In the Patient's Best Interest — A Call to Action, A Call to Balance

by Norma J. Hirsch

Nurses, physicians, and other healthcare professionals often complain that a loss of freedom or other obstacles hinder their ability to act in the best interest of the patient. These barriers cause professional burnout and moral outrage, and may contribute to a migration away from medicine or, more broadly, healthcare. Understanding the historical underpinnings of the phrase "in the patient's best interest," and realizing that healthcare, which is fundamentally a moral enterprise must be built on sound business principles can help healthcare professionals reframe the issue, and reclaim their original commitment to a difficult path.

Practically everyone is aware that many nurses, physicians and other healthcare professionals have left their practices in recent years. The complete picture of this migration remains to be painted. While the reasons given are myriad, they often focus on moral distress: the struggle encountered in trying to do what an individual believes is in the patient's best interest.

One aspect of that migration, the move of healthcare professionals away from the hospital to the outpatient environment highlights the desire for more healthcare provider freedom in advocating on behalf of patients' best interests. If healthcare providers can create a balance between those who have claims on their time and expertise and those who do not presently support their efforts to act in the patient's best interest, perhaps some professional burnout can be eliminated, some moral outrage minimized, and some defections reversed.

Historically, physicians were obliged, indeed took an oath, to act "in the patient's best interest." That is, prior to the modern era in which technology has become central to the practice of medicine, physicians could and often would make unilateral decisions to undertake a palliative care approach designed to provide comfort, rather than cure, to serve their patients' best interest. Yet, on further examination their use of the construct "in the patient's best interest" seems quite different from the one currently in use. One could readily argue that their decisions often represented both the best interest of the greater community and the individual patient.

After a wave of technological advances, the phrase "in the patient's best interest" was narrowed to apply only to interests expressed by autonomous patients. "In the patient's best interest" usually meant whatever would prolong the patient's life. Physician paternalism was replaced by patient autonomy, an autonomy heavily undergirded by the assumption that all patients will want every possible intervention to prolong their lives.

More recently, as economics begins to play a key role in healthcare decisions and our culture grows more diverse, it is increasingly difficult to discern the patient's best interest from the

patient's perspective and more challenging to implement from the community's perspective. It is almost as though we have come full circle – from medical decisions made by paternalistic physicians in the best interest of the patient in a community context, to decisions made by the autonomous patient with little regard for the larger community, back to a consideration of the patient's best interest as part of the larger community. The current context is complicated by the complexity of modern healthcare with its more challenging medical decisions. Further, it is often difficult to know who is entrusted to speak for the larger community — the solitary voice of the patient's physician and the voice of the individual patient have become difficult to hear over the cacophony of multiple voices.

Before trying to tease these very complex and multifaceted issues apart, it is important to recall that healthcare is foremost a moral enterprise. Despite initiatives that might suggest otherwise, healthcare cannot be reduced solely to a business.

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But neither can medicine, or more broadly healthcare, provide fair access while ignoring sound business practices. To fully meet patient needs, the profession's moral foundation and sound business principles must be engaged.

Understanding the Ethical Challenge

Having argued that changes in the delivery of healthcare have altered the construct of "in the patient's best interest," it is appropriate to consider the ethical challenges that result from these changes. Ethical challenges in clinical medicine can be divided into three general types: moral dilemmas, moral distress, and moral dissonance.

Dilemmas

A moral dilemma is present when a situation involves choices between equally satisfactory or unsatisfactory options. A moral dilemma exists when persons disagree about what is in the patient's best interest (e.g., whether or not to withdraw mechanical ventilation, or initiate a DNR order.) Earlier, the supposed Solomonic wisdom of the physician was sought to make these challenging decisions. But when the number of moral dilemmas increased as a consequence of advancing technology and other changes in healthcare, clinical ethics committees were developed as a better way to address the patient's best interest. The clinical ethics committee provides varying perspectives, diverse skills, and comprehensive tools as well as methods for resolving significant disagreement about how to proceed when there is no right answer, but a selection of possible choices, depending on one's vantage point and perspective.

Distress

In contrast to a moral dilemma, moral distress is reflected in painful feelings or the psychological disequilibrium that healthcare providers encounter when confronted by a situation in which the healthcare provider believes that he or she knows the ethically ideal action to be taken (in the patient's best interest) but is unable to carry out that action. Moral distress occurs frequently, often placing healthcare providers in situations in which various factors or systemic obstacles beyond their control prohibit them from doing the right thing; or where doing the right thing can place them in personal jeopardy.

