Comments by Mike Stone on Epsom v Townsend

A few days ago one of my contacts asked me if I was aware of a recent ruling by Lord Justice Baker, and my contact said there is a lot of discussion going on inside 'the NHS' about what the consequences of the ruling will be (the ruling has been appealed so it might not stand). I hadn't read the ruling, but having now looked at it I feel the need to comment.

The ruling can be found here:

https://www.bailii.org/ew/cases/EWCA/Civ/2026/195.pdf

I cannot make coherent logical sense, based on my current understanding of MCA Best Interests, of these three things in Lord Justice Baker's ruling:

69. Any decision about the care and treatment of a mentally incapacitated adult, including the withdrawal of life-sustaining treatment, must be taken in the patient's best interests. There is no carve out for "clinical decisions".

72. If there is agreement between the family, clinicians and any experts asked to provide a second opinion that it is in the patient's best interests for life-sustaining treatment to be withdrawn, there is no requirement for the matter to be referred to the Court of Protection: A NHS Trust v Y. If there is disagreement, "a court application can and should be made" (ibid paragraph 135) The NHS commissioning body responsible for the patient must apply to the Court. The hospital cannot pre-empt court proceedings by unilaterally withholding or withdrawing treatment on "clinical" grounds. A decision whether or not to withdraw treatment has to be a best interests decision.

[in part] 74. In cases such as Mr Barnor's, where the view of the treating team and the second opinion experts is that continuing treatment is clinically inappropriate, the Court will scrutinise the evidence to determine whether withdrawal or withholding treatment is in P's best interests. In many, perhaps most, cases, the Court will conclude that it is not in P's best interests for treatment to continue, and it may reach that conclusion swiftly. In no circumstances can the Court compel the doctors to provide treatment that they consider clinically inappropriate. But the decision is for the Court, not the clinicians.

Judges cannot force doctors to offer a treatment – 68(5): *In exercising its powers to make declarations and orders about the patient's best interests, the Court of Protection cannot compel the doctor to give a treatment that he or she considers clinically inappropriate.*

Now, I have a long-standing dislike of the way the term 'clinical decision' is sometimes used to describe things which are NOT 'clinical decisions'. And, there are doctors in the ruling, who seem to be using [flawed] MCA Best Interests justifications within what they seem to believe is 'a clinical decision'.

I'm not sure if Lord Justice Baker means something which I can 'logically understand', or not – if he had written the following I would have been able to fit it into my understanding of MCA Best Interests and other law:

MCA Best Interests does not reside within the concept of 'a clinical decision', and when the law requires an MCA best-interests determination to be made there is not a 'carve out' 'for clinical decisions'.

I will analyse the above after stating something obvious, and showing sections 4(6) and 4(7) of the Mental Capacity Act.

The obvious: I would not expect a doctor to ask me for any input about diagnosis, possible treatments and prognoses, because they are things which require clinical expertise and I am a layman – and I would be very angry indeed, if my mother was incapacitous and a doctor suggested or implied that a clinician understood my mother's 'beliefs and values' better than I do, because I'm 'close to' my mum and the clinicians aren't.

Now the sections from the MCA:

[4](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.

[4](7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any donee of a lasting power of attorney granted by the person, and
(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

Section 69 from the ruling:

69. Any decision about the care and treatment of a mentally incapacitated adult, including the withdrawal of life-sustaining treatment, must be taken in the patient's best interests. There is no carve out for "clinical decisions".

Bearing in mind that it starts with 'Any' we can instead write:

Any decision about the care and treatment of a mentally incapacitated adult must be taken in the patient's best interests.

That makes no sense if we are considering what care and treatment **is going to be offered**. MCA Best Interests is based on the interests of an individual patient. Patients can be extremely 'selfish'. The NHS must, on grounds of fairness and efficient overall care, be able to distribute funding 'across many patients'. Everything inside section 4(6) might indicate 'This person would find it reasonable to spend all of the NHS's money on treating him, with no consideration of the 'wider good' at all'.

Personally, I don't think those 'wider good' interests can be shoehorned-into an MCA Best-interests determination. Some people probably disagree with me [there is a lack of clarity around exactly what 4(11)(b) means – I favour it meaning 'which it would be reasonable to believe the incapacitous person would regard as relevant'].

However, whatever 4(11)(b) means, we can look at sections 4(6) and 4(7) and analyse how those sections start.

