

... that comes from somewhere else

I recently came across a paper by Emma Cave, and it was reading that [paper](#) which prompted me to write this piece (the url for the PDF version of the paper is [here](#)).

When I read such learned legal discourse, I always have in mind 'how, if at all, does this impinge on the problems I see with end-of-life behaviour?', and I also keep in mind these two things:

Lady Hale, in [Montgomery](#) (116), pointed out:

Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being

I'll translate that: for 'case law', the 'correctness of' a judge's ruling is judged within the wider context of 'the time we are living in' – put simply, 'expectations of what the law should be' change over time, and without a 'clear steer from statute' judges consider [if, often, 'very conservatively'] 'the ethos of the day' when they rule.

However, **it would be pointless to enact new laws** – to create statute – **unless when parliament passed a law, that changed the law** – as Mr Justice Charles explained (OVERVIEW 16) in [Briggs](#):

It is the application of the MCA, rather than the common law and inherent jurisdiction set out in the earlier cases that matters. However, the earlier cases remain relevant because they provide useful analyses of the relevant issues and form a central part of the background to the recommendations of the Law Commission on which the MCA was based and so to the MCA.

A brief diversion away from law to science

In the early days of Quantum Mechanics, there seemed to be two alternative theories – Wave Mechanics and Matrix Mechanics. It was quickly proven that in fact, either theory would give the same prediction, if presented with the same question. The two theories only superficially clashed – at some fundamental level, they both agreed with each other.

There is currently a real clash between Quantum Mechanics and Relativity – they do not 'talk nicely together' when it seems that both are needed in order to solve a problem.

I write about the Mental Capacity Act (MCA) quite differently from the way that judges and lawyers write about the MCA – so, are we saying the same things using different language, or are we saying different things? And if we are saying the same things, then the next question is 'which way of describing the MCA, is easiest to understand for non-expert readers?'

Please bear this section in mind, when reading the rest of this piece, which discusses the

[paper](#) by professor Cave:

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The ill-informed

Consent to medical treatment and the therapeutic exception

[Emma Cave](#)

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15



Abstract

Affirming the doctrine of informed consent, the UK Supreme Court in *Montgomery v Lanarkshire HB* belatedly followed the Australian decision of *Rogers v Whitaker*, decoupling the duty to inform patients about the material risks of medical treatment from *Bolam*. The underlying commitment to patient autonomy coincides with a wider body of medical law that protects the right of capacitous adult patients to make treatment decisions, even if others consider those decisions bizarre and even if they will cause the patient serious harm. It is seemingly anomalous, therefore, that the Supreme Court in *Montgomery* referred to a ‘therapeutic exception’ (TE), as this suggests an underlying paternalistic approach. Contrary to this view, international examples suggest that a TE does not necessarily conflict with commitment to patient autonomy. In some countries, the exception mitigates the effects of a broadly objective test of materiality by enabling clinicians in exceptional circumstances to protect the autonomy interests of the particular patient. In others, it protects those incapable of an autonomous decision from harm. In England and Wales, however, alternative mechanisms can be interpreted to protect such patients from harm. On this basis, it is argued that the TE is obfuscatory, unnecessary and unjustified.

Keywords

[informed consent](#), [materiality of risk](#), [therapeutic privilege](#), [therapeutic exception](#), [Montgomery v Lanarkshire](#), [negligence](#), [Rogers v Whitaker](#)

Discussion of Emma Cave’s paper

I did post some preliminary tweets about the paper – to save re-stating I’ll point at:

https://twitter.com/MikeStone2_EoL/status/995232232238395392

Many things which are written by professor Cave, are almost identical to things which I have written, and so are many of the issues which she raises in her paper.

