Lucy's question to me:

I *think* the MCA is trying to guide our reflections and discussions. If the MCA is supposed to be doing that – guiding how we think, how we talk to each other – do you think it is doing a good job of it on the ground? And if not, what's the problem? And how can we fix it?

Well, I think the MCA is supposed to be guiding actions in the real world – and during my 'standing over someone in cardiopulmonary arrest' there definitely isn't the time for reflections and discussions about what the MCA says.

I'll start with 4(6)

(6) He must consider, so far as is reasonably ascertainable—
(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so.

Now, as this isn't Substituted Judgement although everything in there is flowing-outwards from the patient/person, it says 'MUST CONSIDER those things if you have discovered them'. So, what I usually describe as the person's individuality, logically must be capable of influencing a best-interests determination – put another way, if a decision could never be influenced by the patient's non-clinical individuality, then even if the decision is legally acceptable the decision **cannot be** a best-interests decision.

Rachel told me that when she was visiting one care home, she discovered there was a rule that residents must not talk across the garden fence to people in the next-door garden. Naturally Rachel thought 'Why? The rest of us can talk to our neighbours – why is there this rule?'. It turned out, that one of the residents and a neighbour (I'm not sure if there was another care home next door) had fallen out, and whenever they were both in the gardens there was heated shouting and [I can't recall] perhaps even throwing of objects at each other. The care home had decided to forbid 'across the fence' interactions. However satisfactory that decision was, what bothered Rachel more is that the resident had long gone, and nobody had thought to remove the restriction!

I think that within social care, there will often be many possible solutions to problems, and provided the chosen solution seems reasonable, then that is okay.

Residents want trips out: cinema, zoo, art gallery – well, provided the residents are happy, then fine.

I don't usually think about social care – one reason Rachel was a good discussion-partner for me is that she did – but I think the MCA is telling us to respect the person's individuality. In particular, to not impose 'safeguarding' with the effect of making the person's life joyless and miserable. You could point at 1(6) but I rather like the ruling about the lady who wanted to go on a cruise with her boyfriend. I haven't read the case, but on the phone I think Rachel said the judge said something like 'She might fall overboard – but you or I might fall overboard, and we are allowed to go on cruises'.

I'm more interested in my bedside refusal of CPR discussion.

Suppose we've got a patient in a hospital bed, a doctor and a judge as an observer (my scenario, so I get to choose which judge – I'm happy with Hayden, Jackson or Charles). The patient and the doctor discuss CPR for 30 minutes, with the doctor asking all of the relevant questions, etc, and the patient makes it crystal clear that he is forbidding attempted CPR. As the doctor is turning to leave, the patient has a cardiopulmonary arrest (we can be sure of this, because the patient is connected to a monitor). The doctor looks at the judge with an 'Am I supposed to attempt CPR?' look on her face. I'm sure my judges would say something like 'What problem do you see? You've been told to not attempt CPR, so you must not attempt CPR'.

If we remove the judge from the scenario, then in Wales I hope we could have a doctor, or a nurse, or a paramedic doing the listening, and none of them would attempt CPR – at least, if the doctor, nurse and paramedic were all authorised to complete the DNACPR form which Wales uses. **But in England** I'm not confident that every doctor would withhold CPR, and I can't help feeling that many nurses would attempt CPR. Because of the way that their employers and the NMC treat nurses, and especially have treated nurses in the past.

Move the scenario to my EoL father at home, explaining to me that he doesn't want CPR, and I'm left in the position of not attempting nor supporting CPR.

I don't see this as challenging at all, when you've read the MCA and think about the above situation: the MCA definitely allows for the forward-projection of the refusal of an intervention, and if you think about the logical consequences of 25(4), 26(2) and 26(3), etc, it would be completely mad to dispute 'you know the patient has forbidden CPR in the situation of the arrest – you must not, therefore, attempt CPR'.

Having pointed out in an earlier piece [with my reasoning that welfare attorneys aren't trained, but logically the Act must think that they can make satisfactory best-interests decisions, even though attorneys are likely to be relatives and friends] that normal people must be able to understand best-interests, I'll return to Briggs. Mr Justice Charles at times writes in a way which isn't clear to me (in passing, Mark tells me that at times I write in a way which is impenetrable), but it is clear that what Charles J actually did is:

Convince himself that if Mr Briggs had been able to forbid continued CANH, then Mr Briggs would have forbidden continued CANH. Having convinced himself of that, Mr Justice Charles ruled 'so CANH will be withdrawn'. I haven't refreshed my memory by re-reading the case, but I feel sure that Mrs Briggs was arguing that her husband would not have wanted CANH to be continued – so, Mrs Briggs already knew what Charles J took time to persuade himself was true.

I closed my piece at

http://www.bmj.com/content/356/bmj.j876/rr-7

with:

To Close: (hypothetical)

I have been sharing a home with my now 'dying partner' for 20 years, although my partner has only been 'dying' for about six months. I have talked to my partner a lot during this six months, and during those 20 years. The GP has talked to my partner a little, especially recently. We both talk to the district nurses who have visited a couple of times a week for the last 6 weeks – but they are often different nurses each visit.

My partner has just collapsed. I have called 999 to find out why my partner has collapsed. I am now standing over a 999 paramedic, who is doing something to my unconscious partner. Why on earth, should I accept that this paramedic decides what happens next ?

So, for Lucy's 'do you think it is doing a good job of it on the ground? And if not, what's the problem?'.

In hospitals, it is about staff not necessarily understanding the MCA, and for nurses in particular issues with 'hierarchy', as well as hospitals [necessarily] being very records/document reliant.

For EoL-at-Home, the problem in a nutshell is that 999 are not being told to trust family-carers and relatives as the default position, and that in emergency and information-poor situations clinicians are likely to 'treat first and defend themselves later'. As Rachel put it: They prefer to defend why they attempted CPR, against suggestions that they shouldn't have attempted CPR, as opposed to not attempting CPR and defending themselves against suggestions that they should have attempted CPR.

As for a couple of other things in Lucy's e-mail before her question, I don't think the MCA is particularly 'lax' in its test of capacity. Section 3(1) is a sound description of capacity (although I will add, that in my opinion there is nothing in the process of Informed Consent/Considered Refusal which automatically allows a doctor or other clinician to assess 3(1)(c): the doctor can and must check on the patient's understanding of the consequences of decisions, but that doesn't require the patient to explain 'why I'm accepting or refusing'). So 3(1) is 'robust'. 3(2) and 3(3) are obvious protections against incorrectly preventing a person from exercising his or her right to self-determination, as indeed is 2(3), and 3(4) is so obviously correct/necessary that it somewhat bothers me that the Act feels it is necessary to spell that out.

As for Lucy's 'And how can we fix it?'.

I don't know – dumping ReSPECT and England adopting the superior EoL model/system being used in Wales would be a step in the right direction.

But I do know, that if all patients, family-carers, relatives and friends understood what the MCA actually says, then either clinical and organisational 'mindsets' would have to change under challenge from the layfolk, or else – and especially for EoL-at-Home – we would have an unsatisfactory and chaotic 'us against them' situation. Which would NOT be doing the best thing for patients/loved-ones, because getting to that best-behaviour REQUIRES clinicians and family-carers to be working together: the 'MCA Mind' requires the expertise of BOTH clinicians and family/friends if the 'MCA Mind' is to properly consider best interests.