Moral distress is, in part, a consequence of the transition from support of the patient's best interest through patient autonomy and rugged individualism to promoting justice in healthcare and a heightened recognition of communal life. The obstacles that induce moral distress include such things as limited financial backing, scarce resources, legal limitations, institutional policies, and other barriers.

Examples of situations resulting in moral distress include individuals assigned to work in an area for which they have inadequate training to provide for the patient's best interest; resident

physicians who lack adequate supervision to make optimal clinical decisions; patients discharged prematurely because of insurance company constraints, and testing or research that is done without the patient's informed consent.

Dissonance

More recently a new kind of challenge to a healthcare provider's efforts to respond "in the patient's best interest" has arisen. This challenge is best described as a clash that results from differences in the beliefs and values of those who participate in the decision-making process. This challenge has been termed *moral dissonance*. Examples of moral dissonance arising out of cultural, religious, ethnic, or other differences include the care of healthcare providers who are asked to forgo their basic moral constructs to serve the patient's best interest as defined by a different moral and cultural understanding.

This dissonance can be especially troubling for a healthcare professional should decisions be taken that lead to the death of the patient simply because the patient's family did not put all available modalities of healthcare intervention above other competing interests. Examples of moral dissonance include a family member's decision overriding a patient's personal autonomy, forgoing pain management or the treatment of a preterm infant because of potentially damaging financial consequences.

In an oversimplified and somewhat incomplete way, moral dilemmas have an individual basis, moral distress has an institutional basis, and moral dissonance has a societal basis. Recognizing the differences in the origin of these moral challenges and their potential impact on the patient's best interest yields a clearer understanding of why different approaches are needed to address them effectively.

Moral dilemmas cause us to focus on making the best decision for the patient from the patient's perspective. For many years this goal was shared by all in the helping professions. Everyone was searching for the good seen as the patient's best interest.

Competing Claims

In more recent years, we have been forced to make choices in which the best interest of the individual patient is but one of many claims made on us. The responsibility to serve both the individual patient and the good of others often causes moral distress. It requires healthcare providers to determine, not only (the best) quality of care for the individual, but also the cost of that care to the system (society) and the impact of that care on others' access to healthcare.

In the case of moral dissonance, we are sometimes asked to work counter to our own values in order to provide care that we judge to be suboptimal at its best and counter to the best interest of the patient at its worst. We are often being asked to weigh relative priorities in a cultural system about which we know little and therefore lack a valid perspective from which to act in the patient's best interest.

The fundamental change in this process is a marked increase in ambiguity. Ambiguity is especially difficult for medical professionals who constantly seek to eliminate it through scientific precision. As long as clinicians believed that they were championing the patient's best interest at the bedside, mutual respect prevailed, regardless of the outcome. Individuals could rally around the premise that each decision was based on a notion of the patient's best interest, even when not everyone agreed on what this best interest was. In contrast, the ambiguity of trying to address an individual patient's needs in the context of seeking to provide justice for all claimants is challenging at times and confounding at others.

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Cost Containment

Cost containment issues have been and are par-

ticularly difficult for healthcare providers, often because cost containment is believed to negatively impact the quality of care. Many believe that it is foundationally unacceptable to sacrifice quality (and quantity) to provide access. More recently, the balance between cost on the one hand and quality and access on the other has been foundationally challenged and in some instances irrevocably shifted.

There have been many and great financial and nonfinancial costs to this fundamental shift: the incidence and severity of moral distress have escalated with increasing numbers of departures from medicine, nursing, and other healthcare professions. Others have moved from hospital to nonhospital venues where healthcare professionals are perceived to have more autonomy and the ability to work primarily for the patient. Some argue that quality of care has declined, medical mistakes have increased, and patients have been placed (unnecessarily) at risk. Others argue that there have been and are many negative impacts to the recent restructuring of the healthcare delivery system in this country — for patients and healthcare providers.

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Whatever one's individual assessment of the consequences resulting from these system changes it seems clear that we cannot solve our current problems with the tools of yesterday. Indeed today's problems are a consequence of yesterday's solutions. The healthcare delivery system can no longer avoid the open conflict between the best interests of the patient as manifested in patient autonomy and the best interests of the community in which the patient resides. It must address these conflicts by asking better questions. Not "What is in this patient's best interest?" but "What is in this patient's best interest in the context of his or her community?" The issue has always been with us. But who addresses the issue? In what venue, and how visible is the discernment process and the need for change?

Taking Responsibility

An effective response to the challenge may require nothing less than the respiritualization of medicine. At a minimum we must recognize our participation in the problem. Our abdication helped create the problem by ceding economic decisions to those who were least capable of making them, and by refusing to lend our knowledge and expertise to the cost containment process. We argued that we had to stay focused on making life and death decisions but failed to reflect on the fact that the allocation of resources is also a life and death decision.

