

Further Comments by Mike Stone on the Epsom v Townsend court ruling

This should perhaps be read alongside my earlier comments, which were in the same Dignity in Care discussion thread as these, and it is possible that this PDF was obtained without actually going to the thread – in which case my earlier comments are in the thread at

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/The-implications-of-the-Epsom-v-Townsend-court-ruling/1213/>

and in the PDF which downloads from

<https://www.dignityincare.org.uk/Discuss-and-debate/download/513/>

I wrote the above pieces, without looking at how Lord Justice Baker arrived at his conclusions – I still have a ‘fortunately now vague, but troubling’ memory of reading the arguments put forward by Lord Justice Baker in an earlier ruling, and of how I simply couldn’t make sense of them. But I have now ‘speed read’, or perhaps ‘speed glanced at’, the arguments which Lord Justice Baker uses in Epsom.

I think I’ll start with what I consider to be the important issue – that Lord Justice Baker’s conclusion

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”.

must be incorrect. Or more precisely, that the first sentence, when logically rewritten as

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

must be incorrect.

Such a statement, which purports to be a general truth, falls as soon as it can be proven incorrect in a single instance. The two obvious things which make the above assertion fall, are these.

MCA section 5(4).

I have always considered that section 1(5) of the MCA is problematic, and I've always assumed the reason is that the part of the Act which covered Advance Decisions to Refuse Treatment was 'bolted on' as a late addition. But whatever the reason, it is explicit in the Act, by means of 5(4), that ADRTs and Best Interests are legally separate. If you need the legal protections offered within the MCA when an Advance Decision leads to the withdrawal or withholding of an intervention/treatment, then you need to satisfy requirements that are within sections 24-26 of the Act. You are not, in the context of ADRTs, given any legal protection by sections 4 and 5 of the Act, which cover best interests.

That, alone, means that Lord Justice Baker's 69 falls, in my opinion.

MCA section 3(1).

I think most of the CANH cases which get to a court, are situations when it doesn't really need to be proved that the patient cannot make the decision for him/herself. To put that another way, section 3(1) of the Act will be 'out of mind'.

It is apparent, from section 3(1)(a), that the patient's capacity to consent to an intervention, depends on the complexity of the treatment and its outcomes, and in particular the outcomes can be very complex. This is a situation when we can see where we will get to, merely by having stated 'the question' properly: and here, what you get to is

Without having decided which intervention/s is/are being offered, it isn't possible to describe the information relevant to the decision/s (in 3(1)(a)) and therefore it isn't even possible in most situations to try to decide if the patient is capacitous or incapacitous (usually explained as 'mental capacity is decision and time specific' which covers fluctuating capacity as well) with respect to the decision/s.

We are told right at the start of the Act, that a person must be assumed capacitous:

1(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

As I have pointed out, the Act's approach to the assessment of capacity – which should be thought of as the means by which incapacity can be asserted – is impossible to apply unless there are offered options to apply it to. It does apply – this analysis does apply – to care and treatment in general, but I will be describing the situation for treatment.

It is therefore an obvious logical necessity, that within an NHS context, the first necessity is for the doctor to work out which treatments are on offer – and, it is also a logical necessity that the question is ‘which treatments are on offer **to a capacitous patient**’. There will be constraints on which treatments are on offer: some arising from legitimate but ‘non-clinical’ considerations, which I’ll loosely describe as stemming from considerations of resource allocation and fairness, and some arising from the clinical-effectiveness of treatments. The second stage, is the legal requirement that the application or withholding of an offered treatment is a decision which falls to either the patient if considered capacitous, or ‘to an MCA best-interests determination’ if the patient is considered incapacitous.

I will add, in passing, that the Act considers capacity in the context of a single treatment in section 3. In reality [see McCulloch] there will often be several offered treatments. I can see no reason, why a patient might not be considered capacitous with respect to some of the offered treatments, and incapacitous with respect to respect to others of the offered treatments. **Anyone who thinks I’m going to analyse the consequences of that, can think again!**

It is now clear, why section 1(5) of the Act includes the wording ‘under this Act’.

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests

No decision about care or treatment made prior to consideration of section 3, can involve MCA Best Interests.

It isn’t that there is some sort of ‘carve out’ from the consideration of MCA Best Interests for ‘clinical decisions’ – the situation is that [as I argued in my previous piece] clinical decisions and best interests are indeed fundamentally different, and that is an obvious logical consequence of the Act itself.

