End-of-Life and Perspective part 6: Us and Them

I perceive a distinction between professional clinicians and family-carers, even when no such distinction is justified: my perception, is that there is more to this than simple misunderstanding [for example of best-interests decision-making] and that it **does** indicate a ‘desire’ on the part of clinicians to ‘control’ situations.

On ‘who can do it?’ grounds, such a professional/lay distinction falls down for some interventions – notably for cardiopulmonary resuscitation which is quite widely taught as first aid, and therefore could be attempted by many non-clinicians.

Even more mysteriously, there seems to be an implication within much writing that MCA best-interests decisions about medical interventions can only be made by clinicians: this is so easy to dismantle ‘technically’ by analysing the MCA itself that I will not do that here, and I suggest readers do it for themselves. Instead, I will point to a looser ‘proof’ which while not rigorous, is reasonably compelling, and it goes like this:

1) Nobody has ever argued that a capacitous patient cannot validly consent to, or refuse, the offer of brain surgery, on the grounds that the patient is not capable of performing brain surgery;

2) The MCA’s best-interests framework, is the replacement during incapacity for the Informed Consent of 1) which applies while the patient is capacitous;

3) So why would best-interests decision-making require the decision-maker to be clinically skilled, when Informed Consent does not?