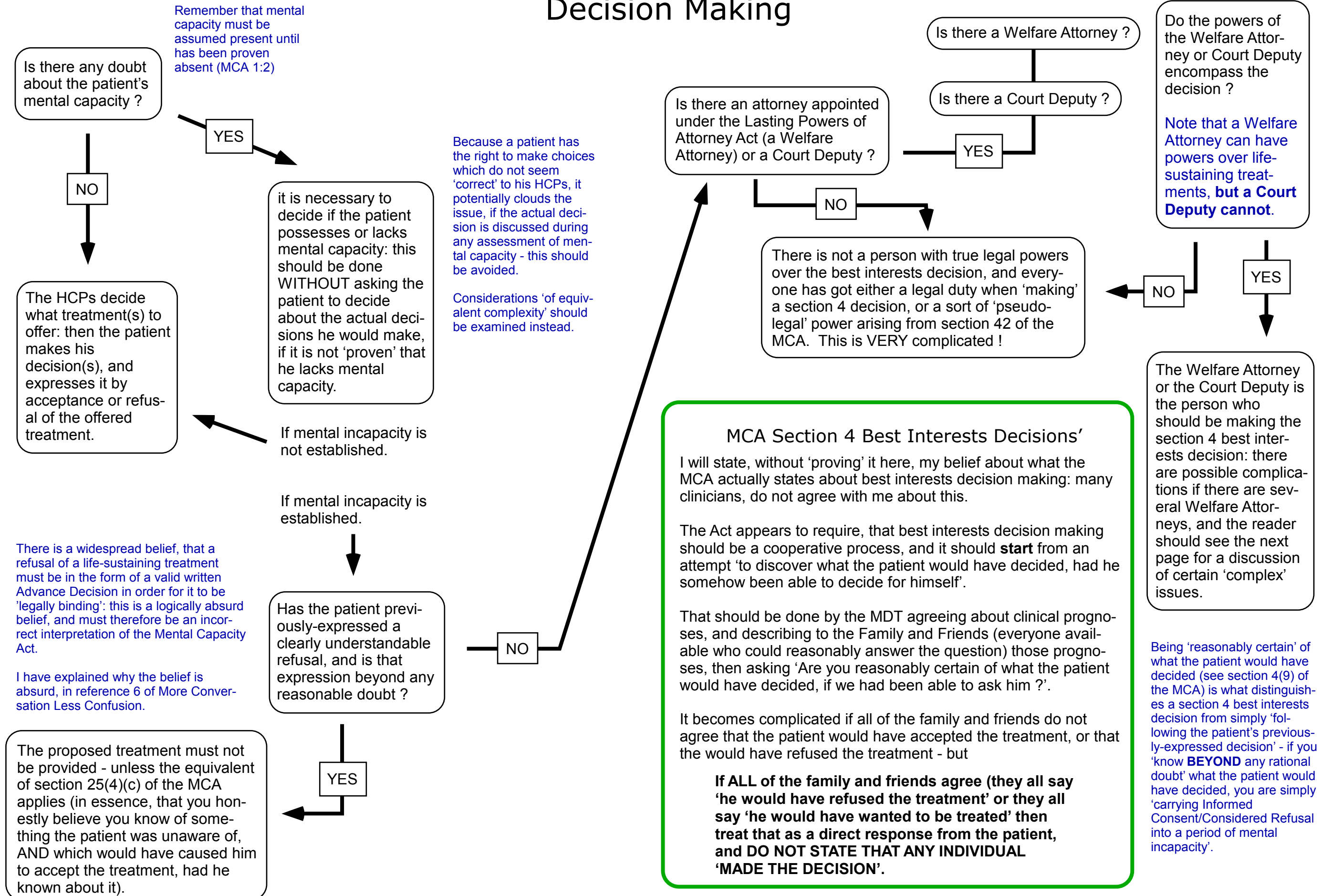


Decision Making



MULTIPLE EQUALLY-QUALIFIED DECISION MAKERS

The Mental Capacity Act, creates the complexity of multiple equally-qualified decision makers (Welfare Attorneys can be appointed with Joint & Several powers) but it avoids resolving the problem: it ‘ducks the issue’ by using decision maker in the singular in section 4, and then by somehow attempting to imply that the senior available clinician is the decision maker in the Code of Practice.

