

Stumbling towards a correct description of the MCA: v2

I have been discussing the Mental Capacity Act with a barrister during the past few weeks. From my perspective, the objective is two-fold:

- 1 To work out exactly what the law says, in a scenario which is described in a paper, currently under peer-review, of which I am a co-author, and
- 2 To work out how that law can be described both correctly and in language which would be understood by readers who range from family-carers to doctors, and who crucially are NOT lawyers.

The problems posed by 1 and 2 are different, and 1 makes 2 distinctly difficult (but I hope not impossible – although at the moment, it certainly looks to be close to impossible than it is to easy!).

During our e-mail discussions, the ‘Aintree’ court ruling cropped up. I had not read Aintree, and now that I have read the ruling, I will use Aintree to explain my arguments. Unfortunately I do not have a link which goes to the Aintree ruling (the barrister very kindly sent me the PDF of Aintree) but the PDF describes the ruling as **Michaelmas Term [2013] UKSC 67 On appeal from: [2013] EWCA Civ 65** and the case is **Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant)**.

I will comment – **a lot of this**, hinges on the fact that I first read the MCA in 2009 and my perspective was that of a family-carer during End-of-Life-at-Home who could in theory have been a welfare attorney (‘LPA’), whereas ‘judges are judges’.

There is one particularly ‘intricate’ issue, which I must thank the barrister for drawing to my attention. I had not cottoned-on to this, despite having been involved in debate about the MCA for a decade. It is so tricky, that I will devote Appendix 1 to a fuller discussion of it. The issue is this: legally, a doctor **cannot** make a decision under the MCA. And I don’t mean that sometimes the doctor would not be the decision-maker – I mean that the doctor can NEVER be the decision-maker. And, a family-carer cannot be a decision-maker either. Nor can a nurse, a paramedic or a social worker.

If you read the original version of the Code of Practice, you would not realise that point. Even if you read paragraph 29 of Aintree, you would be misled (my added bolds):

29. It is important to read these paragraphs as a whole. **As paragraph 5.33 makes clear, doctors have to decide whether the life-sustaining treatment is in the best interests of the patient.** Section 4(5) does not mean that they have to provide treatment which is not in the patient’s best interests. Paragraph 5.31 gives useful guidance, derived from previous case law, as to when life-sustaining treatment may not be in the patient’s best interests. Both the judge and the Court of Appeal accepted them as an accurate statement of the law and so would I. However, they differed as to the meaning of the words in italics. The Code is not a statute and should not be construed as one but it is necessary for us to consider which of them was closer to the correct approach.

The problem, is that our law has adopted the position that only what I will describe as ‘formally empowered’ people can make decisions under the Act – it is expressed in Aintree if you already understand it:

19. However, any treatment which the doctors do decide to give must be lawful. As Lord Browne-Wilkinson put it in *Airedale NHS Trust v Bland* [1993] AC 789, which concerned the withdrawal of artificial hydration and nutrition from a man in a persistent vegetative state, “. . . the correct answer to the present case depends upon the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If in the circumstances they have no right to continue artificial feeding, they cannot be in breach of any duty by ceasing to provide such feeding” (p 883). Generally it is the patient’s consent which makes invasive medical treatment lawful. It is not lawful to treat a patient who has capacity and refuses that treatment. Nor is it lawful to treat a patient who lacks capacity if he has made a valid and applicable advance decision to refuse it: see 2005 Act, sections 24 to 26. **Nor is it lawful to treat such a patient if he has granted a lasting power of attorney (under section 10) or the court has appointed a deputy (under section 16) with the power to give or withhold consent to that treatment and that consent is withheld;** but an attorney only has power to give or withhold consent to the carrying out or continuation of life-sustaining treatment if the instrument expressly so provides (section 11(8)) and a deputy cannot refuse consent to such treatment (section 20(5)).

I will now leave this issue, until I return to it in Appendix 1: it hinges on that ‘with the power to give or withhold consent to that treatment’ and the consequent re-phrasing of that in terms of who can ‘legally make decisions’ under the MCA. I will emphasise – everyone still has to apply section 4, and section 4(9) does apply (and hence so do the legal protections offered by section 5) to everyone, whether or not the person ‘can make a decision’ under the MCA.

