In Memoriam: Rachel Griffiths MBE

I don't think of the Mental Capacity Act as existing to allow for legal discussions in courts. I think of the MCA as existing to guide behaviour during End-of-Life-at-Home. Without asking for court rulings: I don't recall anyone within the EoL-at-Home world, believing that it makes any sense at all for an application to court being made except as a last resort.

I don't consider the Act is owned by, or for, doctors, lawyers and judges. I don't consider the Act is owned by, or for, relatives, friends and family-carers. I consider the Act is owned by, and for, patients.

It is possible – I'm not sure how my mind thinks – that part of my mind conceptualises the Act as being 'a thinking person' which allows me to think in terms of 'what would the MCA decide should happen in this situation?'.

As an aside, and ignoring the deliberate peculiarity of the above, what I've just written does make something crystal clear: there is only one Act, so it would only be one thinking person – so, it follows that in any particular situation, the Act would always settle on one particular decision about what should happen next.

I can also, based on the above, point out that any judgement as to whether or not a person, or group of people, made the right decision should not be made on the basis of who made the decision – was it a doctor, a family-carer, a 999 paramedic, etc – but should be based on 'is it the decision the Act would have made?'.

The above does require, to work correctly, that the laypeople involved understand the MCA's Best Interests concept.

When I read the Gosport Inquiry, it struck me that some of the relatives were 'complaining retrospectively' about what had been happening on the wards. Although it appeared that these relatives had been involved during the events, they didn't seem to have understood enough at the time.

Of course, while what I've just written perhaps explains how my mind processes the Act, the Act itself allows for real-world complexity during decision-making – it doesn't impose consequences for a person's decision being different from 'the decision the Act would have made'.

It is extremely important, during EoL-at-Home, to try and prevent misunderstanding and confusion within the group of people who are in ongoing contact with the patient/loved-one and each other – a group which is typically the patient, family-carers and relatives, a GP and nurses. The most useful way to prevent misunderstanding and confusion, is for everyone in that group to ask ‘why are you doing (or not doing) that?’, and being given honest answers. With anyone asking anyone else. Once you’ve got the ‘why’, you can move on to ‘should we be doing that?’. The answer to ‘should we be doing it’ can often be found within the MCA.

I suspect that most patients and relatives do not understand the Act, and Mark comes across welfare attorneys who do not seem to correctly understand their role. I’ve come across people who think that attempts to save life should always be made, even if the person had said ‘don’t do it’.

It is not obvious that clinicians understand and correctly-apply the Act, either. Rachel used to recount her meeting with a group of doctors who believed they were required to follow the Mental Health Capacity Act: Ben has written about The Protection Imperative; I [and some judges] roll my eyes when doctors mention ‘medical best interests’ if MCA Best Interests is the issue.

On the funeral directors’ ‘Thoughts page’ Mark wrote ‘I am reminded of our mutual understanding of the importance of language and clarity’. Rachel used to be irked when people used less instead of fewer: I am irked when people say me instead of I. HOWEVER: the meaning which those people are conveying, isn’t impaired, however irked we are. I’m sure that in the context of the Mental Capacity Act, Rachel would be satisfied with any language, or ‘form of wording’, which successfully enabled readers to understand and apply the Act.

Mark also wrote ‘I will treasure one of your correspondences to a mutual friend, in which, amongst much praise, you noted their 'idiosyncratic use of punctuation'... 'especially the liberal scattering of quotation marks outside their conventional use.'. Well, ‘say moi’ – I’m the mutual friend. Rachel would be groaning!

A Conclusion stated in advance: perhaps we should stop trying to 'explain' the purpose of the Act by quoting the wording of the Act and relevant court rulings, and instead develop explanations which the average reader will actually understand?

In the summer of 2017 I sent a question to Rachel – see next – and a few months ago I asked Rachel if she still had an ambition that normal people would understand the MCA. Rachel wasn't very optimistic from what I recall, so things haven't improved much – and I'm not optimistic either. I've been writing pieces which attempt to explain MCA Best Interests for years, and I think there is something flawed about the way that 'understanding of the MCA' is being imparted to layfolk. Mark will perhaps be thinking '… and to clinicians!'.

To Rachel:

Rachel,

Some of us were having a very active Twitter chat about the difference between what the MCA says, and what the professionals think it says yesterday - for example the chain at

https://twitter.com/KitzingerCelia/status/900998411842924544

and click on the '8 more replies' to find some input from a lawyer.

