An Ansatz: Mental Capacity Act best-interests described simply.

There is a concept called an ‘ansatz’ in physics. It was much-used during the development of ‘the new physics’ between about 1900 and 1930, when Quantum Mechanics was being developed, because the previously well-established ‘classical physics’ was failing to explain recent experimental results. In physics, an ansatz is effectively an ‘informed guess’ and it normally takes the form of one or more ‘new equations’ – then, it is assumed that the equations work, and if the results seem to fit with experimental results, the new equations are accepted. If the experiments don’t fit the ansatz, then the ansatz is rejected.

I am increasingly frustrated, by discussion of the Mental Capacity Act, and in particular of its ‘Best Interests’ section. There is endless ‘academic debate’ about ‘ethics’, and there are many very verbose court rulings, which typically extensively quote other court rulings. But, the MCA’s best-interests requirement, covers everyone who is making decisions which a mentally-capable person would normally be making: so the MCA applies to normal family carers, nurses, social care staff, doctors and is sometimes eventually argued about by lawyers in court cases.

It must follow, if perfectly normal people are required to make decisions in accordance with section 4 of the MCA, that perfectly normal people must be able to understand section 4 of the MCA: and, because judges tell us that all best-interests decision-makers must apply the MCA, it follows that [with one proviso, which I will come to] we should all be applying the same meaning of the MCA, when we make best-interests decisions.

However, although section 4 of the MCA is short, it still seems to be difficult to ‘decipher’. I think we need something which fits section 4, but which is expressed more simply: ‘best-interests summed up in a nutshell’. I’ll get to my attempt to do that, after a little explanation of where I am coming from – of the ‘informing’ for my ‘ansatz’.

Preliminary

The purpose of section 4 of the MCA, is to guide best-interests decision-making when people are not mentally-capable and cannot make their own decisions: although best-interests covers both action and inaction, often best-interests decision-making replaces Informed Consent. From ‘logical first principles’ we could have two very different approaches to such a law: we could either apply a set of ‘general truths’ to the decision-making (such as ‘preservation of life comes first’), or we could seek to be guided by something else during the decision-making.

Mr Justice MacDonald, when he ruled that a woman could legally refuse life-saving kidney dialysis treatment because she was mentally-capable, explained that we no longer project ‘societal norms’ onto capacitous individuals:

'others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this however is evidence of a lack of capacity ... C has capacity to decide whether or not to accept treatment [so] C is entitled to make her own decision on that question based on the things that are important to her, in keeping with her own personality and system of values and without conforming to society's expectation of what constitutes the 'normal' decision in this situation (if such a thing exists). As a capacitous individual C is, in respect of her own body and mind, sovereign.'

Mr Justice MacDonald questions whether 'a normal decision in this situation' exists in his court ruling, and he certainly states that whatever would be 'the normal decision', mentally-capable people are perfectly at liberty to reject 'normal' and make their own decisions: **mentally-capable people make their own decisions as individuals**.

Mr Justice Jackson made a ruling in the following situation:

The issue in this case is whether it is lawful for the doctors treating Mr B, a 73-year-old gentleman with a severely infected leg, to amputate his foot against his wishes in order to save his life. Without the operation, the inevitable outcome is that he will shortly die, quite possibly within a few days. If he has the operation, he may live for a few years. Mr B also has a long-standing mental illness that deprives him of the capacity to make the decision for himself. The operation can therefore only be lawfully performed if it is in his best interests.

Mr Justice Jackson ruled against enforced amputation of the gentleman's foot:

I am quite sure that it would not be in Mr B's best interests to take away his little remaining independence and dignity in order to replace it with a future for which he understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter.

I would draw attention to the consideration by Mr Justice Jackson of '**a future … which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure'.**

This was a best-interests decision, but the judge looked at the future – actually at the various possible futures – from the perspective of the patient: as Mr Justice Jackson makes clear, his decision leads to a future which another person will have to experience.