My Understanding of what the MCA says about Best Interests

I will explain, what I think the MCA says first. Then, I will attempt to explain why I consider our judges have been ‘stumbling towards a correct description of’ the MCA.: and I will state what is, in my opinion, the correct description of the MCA. Then, I will explain how if you describe the MCA correctly, it makes it simpler to apply the MCA. And I hope to persuade people, that my description is clearer, and therefore is easier to apply: I am not really arguing that the more recent court rulings typically clash with my description, but I am arguing that because my version is more coherent, it allows for clearer thinking.

Aintree paragraph 47 started with:

47. There are some additional comments to be made. First, the interveners have argued that to allow this appeal would be to change the law as previously understood. As I have endeavoured to show, upholding the judge’s view of the law does not in any way change the law as previously understood. If anything, it was the Court of Appeal which did that.

Aintree paragraph 18 includes:

18. The judge began in the right place. He was careful to stress that the case was not about a general power to order how the doctors should treat their patient. This Act is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under this Act, therefore, the court has no greater powers than the patient would have if he were of full capacity. The judge said: “A patient cannot order a doctor to give a particular form of treatment, although he may refuse it. The court’s position is no different”

In general, we could write:

The MCA allows a court to achieve for an incapacitous patient, something which a capacitous patient could do for himself.

Aintree was about the withholding of potentially life-sustaining treatments, and it is useful to rephrase the above in the context of life-sustaining treatments:

An outcome which a patient can achieve by means of an Advance Decision, must be possible as an outcome of the best-interests process.

We also need to consider how patient autonomy applies, during capacity – Informed Consent or its flip side of Considered Refusal. In principle – and this is simplest so we should avoid, while ‘working out the rules’, the more complex case of a patient throwing in additional objectives during the consultation process – a patient can simply say ‘I have this pain in my shoulder – what treatments can you offer me?’. Then the doctor examines the patient, and describes the treatments which are available and their clinical outcomes (the prognoses of the offered treatments if applied). This is important to understand: the prognoses contain uncertainty – **the uncertainty of the outcome of a treatment, is one of the things the patient considers when deciding whether to accept or refuse an offered treatment**. An uncertain prognosis, does NOT prevent Informed Consent from taking place. And – the reasons why the treatment is being offered, are quite complex (but in essence, if we are thinking of the NHS, are ‘would the treatment have a clinical benefit’ and ‘does the NHS fund the treatment’) and **they are quite separate from** ‘the patient’s consent or refusal’.

We need to adopt this way of thinking, about the processes during capacity and incapacity:

At the stage in the process when a capacitous patient considers offered treatments, the best-interests process steps in if the patient is not capacitous with respect to the decision under consideration.

Perhaps a clearer way of expressing this, is to point at the Act’s description of how a capacitous person makes a decision in 3(1):

(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).

and to think of the best interests process as replacing 3(1)(c) if the person is not mentally capable.

It is also necessary, to accept that what the MCA does **is to define** Best Interests in its section 4: as Mr Justice Charles wrote in 'Briggs':

(16) 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.

We also need to understand that while the Act is clear, in not defining Best Interests as being Substituted Judgement, as Mr Justice Charles deduced in Briggs, for life-sustaining treatments the concept to be applied is effectively substituted judgement:

62. 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.

That conclusion, is something I had worked out for the withholding of potentially clinically-successful cardiopulmonary resuscitation (CPR) a couple of years before Mr Justice Charles arrived at the same conclusion for CANH in Briggs. It is best stated like this:

When the non-application or withdrawal of a life-sustaining intervention is being considered, the best-interests process becomes a two-stage one:

STAGE 1: if it sufficiently clear what this particular patient's decision would have been, if the patient had been capacitous in the circumstances, then the best-interests decision is the decision the patient would have made, and

STAGE 2: if the decision which the patient [if capacitous] would have made is not sufficiently clear, then the best-interests decision is to attempt to preserve life.

