

MAKING DECISIONS FOR PEOPLE WHO LACK CAPACITY

Mental Capacity Act 2005

WORKING OUT BEST INTERESTS

This is one of a series of resource materials for clinical ethics committees providing explanation and discussion of the sections of the Mental Capacity Act which are particularly relevant to their work

The best interests principle set out in [section 1\(5\)](#) states:

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

The concept of best interests was well established in the common law prior to implementation of the Act. Except in two situations (see step 1 below) the principle must guide all actions taken or decisions made under the Act (whether by individuals or the courts).

Essentially the best interests approach asks whether any proposed course of action is the best one for the patient all things considered. The term is not defined in the Act - a universally applicable explanation was considered inappropriate given the wide range of people likely to making decisions covered by the Act and the variety of decisions that would need to be made. However in section 4 a statutory 'list' of common factors is set out that must always be considered (as a minimum) by anyone who makes a decisions for someone who lacks capacity. Note that none of the factors in the list carries more weight or priority than another (rather they must be balanced).

Decisions can relate to a person's financial affairs, personal welfare or health care. Some decisions will be routine, minor one whereas others could have serious consequences – such as major surgery.

Change: Although the best interests approach was a common law principle the statutory version is both more extensive and coherent, essentially codifying the common law. It provides a systematic set of procedures and criteria that are designed to ensure that the proposed action is 'best' for the person while also paying due respect to their autonomy.

Step 1: Establish whether the best interests principle applies

There are two circumstances when the best interests principle does not apply (because there are other safeguards that are presumed to be effective). These are:

- 1) **Advance decisions** – if the person lacking capacity has previously made a valid and applicable advance decision to refuse medical treatment (while they had capacity to do so) their advance decision must be respected (*see resource materials on advance decisions*).
- 2) **Research** – in certain circumstances a person lacking capacity can be involved in research. If so, the criteria that must be followed replace the best interest test (*see resource materials on research*).

In all other cases in which decisions are made under the Act the best interests principle must be applied.

Step 2: Identify the decision-maker

The person who makes a decision or acts on behalf of someone who lacks capacity is referred to as ‘D’ in the Act and the ‘decision-maker’ in the Code. Decision-makers can include the following range of people:

- **day-to day actions/ decisions** - family carers, other carers and care workers
- **health care contexts** – doctors or other member of healthcare staff responsible for carrying out the particular treatment/procedure. Treatment includes investigations such as X-rays, as well as procedures like operations and injections
- **nursing or paid care** – the relevant nurse or paid carer will be the decision-maker
- **Lasting Power of Attorney (LPA)** once registered with the Office of Public Guardian attorneys has legal authority according to the terms of their appointment. There are two types of LPAs under the Act, a **personal welfare LPA** which can include healthcare and medical treatment decisions and a **property and affairs LPA** which can include financial matters.
- **deputies** –appointed by the court and typically a family member or person who knows the person well. A deputy can make decisions about a person’s welfare (including healthcare).

The decision made by any of the above can either be a **sole decision** –made by one person or a **joint decision**. The latter may be appropriate when several different people, e.g. healthcare and social care staff are involved in a person’s care. It is always good practice to consult widely among people who have an interest in, or knowledge of, the patient (see step 7 below).

Step 3: Apply the principle of equal consideration

The principle of equal consideration (s.4(1)) is identical to the one which must be applied when assessing capacity. It is repeated in section 4 to remind decision-makers that they must not make unjustified assumptions about what a person's best interests might be simply on the basis of their age, appearance, condition or behaviour. Its repetition is designed to ensure that in the early stages of making a decision about someone else's life, when preconceptions may be particularly influential in shaping how a person is treated, every effort is made not to act in a discriminatory way.

Change: The principle of equal consideration is new. Its prominence in s 4, despite not being one of the five statutory principles underpinning the whole Act, draws attention to the requirement that people who lack capacity must not be prejudged or discriminated against.

Step 4: Involve the person in decision-making

The process of making a decision on behalf of a person who lacks capacity is designed to ensure that all reasonable efforts are made to involve them as much as possible in working out their own best interests. This requirement is bolstered by two very specific sub sections:

- 1) **s.4(3) imposes a duty on decision-makers to consider the chances of the person regaining capacity and, if so, to defer the decision until then, and**
- 2) **s.4(4); whenever reasonably practicable the decision-maker must permit and encourage the person to improve his ability to participate.**

Essentially these two subsections bolster the duty to do everything possible to help and support the person make their own decision. The Code (see Table 1) provides guidance on how the person lacking capacity can be involved in working out their own best interests.

