This attempt to somehow give clinicians authority over MCA Best Interests has been vexing me since I discovered it was happening, over a decade ago.

The Supreme Court, when ruling on the question described in its first section:

1. The question that arises in this appeal is whether a court order must always be obtained before clinically assisted nutrition and hydration, which is keeping alive a person with a prolonged disorder of consciousness, can be withdrawn, or whether, in some circumstances, this can occur without court involvement.

https://supremecourt.uk/uploads/uksc_2017_0202_judgment_1304bcb8a5.pdf

said in its final section (my added bolds here):

126. In conclusion, having looked at the issue in its wider context as well as from a narrower legal perspective, I do not consider that it has been established that the common law or the ECHR, in combination or separately, give rise to the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn. **If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court.** I would therefore dismiss the appeal. In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases.

In ‘Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent Guidance for decision-making in England and Wales’ we can read:

https://www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf

Who is responsible for making decisions?

For significant decisions, such as those to provide or withdraw CANH, decisions should ideally be made and agreed by the whole of the treating team and those close to the patient. Nevertheless, it should be established clearly, at all times, who has formal decision-making responsibility and this information should be shared with those close to the patient. Seeking clarity about who the decision-maker is at an early stage ensures that CANH is provided, or withdrawn, as appropriate for the individual patient and is not continued, 'by default', because nobody sees it as their responsibility to carry out a best interests assessment.

The MCA does not identify a particular individual as having legal responsibility for decision making, focusing instead on collaborative decision-making. Nevertheless, in practice, this will fall to the individual with overall clinical responsibility for the patient's care, as part of their duty of care to ensure that the care being delivered to the patient is in their best interests. This will usually be:

– *In hospital* – the named consultant. Where consultants rotate on a regular basis, it is the responsibility of the Trust or hospital management to have a protocol that identifies at any given time the individual with overall responsibility for the patient, and to ensure that decisions are not delayed because of regular staff changes.

– *In a hospice/palliative care unit* – the named consultant or senior doctor with overall clinical responsibility for the patient's care.

– *In the community (in a nursing or care home or living at home)* – the patient's general practice, which will be responsible for determining which of their GPs has the most direct involvement in the patient's care. In some cases, there will be no named GP and GP practices will provide care on a rotational basis. The GP who prescribes it is ultimately responsible for ensuring that CANH is in the best interests of the patient. Where the patient is under the care of a secondary care team, however, the decision should be made with support from the relevant secondary care clinician.

If the patient is in a nursing or care home with NHS continuing care funding, the general practitioner should be supported by a named individual (usually the case manager) identified by the Clinical Commissioning Group (CCG) or Health Board to take on this responsibility. In these circumstances, the CCG/Health Board must satisfy itself that the package of care the patient receives is appropriate.

WHY WERE/ARE THE BMA and RCP SO DETERMINED TO PLACE A DOCTOR IN THE POSTION OF 'THE BEST-INTERESTS DECISION MAKER' WHEN THE COURT VERY CLEARLY STATED '… IF THERE IS AGREEMENT ABOUT WHAT IS IN THE PATIENT'S BEST INTERESTS'?!

What the Supreme Court said was clearly 'If the clinicians and the 'those close to the patient' **all agree** that withdrawal of CANH would be in the patient's best interests then CANH can be withdrawn' – there is **absolutely no need** to try and identify 'a decision maker' and IT DEFEATS THE PURPOSE OF THE AGREEMENT PROCESS IF YOU TRY TO DO THAT!

The BMA/RCP's 'description' of MCA Best-Interests decision making, as imparted by this guidance, is quite simply wrong!

Written [while vexed!] by Mike Stone, March 2026