We must also understand, that the above is only true because of the consequences of section 4(5) of the Act – unless section 4(5) applies (in other words, if the treatment is not potentially life-sustaining) Best Interests does NOT become [expressed pragmatically] identical to Substituted Judgement. Readers will have noticed, that – much as it is impossible to be clear exactly how the factors in 4(6) are to be balanced when the best-interests process is being applied to interventions which are not life-sustaining – the point which cannot be more precisely explained in the above is the word ‘sufficiently’.

In a wider sense, when a treatment would not be life-sustaining, the complexity of describing best interests remains – Aintree:

36. The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts. As Hedley J wisely put it at first instance in *Portsmouth Hospitals NHS Trust v Wyatt* [2005] 1 FLR 21, “The infinite variety of the human condition never ceases to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests” (para 23). There are cases, such as *Bland*, where there is no balancing exercise to be conducted. There are cases, where death is in any event imminent, where the factors weighing in the balance will be different from those where life may continue for some time.

Personally, I believe that we need some description of the objective of the best-interests process, which is legally correct but much less ‘nerdy’ than ‘read section 4 and work it out yourself’. My suggestion is this sentence, which I published in the Discussion Forum on the Dignity in Care website:

<https://www.dignityincare.org.uk/Discuss-and-debate/download/292/>

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.

Again, I consider the sentence is a correct description of the objective of the best-interests process, but it is not possible to turn ‘the most satisfactory future’ into some sort of simple check-list.

To be very clear about this: I am NOT arguing in this piece, that the MCA’s Best Interests is simple to describe. I AM arguing, that if the process is described correctly, then it makes application of the process easier [and that by describing the process correctly, it is easier to understand what best interests means].

The correct description of the MCA

Except that people, including judges, frequently and both unhelpfully and unnecessarily conflate patient autonomy with best-interests decision-making, by writing ‘a capacitous person decides what is in his own best interests’ instead of the more helpful statement ‘a

capacitous person makes his own decisions', I will move directly on to best-interests decision making because how the MCA applies during capacity is already well-described and well understood. There are some paradoxes within the Act, which I am not going to examine here, in a piece which is in essence about best interests. But I will add, in passing, that section 3(1) does NOT describe how capacity can be assessed – it describes how a person who is capacitous, makes a decision (3(1)(c) is a statement of things which are going on inside the person's mind – and if a clinician asks 'how did you reach your decision' {which amounts to asking about 3(1)(c)} a patient is entitled to say 'How I make my decision is none of your business – unless you are asserting that I lack capacity, your role is to provide me with the clinical information which I then consider').

So, the correct description of Best Interests, in my opinion, involves:

The objective of the best-interests process 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.

Being legally nerdy, it seems we should replace 'make the' with 'arrive at' and we need to replace 'decision' with some other term (I am perplexed, by with what: in theory it would be 'action or inaction') - but I am not sure what a non-legal reader would make of:

The objective of the best-interests process is to arrive at the best-interests action or inaction which would result in the most satisfactory future when considered from the perspective of the incapacitous person as an individual.

We could write 'outcome' instead of 'action or inaction' but, perhaps because judges in those rulings spend ages writing about the differences in legal protections according to whether the outcome is 'action or inaction', I have written it that way here.

We also have:

This is important to understand: the prognoses contain uncertainty – **the uncertainty of the outcome of a treatment, is one of the things the patient considers when deciding whether to accept or refuse an offered treatment.** An uncertain prognosis, does NOT prevent Informed Consent from taking place. And – the reasons why the treatment is being offered, are quite complex (but in essence, if we are thinking of the NHS, are 'would the treatment have a clinical benefit' and 'does the NHS fund the treatment') and **they are quite separate from** 'the patient's consent or refusal'.

And we have:

When the non-application or withdrawal of a life-sustaining intervention is being considered, the best-interests process becomes a two-stage one:

STAGE 1: if it sufficiently clear what this particular patient's decision would have been, if the patient had been capacitous in the circumstances, then the best-interests decision is the decision the patient would have made, and

STAGE 2: if the decision which the patient [if capacitous] would have made is not sufficiently clear, then the best-interests decision is to attempt to preserve life.

All of which, are to be considered in the context of:

At the stage in the process when a capacitous patient considers offered treatments, the best-interests process steps in if the patient is not capacitous with respect to the decision under consideration.