Mr Justice Charles, ruling about the withdrawal of clinically-assisted nutrition and hydration from a patient in a state of very low consciousness, ruled that CANH should be withdrawn (in other words, the patient should be allowed to die), and the reasoning was this:

But, in my view when the magnetic factors engage the fundamental and intensely personal competing principles of the sanctity of life and of self-determination which an individual with capacity can lawfully resolve and determine by giving or refusing consent to available treatment regimes:

i) the decision maker and so a judge must be wary of giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want, and

ii) if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life.

I would draw attention to ii) – which amounts to 'if we can be sufficiently sure that he would have refused CANH in this situation, if he were able to refuse it, then CANH should be withdrawn' - and also to i): **he warns against basing a best-interests decision on 'what the decision-maker would want' and also against basing the decision on what most people would want.**

I will state a position here – this is 'arguably debatable' so I need to be explicit – about MCA 4(11). The section is:

4(11) "Relevant circumstances" are those—

(a) of which the person making the determination is aware, and
(b) which it would be reasonable to regard as relevant.

That section is about the circumstances a best-interests decision-maker should consider – and I interpret the section as follows:

4(11) "Relevant circumstances" are those—

(a) of which the person making the determination is aware, and
(b) **which it would be reasonable to believe the incapacitous person would have considered relevant**, if the incapacitous person had been making the decision.

If we accept my version of 4(11)(b), then it follows that – and this is in my view very important:

A best-interests decision should be <u>invariant</u> across different but equally-well-informed best-interests decision-makers.

In other words, provided we know the same things about the situation which the incapacitous person is in, and about the incapacitous person's individuality, then whichever of us were to make the best-interests decision, we should all reach the same decision.

Put simply – and although it isn't obvious what the 'right' best interest decision is in some situations – if there is a situation, there is an incapacitous person, there is the MCA and there is a decision-maker, then if (see the warning from Mr Justice Charles above) the personal beliefs of the decision-maker (religious, etc) are not allowed to affect the decision, it must be true that the other three factors remain unaltered if we change one decision-maker for another decision-maker.

My Ansatz – a one-sentence-description of best-interests decision-making

So, we reach my 'ansatz' - my suggestion about a simple but correct, one-sentence 'rule' about best-interests decision-making:

The objective is to make the best-interests decision which would result in the most satisfactory future when considered from the perspective of the incapacitous person as an individual.

The only significant instruction in section 4 of the MCA, is about discovering 'the individuality of the patient':

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.

The man's foot could not be amputated against his will, because the man strongly objected and the judge was unwilling to force an uncertain future onto the man, in the knowledge that the man would probably 'hate that future' (my phrase): Mr Briggs was allowed to die instead of being kept alive by CANH, because the judge was persuaded to a high degree of certainty that if Mr Briggs could somehow have made the decision, Mr Briggs would have refused continued CANH (in that case, it amounts to if Mr Briggs had known that he would be in the situation after his accident, he would have created an Advance Decision forbidding continued CANH before he had his accident).

My one-sentence-description of best interests, stresses the individuality of the incapacitous person: this is a good fit with the rules for capacitous people, who can make decisions with no regard at all to ‘any societal expectations of normal, good or bad decisions’. I am not suggesting that if the individuality of the person cannot be ‘established’, that it isn’t possible to make best-interests decisions: clearly decisions must be made. But, I do assert that best-interests decisions which are made with an understanding of the person’s individuality, **are inherently better than** decisions which default to ‘what most people would choose, or what ‘society would expect’’.

Discussion of my Ansatz

Judges usually state that consideration of best-interests involves a Balance Sheet approach - you write two columns, one for 'plus' and one for 'minus', and somehow then do a summing-up balance (a step which is quite often impossible, I think). My ansatz provides a clear 'filter' for what should appear on those two lists: if an item would affect how satisfactory the future was, from the perspective of this person when regarded as an individual, the item should be on the list - but if it wouldn't affect how satisfactory the future was, then it should not be placed on the list.