4(7), which is about who must be consulted (I think 'consulted' is the wrong word unless a welfare attorney or court deputy is the person making the determination,

and the attorney or deputy has section 6(6) authority - 'discussion' is a better description than consultation in other situations), starts with 'He must take into account, if it is practicable and appropriate to consult them, the views of'. Whereas section 4(6) starts with 'He must consider, so far as is reasonably ascertainable'. In other words, if the patient's beliefs, values, etc can be discovered, they MUST be considered when making a best-interests determination. There is no opt-out to the word 'must'. **Logically, the Act would only say that the incapacitous person's beliefs, values, etc, must be considered IF those beliefs and values could affect the best-interests determination.**

It follows, in my opinion, that for any determination which is a best-interests determination, if the patient's 'non-clinical individuality' cannot affect the 'best-interests decision' then the decision cannot be a best-interests decision.

Therefore, if doctors would never offer an intervention to any patient in a particular clinical situation, then the justification cannot be MCA Best Interests. If no patient can ever receive a particular treatment because 'the NHS' has decided the treatment is simply too expensive to offer, then that cannot be an MCA Best Interests decision.

If a capacitous person is trying to achieve something in connection with his own care and treatment, and he cannot achieve it [because 'it isn't achievable as a generality'], then he will not be attempting to achieve his aim inside the Court of Protection. Because '… the court cannot achieve for an incapacitous person, something which a capacitous person could not achieve for himself' it follows that in the context of care and treatment there must be aims, and categories of outcome, which the CoP cannot achieve: it is therefore a waste of time sending such 'cases' to court. It would make sense to identify which aims and categories of outcome fall into that bucket (which of course we could label as 'Not matters of MCA Best Interests') to introduce clarity and to avoid unnecessarily wasting the court's, and the person's, time.

It is also the case that if an ADRT is considered applicable, then there is no best-interests decision to be made.

I will throw in, in passing, that in his 72 Lord Justice Baker says '*The hospital cannot pre-empt court proceedings by unilaterally withholding or withdrawing treatment on "clinical" grounds.*'. I think 'clinical decisions' and other things such as 'the professional practice test' apply to doctors – not to 'hospitals'. But I am wondering:

is a hospital, or similar, legally ‘a person’ for the purposes of MCA section 4? I merely ask – I’ll leave it at my having asked.

I can’t understand, exactly WHAT ‘decision’ Lord Justice Baker considers is for the court to make, with his ‘*But the decision is for the Court, not the clinicians.’* at the end of 74. Clearly the court, and everyone else, should want the clinicians to be applying the MCA correctly – so if best-interests is involved, there isn’t an ‘opt out’. It makes more sense to me, if we do the opposite to Lord Justice Baker’s 69 – he has decided

‘Any decision about the care and treatment of a mentally incapacitated adult, including the withdrawal of life-sustaining treatment, must be taken in the patient’s best interests.’

while I believe the law should say

‘While deciding on the options which will be offered during the care and treatment of a mentally incapacitated adult, clinicians **MUST <u>NOT</u>** consider MCA Best Interests.’

The doctors in Epsom, did seem to be thinking in a way which conflates MCA Best Interests and ‘clinical decision making’, for example here (part of 12 – Dr Prowle):

‘(2) I am also of the opinion that endotracheal intubation or a tracheostomy to facilitate deep endobronchial suction would be invasive interventions that can only be experienced as noxious stimuli. I understand that the family recognise the potential for pain and distress with these interventions and perceive them as invasive. While I recognise the concept of best interests can extend beyond individual’s ability to perceive quality of life to that of a wider family group - I can’t see it being in anyone’s interests to inflict invasive interventions on a loved one with no prospect of sustained benefit.’

In (2) I am not quite sure what Dr Prowle meant when writing ‘While I recognise the concept of best interests can extend beyond individual’s ability to perceive quality of life to that of a wider family group …’ and the sentence then continued with ‘I can’t see it being in anyone’s interests to inflict invasive interventions on a loved one with no prospect of sustained benefit.’.

I don’t believe that MCA Best Interests ‘extends to the interests of a wider family group’ [beyond, of course, the fact that the incapacitous individual him/herself might have considered/valued the interests of the wider family group] and *at least prima facie* ‘I can’t see it being in anyone’s interests to inflict invasive interventions

on a loved one with no prospect of sustained benefit' looks rather like an MCA Best Interests position. Which, if within 'a clinical decision', is either out-of-place or *else proves that the decision isn't a clinical* decision.