In reality, the Code goes some way to making the senior clinician the decision maker if only several clinicians are in dispute - but, the Code cannot resolve disputes between clinicians and laymen (because most laymen are exempted from the requirement to have regard to the Code which is imposed on certain people by section 42 of the Act). The GMC appears to have understood this, if you compare its draft and final versions of ref 3 of More Care Less Confusion, because a single section in the draft became two sections in the final version:

42. You should aim to reach a consensus about what treatment and care would be of overall benefit to the patient. If disagreements arise, either between those close to a patient and the healthcare team, or between you and other members of the healthcare team, and they cannot be resolved through informal processes or independent review (Consent: patients and doctors making decisions together paragraph 77), you must seek legal advice about applying to the appropriate court or statutory body for a ruling. You should alert, as early as possible, the patient or those acting for them and those with an interest in their welfare, so that they have the opportunity to participate or be represented.

Draft version

47 You should aim to reach a consensus about what treatment and care would be of overall benefit to a patient who lacks capacity. Disagreements may arise between you and those close to the patient, or between you and members of the healthcare team, or between the healthcare team and those close to the patient. Depending on the seriousness of any disagreement, it is usually possible to resolve it; for example, by involving an independent advocate, seeking advice from a more experienced colleague, obtaining a second opinion, holding a case conference, or using local mediation services. In working towards a consensus, you should take into account the different decision-making roles and authority of those you consult, and the legal framework for resolving disagreements.

48 If, having taken these steps, there is still significant disagreement, you should seek legal advice on applying to the appropriate statutory body for review (Scotland) or appropriate court for an independent ruling.²² The patient, those authorised to act for them and those close to them should be informed, as early as possible, of any decision to start such proceedings, so that they have the opportunity to participate or be represented.

Final version

The reader should note, that in section 48 - covering applications for court rulings - the other clinicians have disappeared, and only non clinicians are mentioned: presumably, this is because the GMC assumes that section 42 (in England) allows the senior medic to ‘speak for all clinicians in the team’. But during the earlier ‘working towards a consensus’ of section 47, EVERYONE gets a mention. Note also this ‘working towards a consensus’ theme, in connection with what I wrote at the end of ref 2 in More Conversation Less Confusion (basically, that there is not a ‘decision maker’ if consensus is reached).

To discuss disagreement, we must first discuss ‘is there a person with true decision-making powers if there is not a Welfare Attorney or a Court Deputy ?’ and also ‘what does section 4 mean ?’.

My answer to the first question is ‘no’ - section 6(6) gives a legal power to Welfare Attorneys and Court Deputies, but everyone else merely has a legal duty imposed by section 4(9): as I have just discussed, section 42 gives the senior clinician a sort of ‘pseudo-legal’ power but only over other clinicians.

So, if we accept that the decision maker is not definable, anyone who makes a decision and can ‘fall upon section 4(9)’ is a legitimate decision maker: and anyone who makes a decision and cannot rely on section 4(9), is potentially ‘in legal trouble’. This leads us to ‘What does section 4 actually say ?’.

It CANNOT be saying ‘Look at the clinical situation, and decide what is the best option clinically’, because that requires clinical expertise , and despite not necessarily possessing any clinical expertise, Welfare Attorneys are the top-ranking decision makers. So, the logical alternative is to look at section 4(6), which I think can be expressed as ‘Try to work out the decision the patient would have made, if somehow the patient could have made the decision’. And section 4(7) can be interpreted as ‘and involve everyone who can help in finding this out’.

I explained the difference in ‘expertise’ between the clinicians and the family & friends on page 5 of More Conversation Less Confusion, and the simplest way to think of the family & friends is as ‘proxy minds in lieu of the patient’: then you follow the same process as for a capable patient, but substituting the ‘proxy minds’ for the ‘consideration of what the patient would decide’ stage.

What you seem to end up with, is this:

If there is a single Welfare Attorney, the Act effectively designates that person as the person whose section 4 best interests decision should be followed by everyone.

But if for example the ‘proxy minds’ are the two daughters of the patient, and one says after discussion ‘my mum would want the treatment’ but the other says ‘my mum would refuse the treatment’, then it appears that each could equally validly claim the protection of section 4(9). But all of the clinicians, who were not ‘proxy minds’, would it appears not be able to defend themselves by using section 4(9): thus, it seems that in this situation all clinicians must be ‘for the treatment’. **But that does not make the daughter who was against the treatment, wrong - her position is just as ‘correct’ as that of the other daughter**, so you have it seems 2 options (and to be clear, let us assume the question was ‘Would your mother want us to attempt CPR, if she arrests ?’).