Who - which 'organisation or body' - is able to issue 'we believe' or 'we consider' statements, about the interaction of the MCA and written NHS records?

Who could issue a statement of:

'We consider that if an NHS document contains an anticipatory best-interests decision, and that decision was made and expressed by a suitably-empowered Health&Welfare Attorney or Court Deputy, the record should be signed by the attorney or deputy'.

The NHS likes ACP - and it does record anticipatory BI decisions (it is not clear that BI decisions should be made in advance, but that is more complex), but it always has the senior clinician doing the signing. Just for once, the MCA is *blindingly clear about decision-making authority in that in this situation: so it should be the attorney or deputy whose authority encompasses the decision, who should be signing a record of it unless you apply some really weird logic!*

So I would like to make a start, by getting those attorney/deputy signatures to ***replace*** *clinical signatures, where logically appropriate: then 'I can work outwards from there'.*

So, who could issue such a statement with some clout - DH, CQC, NHS England, HEE or who?

You will have guessed the follow-up question - 'and how do i get them to do it?'.

Best wishes, Mike

From Rachel:

I truly don't know the answers to your questions below - I think we need more a cultural shift so that this happens naturally. But there's a similar issue with consent generally, and as for understanding and minimising restraint… don't get me started. Ditto Article 8 rights of all parties. I want everyone in the country to know all about what powers and responsibilities the MCA gives them: my analogy is that in Northern Ireland every citizen knows exactly how many hours you can be held without charge where possible terrorism is suspected; that's because it interests all of them and could apply to any of them. Surely the same is true of the MCA. But I'm not currently holding my breath. 10 years in, and we've not got very far at all.

Your gloomy friend

Rachel

Ben's book A Practical Guide to the Law of Medical Treatment Decisions (Rachel gave me a copy as a Christmas present – I gave Rachel a copy of Kathryn Mannix's book With the End in Mind) uses 'what Best Interests isn't' at one point, and I had also done that in my own writing. It is definitely easier to clearly explain what Best Interests isn't, than to explain what Best Interests is.

However: our understanding of what best interests isn't, doesn't come from us being told that directly in the Act – **we read the Act, work out what it definitely tells us and throw in what we can reason must be true, and then we can elaborate as to what best interests isn't.**

There are **some things** which must be true about best interests, and one of those things poses a profound question about how the Act is being explained to normal people. This is that thing:

Section 6(6) gives welfare attorneys 'authority over' best-interests decision-making, but there isn't an examination on the Act as a requirement of appointment as an attorney – **so by necessary implication 'the Act believes that normal people must be capable of understanding the Act'**. If I understand the Act well enough to make a legally-satisfactory best-interests decision the day after I've been appointed as an attorney, then it is almost certain that I also understood best interests the day before I was appointed as an attorney. And, of course, section 4(9) says 'by a person other than the court'.

Bearing the above in mind, it is perverse and peculiar that hardly anywhere in the descriptions of the MCA which are written by clinicians and their organisations *and aimed at patients and relatives* will you ever find 'Relatives are perfectly capable of making legally-satisfactory best-interests determinations about medical interventions'.

You will also find statements written by clinicians, that Welfare Attorneys and Court Deputies will be consulted by clinicians about best-interests determinations: **again wrong!** Although section 4(7) can be misunderstood, it is perfectly obvious that any attorney or deputy who possesses section 6(6) authority and is discussing best interests, is the person who the Act says is doing the consulting. Therefore it should be 'Welfare Attorneys and Court Deputies will consult the involved clinicians about the patient's best interests'.

The information – a term I'm using loosely – for patients and relatives which accompanied the early versions of the ReSPECT form, was totally hopeless, and although ReSPECT made it nigh-on impossible for themselves by seeking to have a single form which worked across all four countries of the UK, as a contact of mine commented 'I can't see in the ReSPECT form/guidance any difference between the status of a H and W LPA attorney and any other relative or indeed passing stranger - which seems wrong to me'.

Even when clinicians write more correctly about welfare attorneys, they typically don't get it quite right. For example, you can find 'A suitably empowered welfare attorney will make the best-interests decision'. There are assumptions in that – and, to me, it doesn't make it clear that a best-interests determination might be necessary before the attorney can make one – and it would be better if people wrote 'Clinicians should try to facilitate the making of best-interests decisions by welfare attorneys'.