It is reasonably clear from what Dr Prowse has stated, that the two possible options are continued 'active interventions' which the clinicians consider would/might only briefly extend Mr Barnor's life, and at the expense of what I'll here describe as 'causing suffering to Mr Barnor', and palliative care which would lead to a faster, and in the eyes of the clinicians 'less traumatic for Mr Barnor' death.

Dr Elias and Professor Turner-Stokes seem to adopt very similar positions, which are perhaps best-summarised in 13's 'The team at King's would not offer kidney replacement therapy of any sort in these circumstances. We do not believe it would be right to offer a treatment to support someone where deterioration and complications are inevitable, starting from a very low level of consciousness. In practice, Mr Barnor is dependent on high intensity nursing care in a hospital environment to remain well. Any move out of that setting will result in deterioration. Dialysis treatment, even if it were technically and logistically possible, would serve only to prolong inevitable deterioration, without benefit.'.

Patients are allowed to place their own values on 'risks and on benefits', which means that [and conceptually this is a bit weird, because it is always easier to revert to a capacitous patient which of course isn't possible in this situation – so a 'Briggs-style' line-of-reasoning is necessary in practice] 'were Mr Barnor able to do so' he might have indicated 'I accept that recovery is incredibly unlikely – but 'incredibly unlikely' isn't the same thing as absolutely impossible. And I accept the 'suffering/impositions' of continued active treatments, because I want to maximise the extremely tiny possibility that I might recover'. And the beliefs and values to be ascertained in MCA 4(6) are most clearly described as 'what Mr Barnor would have wanted/decided, if he was capacitous'.

As Mr Justice MacDonald pointed out (Kings College Hospital NHS Foundation Trust v C & Anor [2015] EWCOP 80 (30 November 2015)) and with my added emphasis here:

> **97** The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle' outweighs a prognosis that signals continued life **will alarm and possibly horrify many**, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and

> lifelong disability are factors that also weigh heavily in the balance for C. **C's decision is certainly one that does not accord with the expectations of many in society**. **Indeed, others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general**. None of this however is evidence of a lack of capacity. The court being satisfied that, in accordance with the provisions of the Mental Capacity Act 2005, C has capacity to decide whether or not to accept treatment **C is entitled to make her own decision on that question based on the things that are important to her, in keeping with her own personality and system of values and without conforming to society's expectation of what constitutes the 'normal' decision in this situation (if such a thing exists).** As a capacitous individual C is, in respect of her own body and mind, sovereign.

I will also add, that Professor Turner-Stokes in commenting on TDOC, introduced:

'It is first up to the clinical team to decide which treatments are on offer. A clinician may decide that a given treatment would be futile or clinically inappropriate within the particular context of a patient's presentation, in which case they are under no obligation to offer it, and such decisions are made routinely as part of everyday clinical practice.'

I wrote above that I believe the law should say 'While deciding on the options which will be offered during the care and treatment of a mentally incapacitated adult, clinicians **MUST <u>NOT</u>** consider MCA Best Interests.'. Another reason for arguing that, is the way Best Interests works – see my thread 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 in particular the addition made on 23/02/26 and the PDF you can download from

https://www.dignityincare.org.uk/Discuss-and-debate/download/509/

On page 9 of the PDF I argue that section 3(1) of the MCA can usefully be presented slightly differently – in the way I presented it in my piece at

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Section-2-of-the-Mental-Capacity-Act-should-be-unnecessary/1165/

- and my alternate presentation was:

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the options and outcomes of the decision,
(b) to retain the options and outcomes,
(c) to think about the options and outcomes as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).

MCA Best Interests involves considering possible options and their outcomes, and then deciding which option/s is/are 'best' for the incapacitous person – you NEED to have options and outcomes to consider BEFORE you can start to consider MCA Best Interests.

So, I'll now state a few things which I assume almost everyone would agree with:

We don't want most disagreements to be sent to court – too time-consuming all round, too expensive, and to be blunt it is madness to want huge numbers of disputes to be sent to court;

We do want to make sure that if they should be carried out, best-interests determinations are carried out, and are carried out correctly;

Disputes between 'family' and clinical teams, especially once they become serious and 'ill-tempered', are bad for those involved and more widely for the NHS.