OPTION 1

Do not apply to a court for a ruling, and accept that any proxy mind who decided ‘the patient would have refused CPR’ should not do anything that would lead to CPR being attempted, and at the same time accept that any proxy mind who decided ‘the patient would have requested CPR’ , undecided proxy minds and also all of the clinicians must support attempted CPR where clinically possible.

OPTION 2

This is exactly the same as option 1, except that someone applies for a court ruling and if a court ruling is obtained, the court ruling will provide a decision.

COMMENT: Option 2 seems intrinsically unsuited to unstable end-of-life situations, where the patient's medical condition is subject to change - but the analysis above appears to me to be legally and logically sound. So Option 1 seems correct - but its consequence (that different people, in the same set of circumstances, can legally act in opposition to each other) is very awkward to work with. You can't very well claim that someone must act as if they disbelieve their own position, if they are about to defend their position in a court - so the dispute is 'correct and legitimate' until a court ruling has been obtained. It is possible to take actions to preserve life once a court ruling has been applied for (section 6(7) for example) but the Act does not state that one must take such action, it only allows for the option.

If something is legally correct but 'awkward to work with', it is nonetheless
STILL LEGALLY CORRECT

Overall, this is quite tricky - it is even trickier, when one considers the logic for CPR/VoD protocols for patients who are at home.

Now, it is one thing if at least one of the 'proxy minds' (the family and friends who can INDIVIDUALLY 'think like the patient') says 'I am reasonably sure of the decision the patient would have made - it would have been ...' but it is quite another if EVERYONE says 'I cannot reasonably opine, about what the patient would have decided, in the clinical situation described by the clinicians and the overall situation of the present'.

If everyone says 'I cannot reasonably believe that I know what this patient would have decided' then section 4(6) of the MCA does not lead anywhere: we seem to be left with section 4(5) and with what I term 'the historical concept of acting in a patient's best interests' - that historical concept, is loosely describable as previous case law. In that situation, senior clinicians might well need to inform laymen of the previous case law, because it isn't reasonable to expect laymen to be familiar with that case law.

But the 'historical concept of best interests' has been swept away by section 4(6) of the MCA, **if they conflict** (that is how statute 'works'):

4(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

There is also a difference of opinion, about the role of 'family and friends' - some people see the role of these laymen as being 'mere reportage' and that clinicians 'make section 4 decisions after talking to the laymen', but I interpret section 4 as requiring the clinicians to present the clinical prognoses to 'everyone who could validly think as the patient thinks' (i.e. has got enough personal knowledge of the patient, to reasonably say 'I'm pretty sure that in the situation you describe, he would decide to ...'). So I think that any laymen who has been properly consulted and who was 'close (enough) to the patient' **has adequately considered section 4 when he or she individually answers** 'I think Fred would have refused the treatment' - which means that each individual layman, can then use section 4(9) to defend his/her decision.

Life experience of someone - 'knowing the person' - gives you a different position from that of a reporter of mere observation: it is the clinicians who are limited to merely reporting on observation.

And knowing someone, or knowing something, allows you to conclude things, but not to 'explain why you know these things so that other people could work them out'.

If you see a strange dog and its owner, and you are considering stroking the dog, you DO NOT interrogate the owner about 'how the dog thinks and behaves', and then try yourself to work out if it is likely to try and bite you if you try to stroke the animal. You ASK the owner 'Can I stroke your dog, or will he bite me if I try to stroke him ?'.

It is ridiculous to claim that you 'work out if an incapable patient would want a treatment by asking those close to the patient to explain how the patient 'thinks''.

Logically the clinicians should describe the clinical outcomes, and then ask the wife, children, close friends, 'Do you think you are reasonably sure of what he would decide in this situation'.

And having asked, only Welfare Attorneys or Court Deputies 'can legally act 'like a judge' to 'impose' a best interests decision'.

Clinicians do not know patients as well as their spouses, children, close friends etc know them: DO NOT WRITE GUIDANCE IMPLYING THE CONTRARY OR IMPLYING THAT LAYMEN ARE BY DEFAULT UNTRUSTWORTHY.

Because if a doctor implies that relatives are untrustworthy simply because they are not professionals, 'What was Harold Shipman then ?' is a rather obvious riposte !

I consider this all comes down to thinking properly about uncertainties.