And in the overall context of:

An outcome which a patient can achieve by means of an Advance Decision, must be possible as an outcome of the best-interests process.

We now only need to add in to the mix, a few other things.

One, is that the fact that it is possible to do something immediately you have decided to do it, and it is also possible to ‘decide what to do, and also to decide that I will do it tomorrow’. I will not be discussing the issues which arise from this.

The other, is often more than one person might be able to both form a legally-defensible position about best interests, and also to be capable of performing the intervention in question: this is true for CPR, which I will discuss later.

And – **crucially** – we must pay attention to what section 4(9) of the Act actually says:

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.

It is worth pointing out, that nothing in that sentence suggests that relatives cannot justify their actions by claiming to have complied with section 4(9) – and Aintree agrees, as in paragraph 47:

Third, if the clinical team are unable to reach agreement with the family or others about whether particular treatments will be in the best interests of the patient, they may of course bring the question to court in advance of those treatments being needed.

We can now start to apply the above, to what can be found in various court rulings.

How if you describe the MCA correctly, it makes it simpler to apply the MCA

Understandably, lawyers and judges spend a lot of time arguing about exactly what behaviour is legal, and precisely where does the legal protection come from. I admit, that I frequently find the arguments presented to be confusing – and I will now attempt to show that this is in part because the judges are not framing the question correctly (a point which Lady Hale did almost mention, in paragraph 47 of Aintree).

Mr Justice Charles, in Briggs, devoted a quite lengthy discussion to ‘the doctrine of double effect’. The idea of the doctrine, expressed rather loosely, was that if a patient was harmed by a side-effect of a sensible treatment, then the doctor would not be legally liable. But it seems to me, that the Doctrine of Double Effect did not need discussion – for the simple reason that it no longer exists, in legal terms. If you ponder what I have written above, it will be clear that the risks associated with an intervention are described by the doctor, but it is either the patient or ‘the best-interests process’ which then decides whether the risk of administration of the treatment is acceptable. Put simply: the defence which was **formerly provided by** the Doctrine of Double Effect, **is now** provided by the MCA if the Act is properly complied with.

Before I leave the issue of side effects, I will present a logical argument. Under our law, suicide is legal but assisting a suicide is illegal. Many offered treatments involve the risk, if very small, of death – for example, in theory any surgery must leave the patient at a risk of a fatal infection. I write about end-of-life (EoL), and it seems to me that there is nothing illegal about the offer of life-shortening interventions, where the shortening of life is a side-effect of the objective of the treatment, and provided a capacitous patient has consented. If a doctor says ‘I think you will probably die in two or three weeks, and you are already in great pain. Unfortunately the only interventions which we can offer, which would adequately relieve your pain, would probably also shorten your remaining life – to perhaps one or two weeks, instead of two or three weeks’. Surely, that risk is for the patient to accept if he decides to do so. That is not the same as a doctor offering an intervention, which he knows would quickly kill the patient: that would amount to assisted suicide. I will point out – while in principle, this would also be true via best interests, it is very much more problematic if the patient lacks the capacity to make the decision himself.

In passing, I will add that Mr Justice Charles spent quite a lot of time, analysing if he could make a best-interests decision to withdraw CANH. I am still puzzled as to why: he had said that he must apply the MCA, and he had shown us section 11 of the Act which states that a suitably-empowered attorney can consent to, or refuse, a life-sustaining treatment. It is not at all obvious to me, a non-lawyer, why Mr Justice Charles did not simply say ‘In view of 11(7) and 11(8) which make it clear that suitably-empowered attorneys can refuse the carrying out or continuation of life-sustaining treatment, it would be legally perverse if as a judge I could not do the same’.

We can also conclude, from what I have written above, that the withholding of a life-sustaining treatment [on best interests grounds] if it might prolong life but ‘in an awful clinical situation’ should not be described in terms of the prognosis itself being so awful that a ‘typical person’ would not accept that outcome: it should be expressed, in terms of an ability of the decision-maker to persuade himself that step 1 of the 2-stage process described by Mr Justice Charles is satisfied. It should be expressed as ‘I am persuaded, that this particular patient if faced with the likely outcome of the intervention under consideration, would have refused the intervention’.