Table 1	Regaining capacity/participation	Permitting and encouraging
	Code 5.28	Code 5.2
	Factors to be considered include	Practicable steps include
	1. treating the cause of incapacity (by e.g. medication)	1. using simple language
	2. in cases of fluctuating capacity arrange for the decision to be made at a lucid time	2. putting the person at ease by choosing appropriate time/ location
	3. whether new skills could be learnt or easier forms of communication developed	3. breaking information down to easy to understand sections
		4. using specialist interpreters or signers

Step 5: Consider all the relevant circumstances

This step basically involves identifying all the things that a person who lacks capacity would normally take into account if they were making their own decision or acting for themselves. Section s 4(2) states that:

the decision-maker must consider all relevant circumstances when making a decision, i.e. specifically those -

- a) **of which the decision -maker is aware, and**
- b) **which it would be reasonable to regard as relevant**

The Code provides some guidance on the meaning of relevant circumstances (see Box 1)

Box 1 'all relevant circumstances'

Code 5.19 For major medical treatment a doctor should consider:

- clinical needs of patient
- potential benefits and burdens of treatment on person's health and life expectancy
- other factors relevant to making a professional judgement.

Step 6: Find out the person's wishes/feelings/beliefs/values

S. 4(6) makes it clear that the person who lacks capacity must be put at the centre of any decision made under the Act. Thus the decision-maker:

'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**

To achieve the aims in section 4(6) two different approaches are possible, either:

- 1) to make the person's wishes determinative. Such an approach would require decision-makers to guess what he person would have decided if he had been competent. As an approach it can only really work properly where the person has been competent in the past. **or**

- 2) decide that the person's wishes etc will not necessarily be the decisive factor - although they should be a very important consideration, i.e. they must be given a great deal of weight. Under this approach an objective element may well be introduced when working out best interests.

The Act adopts this second approach (see Box 32).

Box 2 General guidance on best interests

Code of Practice section 5.38 explains the intention behind s.4(6) as:

'....[their] wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests. Any such assessment must consider past and current wishes and feelings, beliefs and values alongside all other factors, **but the final decision must be based entirely on what is in the person's best interests.**

Explaining other terms used in [s4\(6\)](#) the Code of Practice states:

- **'reasonably ascertainable'** means:

considering all information at the time available. Accordingly what is available in an emergency will differ from what is available when there is no urgency. Even so attempts should still be made to facilitate communication (Code 5.39).

- **'past and present wishes and feelings':**

These can be expressed through behaviour, expressions of pleasure/distress, and emotional responses. All reasonable efforts must be made to establish past wishes in so far as they may influence the decision that needs to be made.

Written statements (made when the person had capacity) are particularly important evidence of what a person may now wish, especially if they refer to preferred medical treatment ([Code 5.42](#)).

NB. A written statement does not have the legal force as a valid and applicable advance decision (see file 3). It may be very persuasive, however even if not determinative.

- **'beliefs and values':**

Evidence of a person's beliefs etc can be found in things like their e.g. cultural background, religious and political convictions and past behaviour and habits ([Code 5.46](#)).

- **'other factors':**

These could include e.g. the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen ([Code 5.47](#))

Change: Prior to the Act both common law and guidance from the Department of Health had interpreted the term 'best interests' to extend beyond just medical interests. As such factors such as a patient's wishes and beliefs when competent as well as their current wishes etc would normally be taken into account. The statutory version explicitly now incorporates such a requirement. There is now no doubt that they form an integral part of working out a person's best interests (and so incorporate a significant subjective element).

Step 7: Consult significant people

Section 4(7) of the MCA imposes a qualified duty (the duty only arises when it is 'practicable and appropriate') on decision-makers to consult a wide range of people close to the person lacking capacity. The views ascertained must be taken into account.

Box 4

Who must be consulted

S.4(7) imposes a duty to consult the following people:

- a) anyone previously mentioned by the person lacking capacity as someone they want to be consulted
- b) anyone involved in caring for that person
- c) anyone interested in their welfare
- d) an attorney appointed under a Lasting Power of Attorney
- e) a deputy appointed by the Court of Protection

NB.