An elderly lady briefly exchanged some e-mails with me recently, and she wanted to make sure that CPR was never attempted on her. She had, as it happens, done as much as a person can reasonably do to try and ensure that: but I think she still wasn't sure that she had done enough. I told her that she had done everything she could do, that it is effectively impossible to prevent CPR from being attempted if you arrest while you are out-and-about, and that she would be best not worrying about it.

This lady had clearly 'done her research', and I think she would have come across 'an Advance Decision is legally binding'. **Which is not the real situation** – it would be clearer to say that once the reader has decided the ADRT is applicable it is 'legally binding'. And as I would put it 'Only a doctor who is an idiot, would say 'I considered the ADRT refusing CPR to be valid and applicable, but I decided to attempt CPR anyway'.

I've had a long-standing dispute about WHY the Act requires an ADRT refusing CPR to be in writing. **Because, I think in terms of UNDERSTANDING**. And if a discussion has just taken place, and it is clear to the listener that the patient/person is refusing attempted CPR, **and then the patient arrests before**

the face-to-face contact has ended, you know for certain the person has forbidden CPR. This cannot be a best-interests situation – it logically must be a 'patient self-determination' situation.

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Can-a-verbal-refusal-of-CPR-be-legally-binding/1072/

Suppose a plane crash in a remote part of Wales results in a doctor, Tony, and another person, Adam, being isolated in a disused building. The person makes it clear to the doctor that if his heart stops, he wants to be left alone to die without any attempt at resuscitation. If they don't have any writing materials, they can't create a written ADRT. But even if they could create a written ADRT, doing that doesn't increase the understanding of either. The doctor would, perforce, have to be the witness to any written ADRT – and the signature of the witness is only present to confirm to a reader that the author of the ADRT 'was the author'. So Tony's signature, pointlessly confirms to Tony that Adam wrote the ADRT. We also have – and this seems really perverse to me – the situation that if a written ADRT is necessary during such one-to-one contact, then if Tony agrees to witness the ADRT Tony is binding himself to not attempting CPR if Adam arrests: but if Tony refuses to witness the ADRT, then Tony can apply best interests if Adam arrests. How can it be correct, for a potential witness of a written ADRT, to be able to decide which legal concept – patient self-determination or the application of best interests – will apply if the patient arrests?

If you approach things from the perspective of UNDERSTANDING then the idea that a verbal refusal situation of CPR during ONGOING CONTACT is not legally-binding, is BONKERS! And, of course, during face-to-face conversation you can ask the person/patient questions about things which don't seem clear – but you can't put questions to a written document.

There is also what I can at best describe as 'a peculiarity' – and being blunt I would describe it as an unhelpful mistake – when in section 11 the Act says that attorneys can consent to offered treatments (and 'refuse': I would apply the same argument to refusal as I outline below for consent). If you think from the perspective of an attorney who has read section 4, then the attorney will ask him/herself ‘how do I decide whether to consent?’. You would only ‘consent’ if you considered application of the treatment was in the person’s best interests. And [ignoring a potentially lengthy description of why doctors might ask an attorney if there was consent to the treatment] doctors who ask an attorney to consent, must think application of the treatment makes sense: so, if the attorney says (and I myself would definitely say this) ‘I consider it is in the patient’s best interests for the treatment to be applied’ then on what grounds would the doctors not apply the treatment?

I mainly write about end-of-life at home, and I introduced the ideas of ‘us & us’ and ‘us & them’ in a Journal of Medical Ethics paper which I co-authored with three other people [one being Alex]:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Clinicians-and-Relatives-Consensus-Uncertainty-Emergency-and-Trust-a-continuation-from-a-Journal-of-Medical-Ethics-paper/1112/

I always regarded the paper we published, as being ‘Part 1’ of a 2-part analysis – the above link goes to ‘part 2’ which I wrote alone.