Now, if we can successfully explain to layfolk what MCA Best Interests is and means (see pages 10 and 11 of this PDF), then the family and friends of an incapacitous person who are involved during best-interests discussions, are in a position to check that best interests is being applied correctly – EXCEPT for interventions which are NOT being offered. McCulloch, considering how many treatment options must be offered to capacitous patients, decided that the doctor [usually] needs to offer

several options, but is not required to offer [or discuss] all of the treatments which might be clinically effective. This presents a problem in the context of what I've written above: how are family and friends to confirm that treatments which are not being offered, are being withheld because of legitimate reasons?

I will point out, that there is a 'pragmatic' peculiarity in the conclusion arrived at in McCulloch: from memory the example given was something like 'If there are 10 treatments which could sensibly be offered, any particular doctor need only offer 4 of the options for the patient to choose from'. These days it isn't difficult to ask Dr AI 'what treatments can be used [for my condition]?' and all 10 treatments [plus others] will immediately pop-up.

At the very least – if we were to adopt my 'analysis/position' here – the doctors would be required to explain why a treatment not on offer, and raised during a best-interests determination, was not being offered. Something which to me also makes sense during Informed Consent.

My 'instinct', without having thought too-deeply about this, is that it makes sense for the doctor to disclose information about all of the 'clinically more-successful' interventions, and to explain why some of them are not being offered, and also to discuss any intervention outside of that category which isn't on offer and is raised by a capacitous patient or by someone involved during MCA Best Interests.

The significance of a Second Opinion

I've never believed that the significance of the 'opinion of a second clinical team' has been correctly described, within most material which I myself have read.

If the opinion contains a view as to the patient's MCA Best Interests, the significance of that view agreeing with the treating clinicians' position, or of the second opinion disagreeing with the treating team's view, is to be considered, but that is all. Two clinical teams sharing the same position on MCA Best Interests, does not mean their position 'is right'. An entire family of relatives, all agreeing about what is in their loved-one's best interests, does not make their view 'right'. Section 4(9) provides [or leads to if you prefer] a personal defence based on the person's best-interests determination having been made in compliance with section 4 – we never know 'which best-interests decision is right' we only ever know that a person's 'decision' is what I tend to describe as 'legally satisfactory'. Two doctors can disagree, two relatives can disagree – what matters is can a person defensibly claim to have applied MCA section 4 correctly in arriving at his/her best-interests determination/position.

It is known, that clinicians and family/friends tend to arrive at different best-interests positions as groups – look up 'The Protection Imperative'. And we also know, that many clinicians introduce a concept of 'Medical Best Interests' when they should be applying MCA Best Interests.

I will also comment, that the assertion that adequately-informed family and friends, who understand section 4, 'cannot make best-interests determinations', is logically absurd.

Suppose two brothers, Andy and George, are being appointed by their dad as his welfare attorneys. The completed paperwork is sent to the Office of the Public Guardian, and while it is being processed a sudden clinical event causes dad to 'lose capacity'. I sent an e-mail to the OPG about a decade ago, and asked if that would prevent the appointment of the sons as attorneys – the answer was that usually it wouldn't stop the appointment of the sons as attorneys. Now, we layfolk are often told that 'you can't make best-interests determinations [about medical interventions] unless you are a welfare attorney or a court deputy'. Nonsense. At some point the LPA documentation will 'drop through their letter boxes' and the confirmation of their appointments doesn't magically improve their understanding of section 4 of the MCA. The 'quality of' their best-interests positions the day before their appointments are confirmed, will not be altered by the confirmation-of-appointment arriving. All that has changed, is section 6(6) [and a requirement that they now pay some attention to the Code of Practice, can apply to the CoP without asking for permission, etc] now applies.

However: MCA Best-Interests is complex, and if everyone involved, clinicians, family, friends, has arrived at the same conclusion as to what is in the patient's best interests, then that conclusion is probably a good one.

Do NOT describe the above as 'The Family and Friends agreeing with, or not disputing, the best-interests decision made by the clinician/s' – describe it CORRECTLY as 'The clinicians, family and friends all agree on what would be in the best interests of the patient'.

Is MCA Best Interests too difficult to explain to 'normal people'?

I have argued that the best way to check that doctors are properly applying Best Interests is for the layfolk involved to check – which of course requires that family and friends understand MCA Best Interests. I think this can be done: provided we

don't simply point people at MCA and in effect say 'read it yourself'. This takes 'bravery', but I believe the one-sentence description of the objective of Best Interests which I published in 2017 at

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

would make this possible. 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.