NOTE: in the original version of this piece, there was a proof-reading error in the paragraph above [but the final sentence, was correct].

In Aintree, there was much discussion of the question which should be asked, in order to establish where the legal protection offered by the Act comes from. For example:

17. It is tempting therefore to approach the case as if the question is whether it would be in Mr James' best interests to withhold those treatments should they become necessary in order to sustain his life. But is that in fact the right question? Whatever may be the position in relation to declarations about matters other than medical treatment, there are some basic principles relating to medical treatment which may help us to identify how these cases ought to be approached.

My analysis above, will I hope persuade the reader that such a question is totally unnecessary [which might be why judges struggle to answer it]. We simply combine:

An outcome which a patient can achieve by means of an Advance Decision, must be possible as an outcome of the best-interests process.

with the principle that only treatments which are legal can be offered, and it seems to me that obviously best-interests decisions must be legal whether they are the application or the withholding of an offered intervention.

Aintree did arrive at the same conclusion in paragraph 19:

19. However, any treatment which the doctors do decide to give must be lawful.

Unfortunately, in paragraph 18 we can find the mysterious:

Of course, there are circumstances in which a doctor's common law duty of care towards his patient requires him to administer a particular treatment, but it is not the role of the Court of Protection to decide that.

I cannot, myself, reconcile that with what I have reasoned above: there surely can no longer be a 'common law duty of care' in the context of the application or withholding of medical treatments, because the only two possibilities involve either patient autonomy or else the MCA's best-interests concept. Perhaps the judge meant that if the second stage in the 2-stage best-interests process is resorted to, that is not 'genuine' best-interests decision-making (and indeed, I myself describe stage 1, which requires a deep understanding of the patient's individuality as a 'genuine best-interests decision', and stage 2 as 'default preservation of life'). But I am not sure, what the judge meant [and the case was 2005 – which is a long time ago].

I think patients, and relatives during incapacity, have the right to know why the NHS is not offering a treatment. If an intervention is not on offer because it is too expensive for the NHS to afford, we should be told that. In theory, a legitimate reason to withhold CPR might be that the likely cost of care if life were restored by the CPR would be too great for the NHS to bear: I have never seen that given as a reason to not attempt CPR, but in theory it could be legitimate – but it is NOT 'a best-interests decision'.

I cannot resist, briefly mentioning a scenario, which is at the heart of a paper currently being peer-reviewed, and of which I am a co-author. The paper invites an analysis of the legal situation in two scenarios, one of which is described in the paper [and the other of which is implied].

I invite readers, to ponder the law as it applies to both the wife and the paramedic in two situations. **And to then describe the relevant law in a way which a typical wife would understand.**

A) A wife is with her husband when he suffers some sort of collapse, and when the paramedics arrive it turns out the husband is in cardiopulmonary arrest and the paramedics are clearly about to attempt CPR – at which point the wife shouts at them ‘Don’t do that – I know my husband would not want CPR if his heart has stopped!’.

B) A wife is with her husband when he collapses and the wife thinks his heart has stopped. Her husband has made it clear to her, that if his heart has stopped he would never want any attempt made to get it beating again. So the wife simply holds his unconscious hand, until his hand has grown cold and he is clearly dead – then she calls someone.

It is clear to me, that we need agreement about exactly what the law is in the following situation (which is comparable to A) above, if not exactly so):

Suppose a comatose patient is being kept alive by ‘invasive’ life-support measures in hospital. These were put in place on best-interests grounds, after extensive discussions between the clinical team with primary ‘responsibility for’ the patient’s clinical care and the patient’s close family and close friends. If an ‘outside nurse’ - perhaps an agency nurse, or a nurse covering from an entirely different part of the hospital – arrives on the ward at 10 pm on a Saturday night, and is ‘tasked with’ checking that the patient’s life-sustaining interventions are ‘okay’ (no blocked tubes, etc): **what is the nurse’s legal defence against ‘continuing to invade the patient’s body’?** This nurse has suddenly been dropped into the situation – this nurse was not involved in those extensive discussions about best interests, which provide a clear legal defence for the clinicians who were involved in those discussions.