When the patient is at home during EoL, in my opinion ‘us’ should mainly mean ‘everyone who is in close-and-ongoing-contact-with’ the patient. I include within that group both clinicians and layfolk. I still read material which regards all professionals, whether or not in ongoing contact with the patient, as ‘us’ and regards family-carers as ‘them’. For example, some deeply-annoying guidance about Advance Care Planning:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Comments-on-some-NHS-Advance-Care-Planning-Guidance-about-the-principles-of-ACP/1120/

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/NHS-Planning-Ahead-seems-to-be-excluding-family-carers-and-I-am-very-annoyed-by-this-and-I-want-things-to-change./1139/

If there are people who should in a sense be regarded as ‘them’, then those people would be 999 Paramedics – and **my attempts to get 999 and family-carers to be able to regard each other in a truly us & us way have been unsuccessful**. To my annoyance, I am therefore currently being forced to point out to family-carers that 999 regard you as ‘them’, so we (family-carers and relatives) are currently forced into reciprocating (what we are being forced to reciprocate, is a mindset of ‘I don’t trust you by default’):

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/I-believe-that-clinicians-are-downplaying-and-also-misrepresenting-the-role-and-agency-of-family-carers-during-end-of-life./1170/

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/CPR-and-DNACPR-am-I-following-orders/1159/

I would direct readers to my post on 29/10/24 in the thread the second of those links goes to.

We need to **genuinely-adopt** ‘us & us’ because a **deeply-thought-through consideration** of section 4 of the Act requires an understanding of the clinical situation and options, AND ALSO an understanding of the patient’s individuality (the things section 4(6) points to). Especially if ‘emergency’ clinicians are involved, only family-carers and relatives can **genuinely** understand the patient’s individuality.

To put that another way, and although my ‘we’ can be replaced by ‘I’ I’m using ‘we’ here because it would, if we truly were behaving in an ‘us&us’ way, be a question for us,

Are we doing what the patient would have wanted to happen? If not, why not?

We (relatives and friends) genuinely are being insulted and disrespected by professionals who persist in ‘theming’ us within guidance and protocols.

If the conversation doesn't start there is nothing to listen to: if you aren't there you can't listen; if you have listened you can't forget.

See my Father and Son scenario on pages 2 and 3 of the PDF at:

https://www.dignityincare.org.uk/Discuss-and-debate/download/298/

It isn't logical to expect to have been able to listen to a conversation if you could not reasonably have expected to be present – and it is an obnoxious insult to argue that 'I can't trust your word because I wasn't there'.

In a BMJ rapid response which I wrote in 2016, titled 'It would be much simpler if techniques for CPR did not exist'

https://www.bmj.com/content/352/bmj.i1494/rr-3

I wrote:

Without CPR, 'alignment of mindsets' between relatives [who, I believe, tend to see 'my dad doesn't want you to attempt CPR' as the justification for DNACPR] and clinicians [who, it seems to me, are much more concerned with 'could CPR be successful'] would not be a problem for CPR decision-making. When I constructed a 'DNACPR Justification Hierarchy' (ref 3) I placed 'the patient is understood to have refused CPR' at the top, and 'successful CPR seems clinically very unlikely' much lower: but doctors seem to be more concerned with 'we predict that CPR would fail';

I am not blind to 'the perfect is the enemy of the good', and we need to explain the MCA (please note I do NOT do deprivation of liberty, so my comment here is not about that aspect of the Act) at GCSE level, not at degree level. But I also insist that 'good' cannot contain the logically absurd: for example, implying that family-carers cannot make decisions about CPR is absurd when often the only person present with a patient who arrests will be a family-carer. And the good cannot be blatantly insulting – I once read 'guidance' to 999 paramedics written by a doctor, which told them to 'verify before accepting' ADRTs and LPA documentation, but which did NOT tell them to verify DNACPR forms.

It would help, in my opinion, if we could agree on a description of the objective of a best-interests determination – and I've had a go at that:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/MCA-Best-Interests-compressed-to-a-single-sentence-an-ansatz/972/

What I suggested is:

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.

Kathryn Mannix said in a comment:

I like your sentence because it helps decision-makers and those participating in a decision-making process to be clear about the task.

Discussion of who can legitimately be a decision-maker is somewhat intricate, but Kathryn is spot-on with 'it helps those participating in a decision-making process to be clear about the task'.