If you have just listened to a patient verbally refusing CPR, and you have told him everything clinical that he would need to consider, then if he arrests a few minutes later you could not possibly be any more certain that the patient had refused: there is no 'decision' to be made in this situation.

If you are reading a valid written ADRT refusing CPR, and you cannot discuss the ADRT because the patient is already mentally incapable, the MCA tells you that you must not attempt CPR unless something in section 25(4) allows you to ignore the patient's written instruction.

Neither of those two, above, involves 'making a best interests decision'.

The next layer of decision making, is when the patient has not told you his decision, or he is unable to tell you and he had not left a written ADRT for you to read: in this situation any person making a decision should try to comply with section 4 of the MCA. First you must attempt to retain the individuality of the patient - you must attempt to discover, to an acceptable degree of certainty (as opposed to the 'knowing the decision' of the above two), the decision the individual patient would have made, had he been able to make the decision himself.

5(2) D does not incur any liability in relation to the act that he would not have incurred if P—

- (a) had had capacity to consent in relation to the matter, and
- (b) had consented to D's doing the act.

26(1) If P has made an advance decision which is—

- (a) valid, and
- (b) applicable to a treatment,

the decision has effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.

It gets trickier, if you cannot justifiably 'reasonably believe you know the decision the patient would have made' - now you are forced to discard patient individuality, and to resort to previous case law and the preservation of life. But you can still claim the protection of section 4(9) provided 'there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7))'. You need to be able to show 'that I have properly looked into the decision I've made' (my phrase). I'm having problems with the phrase, because whatever I write, I do not wish it to be interpreted as conflicting with my next sentence.

999 Paramedics who are called to a patient already in CPA, and similar 'peripheral' clinicians, CANNOT 'make a decision and use section 4(9) as a defence of it' - **they cannot have the necessary time to properly consider a section 4 decision, whatever is written down or recorded.** That is what makes DNACPR Forms such complicated beasts !

The DNACPR Justification Hierarchy

1 A face-to-face discussion with a mentally capable patient, which takes place during the clinical events which lead to his CPA, the outcome of which is that the patient issues a DNACPR Instruction which those who were involved in the discussion can interpret correctly

2 An apparently valid and applicable Advance Decision refusing CPR which has not been discussed with the patient

3 A DNACPR decision made and communicated by either a single welfare Attorney (where only one has been appointed), or agreed and communicated by all Welfare Attorneys

(Note: for non life-sustaining treatments, a Court Deputy can fit here between 3 and 4 - see section 20(5) of the Act))

4 A DNACPR decision made by any person who is sufficiently informed of the patient's clinical situation and likely wishes, to enable that person to defensibly consider section 4 of the MCA.

5 A DNACPR action, which is based upon information supporting the reasonable belief that something within categories 1 to 4 makes DNACPR the best available behaviour