- 1) The duty of consultation is qualified, i.e. it applies only if 'practicable and appropriate'
- 2) If there is no-one in the above category an Independent Mental Capacity Advocate may have to be consulted (see step 8)
- 3) If a LPA has been made and registered the attorney will be the decision-maker (rather than just having a right to be consulted for decisions within the scope of their authority).

Change: s.4 (7) incorporates what was long (but mistakenly) previously believed to be a legal duty rather than simply good practice. Now there is no doubt that various people, who may shed some light on a person's best interests should be consulted. Their views are not, however, determinative.

Step 8: Categorise the level of treatment

For convenience health care and treatment decisions will be divided into three categories, reflecting their different levels of 'seriousness'.

a) Level 1: Minor treatment

This category includes routine minor healthcare care and treatment options such as nursing care, giving medication, taking blood and urine samples, physiotherapy, chiropody and carrying out diagnostic examinations and tests (to identify an illness, condition or other problem).

b) Level 2: Serious treatment

This category includes major healthcare and treatment decisions which have significant consequences for the person concerned. Thus it will include major surgery or a decision not to attempt to resuscitate a patient (DNAR order) as well as emergency treatment such as CPR.

It also includes what the act refers to as 'serious' medical treatment (being proposed by an NHS body (or one that an NHS body is proposing that another organisation such as private hospital carry out) that would trigger the appointment of an **Independent Mental Capacity Advocate** (because there is no appropriate person to consult under step 7 above other than paid care staff: see resource materials on Independent Mental Capacity Advocates).

The concept of 'serious medical treatment' is defined in Regulations (2006 No.1832) as treatment which involves:

'providing, withdrawing or withholding treatment in circumstances where-

- a) a single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks,**
- b) there is a choice of treatments, the decision as to which one to use is finely balanced, or**
- c) what is proposed would be likely to involve serious consequences for the patient.**

The Code of Practice (10.43) provides examples of what the terms '**serious medical treatment**' and '**serious consequences**' mean in this context (see Table 1).

Table 1	
Serious medical treatment	Serious consequences
Code 10.45 identifies the following non-exhaustive list	Code 10.44 identifies treatments with serious consequences
1) chemotherapy and surgery for cancer	1) cause serious and prolonged pain or side effects,
2) electro-convulsive therapy	2) have potentially major consequences for the patient, e.g. stopping life-sustaining treatment or having major surgery such as heart surgery
3) therapeutic sterilisation	3) have a serious impact on the patient's future life choices (e.g. interventions for ovarian cancer)
4) major surgery (e.g. open-heart surgery	
5) treatments involving permanent loss hearing or sight	
6) major amputations (e.g. loss of arm/leg	
7) withholding or stopping artificial nutrition or hydration	
8) termination of pregnancy	
NB. A special factor applies to decisions life- sustaining treatment (s.4(5)), i.e the fundamental rule that anyone deciding whether or not life- sustaining treatment is in the best interests of a patient must not be motivated by a desire to bring about that person's death.	

c) Level 3: Court sanctioned treatment

Some treatment decisions are so serious that only a court has the power to make them- unless the person lacking capacity has:

- a) made a **Lasting Power of Attorney** (File 4) authorising an attorney to make the healthcare decision in question , or
- b) has a valid and applicable **advance decision** to refuse the proposed treatment (see File 3).

According to the Code of Practice (6.18) Court of Protection approval must be obtained for the following cases:

- withholding/ withdrawal of artificial nutrition and hydration (ANH) from a patient in PVS
- where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person
- non-therapeutic sterilisation of a person who lacks capacity to consent (e.g. for contraceptive purposes)
- where there is doubt about whether a particular treatment is in a person's best interests
- involving ethical dilemmas in untested areas, such as innovative treatment for variant CJD

- where there are irresolvable conflicts between healthcare staff, or between staff and family.

Step 9: Choose the least restrictive option

The last of the five statutory principles comes into play at this stage:

s.1(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

This fundamental principle obliges decision-makers to question if they can choose a different less invasive course of action. The effect of this principle is to introduce a presumption in favour of the least intrusive action. Referred to in the Code as finding the 'less restrictive alternative', it includes deciding whether there is a need to act or make a decision at all. It also includes exploring ways that would allow the greatest freedom for a person who lacks capacity to make the decision in question.

Change: This statutory principle had previously been recognised by common law most notably in relation to sterilisation cases. Its incorporation in s.1 makes it clear that it must govern all actions and decisions taken under the Act.

