https://www.supremecourt.uk/watch/uksc-2017-0202/270218-am.html

A lawyer, Tor Butler-Cole, tweeted the above link to me last week: it is to a video of a Supreme Court case, and Tor said something like 'you might be interested the discussion which starts at about 1hr and 11min in the video'.

I have looked at some parts of the video, and it is a case which involves much discussion of the Mental Capacity Act (MCA): I often write about the MCA, and if anyone has thought 'he isn't describing the MCA very well, or concisely enough', when reading my own pieces, I would invite you to watch that video of the Supreme Court.

This video, offers me an opportunity to make a few points. I have never seen a video of such a court case 'as it happens', nor been present at such a court case, and previously I had only read court judgements. But, in general I would point out that:

* In court cases, there will be lawyers who are arguing in favour of their client's opposing positions, and there are judges who are attempting to make a ruling which fits the law – and these court cases are always about a specific real-world situation;

* Although I stand firmly in the patient and family carer position, I do attempt to analyse the MCA 'neutrally' - and I construct hypothetical scenarios, 'thought experiments', which are intended to help with analysis of the MCA.

The judges, can only make a judgement that 'makes clearer' an aspect of the MCA, if they can do that within the confines of a particular court case: they lack the freedom to 'explain the MCA 'as a whole''.

Judges are explaining the MCA – but very slowly

The MCA was our English (and Welsh) law by 2007, and I first read the Act in 2009.

As soon as you read the MCA, it is clear that one question which needs an answer, is the one thrown up by 4(5) and 11(7):

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.

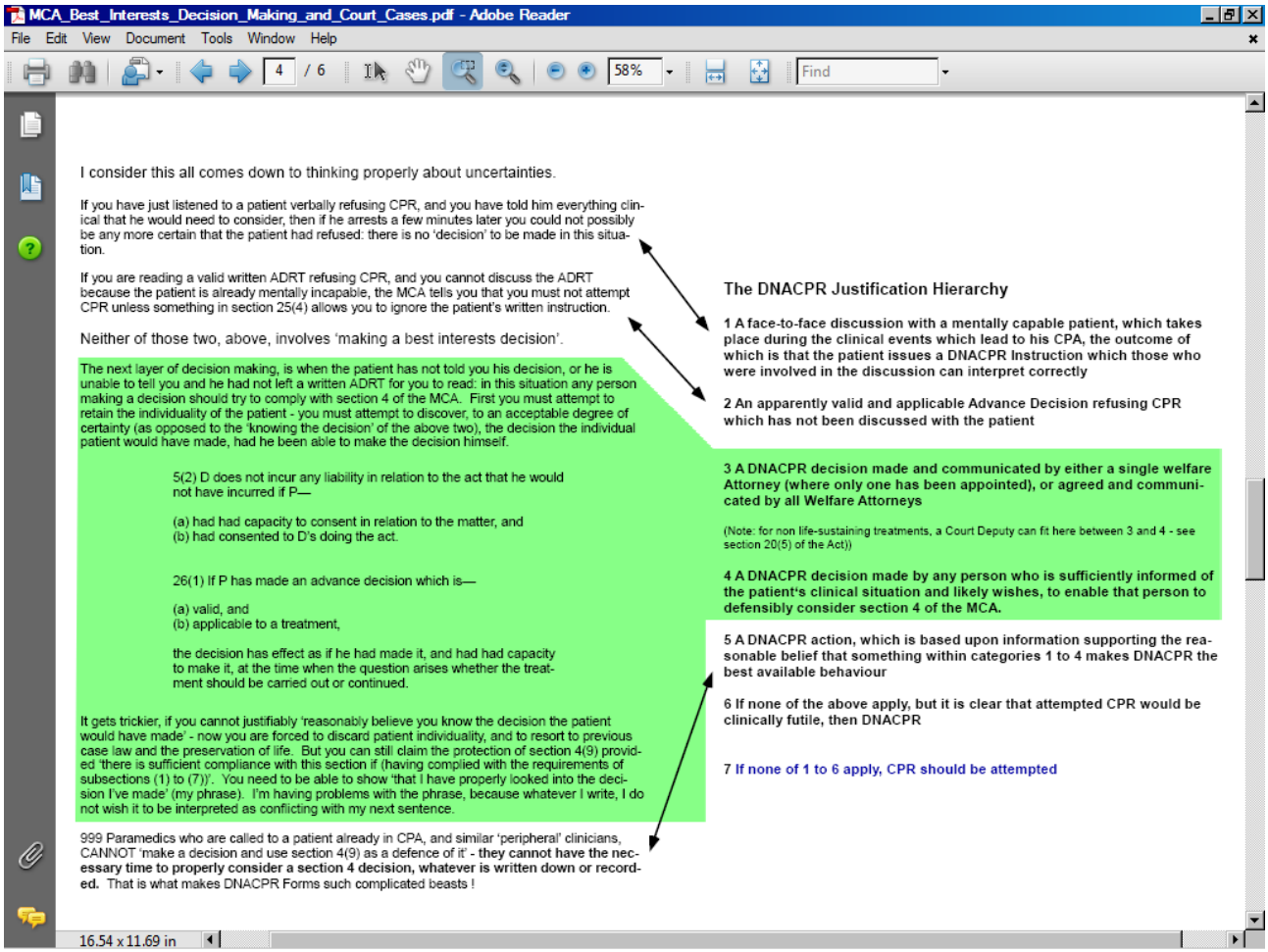
11(7) Where a lasting power of attorney authorises the donee (or, if more than one, any of them) to make decisions about P's personal welfare, the authority—
(a) does not extend to making such decisions in circumstances other than those where P lacks, or the donee reasonably believes that P lacks, capacity,
(b) is subject to sections 24 to 26 (advance decisions to refuse treatment), and
(c) extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P.