In Conclusion

I told the barrister I have been discussing the MCA with, that I was going to write this piece. Before I had written it, he pointed out that I would understand why if what I wrote disagreed with what judges had written, he would necessarily go with what the judges had written. After he reads this piece, I await with interest his view on whether what I have written, is in reality different from ‘what judges have been trying to get across in their rulings’.

Appendix 1

There is something in the law, which I admit had effectively passed me by until my recent discussions with the barrister. Knowing this does not really affect my analyses of how best-interests as a process works – but it changes how the process should legally be described.

It hinges on the phrase 'consent to, and refuse, an offered treatment'. Apparently, in law, only legal proxies (welfare attorneys and court deputies) and courts can 'be decision makers under the MCA'. But, anyone can claim the legal protections offered by section 5, provided the person can defensibly claim to have satisfied 4(9).

In a nutshell, technically welfare attorneys, court deputies and courts, can be described as decision makers (and also as being able to consent/refuse) under the MCA: and nobody else can be described as a decision maker.

So doctors, family carers, paramedics, friends, nurses and everyone else, can never in law be described as decision makers under the MCA.

I had always described anyone who worked through the requirements of section 4 and satisfied 4(9) as a decision maker – then on top of that, I described attorneys and deputies as possessing legal power over best-interests decision-making.

This is so awkward to write about, that the Code of Practice did not seem to even attempt to not describe doctors, etc, as 'decision makers'.

And even in Aintree, we can find in paragraph 29 the sentence:

Both the judge and the Court of Appeal accepted them as an accurate statement of the law and so would I. However, they differed as to the meaning of the words in italics.

The sentence refers to three sections of the Code, reproduced in paragraph 28, the third of which (5.33) includes the sentence:

Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests.

Third, if the clinical team are unable to reach agreement with the family or others about whether particular treatments will be in the best interests of the patient, they may of course bring the question to court in advance of those treatments being needed.

All I can really say, is that since my discussions with the barrister have now improved my legal understanding to about GCSE grade 4 level, I can understand who is, and who is not, 'legally a decision maker under the MCA' - but that if anything, makes it more difficult to describe the MCA in language which 'the woman on the Clapham omnibus' could easily understand.

It also raises some apparent complexity. A welfare attorney would 'consent or refuse' if clinicians asked 'do you consent to us applying this treatment'. If the clinicians asked 'would it be in the patient's best interests for us to apply this treatment' (which is a question carrying the implication that the treatment is being offered – especially as the nature and prognosis of the treatment would need to be described to the attorney) then presumably the attorney would reply 'application of the treatment would be in his best interests'.

I now need to digress, and to discuss how the MCA appears on the page in the version of the Act which I refer to. Section 4(7) appears like this (and in passing, section 4(7) can easily be misleading – sections (c) and (d) clearly do not apply if the attorney or deputy has legal authority over the best-interests decision being considered):

(7) He must take into account, if it is practicable and appropriate to consult them, the views of

—

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (b) anyone engaged in caring for the person or interested in his welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

Logically, that must 'mean' this:

(7) He must take into account, if it is practicable and appropriate to consult them, the views of

—

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (b) anyone engaged in caring for the person or interested in his welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court,

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

Using similar reasoning, while section 6(7) appears as:

(7) But nothing in subsection (6) stops a person—

- (a) providing life-sustaining treatment, or
- (b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition, while a decision as respects any relevant issue is sought from the court.

it presumably should be read as being:

(7) But nothing in subsection (6) stops a person—

- (a) providing life-sustaining treatment, or
- (b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a decision as respects any relevant issue is sought from the court.

Which gets me to something I am a bit puzzled by. There is no doubt, that section 6(7) applies if a welfare attorney expresses a best-interests decision, that a potentially life-sustaining intervention should be withheld. And it specifically allows the clinicians (actually it allows 'any person') to act to keep the patient alive 'while a decision is sought from the court'.

I cannot see, where there is a similar provision if the attorney 'refuses' an offered treatment. Clearly the clinicians can apply for a court ruling (or, more correctly, they can apply for permission to apply to the court) – but I cannot see where they are given a legal authority to keep the patient alive until the court has become involved?

Written by Mike Stone, June 2020.

