

Comments on Practising Realistic Medicine

I have recently read [Practising Realistic Medicine](#) and also [a paper](#) by Kit Byatt and Sarah Chapman.

Both pieces discuss the Montgomery court ruling, and they also both discuss 'evidence-based medicine' and the contribution of Sackett. Page 16 of Practising Realistic Medicine includes the following:

The Montgomery ruling states that healthcare professionals must make patients aware of risk, benefits and alternatives that a reasonable patient would think were material and that a reasonable doctor would be aware are relevant to that particular patient. This emphasises the importance of dialogue and a person-centred approach and a move away from the more paternalistic approach that has predominated before.

The new legal test requires courts to determine what the reasonable person would expect to be told; individual patients now have full autonomy regarding decisions about their health and bodily integrity, bringing the law into line with the modern practice of medicine, including professionally acceptable standards of communication between patients and health care professionals. It is therefore vital that in patient interactions we ascertain what matters most to them, discussing the various treatment options, their risk and their benefits, so they are able to make decisions about their care and treatment.

In fact, it isn't clear that Montgomery represented 'the law catching up with the modern practice of medicine' because although the [Montgomery](#) ruling was made in 2015, in its 'appendix' written by Lady Hale, it is clearly explained that the 2015 ruling is based on the legal situation as it existed in 1999, when the events of the case happened.

More to the point: it seems to me that there are very different reasons 'for doing what Sackett argued for' compared to 'obeying Montgomery'. **Sackett was presenting a case for behaviour, based on concepts such as 'better outcomes' whereas Montgomery was making it clear 'the law requires ...'**. So, support for 'Sackett's suggestions' is essentially 'a matter of opinion' – but 'follow Montgomery' is a matter of law.

I don't think that Practising Realistic Medicine is entirely correct in its assertions about 'consent law' [although I am using 'consent law' in connection with England and Wales, where 'all of our 'consent law' is contained within the Mental Capacity Act' – and PRM is about medicine in Scotland] but the consequences of Montgomery are usually described, as PRM does, in terms of 'medical paternalism is now dead'. However, logically, the MCA has gone further than to remove medical paternalism: logically, the MCA has separated 'medical expertise' from 'consent/best-interests'.

Within the Bolam world, it can be [loosely] stated that 'informed consent was not 'genuine', because doctors could use their experience and expertise to legitimately restrict the information supplied to the patient, and that in turn of course could influence the patient's decision-making'. This was part of a legal framework, which also included other ideas –

notably 'preservation of life usually prevails' during mental incapacity. That older legal framework, still lingers post-Bolam in the sense that 'the unavoidable of application of 'necessity'' is obviously still a fact – but I stress that word 'unavoidable'.

We are now, post-MCA, living in a world where the patient's 'individuality' has become central: so, as Montgomery made clear, 'we now have **genuine** informed consent' and also, 'the patient's individuality can come before preservation of life' (see [Briggs](#)). There is an obvious logical consequence, to that change:

'Expert Status' is what was really 'removed' – not simply 'paternalism'.

Put simply, and of course I am now discussing MCA best-interests decision-making, once 'the patient's individuality within a clinical [and wider world] situation' has been placed centrally within best-interests decision-making, the understanding possessed by doctors of 'average patients' becomes secondary during best-interests decision-making compared to an understanding of the 'patient as an individual'. The understanding of the patient as an individual becomes central – and that is an understanding which is possessed not by the clinicians, but by the family and friends of the patient. So, I am not asserting that the 'expert status' of clinicians has been removed by the MCA in the context of how a medical intervention is performed – but, the MCA has clearly removed any implication that by being an expert in 'clinical things', clinicians are somehow 'also experts for best-interests decision-making'. The logic of the MCA, and the problem it presents for clinicians and 'the NHS', is obvious and [as I pointed out](#) several year ago:

I think the real issue, is that clinicians and 'systems' find it very challenging indeed, to adapt their own behaviour, to the logic of what the MCA seems to lead to. The NHS 'likes' hierarchies, single decision-makers, and record-keeping - but the MCA seems to not necessarily provide 'a hierarchy', and it also seems to sometimes lead to opposing but equally valid decisions about 'best interests'. However, that is what the MCA appears to lead to, unless you distort the wording/meaning of the Act: and it IS a law !