6 If none of the above apply, but it is clear that attempted CPR would be clinically futile, then DNACPR

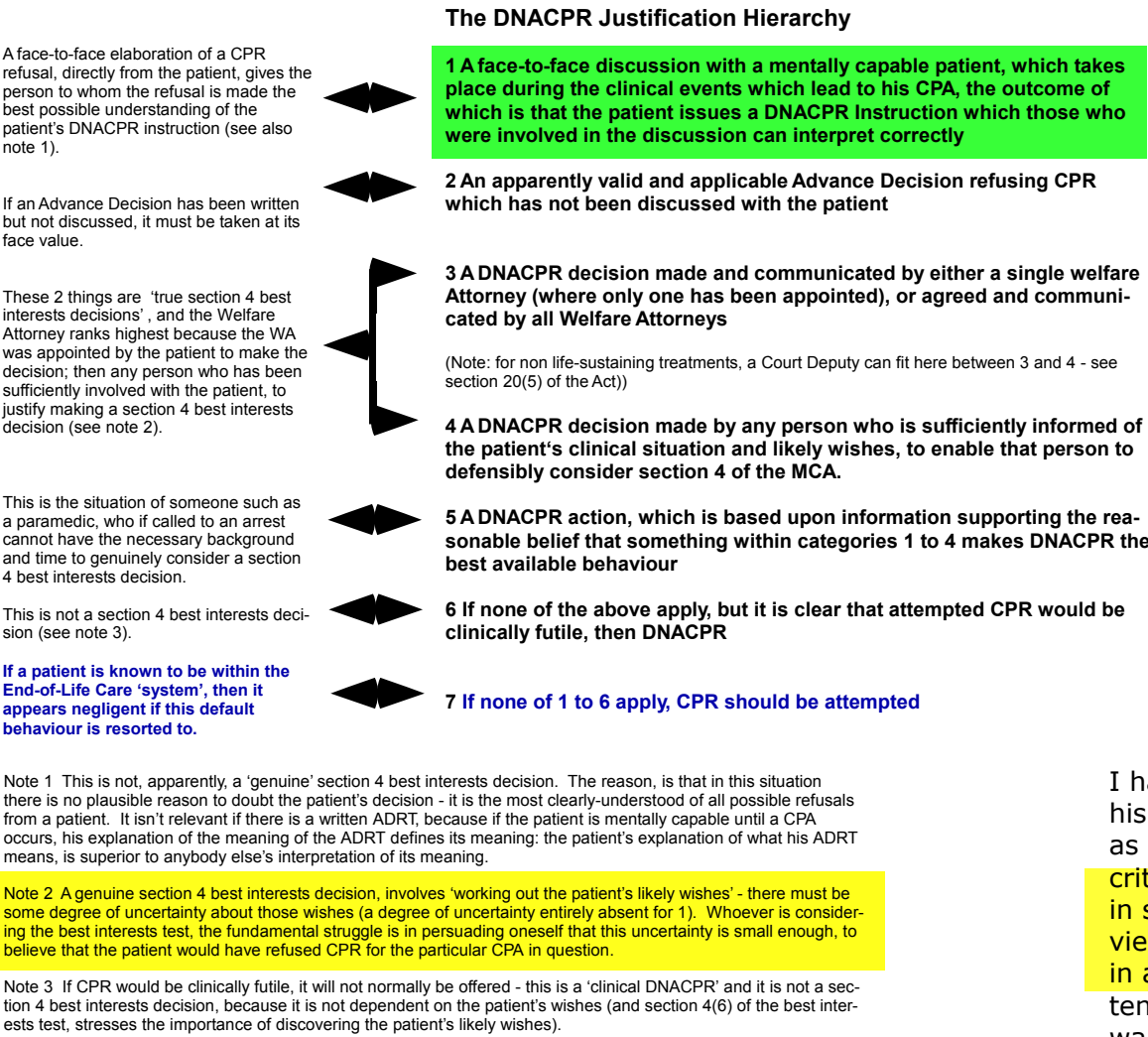
7 If none of 1 to 6 apply, CPR should be attempted

Comparison of my DNACPR Justification Hierarchy with the Mr Justice Hayden Release

Also from W v M.

67. First, Lord Keith reiterated the principle, derived from the earlier House of Lords decision in Re F (Mental Patient: Sterilisation) [1990] 2 AC 1, that it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent.

“A person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person, in anticipation of his, through one cause or another, entering into a condition such as PVS, gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive” (p 857)



There is a court release at:

<http://www.bailii.org/ew/cases/EWCOP/2014/4.html>

The release was dated 22 May 2014, so at the time of writing (early July 2014) it is very recent. The interest, is that contrary to various earlier court rulings, which do not support the 'substituted judgement test' (see bottom left), Mr Justice Hayden makes a point of telling us:

53. If ever a court heard a holistic account of a man's character, life, talents and priorities it is this court in this case. Each of the witnesses has contributed to the overall picture and I include in that the treating clinicians, whose view of TH seems to me to accord very much with that communicated by his friends. I am left in no doubt at all that TH would wish to determine what remains of his life in his own way not least because that is the strategy he has always both expressed and adopted. I have no doubt that he would wish to leave the hospital and go to the home of his ex-wife and his mate's Spud and end his days quietly there and with dignity as he sees it. Privacy, personal autonomy and dignity have not only been features of TH's life, they have been the creed by which he has lived it. He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation. I have given this judgment at this stage so that I can record my findings in relation to TH's views. Mr Spencer on behalf of the Trust does not argue against this analysis, he agrees that nobody having listened to the evidence in this case could be in any real doubt what TH would want.

I have no doubt that he would wish to leave the hospital and go to the home of his ex-wife and his mate's Spud and end his days quietly there and with dignity as he sees it ... He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation ... nobody having listened to the evidence in this case could be in any real doubt what TH would want.

Mr Justice Hayden certainly appears to be examining 'substituted judgement': he has not explained yet whether he considers those 'clear wants' must be followed however:

25. I pause there to interpolate that the best case scenario or the worse case scenario rather depends on the individual's perspective of TH's best interests.