In some instances we kept prices high by arguing that we were advocating for quality. We must understand, however, that higher cost does not necessarily assure better quality. Nor does cost containment necessarily mean lower quality. We must admit our part in the evolution of the problem and understand that blaming someone else for the problem will not fix the system, or respond to the patient's best interest.

Finally, we know from clinical practice that taking the victim's role is not a position of strength. Though healthcare professionals may vehemently resist the notion that they perceive themselves as victims, they are vulnerable to perceiving themselves as part of an oppressed group. Once one succumbs to seeing oneself as oppressed, loss of trust and destructive behaviors quickly follow.

Using the Power of One

We must clearly recognize and regularly use the power of one. During this changing and difficult time in the practice of medicine, we must challenge the prevailing winds. We need to say yes when others say no, and vice versa! A quick test of one's willingness to exercise the power of one is

the simple question: When did you last bump up against a firm no? One who declines to act because the anticipated response is "No!" forfeits one's own power and the ability to empower others.

Healthcare professionals must learn to reframe the chaos. In nature we learn quickly that chaos can lead to breakdown or breakthrough. We are well advised, then, to use our clinical skills to help shape the issues. We must recognize that the outcome of chaos depends on how we view and use chaos. Does it push one toward breakdown, or do we use it to empower breakthrough? Thoughtful action is one of the best ways to manage the anxiety that chaos creates, because action gives us hope that things can change, that breakthrough is possible. Allowing the fear of breakdown to inhibit our management of chaos paralyzes us. So long as we retain the ability to act, we nurture hope, and expand the possibilities.

Hope has great tensile strength, but it is also vulnerable. Recognizing hope's vulnerability reminds us that we must seek occasions and create times to celebrate our successes. Celebration recognizes that past action can empower a better present and engender hope for a better future. In a similar vein, we must recognize that acting in the patient's best interests will not be possible, if we do not also attend to our own well-being – physically, mentally, emotionally, and spiritually.

If we are to stem the growth of moral distress (and its negative consequences), we must reconnect with what brought us to medicine or healthcare in the first place. We must be open to the development of new skills and tools, new approaches to increasingly difficult problems. The skills and tools that we use well to address moral dilemmas will not suffice for reckoning with moral distress and moral dissonance. In the latter cases, we address a more complex question: "What is in the patient's best interest in the context of the larger community?"

Holding On

During this time of chaotic change, it is profoundly important to remember that change agents cannot look for approval from the group they are trying to change. We must stop individually and collectively disappearing into our roles. If we choose to serve the change by exercising our power, rather than being paralyzed by our fear, we can expect to be told "No!" at times. Despite disapproval in the prevailing environment, we must know and act on our beliefs. Healing will not be accomplished quickly; we must be both patient and persistent.

Likewise, it is wise to remember that healing is not the same as fixing. What it takes to heal the current diseased — some would say agonal — status of the healthcare system will not be the same thing that it takes to fix it; that is, to restore the system to its former state. As with some patients, the healthcare system that we knew in the 1990s cannot be fixed; it cannot be returned to its former state. It can only be healed. We must find meaning in the potential for healing, even when cure (fix) is not possible. We can avoid the pain, learn from the pain, or simply get through the pain. The choice is ours, and the outcome of each choice is quite different.

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As healthcare providers we may find it difficult to hear and acknowledge that we have contributed to the problem by abdicating our responsibility. We have lost trust in the system and in others, sometimes even in ourselves. We have become disorientated by the pace of change and the accompanying chaos. We have become overwhelmed by the pain — ours and others. Despite the odds that face us, however, we have some power: we can and must continue to advocate in the patient's best interest, but in a broader context.

We cannot resolve moral distress nor eliminate moral dissonance by using our heads alone; we must engage our hearts as well. We must recognize that succumbing to our fear paralyzes us and

prevents us from acting in the patient's best interest. We must recognize the value of working with both our strengths and weaknesses, our resilience and vulnerability.

To do anything at all about moral dilemmas and distress, we must first of all do something about moral dissonance. To begin, we must stop blaming others and guilting ourselves. Like Harry Potter, we must recognize that the path ahead will require spiritualization, not simply tighter numbers crunching. It is in everyone's interest that we pursue the patient's best interest in the context of the larger community, thereby bringing action and balance to our work.

We know that it will not be easy and that the cost will be high. But we also know that the cost has *already* been high. The path to address moral distress and moral dissonance requires a call to action that will balance our efforts to serve the patient's best interests in the context of the greater community. Now that we see this charge in clearer view, it can be addressed more effectively, more comprehensively, and more justly.

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