

MCA Best Interests positioned in the process

I have recently been irritated by terms such as 'clinical decision' and 'futile' in the context of decision-making for medical interventions. Those terms and also some others, in my view fail the test of 'clarity': they obfuscate, rather than shedding light.

In this piece, I will use as the base of my analysis the description within some 2010 General Medical Council guidance, of the process which leads to either Informed Consent or a refusal of an offered treatment. The GMC wrote this:

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.

I consider the above to be a correct description of the process if the patient is capacitous, and I will now address the process when the patient lacks capacity, based on the above.

Sections a) and b) need a little modification if the patient lacks capacity, so here I will express the combination of sections a) and b) as meaning this:

The first stage of the process, is to establish what treatments might improve the patient's clinical condition, and the risks and benefits for the treatments are determined and outlined.

So I will now present a variation of what the GMC wrote, as follows:

a) + b) The first stage of the process, is to establish what treatments might improve the patient's clinical condition, and the risks and benefits for the treatments are determined and outlined.

(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.

We now need to introduce a piece of 'external argument'. Presumably, it should not matter, in terms of what treatments **are offered**, whether or not the patient is mentally capable? Because to do otherwise, would surely be unacceptable: refusing to offer a cure for the pneumonia of a person with severe learning difficulties, because of the person's learning difficulties, for example, simply isn't on in 2021!

So, my modified a) + b) works for both capacitous and incapacitous patients.

It is now easy to see, that the Mental Capacity Act's best-interests process stands in at stage c) – at the point when a capacitous patient would consider the options, and then accept or refuse an offered treatment, we have no option but to use Best Interests instead if the patient lacks capacity.

The above is important, because it makes it obvious that whatever the reasons are why a treatment is offered (so, engaging with the term 'clinically indicated', here), **those reasons are nothing to do with MCA Best Interests.**

There is something else of interest, which this use of the GMC's description of a consultation during capacity, but used as it would have to be logically-modified to apply during incapacity, raises. Readers will note, that in section d) the GMC considers the situation of a capacitous patient asking for a treatment which has not been offered by the doctor.

The GMC's section d), is apparently intended to cover treatments which the doctor did not offer because the doctor considered the treatment would not work: however, treatments

which would probably work but which the NHS is not funding will also not be offered. And, it might be pointed out that 'if you pay privately, you can get a different treatment or you can get the treatment sooner'.

We are often told, that Best Interests is only about offered treatments. We are told that a Welfare Attorney can only decide whether an offered treatment is in the patient's best interests. I am not at all sure about that: in the same way that I made it clear that a) and b) must involve different criteria from c), I think a welfare attorney could reasonably say 'I think treatment X would be in the patient's best interests – but as the NHS isn't offering treatment X, she can't have that treatment, can she'. It then gets a little interesting: the welfare attorney, if treatment X is not being funded by the CCG but if the welfare attorney thinks it would be the best option if it were available, can surely argue to the CCG that provision of treatment X would be in the patient's best interests (in the way that a capacitous patient, who wanted a treatment the CCG was not funding, might lobby the CCG to try and persuade the CCG to fund the treatment). Whereas the doctor – who is part of an NHS 'which has to use its resources in a way that is fair to all patients' - has more complex issues to consider, when deciding whether to lobby the CCG to provide the treatment (basically, the NHS has to try and spend its money to help all of its patients – it cannot afford to offer hugely expensive treatments to all NHS patients: however MCA Best Interests is about what would be best for the particular [incapacitous] patient).

Anyway: the take-away from the above, is that whatever Best Interests actually involves, ***it stands-in for the stage of 'Informed Consent/Considered Refusal' when a capacitous patient would make his or her decision***. So there is not any 'MCA Best Interests' involved in determining which treatments are [at least initially – i.e. if we only consider a) to c), and set aside any issues arising from d)] offered by a doctor.

I feel sure, that in reality, there is often some 'blurring' of the stages which the GMC has described: in particular I suspect that often aspects of a) and b) will 'flow into each other', which is why when I modified the GMC's description I lumped both a) and b) together.

But we should not 'blur' c) with the earlier stages – we cannot accept what amounts to 'the doctor failing to offer a treatment 'because the doctor thinks it would not be good for the patient''.

In the lawyer Ben Troke's recent book (A Practical Guide to the Law of Medical Treatment Decisions), Ben mentions that sometimes doctors will make a DNACPR decision which is ostensibly on the grounds of 'futility', but which is in fact 'a covert best-interests decision'. Ben suggests, on page 23 of his book:

'The best way to tease out the clinician's reasoning is to ask whether, if the patient had capacity to decide and wanted to take all the risks involved for the small chance of benefit, the doctor would be willing to provide the CPR. If they would, then it cannot be said to be 'futile', and any DNACPR being led by the clinicians rather than the patient's own choice is really a best interests decision and ought to be seen as such, following the MCA appropriately.'

I know what Ben is saying – although I suspect the final sentence might be a little confusing: I am confident that Ben is saying 'if the DNACPR decision would be for the patient to make if the patient is capacitous, then in the same clinical situation (re CPR) if

the patient lacks capacity the MCA's best-interests process must be applied'. Which might not, as it happens, be any clearer to readers! What Ben is pointing out, but in a different way, is what I have said earlier (We should not 'blur' c) with the earlier stages – we cannot accept what amounts to 'the doctor failing to offer a treatment 'because the doctor thinks it would not be good for the patient'').

What we should do, is to completely stop using the word 'futile' - if doctors always stated 'attempted CPR could not restart the heart' then we would not have this problem with the meaning of 'futile'.

I don't think any of the above is 'revelatory', and it seems pretty-much obvious to me and presumably to many other people. But, as the MCA still seems to be surprisingly poorly understood, I felt it worthwhile to point it out, even if explaining it (as opposed to understanding it) is something I might not be doing very well!

If we change my:

We cannot accept what amounts to 'the doctor failing to offer a treatment 'because the doctor thinks it would not be good for the patient''

to

The doctor should always offer CPR if CPR stands a chance, even a very small chance, of keeping the patient alive

then it might be clearer.

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