancing ethical training for healthcare professionals, promoting advance directives, establishing interdisciplinary ethics committees, and refining legal standards to accommodate cultural and religious diversity. By fostering a more transparent, patient-centered approach, the healthcare system can better navigate these dilemmas, uphold patient rights, and mitigate conflicts, ensuring that the Best Interest Theory remains a compassionate and equitable tool in medical practice.

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