

My subconscious has still been like a dog with a bone on the conclusions of Lord Justice Baker – although I consider the fact that ADRTs are separate from Best Interests, and my argument based on 3(1)(a) to be sufficient (keeping in mind that even if it is believed that a patient would lack the capacity to make a decision for herself, her capacity to make the decisions should still be checked – and that involves 3(1)(a) [so it isn't the case that section 3 only applies if the patient hasn't been asserted as incapacitous]).

These are the parts of Lord Justice Baker's conclusions which I disagree with – with wording that bothers me made red (in the PDF) here:

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".

74. Once proceedings have been started, however, the judge will exercise their case management powers as the circumstances require. Many of these cases are very urgent and, as proposed by Lady Hale in *N v ACCG* in the context of a refusal to fund treatment, it is open to the Court to use its case management powers to adopt an abbreviated process. That again is a matter for the Court to determine, not the parties.

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.

I suspect that my subconscious wanted something which only happens when the patient is considered incapacitous in respect of the decision, which seems 'simpler'. There is, as it happens, something that fits the bill inside the Act. It is also something which I have always considered to be 'a mistake' within the Act. First, I need to start with section 4(9):

[4](9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

That doesn't say that judges – I'm equating 'the court' with judges – need to follow section 4, but in fact there are many rulings when the judge makes it clear that he or she is applying section 4 of the MCA. So, everyone and also Court of Protection judges is trying to follow section 4.

The section of the MCA which I have always considered to be incorrectly expressed – I stress that its thrust is correct, but I object to its wording – suddenly 'appears from nowhere' in section 11 (my added bolds (in the PDF) here):

[11](7) Where a lasting power of attorney authorises the donee (or, if more than one, any of them) to make decisions about P's personal welfare, the authority—
 (a) does not extend to making such decisions in circumstances other than those where P lacks, or the donee reasonably believes that P lacks, capacity,
 (b) is subject to sections 24 to 26 (advance decisions to refuse treatment), and
 (c) extends **to giving or refusing consent** to the carrying out or continuation of a treatment by a person providing health care for P.

The authority over treatments, is correct: but the welfare attorney is making best-interests decisions, so the decision should be expressed in best-interests terms: as 'it would be in his best-interests for the offered treatment to be applied' or 'it would be against his best interests for the treatment to be applied' ('his' being the donor's/patient's). Consenting and refusing are things that capacitous patients do when offered a treatment – welfare attorneys make best-interests decisions when a treatment is on offer. **But, wording aside, this part of the Act is clear: the attorney makes a best-interests decision about an OFFERED treatment.**

Now, welfare attorneys are quite similar to judges, as opposed to being similar to doctors, within the Act. If you disagree, then I'll explain why: because [as a lawyer who is an expert in the MCA pointed out to me – I'd always considered that 11(7)'s reference to 'consent and refusal' must have been a drafting error, but the lawyer said it was deliberate] only judges, welfare attorneys and court deputies can make DECISIONS about Best Interests – everyone else, doctors included, can only make best-interests DETERMINATIONS. This is why the word 'determination' appears within section 4.

A welfare attorney can make a best-interests decision about an offered intervention - to follow Lord Justice Baker's 74 'the decision is for the attorney, not the clinicians'. Nobody has ever suggested that a welfare attorney can force doctors to offer a treatment. And most best-interests determinations are not made by judges in the

Court of Protection: MCA Best Interests is most-often considered 'on the front line'. The best-interests decisions which Lord Justice Baker asserts are 'for the court' are only 'for the court' because the case has reached a court. The best-interests decisions which are 'for a welfare attorney' are only 'for a welfare attorney' because a suitably-empowered attorney is involved. MOST day-to-day and hour-by-hour or even minute-by-minute best-interests determinations are made and acted on by doctors, family carers, social workers, care staff, nurses etc. Definitely NOT by judges, or even by welfare attorneys and court deputies.

As I've argued previously, we shouldn't be telling doctors that, to use my phrase here, 'your clinical decision-making must be made in the patient's MCA Best Interests' - we should be telling doctors 'you must NOT consider MCA Best Interests while making clinical decisions', along with stressing that 'whether an intervention is applied or withheld is NOT a clinical decision'.