So, when she explains:

What is considered material would on a utopian conception involve the courts asking whether patients were given the information that they required in the particular circumstances.⁷ At first, this was considered beyond the capacity of the law and a more objective test was settled upon. The test set out in Bolam v Friern Hospital Management Committee⁸ (Bolam), which governs the standard of care for professional persons, requires that clinicians act in a manner 'accepted as proper by a responsible body of medical men skilled in that particular art'.⁹

I completely agree, although I was unhappy with Bolam as soon as I became aware of it. And, I read the MCA before I had even heard of Bolam – I was deeply annoyed by Bolam as soon as I came across it, because to paraphrase my title 'Bolam comes from somewhere else, compared to wherever patient autonomy is!'.¹⁰

I will now make a combined comment about the 'Kerr/Reid test':

The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

and about this:

In the seminal US Court of Appeals for the District of Columbia case of Canterbury v Spence,¹² the prudent professional test was rejected in favour of a rights-based approach that focused on the hypothetical reasonable patient. The Australian High Court in Rogers v Whitaker¹³ went further still, adding a subjective limb to the objective prudent patient test. This requires clinicians to disclose risks where they are aware or should be aware that the particular patient would find them significant.

Mr Justice MacDonald, has [explained](#) that unless proven mentally-incapable, it is solely for the patient to decide whether to refuse an offered treatment (section 97 of his ruling – or, perhaps, of his explanation as to why he could not make a ruling):

97. The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle' outweighs a prognosis that signals continued life will alarm and possibly horrify many, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and

lifelong disability are factors that also weigh heavily in the balance for C. C's decision is certainly one that does not accord with the expectations of many in society. Indeed, 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. The court being satisfied that, in accordance with the provisions of the Mental Capacity Act 2005, C has capacity to decide whether or not to accept treatment 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.

The concept of 'a prudent typical-of-everyone patient' is not a good fit with the acceptance by Mr Justice MacDonald, that C's 'extremely atypical individuality' does not result in her lacking decision-making capacity – so, I think it makes sense to stop talking about 'prudent patients' and instead to use the concept of

'a typical patient within the specific patient's peer-group [of similar patients]'

I accept that I am not explaining how the more restricted 'peer-group of similar patients' is to be defined – but, there is a tension within the Kerr/Reid test, between '*a reasonable person in the patient's position*' and the following '*the particular patient would be likely to attach significance to it*' within the same sentence.

A little bit of thinking

It doesn't take much thought, to realise that 'something has to guide decision-making'. And there are only, it seems to me, two possibilities:

- 1) 'Societal 'norms'' - things such as 'sanctity and preservation of life comes first' - is the guide: and an understanding of those things can be gained through professional training and experience, or
- 2) 'The individuality of the patient/person prevails' during decision-making.

It is very obvious, that the MCA is based on 2 – and when the decision-making depends on the patient's individuality, the concept of 'a good decision' is lost during capacity (replaced by 'an informed decision'): **and, for decision-making during incapacity, understanding the patient as an individual becomes fundamental – and that understanding is possessed by the family and friends of the patient, not by the professionals.**

One of my correspondents, summed this up perfectly in an e-mail to me, when we were discussing our issues with ReSPECT:

I do think, incidentally, that the more people know about their rights to make decisions in advance about future care or treatment, and how to do this, the better. This is the tenth birthday year of MCA implementation: maybe we can all tell our local communities about the rights it gives us? In my view, and despite the admittedly slow burn on this one (putting it politely), this will in future be recognised as the greatest change that the MCA has brought about - the change from paternalism 'Nurse knows best' to making it clear we can make our own decisions, and telling us how.

On pages 153/154 of Cave's paper, there is a discussion which I suspect I do not agree with, but there is something within it which is central to how I write about not 'the therapeutic exception', but about best-interests decision-making:

Under Montgomery, however, the reasonable patient would attach significance to the risk but if the clinician had specific knowledge that the nature of the risk would be unlikely to adversely affect the patient but that the provision of information would frighten the patient and therefore obfuscate the decision, then there is scope to limit or adapt the information. Section 2(3) of the MCA makes clear that such 'knowledge' must not flow from unreasonable assumptions based on the patient's age or other characteristics, but it might come from the patient himself. It might be, for example, that a family member or carer suggests that this information would alarm the patient in which case the clinician can explore this with the patient if there is a sense that disclosure would risk serious harm.

It should read '*but it might **not** come from the patient himself*' (confirmed to me by Emma Cave via e-mail when I asked her) - but aside from that, Cave has pointed out that 'knowledge' {here, an understanding that disclosure might seriously harm the patient – and I rather object to replacing that with 'alarm' if there is an implication that relatives can only judge 'alarm' and cannot judge 'the risk of serious harm'} can be possessed by relatives, not by the professionals.