Step 10: Demonstrate 'reasonable belief' that treatment is in a person's best interests (to gain legal protection)

As was noted in relation to assessing capacity, s.5 operates to protect those caring and treating people without consent – providing they have a 'reasonable belief' that the person did in fact lack the capacity to give permission for the action. But to gain s.5 protection – i.e. to treat person without their consent without fear of legal action- it is also necessary to have a reasonable belief the care and treatment is in the person's best interests (s.5(1)(b)(ii)).

According to s.4(9) if someone acts or makes a decision in the 'reasonable belief' that what they are doing is in the person's best interests then –provided they have followed the checklist in s.4- they will have complied with the best interests principle set out in the Act.

Further guidance on 'reasonable belief' about best interests is contained in the Code of Practice (Box 5).

Box 6

'Reasonable belief in relation to 'best interests'

Code 6.28 -34 states that to demonstrate 'reasonable belief' in relation to best interests decision - makers should:

- apply all elements of the best interests test (in s.4 of the MCA)
- consider all relevant circumstances
- consider whether the person is likely to regain capacity to make the decision in the future
- consider whether a less restrictive option is available
- have **objective** reasons for thinking an action is in the best interests of the person who lacks capacity
- be aware that the skills and knowledge of healthcare staff will affect what is classed as 'reasonable', i.e. they should apply normal clinical and professional standards when deciding what treatments to offer.

NB.

1. S.5 does not provide a defence in cases of negligence (because a belief negligently held is by definition not reasonable).
2. Valid decisions by attorneys or deputies take priority over any action which might be taken under S.5 (although action can be taken to sustain life while any dispute is being resolved).
3. In cases where emergency treatment is necessary to save a person's life (or prevent them from serious harm) what steps are 'reasonable' will differ to those in an emergency. Furthermore in emergencies, it will almost always be in a person's best interests to give urgent treatment without delay (Code 6.35)

The final responsibility for deciding what is in a person's best interests lies with the health professional proposing to carry out treatment. To make sure the clearest evidence exists of the decision-making process – should any doubt subsequently arise- the Code recommends that the following should be recorded (and should remain on the person's file):

- the decision itself
- how the decision was reached
- why a written statement (e.g. expressing preferences about medical treatment) was not followed
- what the objective reasons for reaching the decision were
- who was consulted to help work out best interests
- why was a particular person or persons not consulted (who should have been consulted according to s.4(7))
- what particular factors were taken into account

Step 12: Final checks

As precautionary measure the following checks should be made to make sure that the decision-maker (e.g. doctor) has legal authority to treat the person without capacity.

- 1) whether an attorney has been appointed (under an LPA) to make the decision in question
- 2) whether a deputy (appointed by the court) has been given the authority to make the decision
- 3) that no valid and applicable advance decision exists covering the situation.
- 4) that the treatment does not need require the court's permission before it can be carried out.

Step 13: Carry out the treatment (or do not treat)

If the previous 12 steps have been followed care and treatment can now be provided (or it can be withdrawn or withheld). If treatment is provided but cannot be provided without restraint, one further condition must be met (Box 7).

Basically a person uses restraint if they:

- a) **use, or threaten to use force, to make someone do something they are resisting, or**
- b) **restrict a person's freedom of movement, whether they are resisting or not** ([s 6\(4\)](#))

To be lawful (and thus come within the protection of s.5 (see step 10) two conditions must be met. These are set out in s.6(2) & (3) and require the person using the restraint to

- 1) **reasonably believe that the restraint is necessary to prevent harm to the person who lacks capacity, and**
- 2) **that the restraint must be a proportionate response to the likelihood and seriousness of the harm**

Box 7

Use of Restraint

The code of Practice section .44 states that Restraint is **necessary**:

- if the person using the restraint has objective reasons to justify that the restraint is necessary
- if it is not appropriate to get an advocate to work with the person to see if restraint can be avoided all together

An example of necessary restraint would be what is appropriate to enable e.g. a blood test to be taken

Code 6.45 Harm

The definition of harm very much depends on the context but it could include e.g.

- behaving in a dangerously provocative way
- encouraging others to assault or exploit them

Code 6.47 Proportionate response means

- using the least intrusive type and the minimum amount of restraint
- using restraint for the shortest possible time

NB 1. Although s.5 permits the use of restraint there is no protection under the Act for actions that result in someone being deprived of their liberty (unless formal authorisation from the court has been obtained).

2. Restraint can also be used at common law where there is a risk that the person lacking capacity may harm someone else.