So, we use the patient's individuality, to decide what should be on the two lists [sides] of the balance sheet: you could express it as 'things which would affect this person's quality-of-life should be placed on the list and considered, but things which would not affect this individual's quality of life should be omitted from the lists'. For example, a person living with severe dementia, might appear to enjoy listening to classical music, but seemingly be irritated by pop music: 'hearing classical music' would go on the plus list, and 'hearing pop music' would go on the minus list. A different individual living with severe dementia might seem totally non-reactive to any type of music - so music would not appear on the lists. If, however, broadcast speech - for example BBC Radio 4 - appeared to make the person 'more contented', then 'hearing speech radio' would go on the plus list, for that individual.

It logically follows, that we should try to get as much understanding as is possible, of those factors which do affect the person's quality-of-life, onto the 'balance sheet' - personally, I would express this as:

'We should be trying to discover as much as possible about how the possible best-interests decisions would affect the future quality-of-life for the person'.

I admit to a certain amount of ‘unease’ around section 4(5) of the MCA and its interpretation within section 5.31 of the MCA Code of Practice: my unease is mainly around the word ‘compassion’ in the code, and **in situations when we cannot use** the justification of Mr Justice Charles in the Briggs ruling (when he **effectively** ‘constructed a pseudo-Advance Decision’). The sections are these:

4(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

5.31 *All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.*

Mr Justice MacDonald did point out that the amputation of the patient's foot, and subsequent 'rehabilitation', were subject to much uncertainty, and would definitely be 'burdensome' to the patient – but I think he also believed that, to use my phrase, 'a future life as an amputee would almost certainly, even viewed on a 'best-outcome' basis, be regarded as 'very burdensome' by the patient'. Is that 'compassion for the patient'? Because 'compassion' is ruled out as a valid justification, by 5.31.

Mr Justice Jackson's patient did exhibit 'views or opinions' - what, if we consider the same situation, but with a patient who exhibits no 'cogency' and only seems to experience more 'primal' feelings: pain, discomfort, contentment, 'happiness', etc. We could create that balance sheet - 'seems happy about when ...' on the plus side, 'seems to be in pain when ...' on the minus side. But if we are considering a life-sustaining intervention, such as the amputation of a severely infected foot or no operation and probable death quite quickly, and if even without any pain from the foot the patient clearly seems to only experience 'negative things, such as pain and discomfort', is it possible to defensibly make a no-amputation best-interests decision: doesn't that look awfully like 'a decision justified by compassion'?

I have no answer to that question: I can understand why section 4(5) is there, but equally it appears that lengthening what 'appears to be' a life which is experienced by the patient as only being 'full of pain and distress' is akin to torture.

However – I am left with that difficulty, when I use the MCA's wording of best-interests decision-making. My question – is my one-line sentence equivalent to the guidance in the MCA about how best-interests decisions should be made, but shorter and clearer [if we set aside 4(5) and 5.31]?

most satisfactory future = establish options and prognoses, and then;

considered from the perspective of the incapacitous person as an individual = consider the things listed in section 4(6) of the MCA and then weigh 'benefits against burdens' having listed those according to how the particular incapacitous person experiences them

The objective is to make the best-interests decision which would result in the most satisfactory future when considered from the perspective of the incapacitous person as an individual.

considered from the perspective of the incapacitous person as an individual REQUIRES the involvement of close family and close friends in most situations

LOGIC requires the involvement of 'the professionals' to describe clinical options and clinical outcomes, etc (to describe different possible futures)

So 'considered from the perspective of the incapacitous person as an individual + logic' leads to section 4(7) of the MCA

Footnote: none of this, addresses 'who can make best-interests decisions?' - I am firm about the answer to that question, which is 'anyone who can satisfy section 4(9)':

4(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.