

There is one thing in the consultation (currently open as I write) about the Mental Capacity Act's new Code of Practice, which really bothers me. It is a section in the Code, which seems to 'go against what Mr Justice Charles concluded in the 'Briggs' ruling'. I think, there is some 'pre-MCA thinking' involved here.

The section in the draft code which I dislike is this one:

5.63 Asking what is in a person's best interests is not the same as asking 'what would the person have done?'<sup>44</sup>. The final decision must be based entirely on what is in the person's best interests.

And reference 44 is to the Briggs ruling:

44 Briggs v Briggs (No 2) [2016] EWCOP 53, available at:  
<https://www.bailii.org/ew/cases/EWCOP/2016/53.html>

What bothers me, is that Mr Justice Charles wrote in his ruling this:

61. In such cases it can be said that the court is not enabling P to do what he could and would do for himself or herself if of full capacity

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.

A lawyer who I discussed this with, commented that Mr Justice Charles had written earlier in his ruling that he must make a Best Interests decision – but the lawyer failed to point out that Mr Justice Charles had also been very clear that it was 'best interests AS DESCRIBED IN THE MCA' that he was required to work out (in his OVERVIEW section):

(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.

Which brings us to the heart of this: because if we must deduce the meaning of Best Interests BY READING THE MCA ITSELF then all we have to really work from, is section 4 of the Act. And section 4 of the Act, covers all degrees of mental incapacity from capacitous, to 'not-quite-capacitous', and then all of the way to something such as 'comatose'. And, the concept of best interests, applies to a huge range of decisions and in a wide variety of situations.

As Mr Justice Charles stated in his section 61 (see above) 'In such cases it can be said that the court is not enabling P to do what he could and would do for himself or herself if of full capacity' BUT he then opened his section 62 with '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:'.

We might think of 'advance directives' for a moment. The concept of advance directives existed before the MCA was enacted, as did the concepts of 'best interests' and 'substituted judgement'. But the MCA gave us Advance Decisions [to Refuse Treatment] as our (England and Wales) legally-defined version of an advance directive – other countries have different versions of an advance directive. For example, South Australia's version involves an official form which must be completed as detailed in its legislation. It isn't clear (prima facie it seems it is not possible), if it is possible to have a verbal advance directive in South Australia, whereas the MCA allows for advance decisions [which do not involve life-sustaining treatments] to be verbal.

There is, if we work solely from section 4 of the MCA, no reason to believe that in certain tightly-defined situations, the MCA's best interests cannot be 'we should do what the patient would have decided, provided we are sufficiently certain of what that is'. You cannot simply argue '... the MCA uses best interests and it doesn't use substituted judgement' - that is applying a sort of 'pre-MCA argument'.

The circumstances of Mr Briggs – and, it is clear to see of a cardiopulmonary arrest when before the arrest the patient was mentally capable – are:

- 1) A mentally-capable person was rapidly rendered comatose or unconscious, and

2) The decision is whether or not to continue, or apply, a potentially life-sustaining intervention (continued CANH for Mr Briggs – attempted CPR in the situation of the cardiopulmonary arrest).

It is not clear – at least to me – exactly what Mr Justice Charles meant by ‘generally’ in his section 62. However, in the situations above, there is only one capacitous mind, and there is no ‘incapacitous but engaged-with-life’ mind (so it isn’t a situation such as long-term advanced dementia: in the situations I am describing there are no ‘views from an incapacitous person’ to take into consideration). So, considering the strength of Informed Consent and self-determination while capacitous in our modern law, the approach of Mr Justice Charles which amounts to ‘if the patient while previously capacitous had been able to consider the present situation with everything we currently know about it, what would ‘that capacitous mind’ have decided?’ is in my view an obvious and reasonable one. And it also deals with the difficulty around ‘motivation’ which is introduced by MCA section 4(5).

Personally, I find it disturbing to ‘argue with’ a dying loved-one. So if a terminally-ill loved-one (the ‘terminally ill’ aspect isn’t necessary in legal terms – but I’m usually considering end-of-life situations) had made it perfectly clear to me that ‘If my heart stops, I want to be left alone to die – I absolutely do not want anyone to try and restart my heart, under any circumstances’ then I have to be against attempted CPR. And, if I’m sharing a home with that loved-one, then I would of course assume that if my loved-one had a change of mind, my loved-one would tell me of that (see footnote). For this situation and CPR, the ‘family carer’ is in a subtly different situation compared to Mr Justice Charles: Mr Justice Charles had to work out what Mr Briggs would have wanted – the family-carer already knows that the loved-one doesn’t want CPR (but, the family-carer might not be sure if the loved-one’s collapse was because the heart had stopped).

#### FOOTNOTE

The Mental Capacity Act is applied with all-manner of ‘uncertainty’. And it is unreasonable to seek ‘100% uncertainty’ in most real-world situations. If a ‘dying’ loved-one has made ‘decisions about future interventions’ clear to a family-carer who is living in the same home, then the family-carer will of course assume ‘if dad decides to change his mind, and no longer absolutely doesn’t want CPR to be attempted, then he will tell me’. That is IN THE REAL WORLD as certain as it is ever possible to be, ‘that dad doesn’t want CPR’. It is much more certain, than a person who is reading an ADRT refusing CPR but who doesn’t live with the patient could be: there, the ‘doubt’ is ‘has he retracted this ADRT’. The family-carer would of course have almost no doubt regarding any possible retraction of an ADRT – ‘the first thing dad will do if he decides to change his ADRT, is to tell me he has done that’.

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