Why I think I disagree with Cave, is because I dislike '*patient would attach significance to the risk but if the clinician had specific knowledge that the nature of the risk would be unlikely to adversely affect the patient*' - that seems to imply 'that the doctor 'knows the patient better than the patient knows himself': that isn't in line with the ruling by Mr Justice MacDonald (pages 3/4) and it isn't the same as 'the information would prevent the patient from being capable of making the decision'.

A reader might be wondering why I've introduced best-interests decision-making, because the therapeutic exception is very obviously 'a caveat which is applied during patient autonomy': the reason is a little 'woolly', but in-the-round very significant, from my 'end-of-life' perspective.

A little bit of thinking

It doesn't take much thought, to realise that compared to the concept of patient autonomy during mental capacity, the MCA's description of best-interests decision-making during mental incapacity is far more complex and challenging. Anyone who doubts this, should take a look at General Medical Council guidance for doctors about decision-making: the description of decision-making when the patient is capacitous, is very concise and also very much clearer, than the description of decision-making during incapacity.

If it is so difficult to 'explain' the therapeutic exemption, it seems likely [and I find this to be true as an observable fact] that 'explaining best-interests will be incredibly difficult' - but from the family-carer perspective, it is important that we manage to 'explain best-interests'.

I must admit that I immediately 'recoil in horror' when I come across sentences such as this one:

This represents a positive development, distancing the law on informed consent from a mechanical checklist approach and demanding meaningful engagement with the patient.

The mere implication, that some judges might have considered that 'informed consent' **doesn't** require '*meaningful engagement with the patient*' strikes me as totally bonkers and entirely unacceptable – and a small book could be written on the logical flaws of describing decision-making 'using 'a checklist approach'', as well as a similar small volume on the problems of the often-inappropriate professional tendency to turn principles into checklists to be followed.

However, I could have written this myself with only slightly different wording (I don't think I have ever used the term 'beneficence') – and I have often done that, as it happens:

Beneficence in the form of the TE might be utilized to safeguard the welfare interests of those patients whom clinicians reasonably believe would be rendered incapable of a rational decision and subjected to serious harm if the material risk is disclosed. If so, this marks a divergent approach from the MCA 2005 which utilizes incapacity as the benchmark for best interests decision-making.

For example, in my piece <http://www.bmj.com/content/352/bmj.i222/rr-0> I wrote:

We need to analyse the word 'representatives', and to define the circumstances of the disagreement. The MCA describes two situations: either a patient is mentally capable [with respect to the particular decision], in which case the patient considers clinical information provided by his clinicians, and then the patient makes and expresses a decision; or, the patient is not mentally-capable, and somebody else makes a best-interests decision. In both cases, as is

logically obvious from that separation, the question of capacity has to be settled before the process moves on to the consideration of the decision. Danbury mentioned the recent ruling by Mr Justice MacDonald, which pointed out in very clear terms that 'mediation' does not apply if the patient is mentally capable, and that the patient alone makes the decision [whether or not to consent to offered treatment]. What 'so troubles clinicians' is the 'value-free' aspect of that - there is no assessment of whether the decision the patient makes 'is a good one', there is simply the decision that the patient is mentally capable [even if also self-destructive].

A little bit of thinking

Cave has hinted at what the MCA does in the wording I have shown on page 6. I am no lawyer, nor am I clinician, but it is obvious when I read the MCA as a person with degrees in chemistry, that the MCA:

In overall terms, is a description not of good or bad decisions, but instead of decision-making, the presence or absence of decision-making authority, and to phrase this loosely 'how to avoid being charged for intervention without consent if the person cannot give consent'.

The MCA is not about 'beneficence' during capacity – and even during incapacity, 'concepts of beneficence' are not determinative during best-interests decision-making.

