

Commentary on Charles Foster's "The rebirth of medical paternalism: An NHS Trust v Y"

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Professor Charles Foster [1] argues that the recent decision by the Supreme Court [2] on the process of making decisions about medical treatment in people who lack capacity due to a prolonged disorder of consciousness is fostering medical paternalism. He considers that the judgment shows “*deference to the guidelines of various organisations*” and then that “*The guidance has effectively become a definitive statement of the relevant obligations.*”, concluding that “*This usurps the function of the law.*”

Healthcare teams make all decisions concerning medical care provided; no-one else can. Both the clinicians themselves, and any guidance provided to them, must comply with the Mental Capacity Act 2005. [3] Lady Black’s judgment makes clear that “*The basic protective structure is established by the MCA 2005.*” (para 106) and that the associated Code of Practice [4] “*contains valuable guidance*” (para 107). She specifically highlights that the decision-maker must ensure that “*account has been taken of the patient’s previously expressed wishes and those of people close to him, as well as the opinions of other medical personnel. The MCA 2005 requires this to happen, and is reinforced by the professional guidance available to doctors.*”

The Act says:

“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.*

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)."*

Therefore it is a legal requirement that the decision-maker consults with family members and others about the patient's attitudes, values and any other factors relevant to identifying their likely decision.

The many guidance documents available to healthcare teams [4][5] explaining the use of the Mental Capacity Act 2005 also emphasise that decisions must be made in the Best Interests of the patient and stress the need to consult widely and use a broad range of information.

Nevertheless, because decisions are considered medical, Professor Foster thinks a doctor will be the decision-maker and will make a 'medical best interests' decision. He implies that a doctor will necessarily not take a 'holistic best interests decision'. He gives no evidence to support this assertion, nor does he suggest who would be better placed to be holistic. He also overlooks the fact that families are often ignored [6] and have to fight 'medical paternalism' to achieve a patient's best interests.

I could reply by asserting that most doctors are as holistic as any other profession. Instead I will emphasise that but the Act applies to the decision-maker regardless of status, and it requires consideration of patient values. Moreover, although decisions of this type may be articulated

by a doctor, they arise out of a multi-disciplinary discussion with full involvement of family and friends as required by the Act. There is no risk of “*drowning out other, non-professional voices, of ousting or muting non-medical criteria and making doctors the sole de facto decision-makers.*”

He is worried that guidelines have been given “*the additional imprimatur of the Supreme Court*” which “*means that impeachment [challenging] of a guideline’s conclusion about best interests will be practically impossible.*” Apart from observing that a guideline cannot conclude a person’s best interests, this statement ignores the fact that all guidelines emphasise the importance of the Act and of determining a patient’s best interests.

The Supreme Court judgment also states, unequivocally: “*If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient’s welfare, a court application can and should be made.*” (para 125). It is true that funding might be an issue, but this is a matter for the Legal Aid board and/or the NHS and is not within the remit of this judgment.

Professor Foster states that “*the algorithmic formulation of the guidelines suggests that (now legally unimpeachable) compliance with the letter of the law rather than the spirit of the Act is likely to become the norm.*” I agree that guidelines may adversely influence good clinical practice, but guidelines are not legally binding and should not be followed unthinkingly. He, like many others, over-rates guidelines as being “*based on a large body of evidence*”, whereas in reality they reflect the opinions and judgments of their authors, because the evidence base is always limited.

His solution is to recommend statutory mediation by an independent lawyer, which would replace one system that has many disadvantages outlined in the judgment with another, and

has nothing to recommend it, and to recommend 'proper access to the courts' even though it has not been restricted. I suggest no solution is needed, because the judgment returns power to families and the patient rather than leaving it with professional doctors and lawyers. [7]

Competing interests

I am closely involved in the development of guidance on this matter being undertaken by the British Medical Association, the Royal College of Physicians, and the General Medical Council, but I am not a member of the working group. I attend the public meetings, and comment on proposals put out for consultation.

I am often asked to see patients with a prolonged loss of mental capacity and needing a decision on continuing gastrostomy feeding or other treatments, as a second opinion and/or as part of the legal process. I am paid sometimes, but not always.

I speak and teach on this clinical topic, and I write about it.

I am developing (with many others) an application for money to devise a method to assess awareness and responsiveness in people who are in a prolonged disorder of consciousness.

Exclusive licence

I have the right to grant an exclusive licence as set out in the submission process.

Contribution

There are no other contributors.

References:

1 Foster C

The rebirth of medical paternalism: An NHS Trust v Y

Journal of Medical Ethics.

2 Lady Black

An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants)

[2018] UKSC 46.

<https://www.supremecourt.uk/cases/docs/uksc-2017-0202-judgment.pdf>

(Accessed October 8th 2018)

3 Mental Capacity Act 2005.

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

(accessed October 8th 2018)

4 Mental Capacity Act 2005. Code of Practice.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

(accessed October 8th 2018)

5 Making decisions. A guide for people who work in health and social care.

Office of the Public Guardian (OPG603)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/348440/OPG603-Health-care-workers-MCA-decisions.pdf

(accessed October 8th 2018)

6 Kitzinger J, Kitzinger C

Causes and consequences of delays in treatment-withdrawal from PVS patients: a case study of Cumbria NHS Clinical Commissioning Group v Miss S and Others [2016]

EW COP 32

Journal of Medical Ethics 2016 Online First 23-Sept-2016

2016;0:1-10. doi:10.1136/medethics-2016-103853

7 Wade DT

Clinically assisted nutrition and hydration. Landmark decision returns decision making to clinical teams and families.

British Medical Journal 2018;362:k3869 doi: 10.1136/bmj.k3869