I don't think family-carers are being given an accurate description of their legal situation, although it isn't particularly difficult to explain so far as I can see:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/DNACPR-at-Home-and-a-Twitter-thread-what-is-the-legal-situation-for-relatives/1110/

Digressing somewhat from the 'theme' of this piece, but sticking with 'the clinicians keep getting it wrong!' and my 'we need to be working together as us & us' assertion, the issue of 'DNACPR documents' has caused endless aggravation within the NHS for decades. I've suggested a different version of a CPR document, which it seems to me fits with both our law and also with logic – it is at:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Mikes-Cheeky-Blog-a-proposal-for-a-different-type-of-DNACPR-document./1142/

I started my introduction with two sentences, which to my mind resolve the issues which 'the NHS' has been incapable of resolving:

The PDF explains my suggestion in more detail, but in essence I think we should describe any form which mentions CPR or DNACPR and is attached to a specific patient as 'a CPR form', and that what we should see on the form is information: not 'recommendations' or 'instructions', but information. And the information we can see, should be 'what I would do if the patient had a cardiopulmonary arrest NOW'.

There is so much of my 'thinking and position' within one of my posts in the above thread, that I've decided to include it here:

In my PDF, I didn't really elaborate on what '... move the rest into training' implied.

Well, all of the guidance about DNACPR, does state what amounts to 'unless something new or not-previously-considered makes DNACPR inappropriate at the time of the arrest' - i.e. that between creating a DNACPR document and a future arrest, things can change.

Usually, clinically-authored material implies that this 'thing which has changed or wasn't considered' is a clinical factor: but, it doesn't have to be a clinical factor at all. It can be anything, which would have affected the 'CPR or DNACPR?' decision when that decision was being considered. And, if the patient is mentally-capable when the DNACPR is completed and afterwards, the patient subsequently expressing a change of mind about CPR definitely counts.

The crucial piece of logic, if a 999 paramedic or other 'emergency clinician' was reading my form, amounts to 'These people had plenty of time to think about CPR/DNACPR, they were clearly talking to each other and should all have been well-informed, and they weren't doing everything with no time to think [like I am!]: so, if they have been trying to keep this form up-to-date, what could I observe when I arrive to find a patient in arrest, which could make me think I understand the situation better than those people who were involved when the

DNACPR was created?'. Viewed in that light, 'what I would do if the patient arrested now' recorded on a form which is being kept up-to-date, is equivalent to 'a recommendation to a future reader'.

I will not deny, that I definitely want these forms to make it clear (and I believe that adding signatures beyond those of clinicians is the best way to achieve this) that End-of-Life, and especially End-of-Life-at-Home, involves many more people than simply the clinicians, and that 'who can legitimately decide what?' is a question which does NOT lead to the answer 'just the GP' or 'just the Consultant Doctor'.

CPR/DNACPR and Mental Capacity Act best-interests decision-making, is definitely not 'the doctor decides' and forms which reflect that fact, will promote an understanding of it.

Returning to decision-making, MCA Best Interests stands in for Informed Consent/Considered Refusal when the patient cannot make the decision. And best interests must be inserted at the same point in the process: at the point where a capacitous person would decide which option/s, if any, to accept. So it has to be, first the medical situation and possible treatments are described [which the clinicians understand] and then best interests is applied [which amounts to involving section 4(6), ‘the patient’s individuality’, and that is something family and friends understand]. It cannot, logically, be anything other than the family and friends who are answering the crucial question of ‘what would the patient/loved-one decide, if he/she could decide?’. And, as I’ve pointed out elsewhere, once you understand ‘what the patient [if somehow capacitous] would have decided’ then provided you understand the Act’s best-interests concept you can arrive at a best-interests determination.

If a wife and a 999 paramedic are standing over her collapsed husband, and the paramedic has determined that the husband’s heart isn’t beating, then it is the wife’s understanding of her husband’s individuality which is crucial in arriving at what is in her husband’s best interests. **It is an absolute insult if the paramedic somehow implies, by statement or behaviour, that he/she can understand whether attempting CPR would be in the husband’s best interests, better than the wife can**.

I need to make a crucial point about CPR here. While in theory, the MCA seems to require that a best-interests decision is made during an arrest, and while it is clear that only those who already understand the person in arrest as an individual could possess sufficient understanding of section 4(6) to form a deeply-thought-through best-interests position, IN REALITY EVEN THOSE PEOPLE CANNOT DO THAT. We are not computers – we need time to think. There isn't enough time to think during an arrest. So in reality, you need to already understand whether it is right to attempt, or withhold, CPR when an arrest happens.