As I pointed out near the start of my piece [Mike's Little Book of Thoughts about End-of-Life v2](#) this makes application of the MCA very challenging for working clinicians. For example, I wrote:

The MCA includes our law *for the whole of* 'consent' whether or not the patient is mentally capable – and its description is deeply 'problematic' if you are a working doctor. The MCA states that patients must be assumed capacitous until proven otherwise, and 'being self-destructive' is not sufficient to 'prove mental incapacity'. Interpreted 'neutrally', if a patient who is part of the way through a suicide attempt 'washes up in Accident & Emergency' and refuses to be treated, the doctors should not treat the patient – according to the MCA 'if the person seems capacitous, the person should be allowed to die'. So, suppose there is such a suicidal patient who unless treated will die, who is refusing treatment: if the doctors in A&E do not treat him, and he dies, you can imagine the conversation the following day with an angry relative - '**What the hell do you mean – you could have kept my brother alive, but he told you not to so you just let him die !!!**'.

On page 155 of Cave's paper, this sentence appears:

It is submitted therefore that the TE is obsolete and that its existence has potential to contradict the principles of the MCA by subjecting those capable of a capacitous decision to a best interests framework because they are at risk of serious harm, without appropriate safeguards.

This is a really interesting sentence – I write about this myself (frequently!) but **I take it as a given** that 'the MCA's best-interests framework only applies if the patient is 'proven mentally-incapable'', and I use 'safeguarding' in a different context:

<http://www.bmj.com/content/350/bmj.h2877/rr-7>

Duty of Care is not modified by Informed Consent: the elephant in this particular room is that Informed Consent is fundamentally irreconcilable with Duty of Care

'Duty of Care', was used by Mair A Crouch in this series of rapid responses(17 June), quoting from an earlier response by Jay Ilangaratne. When clinicians use the phrase Duty of Care, it often seems to mean something similar to the phrase 'acting in the patient's best interests', and both seem to be 'ethical concepts' which are linked to the idea of 'best outcomes'. While the concept of 'duty of care' remains valid for minors or adults who lack mental capacity, the concept cannot be reconciled with the legal position that for mentally-capable adults 'the rule is informed consent'.

Rathbone has pointed out (ref 1) that 'the term 'best interests' should be avoided outside the context of considerations of mental capacity. Invoking such a concept in patients who do not lack capacity would put doctors at risk of accusations of paternalism and breach of autonomy which are viewed unfavourably by the law.'

Justice Sir Mark Hedley explained to The Independent (see ref 2) that if a mentally-capable person has taken an overdose in an attempt to commit suicide, the law does not authorise doctors to treat the patient against the patient's refusal.

English law has settled on patient self-determination, and it allows for patients to 'make 'poor', or even self-destructive, decisions': this is something very difficult for doctors and nurses, whose role is 'to care', to easily come to terms with. But the law has settled on patient self-determination: and philosophical debate about 'how autonomous a patient really is' is unnecessary, because the law uses a simpler real-world version of self-determination (I discuss this in ref 3).

So the phrase 'Duty of Care' should be replaced by 'Duty to Offer Care' - I am aware of how awkward this makes certain aspects of the working life of clinicians, but the clarity of decision-maker inherent in Informed Consent is to my mind better than irresolvable disputes about the meaning of 'the best outcome'. Informed Consent leaves unchanged the requirements for competence during the application of an accepted treatment, 'fairness' in the offering of treatments, etc: but it removes concepts such as 'patients must make decisions in their own best interests [and if they don't do that, then clinicians need not respect the patient's decision]'

I readily admit, that while I find the concept of 'mental capacity followed by informed consent' satisfactory in terms of logic, I am very unclear about how mental incapacity, unless 'it is blindingly obvious', is to be established ! I am also not claiming that Informed Consent leads to 'better overall outcomes' than 'paternalism' - I don't know how outcomes compare or indeed could be objectively assessed as 'better or worse': but I am claiming that informed consent is 'conceptually clear', while the alternatives are not.

Cave also writes this on page 155:

But the extent of the Act's application in the context of information disclosure is unclear. The Act provides a model for decision-making rather than information provision.

I cannot do anything except 'claim that Cave is wrong' about that. And I'm puzzled – because on page 156, Cave mentions MCA 3(4).