Most of the things in section 4, are reasonably intuitively obvious if you know that the objective is to do the above. I harvested views on my sentence (you can find them if you follow the url above), and they were largely very positive. Dr Kathryn Mannix hit the nail on the head in her comment, with 'I like your sentence because it helps decision-makers and those participating in a decision-making process to be clear about the task'.

Who can legitimately decide What, How and When?

When I write about EoL/MCA/CPR I am often trying to answer the question 'who can legitimately decide what, how and when?'.

If the who is Lord Justice Baker, the when and what are in his court and the case being considered, and the how, if I understand what he has said, is by applying MCA Best Interests [which makes me assume that LJ Baker never rules on ADRTs].

I analyse some of the whos, whats, hows and whens for CPR-at-Home in my PDF at

https://www.dignityincare.org.uk/Discuss-and-debate/download/475/

For example, assume that my 'EoL-but-capacitous' father has told his GP that if his heart stops he wants CPR to be attempted, his GP says 'I believe you are too frail for CPR to be successful so I am not going to attempt CPR', and I throw in 'If my dad arrests I'll attempt CPR because my dad wants me to'. The only person in here who

could not possibly attempt CPR is my dad: my dad and I can't make the GP attempt CPR, the GP cannot prevent me from attempting CPR, and although at the time CPR would be attempted or withheld my dad would be incapacitous, a CoP judge would not be making a ruling because there isn't the time to involve a court when a person arrests [and, of course, prior to the arrest the CoP can't get involved because my dad is capacitous].

We should also throw in, the different legal situations of clinicians and family-carers – my piece about that is at

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/

I'll finish my analysis of Lord Justice Baker's ruling now, in an 'internal sense', and speculate on what its consequences might currently be. I'll return to 'my contact said there is a lot of discussion going on inside 'the NHS' about what the consequences of the ruling will be'.

I'm not inside the NHS, so what follows is simply speculation. And my speculation as to 'what they might be doing' is presented in green text here to make this more-easily readable.

Clinicians might be thinking rather harder, about what genuinely is 'a clinical decision'.

Doctors might involve and communicate more deeply with 'family', which is I think a good thing. But I'm less certain that when such involvement is in the context of MCA Best Interests, that the clinicians/NHS will be doing it properly. In a piece at

http://www.bailii.org/ew/cases/EWCOP/2014/4.html

Mr Justice Hayden made it clear that the 'experts on the patient as an individual' (my phrase) are not simply 'closest family', when he wrote (my added emphasis here)

53. If ever a court heard a holistic account of a man's character, life, talents and priorities it is this court in this case. Each of the witnesses has contributed to the overall picture and I include in that the treating clinicians, whose view of TH seems

to me to accord very much with that communicated by his friends. I am left in no doubt at all that TH would wish to determine what remains of his life in his own way not least because that is the strategy he has always both expressed and adopted. I have no doubt that he would wish to leave the hospital and go to the home of his ex-wife and his mate's Spud and end his days quietly there and with dignity as he sees it. Privacy, personal autonomy and dignity have not only been features of TH's life, they have been the creed by which he has lived it. 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*. I have given this judgment at this stage so that I can record my findings in relation to TH's views. Mr Spencer on behalf of the Trust does not argue against this analysis, he agrees that nobody having listened to the evidence in this case could be in any real doubt what TH would want.

I wrote in my thread which was prompted by the death of my friend Rachel Griffiths

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/

‘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?’.’

I’ll also correct here, a lack of ‘nuance’ in what followed directly from the above (this is in the first PDF you can download from that DiC thread) which was:

‘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 was thinking about CPR and similar, when there are only two options, or about more complex decisions but when there is only one ‘best option’ – but in some situations it is possible for there to be more than one ‘equally good’ option [in which case ‘the Act would in principle identify all of the equally-good [and therefore equally acceptable] options’].

Doctors and Hospitals might become ‘more defensive’ and also more concerned with ‘the paperwork’.

Welfare attorneys and court deputies might ask ‘If all of the care and treatment decisions are to be made on best-interests grounds, then I was appointed to make best-interests decisions – so do all of those decisions fall to me to make?’.

I also believe that a lot of NHS/Clinical folk, will be struggling to write guidance which incorporates Lord Justice Baker’s assertion in his 69 – because, as will be clear to the reader, I believe his conclusion is flawed.

I think I’ll end here, as I’ve written enough,

Mike Stone September 2026