

Hi Everyone,

I've been slowly fading away from the EoL/MCA/CPR world recently, but the demise of my friend Rachel has prompted me to write a piece asking if the MCA is being explained and taught in an effective manner. The relevant PDF can be downloaded from the thread [which contains extra relevant discussion and argument] at

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Understanding-and-Teaching-the-Mental-Capacity-Act-and-In-Memoriam-Rachel-Griffiths-MBE/1183/>

and I have also attached it.

Back in the day, when the first Star Trek TV series was a thing, and when a doctoral thesis was created by metal striking ribbon and pushing ink on to paper, you had to create several copies of your thesis. A friend of mine inserted an extra page into his own copy of his thesis, near the front. It was a cartoon-style drawing, of an unhappy-looking donkey facing towards us, with my friend sitting on the donkey and pushing the donkey's ears outwards. Caption: Pushing the front ears sideways.

I can't help wondering if we've been pushing understanding of the MCA 'sideways' for a decade.

Rachel told me relatively recently, that she believes understanding of the MCA was improving until some years ago, when things got worse because money and effort was no longer being put in to training. Personally, I consider that before about 2014 there were some court rulings which instead of applying the MCA, were applying the legacy beliefs of judges. And since 2014, a series of court rulings have appeared which do correctly apply the MCA. But I'm not sure that behaviour 'at the coal face' reflects this more-correct description of the [consequences of] Act in court rulings.

I think it was on Twitter, but it might have been in an e-mail, that Mark said it is hard for doctors to come to terms with the fact that central to best interests is the bit the family and friends understand better than the doctor: the bit so eloquently expressed by Hayden J - *He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation.*

It must be 'a bit scary' for a doctor to admit to family and friends, having summoned them to a best-interests meeting in a hospital, that the logic of the MCA does mean

that the discussions will be likely to enable family and friends who do understand the MCA to arrive at perfectly 'defensible' best-interests determinations. To hope that at the end of the discussion, everyone who says 'I think it is in best interests to ...' and for everyone to be in agreement. But if there is complete agreement, then everyone, including the doctor, will be more confident of the correctness of the best-interests determination as to what should happen next. And, the claims being made in current 'guidance/information' that 'the family and friends are **only** helping the doctor to make a best-interests determination' don't stand up to challenge from a family or friend who confronts that assertion anyway.

Mr Justice Charles in Briggs, 'dismissed' an earlier ruling [which, when I'd read it, 'had steam coming out of my ears', by the way] by Baker J (section 80 of Briggs).

However – and it will be clear from the PDF that I argue in a different way from judges – I would provide a different argument around (5) in Briggs, and I think Aintree got the question wrong. I agree with (15) and with (16) – but I'm not persuaded about (17). My reasoning is as follows.

We have described CANH as treatment (17) and we (Charles J) are applying section 4 (15). We KNOW (11(7)(c)) that a welfare attorney's authority 'extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P.'. Confirmed by 11(8) as applying to life-sustaining treatments if the attorney is so-authorized by the LPA.

Section 6(7) would allow doctors who supported the continuation of a life-sustaining intervention which a welfare attorney had 'refused' (I don't think the WORDING is right – I think the attorney should be saying 'isn't in his best interests') to apply for a court ruling. If a judge could not make a best-interests decision that it is not in the patient's best interest that a life-sustaining treatment continues, which to me is exactly the same as deciding that withdrawal or non-application of the treatment is in the patient's best interests, then the judge would ALWAYS have to rule in favour of the doctors. So, what would be the point of giving the attorney section 6(6) authority, if when doctors appealed to court, the judge must always rule that life-sustaining treatment must continue?