I spent quite a long time, pondering the problem of doctors asserting that 'patient confidentiality must be respected when best-interests decisions are being made' - that is an assertion, about the resolution of an obvious conflict between MCA 4(6) and the situation if a now-incapacitous patient, had said while still capacitous 'I forbid you from disclosing clinical information to my friends and family'. There is a section of the MCA which covers this – it is explicitly about 'information provision' because it is within section 3 of the MCA {section 3 describes the process of consultation with a capacitous patient}. The section is 3(4):

3(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—
 (a) deciding one way or another, or
 (b) failing to make the decision.

Unless section 3(4) is explaining what information the clinician must disclose during a consultation which would lead to either consent or refusal from a patient, what could 3(4) be about?

3(4)(a) amounts to 'the clinical outcomes of consent to or refusal of an offered treatment must be explained to the patient during the consultation'.

3(4)(b) applies to the question above. While it seems clear that if a clinician is, during future incapacity, enacting a decision made and expressed by the previously-capacitous patient, that the clinician can comply with the patient's 'I forbid you from telling my family and friends about my clinical situation', if the patient failed to make and express the necessary anticipatory decisions while still capacitous, then 3(4)(b) implies that the clinician **could say either of these** to the patient:

'If you have forbidden me from revealing to the people who know you, the clinical information which I would need to reveal in order for best-interests decisions to be made, then I will be forced to try and keep you alive however much you seem to be suffering'

or

'Unless you make in advance any decisions about treatment which would need to be considered if you become incapacitous, I will be forced to reveal to your close family and friends those details of your clinical situation which are necessary during best-interests decision-making, so I will not be able to respect 'patient confidentiality''

The GMC published a piece 'Treatment and care towards the end of life: good practice in decision making' on 20 May 2010, and it was the first piece of GMC guidance that I read – it explains the process of consultation between a mentally-capable patient and a doctor like this (my own added italic bold):

Patients who have capacity to decide⁷

14 If a patient has capacity to make a decision for themselves, this is the decision-making model that applies:

(a) The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.

(b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are clinically appropriate and likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, burdens and risks of each option. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

(c) The patient weighs up the potential benefits, burdens and risks of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor ***or for no reason at all.***

(d) If the patient asks for a treatment that the doctor considers would not be clinically appropriate for them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be clinically appropriate to the patient, they do not have to provide the treatment. They should explain their reasons to the patient and explain any other options that are available, including the option to seek a second opinion or access legal representation.

That, looked to me like a good translation of section 3(1) of the MCA, which I show on the next page.

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

The doctor's 'clinical expertise' appears in section (b) of the GMC's description – it is used during identification of which treatments to offer, and if the Therapeutic Exception were to appear then it would be in the second sentence of (b): it isn't there.

The third sentence in (b) seems to run counter to the idea that a doctor can legitimately influence the patient's decision, by failing to mention relevant information [which is what the Therapeutic Exception amounts to].

Mr Justice Jackson is [reported](#) to have said:

"Anyone capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. In the absence of consent, any invasion of the body will be a criminal assault. The fact that the intervention is well-meaning or therapeutic makes no difference. The right to decide whether or not to consent to medical treatment is one of the most important rights guaranteed by law. The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, to put it another way, to allow the tail of welfare to wag the dog of capacity."

I often read suggestions that part of 'the consent consultation' is the 'confirming of the patient's capacity DURING the consultation'.

I believe that the logic of the MCA, is that the patient's capacity should be questioned BEFORE the consent consultation, if a lack of capacity is suspected: not only are the MCA's decision-making frameworks very different for capacity and incapacity, but that '... cart before the horse' issue is problematic if capacity is questioned after the patient has expressed a decision.

I would also point out – the GMC's description, and Mr Justice Jackson's wording, are not an easy fit with the idea that 'the patient's rationality can be assessed' during a consultation.

A little bit of thinking

I cannot see where the concept of 'Informed Consent or Considered Refusal' requires that a patient 'explains why I am deciding as I am' - if we use my argument that 'capacity should be challenged before the actual treatment on offer is discussed', then the logic of the MCA fits much better.

I fully accept, that if during the consultation things emerge which seem to suggest the patient lacks capacity, the doctor must consider the issue of capacity - but, if the doctor asks 'why are you deciding that way' it seems to me that the patient can perfectly legally reply 'that is my business - not yours'.