26. I repeat, the real issue in the case is whether it is in TH's best interest to receive nutrition and hydration or whether he should quite simply be permitted to bring his life to an end in the manner and timescales of his choice.

55. I must record that the Official Solicitor's lawyers appear not to share my analysis of the cogency and strength of TH's wishes regarding his treatment. I confess that I have found this surprising. If I may say so, they have not absorbed the full force of Baroness Hale's judgment in Aintree and the emphasis placed on a 'holistic' evaluation when assessing both 'wishes and feelings' and 'best interests'. They have, in my view, whilst providing great assistance to this court in ensuring that it has the best available medical evidence before it, focused in a rather concrete manner on individual sentences or remarks. To regard the evidence I have heard as merely indicating that TH does not like hospitals as was submitted, simply does not do justice to the subtlety, ambit and integrity of the evidence which, in my judgment, has clearly illuminated TH's wishes and feelings in the way I have set out.

This is extracted from the case W v M and others [2011] EWHC 2443 (Fam) - I comment that it is clearly wrong about its final statement (because that is exactly what a Welfare Attorney can do since the MCA was enacted):

71. Finally, Lord Goff stated (at p 871) that the so-called "substituted judgment" test adopted in most American courts - whereby "the court seeks, in a case in which the patient is incapacitated from expressing any view on the question whether life-prolonging treatment should be withheld in the relevant circumstances, to determine what decision the patient himself would have made had he been able to do so" - did not form part of English law in relation to incompetent adults, "on whose behalf nobody has power to give consent to medical treatment".

On the previous page, I discussed a few court cases, and in particular linked some writing by Mr Justice Hayden with something I presented in my ‘Thinking Clearly’ series (the DNACPR Justification Hierarchy).

There is a strange - and to my mind pretty useless - idea [sometimes even expressed by judges - but not, I think, by Mr Justice Hayden] that ‘best interests as a term, means whatever is the norm for clinical practice’. This makes no sense at all, for the ‘best interests’ mentioned in the Mental Capacity Act: it makes no sense, because of section 6(6) of the MCA, combined with the fact that if there were many Welfare Attorneys appointed, it seems clear that most would be laymen. The logic is [as usual] so obvious that it should not really need explicit explanation, but I have explained it at:

http://www.dignityincare.org.uk/Discuss_and_debate/Discussion_forum/?forumID=45&obj=viewThread&threadID=732

<http://www.bmj.com/content/348/bmj.g2043/rr/700882>

It is also very unhelpful, for clinically-authored guidance to imply that ‘the MCA is clear about everything’ (which it definitely isn’t), or that patients and relatives should ‘ask a lawyer’. Professionals are often ‘asking a lawyer’ for purposes of ‘professional protection’ - a quite different thing, from establishing what a law actually means. As someone from NHS Choices pointed out:

The precise effect of legislation in any sphere is often unknown or unrealised until tested in the courts, and even then the courts themselves disagree or are critical of the legislature for having drafted regulations open to wide interpretation.

I would add, that ‘the courts themselves [sometimes] disagree [with each other]’ is definitely true, as would be obvious to anyone who has read a number of end-of-life court judgments.

But there is conceptual difference between ‘the law isn’t clear about this’ and ‘the law could legitimately be open to differing interpretations’ - if the latter is taken to its logical extreme, then any interpretation would be valid (so, nobody could actually breach the law, whatever the person decided to do). Although I object to that ‘anything goes’ possibility, I would accept it as ‘a possibility’ until people change it to ‘We professionals can have differing legitimate views about the meaning of the law, but your lay interpretations are not valid in any event’.

But doctors and nurses, claim to wish to apply to their practice ‘evidence-based behaviour’. For a treatment, that equates to ‘For any given clinical presentation, we have identified the best-available treatment, and we try to always provide that best treatment’.

For ‘MCA best interests’, ‘evidence-based behaviour’ would imply that [at least in many cases] there is an ‘optimum best interests decision’: and it isn’t clear how such a decision, could legitimately vary with the decision-maker (in the same way that the best surgical procedure, should vary with the patient’s presentation, but not with the surgeon). So there should be something - and this must be inside the MCA itself - which points clinicians and laymen, towards making the same best interests decision, for the same circumstance.