In a nutshell, the problem is that it isn't logically possible, to create a reasonably-well-defined law, without some indication of what 'best interests' as a concept means. And it isn't reasonable to leave 'best interests' as so vague a concept, that it can mean almost whatever whoever is making a best-interests decision, wants it to mean. And as we must start from the fact that it is deeply established in English law, that mentally-capable patients have the right to refuse any offered treatment, and that one aspect of the MCA was an intention to extend a patient's decision-making ability into future periods of anticipated mental incapacity, there are some 'hints' and some 'restraints'.

It also seems to make little sense, that a best-interests decision, should depend on the decision-maker - surely, the decision should somehow 'flow outwards, from the combination of the patient's situation, and the patient's individuality' ?

So, what you seem to get to, and probably the reason that 'the system' is so reluctant to accept this, is:

'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'.'

As an analogy: 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 ?'.

The bit the system 'cannot stomach' is that the important ability, is not the description of the clinical situation - the IMPORTANT bit, is the ability 'to think like the patient'. And EACH of those family and friends, can INDIVIDUALLY claim 'to have arrived at a defensible best-interests decision' provided they are reasonably sure of what the patient would have decided (see section 4(9) of the MCA). It isn't a case of 'everyone getting together, having a discussion, and then a specific individual 'making' the best interests decision (unless there is a welfare attorney, a court deputy, or a judge): the logical reality, is that each of the people who can legitimately 'think like the patient' HAVE ARRIVED AT a best interests decision, IF THEY BELIEVE 'that I know what he (the patient) would have decided'.

But there ISN'T a way of resolving disagreements between the family and friends - the guidance written by clinicians claims there is (they claim that 'the clinician makes the decision after consulting with the family and friends') but you can't find that, inside the MCA itself. As I've written in the attached piece:

'Only Welfare Attorneys or Court Deputies 'can legally act 'like a judge' to 'impose' a best interests decision'.' (see section 6(6) of the MCA)

I consider that this corruption of the MCA - the persistent claim that ultimately the clinicians make the best interests decisions - is hugely damaging, by allowing clinicians to avoid potentially upsetting and fraught discussions with family and friends [by 'arguing/thinking' that 'ultimately we clinicians make the decision'].

There is 'some approximation' in there – notably, 'best-interests isn't the same as substituted decision-making' but [as nobody can clearly explain exactly what best-interests is](#), and as Mr Justice Charles in Briggs has effectively stated that best-interests 'collapses to substituted judgement when we are sufficiently certain of 'what the patient would have decided'', then it is only a minor 'approximation'.

The MCA covers all situations, so it is quite tricky to describe – but, if we try to dig into the MCA's description of best-interests decision-making, then I think it is reasonable to assert this:

'A genuine best-interests decision, requires an understanding of the patient's individuality'

It immediately follows that the non-attempting of an intervention which could not be clinically-successful, cannot be a best-interests decision. Nor, using that definition, can 'a resort to

necessity' qualify as a 'genuine' best-interests decision (see a) in my piece [here](#)).

Of course, the MCA does leave room for decision-making when the patient's individuality is not well-understood by the decision-maker: in that situation those earlier concepts such as 'preservation of life' and 'what most patients would choose', and also 'what society expects to happen', must guide the decision-making. Doctors **can be** more 'expert' about those things, than the patient's family and friends are – but, **crucially, that is a fall-back position which should be resorted to ONLY IF 'best-interests decision-making with an understanding of the patient's individuality is not possible'**.

Another way of expressing this, is to say that from my perspective, **the ideas argued for by Sackett seem to me to have been admirable before the MCA enshrined 'Sackett's approach' as English and Welsh law – but, now that we have the MCA, it is simpler and more logically-compelling to argue 'you must follow the MCA!'**. Certainly, if we are in England or Wales: many doctors, who see medicine as a world-wide community and who seem to prefer medical ethics compared to law, will naturally 'look to Sackett' because that can be done across legal boundaries, and in countries with law which lacks the clarity of the MCA. The other advantage – from my family-carer perspective – of 'use the MCA – don't 'use Sackett'' is a simple one: the MCA applies to family-carers, but how many family-carers will be familiar with these rather arcane ideas such as 'Sackett and EBM'? That is a particularly compelling – for me – 'pseudo Occam's razor' line of reasoning, which I have explained [here](#).

I could carry on – but I'm not going to, because I wanted this piece to be short (and also, I'm not convinced that I'm explaining it very well, despite having pondered how to explain it). Before I close, I will add that Practising Realistic Medicine, and many other authors, describe the problems of patients 'not wanting to make their own decisions', and similar issues, very well (and [I am aware of those issues](#)) – but, those problems need to be addressed, whichever approach ('follow the MCA' or 'agree with Sackett') is being proposed or adopted.