This line of reasoning casts doubt on the 'prudent' patient requirement, and it makes it deeply challenging to apply the concept of a 'rational patient': it is obvious that if we are to have a concept of mental incapacity, then we need to somehow have a 'test for incapacity' if we are to apply the concept in practice. But, it seems to me that in reality the MCA describes concepts - 'if capacitous the patient decides' and 'if incapacitous best-interests applies' - but because it is very difficult to explain how capacity can be assessed, the MCA rather dodges that issue. Then, for various reasons which include 'beneficence' and 'concepts of safeguarding', working professionals construct guidelines and behaviours which often seem to conflict with the MCA itself.

There must also be a question, around an 'apparent assumption' that the doctor will be aware of clinical factors and the patient will not: these days we have both 'expert patients' and social media and the internet. The applicability to the Therapeutic Exception would involve an analysis of 'the irrational but fully informed' patient concept.

I will throw in something from Justice Sir Mark Hedley now, and then I will close with a few observations about the Therapeutic Exception but posed as questions. This is the bit from Sir Mark Hedley:

An even clearer example of this patient self-determination, can be found in a story a Court of Protection out-of-hours duty judge, Sir Mark Hedley, told to a newspaper - I gave the details in my piece:

<http://www.bmj.com/content/350/bmj.h2883/rr-2>

In essence, the judge told some hospital doctors that they could not legally treat a suicidal patient against the patient's wishes. As I explained in the above piece:

'There was a report in The Independent (newspaper), June 24th 2013 (carried on pages 1, 6 and 7), when Sir Mark Hedley, a recently-retired judge, explained that 'I decided at 10pm that a suicidal man with mental health problems could be allowed to die of an overdose rather than order doctors to pump his stomach ... I decided he had capacity [to refuse treatment], so he died that night. That's exactly what he wanted to do... That one never found its way into any report of any sort.'

It was explained by Sir Mark, that the hospital's doctors phoned him [he said that was unusual – it would usually be the hospital's lawyers who phoned] – but, it is clear that being suicidal does not necessarily remove mental capacity, according to the MCA. This is 'deeply challenging for doctors' - and probably even more challenging, for 999 staff.

This piece is becoming too long, so I will now state my observations about the Therapeutic Exception. I'm not sure that all of these are in Emma Cave's paper, although the 'lines of reasoning' probably are.

1) The MCA's framework describing Advance Decisions – especially written ADRTs which would be first read and considered only after a patient had lost mental capacity – do not seem to include, or even allow for, any concept of the Therapeutic Exception.

2) There is definitely an influence on the patient's decision-making, if the Therapeutic Exception is exercised by a doctor during a consultation with a capacitous patient: it 'blurs the boundary between the MCA's Informed Consent and the MCA's Best Interests'. And by the nature of the TE, **the patient isn't aware**. If a doctor tells a patient 'I do not consider you to be capacitous – it isn't your decision' then in theory the patient can phone a Court of Protection judge, who might say to the doctor 'your patient seems capacitous to me – it is the patient's decision, it isn't your decision'.

But the covert way in which the Therapeutic exception works, means the patient is not aware of it – so, how can the patient 'claim the protections provided by the MCA'?

3) Cave did point out, that it might be a friend or relative, who understands that 'telling the patient would probably cause serious harm'. Cave goes on with:

It might be, for example, that a family member or carer suggests that this information would alarm the patient in which case the clinician can explore this with the patient if there is a sense that disclosure would risk serious harm. Provided clinicians carefully recorded this in the patient's notes, they should have nothing to fear from the law of negligence or professional regulation. There is no need in these circumstances to invoke the TE: the test for materiality is now sufficiently nuanced to allow clinicians limited scope to adapt the information to suit the needs of the particular patient.

Suppose that this patient, who is not being given certain pieces of clinical information because of the TE, has previously appointed a Welfare Attorney under the LPA. The invoking of the TE blurs the line between Informed Consent and Best Interests – and if 'we do something that strays into MCA best interests', and arguably TE must be doing that, isn't it for

the patient's welfare attorney to decide what is in the patient's best interests, and therefore for the attorney to decide whether the TE should be invoked?

