

I am going to analyse a section from some General Medical Council guidance about end-of-life, which was originally published in 2010 and has been updated in 2022:

## Treatment and care towards the end of life: good practice in decision making

Published 20 May 2010.

Comes into force 1 July 2010. Updated 15 March 2022.

You can find the latest version of this guidance on our website at [gmc-uk.org/guidance](https://www.gmc-uk.org/guidance).

This is the section, I will analyse here:

### **Patients who lack capacity**

**139** If a patient lacks capacity to make a decision about future CPR, you must consult any legal proxy who has authority to make the decision for the patient unless it is not practicable or appropriate to do so. If there is no legal proxy with relevant authority, you must discuss the issue with those close to the patient and with the healthcare team. You must make all reasonable efforts to have these consultations or discussions at the earliest practicable opportunity and they should be approached with sensitivity. In your consultations or discussions, you must follow the decision-making model in paragraph 16. In particular, you should be clear about the role that others are being asked to take in the decision-making process. If they do not have legal authority to make the decision, you should be clear that their role is to advise you and the healthcare team about the patient's wishes and preferences to inform the decision about whether attempting CPR would be of overall benefit to the patient. You must not give them the impression that it is their responsibility to decide whether CPR will be of overall benefit to the patient, or that they are being asked to decide whether or not CPR will be attempted. You should provide any legal proxy and those close to the patient, with the same information about the nature of CPR and the burdens and risks for the patient as explained in paragraph 137.

I will start, by making it clear that my analysis will assume the Mental Capacity Act applies – that we are in England or Wales.

I will start, with '*If a patient lacks capacity to make a decision about future CPR, you must consult any legal proxy who has authority to make the decision for the patient ...*'.

What the Mental Capacity Act (MCA) actually states, in its section 4 [and 'flowed together' here], is:

'The person making the determination must consider all the relevant circumstances and, in particular, take the following steps ... He must take into account, if it is practicable and appropriate to consult them, the views of ... as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).'

This is where 'must consult' comes from – from section 4(7) of the MCA. But, if the legal proxy has authority to make the decision, then logically the GMC should have written 'If a legal proxy has authority to make the decision for the patient, then the legal proxy will consult the doctor'.

**HOWEVER** – that word 'consult' is probably unhelpful, especially when there is NOT a legal proxy with authority involved. The word 'discuss' is better. Because, as is clear from the wording of section 4(9) of the MCA (my added **bolds** here), any person can arrive at a defensible best-interests determination if the person can defensibly claim to have 'done' section 4 correctly:

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.

As the GMC states at the end of section 139 'You should provide any legal proxy and those close to the patient, with the same information about the nature of CPR and the burdens and risks for the patient as explained in paragraph 137.'

A lawyer who is very involved with the MCA, agrees with me that family-carers who are NOT legal proxies can make best-interests determinations:

From me to the lawyer:

*In reality, I am not very bothered about how judges view the Act. My main issue, is an acceptance that family carers who claim to have complied with 4(9) can then claim identical s5 legal protections as a clinician who claims to have complied with 4(9).*

From the lawyer to me in reply:

*Yes, family members can certainly claim to be able to benefit from the s.5 defence (with s.4(9) as the underpinning) if they have carried out an act in connection with care or treatment in relation to the person.*

The MCA is framed in terms of providing a legal defence against accusations of 'intervening without consent' - basically, something such as cardiopulmonary resuscitation is 'prima facie' an assault, and it is compliance with MCA section 4 which protects a person who attempts CPR or performs another invasive intervention. And what alters if there is a suitably-empowered legal proxy, is that then sections 6(6) and 6(7) of the MCA apply:

6(6) Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by—

- (a) a donee of a lasting power of attorney granted by P, or
- (b) a deputy appointed for P by the court.

6(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 isn't that any sufficiently-well-informed person could not arrive at a legally-sound view as to whether or not the provision of a medical intervention would be in an incapacitous person's best interests: it is that once a suitably-empowered legal proxy has expressed a best-interests decision, section 6(6) [and 6(7)] applies.