I cannot see any flaws in those arguments based on 5(4) and 1(5)+3(1)(a), so ‘job done’ – but I will indulge myself, by ‘rambling on’ for a while.

I am currently reading ‘COMMAND – How the Allies Learned to Win the Second World War’ by Al Murray.

In the book, he writes:

*Syphilis, which once stalked the world, is a wily, evil bastard of a disease.**

** This is one of those times I'm glad I'm not a historian and can write something like that.*

Well, I'm not a lawyer – so I'm allowed to write 'it seems absurd' and 'it seems obvious'.

I have, however, been thinking about MCA Best Interests for over 15 years. If I haven't got a decent grasp of best interests by now, then how well can we expect family and friends who are 'thrown into situations when best interests determinations are being made' (a loved-one has a severe stroke, a bad car crash, etc) to understand the MCA? And the MCA inherently assumes that relatives will be able to adequately-understand the Act's concept of Best Interests: think of welfare attorneys, and of the fact that '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'.

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.

It also seems obvious, that we might have an expectation that if judges are simply applying law, and where the law is 'lacking' are 'filling in the gaps', then it shouldn't really matter which judge makes a ruling. But Mr Justice Charles, in his Briggs ruling, makes it clear that isn't true – he states [in his sections 80 and 81] that he considers that the judge in an earlier ruling had not viewed best interests sufficiently holistically, and he states 'As appears above I prefer the approach taken by both Pauffley J and Hayden J to the assessment of P's past wishes and feelings, beliefs and values in the application of s. 4(6) of the MCA.' Mr Justice Charles mentions that 'Aintree' was after the ruling that didn't take a 'holistic' approach to section 4(6), but it seems obvious to me, from simply reading the Act, that the ruling made by Mr Justice Charles in Briggs fits with section 4 of the MCA. Which, as it happens, isn't a retrospective view: I considered how a welfare attorney could arrive at a best-interests decision to forbid potentially life-sustaining CPR about four years before

Briggs, and my justification was identical to that which Mr Justice Charles arrived at in Briggs for the withdrawal of life-sustaining CANH.

I think the 'labels' used within healthcare, often carry correct implications. Most people use Informed Consent for the situation during capacity – there is the word 'informed' but there isn't the word 'best'. Best Interests, does contain the word 'best'. Other labels – notably Shared Decision Making – are somewhere between unclear and downright misleading.

It seems obvious, reading Epsom, that there needs to be more clarity about what is, and what isn't, 'a clinical decision'.

This appears in Epsom:

[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.

In my view, this is hopelessly logically muddled [as I have already explained above]: how can a court whose task is to make best-interests decisions, and which cannot force doctors to provide a treatment which they consider to be clinically inappropriate, conclude 'that the decision is for the court, not the clinicians'? We can read in 74 '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*' but I think it is more helpful to consider the other cases – the cases when the court does NOT conclude that it is not in P's best interests for the treatment to continue, in other words when the court concludes that it is IS in P's best interests for the treatment to continue. How is that 'a genuine decision' when the court cannot compel the doctors to continue to provide the treatment?

One obvious problem with considering the cases when the doctors believe that continued provision of CANH would not be clinically appropriate and the court decides that withdrawal of CANH is in the patient's best interests (which is usually stated as 'continuing CANH is not in the patient's best interests' – but it is obvious that 'not continuing' and 'withdrawing' are exactly the same action in the real world), is that we can't easily work out why CANH is being withdrawn.

In 32 and 33 of Epsom v Townsend we can find:

[in 33]

(3) The judge erred in holding that a “clinical decision” to withhold life sustaining medical treatment is not subject to best interests considerations and hence is not subject to the supervision of the Courts.

(4) In the alternative, if there is a legally significant distinction between clinical and best interests decision-making, such a distinction must be based upon objective criteria and in the event of a dispute the Court must examine whether these criteria are met: in the circumstances the judge erred in not granting permission so that the court could establish whether such criteria were met.

[in 34]

The real issue here is the point raised in ground 3.

During Lord Justice Baker’s reasoning, he does show us this:

53. Thus doctors, like other decision-makers, have to evaluate treatment options by reference to the patient’s best interests. Having cited paragraphs 5.31 to 5.33 of the Code of Practice, Lady Hale (at paragraph 29) noted: “As paragraph 5.33 makes clear, doctors have to decide whether the life-sustaining treatment is in the best interests of the patient.”

