Best interest and family compromise

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It is not unusual to hear medical professionals complain that the 2005 Mental Capacity Act (MCA)[1] precludes a certain kind of humane family compromise – especially medical professionals with experience of working in the previous legislative framework. It is not hard to see why. The MCA requires that decisions be based on the best interest of patients. The process of determining the best interest of the patient may seem to preclude a certain kind of open-ended discussion between the relevant medical professionals and family members.

This may reflect a broader misunderstanding of 'best interest'. The outcome in the best interest of a patient is often identified with the outcome which is medically best. However, the best interest of patients without capacity is, according to the legislation and to the accompanying Code of Practice,[2] to be determined in relation to the patient's preferences and values, at least when these can be ascertained. That is, it is sensitive to the patient's subjective view of their best interest, not only to objective concerns, let alone only to medical concerns.

This misunderstanding is by no means limited to medical practitioners, nor is it universal among them. For example, Coggon[3] criticises Baker J's judgment and reasoning in *Re M*.[4] According to Coggon, Baker J misunderstands the Code of Practice and the MCA. Baker J views these as claiming that although those assessing capacity should be concerned with the values and preferences of the patient, the decision that they make for the patient should ultimately be governed by the patient's best interest alone, which Baker J sees as a separate issue from the patient's values and preferences. Coggon argues, conversely, that according to the Code of Practice and the legislation, a patient's values and preferences are part of determining their best interest, but they are not the sole determinant of medical decision-making any more than they are in the case of a capacitous patient. Even capacitous patients cannot, for example, demand treatment that they do not need and that would not be medically justified.

How does a broader understanding of best interest affect the possibility of family compromise? When it is possible to ascertain an incapacitous patient's reflective preferences and values (normally from the time that they were capacitous), these should be treated as partly determinative of best interest. Many people have other-regarding preferences and values. Many of us would prefer that our loved ones be happy than unhappy, and many of us would prioritise this preference over preferences regarding the minutiae of medical treatment. When it is possible to ascertain such preferences, they should be factored into determining the best interest of the patient.

What this means, at the very least, is that when there are decisions regarding incapacitous patients to be made and the prospective outcomes are medically similar, it is often legitimate for the preferences of family to determine the course of action. It is legitimate exactly in as much as the patient has an attested preference for keeping their loved ones happy. It would not be at all legitimate in the case of a patient without such a preference. It would be entirely legitimate in the

case of a patient who had clearly expressed and acted upon a preference for keeping their loved ones happy.

It is widely known that in determining best interest, 'previously expressed preferences' are extremely significant, perhaps the most significant factor. However, it often appears to be implicitly assumed that such preferences must bear directly on different possible courses of medical treatment: to represent preference for one kind of treatment over another. This is not required either by the MCA or the Code of Practice. A previously expressed preference to avoid family drama is just as legitimate a determinant of best interest as a previously expressed preference against long-term life support or against highly invasive surgeries.

There may be some understandable squeamishness around such other-regarding preferences and values. Family members may be incentivised to overstate the extent to which their incapacitous relative has expressed a preference to keep them happy. Even aside from the issue of ascertaining such preferences, there may be worries that such preferences should not be involved in life-or-death decisions. The Association for Palliative Medicine[5] goes beyond capacity law in some cases, asserting that withdrawal of assisted ventilation must not be 'driven by mistaken kindness to the family' (p. 15).

Even so, there is space for other-regarding preferences and values to affect best interest decisions in less extreme cases and those in which they can be safely ascertained. They are, after all, not the sole determinant of best interest. They should, nevertheless, be part of the determination of best interest, meaning that it will at least be possible to search for family compromises around treatment plans in exactly those cases in which it should be possible: those in which it is clear that such compromises are in line with the patient's values.

REFERENCES

1 *Mental Capacity Act 2005*. TSO (The Stationery Office), 2005.

2 Great Britain: Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. TSO (The Stationery Office), 2007.

3 Coggon J. Mental capacity law, autonomy, and best interests: an argument for conceptual and practical clarity in the Court of Protection. *Med Law Rev* 2016; **24**: 396–414.

4 *Re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment) [2011]* EWHC 2443 (Fam); [2012] 1 WLR 1653.

5 Association for Palliative Medicine of Great Britain and Ireland. *Withdrawal of Assisted Ventilation at the Request of a Patient with Motor Neuron Disease*. Association for Palliative Medicine of Great Britain and Ireland, 2018 (https:// apmonline.org/wp-content/uploads/2018-guidance-on-withdrawal-of-assisted-ventilation_final-4.pdf).