There is, to my mind, too much legal-dancing-on-pinheads going on here. The decision to withdraw or withhold the intervention is to be made on what I'll call 'legitimate best-interests grounds' and while the patient's untreated clinical condition will result in death, it is the clinical situation that kills the patient. We know while considering best interests that the patient will die, but I find 'The court

will not be able to give its consent on behalf of Mr Briggs and it will follow that it will be lawful to withhold or withdraw it' (17) as not fitting with the wording in 11(7)(c) of 'giving or refusing'. Even though I also think section 11 is phrased unhelpfully, and should be phrased in terms of the attorney's best-interests decisions.

It would be perverse, if a judge could rule that an attorney can forbid life-sustaining interventions on MCA section 4 grounds – and I've just explained that section 6(6) is pointless if the judge didn't consider that an attorney can forbid life-sustaining interventions – while also arguing that a judge can't forbid life-sustaining interventions on MCA section 4 grounds.

I also find it very strange that in (17) Charles J points to Bland to support the framing of a best-interests 'refusal' with wording which I don't like, when Bland was 1993, and when Charles J in (16) says 'It is the application of the MCA, rather than the common law and inherent jurisdiction set out in the earlier cases that matters.'

My argument as to how section 4(5) is 'overcome' would be, because I think like a welfare attorney:

I know from section 11 that I can forbid a life-sustaining intervention: **my motivation** is to apply section 4 and **my ONLY desire** is to make the best best-interests decision which I can; so the only 'desires' which are involved in my best-interests determination, are the patient's desires which are within section 4(6).

I'm loath, however, to point at section 5 itself, because then we are likely to become involved with arguments about 'consenting to illegality' – i.e. arguments around 'assisting a suicide', and what a treatment is.

Once Mr Justice Charles had moved on to '... so how could I arrive at a best-interests decision which withdraws the CANH?' then his reasoning was the same as I had previously worked out in the context of CPR.

On Saturday, while I was looking for and failing to find a different piece, I stumbled across a piece I'd written in 2017

<https://www.dignityincare.org.uk/Discuss-and-debate/download/326/>

I had included in my piece an e-mail, and its eloquence proves that it was sent to me by Rachel. As I wrote in my piece:

One of the people I discuss the MCA with, has done far more than I have to promote better implementation of the MCA, and my correspondent is also a much better

writer than I am – my correspondent hit the nail on the head with the following, when we were discussing something called ReSPECT:

**I have heard ‘on the grapevine’ that the FAQ guidance is in the process of being amended to highlight the primary decision-making role of these people appointed by the person. A small change but I’ll be delighted when I see it. I appreciate this still doesn’t do anything to address the position of other people who also know the person far better than the professionals. However the guidance is at least being revisited with a view to balancing the professional/lay rights regarding appointed proxies. It’s a start.**

**I do think, incidentally, that the more people know about their rights to make decisions in advance about future care or treatment, and how to do this, the better. This is the tenth birthday year of MCA implementation: maybe we can all tell our local communities about the rights it gives us? In my view, and despite the admittedly slow burn on this one (putting it politely), this will in future be recognised as the greatest change that the MCA has brought about - the change from paternalism ‘Nurse knows best’ to making it clear we can make our own decisions, and telling us how.**

That is the change in law, which the MCA drew together and 'made clear' back in 2007 – we have changed from 'doctor knows best' to 'doctors provide clinical information, and the patients make their own decisions' for patients who are mentally-capable: and we have moved away from 'if the patient can't make the decision, then preservation of life and 'societal expectations' are what matters most', to 'if the patient can't make the decision, then what matters most is what the patient would have decided, if the patient could have decided'.

So, using Rachel’s slightly modified wording within a question I’ll construct, I’ll close with this:

To NHS and clinical organisations:

**Does the guidance, protocols and advice which your organisation gives to clinicians and the public, correctly reflect the changes which the Mental Capacity Act should have led to - highlighting the primary decision-making role of people appointed by the person (LPAs), addressing the position of other people who also know the person far better than the professionals, and recognising the greatest change that the MCA has brought about - the change from the paternalism of ‘Doctor knows best’ to making it clear we can make our own decisions, and telling us how.**