In 66 we can read – and I assume this means the emphasis has been added by Lord Justice Baker -

4. If, at the end of the clinical decision-making process, [emphasis added] there is disagreement between any of the parties that cannot be resolved by discussion and/or mediation, then the matter should be referred to the Court of Protection. Similarly, an application should be made if the decision is ultimately one that is finely balanced due to residual uncertainty about best interests.

I cannot get from 66(4) to the following:

68. The following principles are therefore clearly and consistently established by the case law and professional guidance.

(1) All decisions about incapacitated adults, including clinical decisions, have to be made in the patient's best interests, taking into account all relevant circumstances and taking the steps identified in s.4 of the MCA.

There is a lot of what Lady Hale said in Aintree, which was a 2013 ruling, mentioned (52 onwards). I will point to something Lady Hale said in 2015 in Montgomery [My added emphasis]:

115. In any event, **once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear, as Lord Kerr and Lord Reed conclude at para 85, that the Bolam test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite.** A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the “natural” and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide (*St George's Healthcare NHS Trust v S* [1999] Fam 26). There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.

In my opinion, this fits nicely with the way I think of the difference between Informed Consent and Best Interests. In essence, suppose a patient has got a bad cut which has become infected, and there is a concern that sepsis is developing. It seems to me that appropriate antibiotics should be offered, irrespective of whether the patient is capacitous or incapacitous. Ditto, for example, if a patient has got pneumonia. I think of the diagnosis and the decisions about possible treatments as being the same, and then at the ‘consent stage’ if a patient isn’t capacitous and cannot consent, a best-interests determination steps in at that point. The patient, or the best-interests determination, involves ‘value judgments of this sort’ and the decision ceases to be ‘a clinical decision’ (in *Montgomery* Lady Hale points at Bolam becoming ‘quite inapposite’ - more generally, once ‘the patient’s non-clinical individuality’ comes into play [as in section 4(6) of the Act], in my opinion we have departed from the realm of ‘clinical decisions’).

Personally, I think the Court of Protection should be investigating if it seems possible that doctors/hospitals are presenting what should be an MCA best-interests determination as ‘a clinical decision’. But beyond that, I don’t think the CoP should

be involved. If an intervention is not on offer for a legitimate non-MCA reason – which could be ‘NHS resource allocation’ or ‘the intervention would have NO clinical effect*’ for example – then I think the CoP should leave those alone. But as I wrote in my previous piece, I do think we need to understand which legitimate reasons for not offering an intervention exist, and this should be made clear to everyone.

* I think it is a fairly standard medical position that if a treatment definitely would have no clinical effect, then it need not and usually should not be offered. It is not easy to construct a scenario when the offering of a definitely-not-clinically-effective treatment could be justified on best interests grounds, but it is not necessarily impossible. If an incapacitous but ‘engaged with life’ patient is convinced he needs a clinically-ineffective treatment, and not receiving the treatment ‘would cause the patient mental anguish’, then if the treatment itself has not got significant side-effects it could be argued that it should be administered on best-interests grounds [or, if this could work, it could be argued that ‘a placebo and ‘deception’ would be a satisfactory best-interests decision].

I’ll close, by returning to something I write about a lot – and a comment about something from Lady Hale.

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.

That can only happen IF ‘family’ DO UNDERSTAND MCA best interests – we need to find a way of explaining MCA Best Interests to relatives, friends and the public in general.

The bit about Lady Hale. In 58 of Epsom, there is a bit from Lady Hale which includes, with my underlining here

Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P’s best interests for the act to be done.

I don’t know if ‘a general authority’ is some type of legal jargon. When I read the Act, section 5 is giving a legal defence. I only use ‘authority’ when I’m writing about MCA Best Interests, in the context of section 6(6).

Lady Hale did write, at the end of her 'appendix' in Montgomery – my added bolds:

These additional observations, dealing with the specific example of pregnancy and childbirth, are merely a footnote to the comprehensive judgment of Lord Kerr and Lord Reed, with which I entirely agree. **Were anyone to be able to detect a difference between us, I would instantly defer to their way of putting it.** I would allow this appeal.

Written by Mike Stone.