This is further complicated, because there are models-of-behaviour for 999 paramedics which amount to 'start CPR until you are persuaded that CPR is inappropriate'. And I can't believe that a person has ever explained to a relative 'I don't want CPR – although I'm happy for paramedics to start CPR while you are persuading them to stop'. That is akin to someone saying 'I don't want to be punched in the face – although being punched a few times would be okay, provided the punching then stopped'.

Alex wrote a piece pointing out that section 6(6) only applies at the time of the potential intervention. Which is true [although there is an interesting court case which I'll mention] - but that is not [and I'm not sure if Alex made this clear] - anything specific to welfare attorneys. Logically a best-interests decision has to be made at the time the treatment would be applied or withheld – i.e. at the time when a capacitous patient would consent or refuse. What Alex's piece didn't, so far as I can recall, dig into was the fact that logically a brother and sister who were attorneys with an incapacitous father in hospital, thinking through Alex's [correct] statement, would conclude '... so for us to make the best-interests decisions, which is what dad wanted us to do, we need to camp out at dad's bedside - one of us will need to be there 24/7'. **How is that helpful!**

Surely it would make more sense for the brother and sister to discuss things with the doctors, then for the brother and sister to record on a document what their decisions would be if various things happened and to sign that, and for the doctor/s to record what they had agreed to do in the event of those things happening [if nothing significant had changed] and to sign that. With the obvious 'extras' – contact numbers for the brother and sister, the 'if anything changes we'll try to tell you' from the doctors, etc – also on the document. Two copies (as in two 'originals'), one retained by the brother and sister and one retained by the doctors. Then, should for some reason a dispute arise in the future, there would not be any dispute about what had been said and agreed to.

The court case I mentioned, is a ruling by Mr Justice Jackson

https://www.bailii.org/ew/cases/EWCOP/2015/60.html

We can read (45 and 3)

I am quite sure that it would not be in Mr B's best interests to take away his little remaining independence and dignity in order to replace it with a future for which he understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter.

I emphasise that the effect of my decision is not that it would be unlawful to carry out the operation, rather that it would be unlawful to carry it out against Mr B's opposition. Given his views on life and death, it is very unlikely that he will change his mind. But if he does, there is nothing to prevent the operation taking place, unless it is by then too late.

This is a best-interests decision which definitely is being projected into the future: and it isn't obvious to me, why a welfare attorney could not arrive at exactly the same best-interests position.

'Best Interests Meetings' are often presented, within clinically-authored material, as meetings during which the family and friends assist the doctor to make a best-interests determination. Family and friends should be forceful in rejecting this: we should insist that such meetings can lead to both clinicians and family and friends [on an individual basis] arriving at best-interests positions. So we should insist that the purpose of the meeting is to enable individuals to properly consider section 4, and to then express their best-interests positions [if they wish to do that] – and in the hope that everyone will agree about what is in the patient/loved-one's best interests. **Best Interests can be described as something which as a concept is at best a little opaque, and at worst is mysterious to many people. If everyone agrees about a best-interests determination then it gives everyone involved greater confidence**

that the best – or at least a good – best-interests determination has been arrived at.

I'll draw this to a close. I've had a go at explaining MCA Best Interests in my piece 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/

What we need to achieve, is sensible behaviour 'at the coal face' – when patients, clinicians, relatives, attorneys are interacting with each other. It surely cannot be helpful, if we are forcing the laypeople who do understand the MCA and also the way that clinicians behave at present, into a 'Well, if that's your attitude, then …' position.

'Well, if that's your attitude, then either my brother or I will need to be at my dad's bedside 24/7 so we CAN make the best-interests decisions'

'Well, if that's your attitude, then if my dad seems to have arrested, and despite the fact that I'd like to immediately call 999 to be sure he has arrested and hasn't collapsed with a stroke, I probably will not immediately call you because you would probably attempt CPR which I am certain my dad would not want'

We need to somehow impart an adequate understanding of the MCA to laypeople, and we need a change in clinical mindsets.

As Rachel wrote in that e-mail:

I truly don't know the answers to your questions below - I think we need more a cultural shift so that this happens naturally.

The problem seems to be, that things clinicians do understand – patient confidentiality for example – and things which are thrust upon them – notably 'safeguarding' and the NHS mindset around documentation – push in the opposite direction to the 'culture' which is emergent from the MCA if you understand the MCA – and many clinicians do not understand the MCA anyway, nor do they think about it from the family-carer's perspective.

Written by Mike Stone, February 2026