NHS Choices also commented:

The NHS is, or course, composed of thousands of separate organisations, sometimes competing and often interpreting and applying laws and policies in slightly differing fashions. A similar situation exists in social care situations across England. In both settings, different groups of professionals operate under different sets of ethical and professional guidelines, practical considerations and constraints. These conflicting interests inevitably result in tensions and contradictions between (and, indeed within) different groups of professionals and different organisations

<http://www.bmj.com/content/348/bmj.g4094/rr/703333>

Many end-of-life patients will either have lost capacity before they became ‘end of life’ (dementia for example), or will lose mental capacity as part of their deterioration towards death: but there is a definite problem if a patient could have indicated future choices about things such as CPR, but would not discuss such issues. This is compounded by the belief amongst clinicians, that a patient who does not explain his/her future choices about possible treatments, can nevertheless ‘forbid future disclosure of clinical information to family and friends’. Section 4 of the Mental Capacity Act, is surely saying that the first objective of any genuine best interests determination is to ‘try to work out what the mentally-incapable patient would have decided, if somehow he/she could tell us his/her choice [while he/she is incapable]’. That is different from the case when you are certain of the patient’s decision: that is not ‘best interests’, it is simply following an expressed and understood refusal of consent.

This is an equivalent problem, to that of asking ‘What food and drink would a specific person select from a menu’ - you cannot work that out if you only know what most people select, because the question is about the choices of an individual. And it is the family and friends, who ‘understand how the patient ‘thinks’’. So, unless the patient has made the decision(s), either ‘patient confidentiality’ or ‘section 4(6)’ has to give way: they obviously conflict. Section 4(6) logically implies that clinical prognoses need to be disclosed to ‘those who could think in lieu of the [incapable] patient’ - and it is the family and friends, who can legitimately be those ‘proxy minds’.

The MCA does, in fact, partly address this conflict. Section 3(4)(b) of the MCA, states that when discussing treatments with a mentally-capable patient, the consequences of the patient not making the decision must be explained to the patient. So, if a patient refuses to make a decision about possible CPR, but also says ‘and I don’t want you to discuss this with my family’, it would appear that the doctor could either say ‘If you will not tell me your decision, I will need to break confidentiality because I’m required to do that in order for a best interests decision to be reached’, or the doctor could say ‘In that case, it will be impossible for me to arrive at a genuine best interests decision, so I will need to default [because of section 4(5)] to attempting CPR even if the likely outcome seems very bleak indeed’.

I wrote in the Foreword to More Conversation Less Confusion:

After a very unsatisfactory series of events around my mother’s death at home just before Christmas 2008, I became involved in a quest to work out why things which appeared insane to me, apparently made perfect sense to various professionals - and vice versa. The issue wasn’t the treatment my mother had received, which was fine: the issue was how I was treated by various professionals.

It fairly quickly became clear to me, that this is because although as a patient or relative you regard ‘the death and the progression towards the death’ as being a single process, different professionals split this into ‘my job, your job’ and there simply isn’t coherence between the ‘behaviour sets’ of different professionals. There is also a remarkable amount of lack of clarity, some of which is understandable, and internal contradiction, which isn’t acceptable, within the guidance around end-of-life for professionals, as it currently exists. The guidance is improving: but it ‘isn’t there yet’.

As I wrote during a piece analysing DNACPR Forms:

One way of thinking about the MCA, is in terms of ‘a requirement to anticipate future events’.

Doing that, you could reasonably argue that ‘anyone caring for an already mentally-incapable patient, should be considering in advance what he/she would do, if some postulated future event happened’ (here, cardiac arrest): this would apply to anyone who might be ‘with the patient’ when a CPA occurred. This is logical, because anyone ‘caring for/closely involved with’ the patient, if faced with a situation where some decision were necessary, should ‘be making it in the patient’s best interests’.

[This would be true of the nurses and doctors around the patient in a hospital, hospice or care home - but it would be equally true of the patient’s ‘family carers’ if the patient were at home.](#)

So deliberately depriving any carer - lay or professional - of ‘the information necessary to make a ‘good’ decision, if faced with a decision to make’, SEEMS VERY WRONG (whoever is withholding the necessary information).

Good EoL care and behaviour, requires TEAM-WORK: not teamwork within an MDT, or within a family group, or within nursing staff or within medical staff - it requires GOOD TEAMWORK where EVERYONE ‘CLOSELY SUPPORTING THE PATIENT’ IS PART OF A SINGLE UNIFIED TEAM.