11(8) But subsection (7)(c)—
(a) does not authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect, and
(b) is subject to any conditions or restrictions in the instrument.

Put simply, it is clear that it must be possible to validly arrive at a best-interests decision which would inevitably lead to the death of a patient, when it would be possible to keep the patient alive: the obvious question, is ‘how can such a life-ending best-interests decision be justified, bearing in mind section 4(5)?’.

Judges spend an age, playing with wording here – basically that ‘the best-interests decision isn’t what kills the patient, it is the clinical condition that kills the patient’ and pointing to the fact that withdrawal of a treatment is not the same as the administering of a lethal drug: all, while not incorrect, **in my view unnecessary because we already know from sections 11(7) and 11(8) that the decision must be possible.**

I had pondered that question, in the context of ‘how can a best-interests decision justify the withholding of cardiopulmonary resuscitation (CPR), while CPR might still be clinically successful?’. I think I came to an answer – which I suspect is the only logically-possible answer – about 2012 or 2013: I certainly included my answer in a piece I put online during 2014. My solution to the question, was included as a note to a DNACPR Justification Hierarchy:



The wording I used is the first part of the green section:

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.

Our judges had not answered that question, until Mr Justice Charles in his 2016 ruling in the Paul Briggs case, explained his own justification for the withdrawal of clinically-assisted nutrition and hydration (CANH) – his wording was:

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.

Although we used different words, we were both saying the same thing (see the parts I have made red, which are the crucial words).

There are some MCA issues, which in my view are much more difficult to analyse than that one: and it took the best part of a decade, for a judge to get to that one. For example – *exactly how* a best-interests decision-maker incorporates within best-interests decision-making the currently-expressed wishes of an incapacitous person, is probably almost beyond explanation (and - 'use a balance sheet approach' is **not** an explanation!).

Now – a short analysis of the withdrawal of CANH

I admit, that I am not in fact sure who is arguing what, in the Supreme Court video – so far, I've simply been watching it with an 'is that 'getting the MCA right'' eye on it. But, there have been many court cases involving various types of 'coma', and I wish to draw attention to something which should be obvious – but, I'm not clear that this point is 'obvious'. Put at its simplest: ***uncertainty of prognosis, is not determinative in decision-making – such uncertainty is a factor inside decision-making, and nothing prima facie greater than that.***

The logical argument, working from the MCA, is:

25(4)(c) > 4(6) and the justification for a life-ending best-interests decision which both Mr Justice Charles and myself have arrived at.

However – while '25(4)(c) > 4(6)' is the shortest way of putting the argument, I have learnt that most people will see it as 'baffling – not 'short''!

So – the long version.

The MCA allows a person to forbid a future treatment, when at that future time the person has lost mental capacity and would not be able to simply say face-to-face 'don't do it'. The mechanism is an Advance Decision (ADRT), and 25(4)(c) explains when the instruction within an ADRT can be ignored – the instruction could be 'do not attempt CPR' or 'do not give me CANH'. This is section 25 of the MCA – sections (a) and (b) refer to things which are normally written on such an ADRT, but **section (c) is about things which are usually not within an** ADRT:

(4) An advance decision is not applicable to the treatment in question if—
(a) that treatment is not the treatment specified in the advance decision,
(b) any circumstances specified in the advance decision are absent, or
(c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.

An advance decision, is a decision **which has already been made** by the patient: it is therefore possible for a patient to exclude those 'reasonable grounds for believing' in 25(4)(c) by writing something like:

'I refuse CANH, and my refusal is made with the understanding that when CANH might be able to keep me alive if it took place, my future prognosis – whether or not I might make, or be expected to make, a full or limited clinical recovery if CANH was provided – might be very unclear: but whether or not I might make a recovery, even a recovery to full health, if CANH were provided, I am refusing CANH.'

Now, a capacitous person could create such an ADRT – and, I think that point is legally accepted.

If you combine 'such an ADRT can be created' with the logic of Mr Justice Charles and myself, which I have shown earlier, then you arrive at:

'If a best-interests decision-maker can be sufficiently certain that the patient would have refused the intervention even when the prognosis was deeply uncertain, then the best-interests decision can legitimately be that the intervention should be withheld'.

This makes the achievement of the necessary certainty [of understanding that the person would have refused] more challenging – **but, it does NOT logically lead to** 'a best-interests decision cannot be made until prognostic certainty has been established'.

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