CLOSING

I will close, by mentioning something written by Mr Justice Hayden, and which is relevant to Informed Consent, even if it comes from Best Interests, and something said by Lady Hale. I'm not entirely sure, that any of us really understand exactly why we make many decisions: we definitely rationalise our own decisions, but all the rest of the world can observe 'is what we do and say'.

Mr Justice Hayden, in a wonderfully-worded [description](#) of his considerations when a patient was not mentally-capable, pointed out the obvious – that 'a person's mind is revealed by her actions as well as by her words' (my own added bolds):

*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.*

It always strikes me, when I am reading 'legal debate', that particular phrases used within court rulings are 'endlessly trotted out' as if the words are what is fundamental: it isn't the words that are fundamental, it is the 'thinking inside the judge's mind' which is fundamental. As [I have](#) pointed out 'judges sort out the principles in their own minds, and then are forced to try and explain these principles using words (a process, which is not without its problems)'.

Lady Hale, seemed to say the same thing in *Montgomery* (117):

These additional observations, dealing with the specific example of pregnancy and childbirth, are merely a footnote to the comprehensive judgment of Lord Kerr and Lord Reed, with which I entirely agree. Were anyone to be able to detect a difference between us, I would instantly defer to their way of putting it. I would allow this appeal.

From my patient and family-carer during end-of-life perspective, I can't help thinking that it would be better to sort out various other problems with MCA interpretation and implementation, before trying to address the TE – most notably, [this](#) one:

One place where this can easily be seen, is the issue of cardiopulmonary resuscitation (CPR) when a patient is at home, and a cardiopulmonary arrest (CPA) is not considered likely. Clinicians often imply, in their writing, that in this situation the patient cannot refuse CPR by means of a written Advance Decision (ADRT). This is utter rubbish, logically: I am not expecting that a drunken driver will swerve his car onto the pavement and hit me, but I can certainly think about the likely consequences, if that were to happen. Similarly, I can consider the consequences of an unexpected CPA.

The only thing which does definitely follow from a home CPA being unexpected, is that the GP could not certify the death – but that is an unrelated issue, to whether I can use an ADRT to forbid attempted CPR for a 'sudden CPA'.

If I consider such a 'sudden CPA' and then I write an ADRT refusing CPR for it, I would be doing that in the knowledge that if I were in CPA when 999 paramedics arrived at my home [after, probably, having been called by another person such as a spouse, who had seen me collapse], I would not be conscious – so, I would have written the ADRT with the intention that it should be followed, in exactly that situation (of an unexpected arrest, and when there was no time to look at my ADRT beyond confirming its Prima Facie validity).

Clinicians seem to think, that in this situation – when there is 'an emergency' – my ADRT can be ignored, because there is no time 'to confirm it'. But to the author of such an ADRT, surely that is exactly the opposite of what you would expect – as I wrote in 'ReSPECT is incredibly DISRESPECTFUL':

'An ADRT which appears prima facie valid should be accepted as being valid, if there is not enough time to check in more depth: it is during a non-emergency that the prima facie apparent validity of a written ADRT should be further examined !'

By the way – I've only just remembered that I wanted to comment on this.

The justification for 'necessity' is **not** 'a clinical emergency'.

The justification is 'there is 'a clinical emergency' and it isn't possible to apply best-interests'.

Written by Mike Stone, May 2018

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If you liked this piece – then I'm quite surprised!

Another piece I've just started on - 'Yes – but no, but ...' should be a much better read, if I get it right. The analytical theme of that piece, is why healthcare professionals have so much trouble when the MCA impinges on their day-to-day working lives: I will be explaining, that the problem isn't the MCA itself, it is the other stuff ('safeguarding', 'records and audit', etc) which are thrust onto the shoulders of doctors and nurses, and which often seem to conflict with the MCA. As a GP in London told me in an e-mail a few years ago:

I recently had MCA training and it was made clear that the hope of the act was that it would be empowering of the patient and perhaps the development of the IMCA role demonstrates that aspiration.

We also have the whole 'safeguarding' agenda pushing in the opposite direction.