It is in my opinion better thought of, as I wrote in a piece about the ReSPECT form and the flaws I perceive in that form:

It is surely logically the case, that **in the absence of an attorney or deputy with authority** over best-interests decision-making conferred by 6(6), after the discussions between the various parties involved in the ongoing care of an already incapacitous person, **there will often be a group of people** – loosely, I'll here write 'a group composed of family and clinicians' - **who can each individually say** 'my decision would be 'whatever' - and I think I can claim to have made that decision in compliance with section 4(9)'.

So, this section from the GMC's 139 is incorrect:

In particular, you should be clear about the role that others are being asked to take in the decision-making process. If they do not have legal authority to make the decision, you should be clear that their role is to advise you and the healthcare team about the patient's wishes and preferences to inform the decision about whether attempting CPR would be of overall benefit to the patient. You must not give them the impression that it is their responsibility to decide whether CPR will be of overall benefit to the patient, or that they are being asked to decide whether or not CPR will be attempted.

In no particular order, we can reason:

1) If an already-incapacitous person is at home with a family carer, then in principle the family carer should be applying the MCA – so the family carer does 'have a responsibility' (implied by having accepted the 'interventionist-role' of family-carer) to act in their loved-one's best interests: this includes the decision-making around CPR if the loved-one arrests at home,

2) This is both wrong and right, at the same time: 'their role is to advise you and the healthcare team about the patient's wishes and preferences to inform the decision about whether attempting CPR would be of overall benefit to the patient'. It is true that from the perspective of a doctor involved in the best-interests discussions, the family and friends

will be providing information which helps the doctor to arrive at a best-interests decision (technically, at a best-interests 'determination' but we'll ignore that very-annoying issue here!). BUT – **it is also true** that from the perspective of a friend, relative or family-carer who is involved in the discussions, the doctor will be providing information which [certainly potentially] helps the family-carer, relative or friend to arrive at a best-interests decision.

**When section 6(6) does not apply, then many people can in principle form defensible best-interests 'decisions' about CPR – but nobody can impose their own decision on anyone else** (except within the ranks of the clinicians, when it might be possible [but it is hideously complex!] for a senior clinician to 'impose' a decision on other clinicians: this arises because of section 42 of the MCA [via the Code of Practice]). And whether anyone can act on their decision, depends on the situation: it is not possible to attempt CPR if you are not present when the patient/loved-one arrests, and typically relatives will not be present if the person is in hospital, and clinicians will not be present if the person is at home.

I will stress, that this analysis hinges on the MCA being law in Wales and England – other countries, have laws which are different. Basically, the above flows from that 'a person other than the court' in section 4(9) and from section 6(6).

We know that normal people are capable of arriving at sound best-interests decisions about medical interventions – otherwise people would not be allowed to empower relatives and friends as legal proxies with authority over those decisions. We also know that weighing one possible best-interests decision against another possible best-interests decision is often somewhere between 'conceptually very tricky' and 'conceptually impossible' – but, fortunately, nobody is required to prove that 'the best-interests decision I made was the right one': an individual only needs to have defensibly complied with MCA section 4. **And it is surely, therefore, the most satisfactory situation** when we can say 'We all – family, friends, doctors, nurses – put our heads together, and we all agreed about what would be in the best interests of the patient/loved-one.'.

Which ISN'T '... the clinicians made the best-interests decision, and the family and friends didn't disagree with their decision'. And it ISN'T '... the family and friends made the decision, and the clinicians didn't disagree with their decision'. It is 'we all formed our own individual views about best interests, and we all arrived at the same conclusion'.

And what the GMC has written, **implies that** 'the doctor understands what is in your loved-one's best interests better than you do' - **which is, to be frank, offensive and illogical, and NOT a good starting point for the sort of collaborative behaviour which the MCA [and good end-of-life care] calls for.**

I'm rambling – anyone who is still interested, should probably read my piece about MCA best interests at:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/I-think-we-need-a-different-way-of-explaining-and-teaching-the-Mental-Capacity-Act-MCA/1114/>

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