DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS

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We are all well aware that adults with capacity must make their own treatment decisions. There is no justification or need to determine the best interests of such patients since they can (by definition) decide these matters for themselves. Accordingly , their ‘best interests’ are never explored. Naturally , clinicians will on occasion disagree with a capacitous patient’s decision, and they are at liberty to try and persuade the patient to change his or her mind, but the patient with capacity has the last word. This is starkly exemplified by the adult with capacity who chooses to refuse the blood that would otherwise have saved his life. Or the capacitous woman who refuses the caesarean section that alone would allow her child to be born alive. But for those who lack capacity to make decisions relating to their treatment, clinicians have become accustomed to acting in the patient’s best interests . Meetings devoted to this subject are a ubiquitous daily occurrence in hospitals across the country . Again, we are all well aware of the general principle standing behind ‘best interests’; the incapacitated patient’s welfare must be viewed in its widest terms, not simply in the sense of medical but also social and psychological interests. The patient’s previously expressed wishes, values, feelings and beliefs must be taken into account. This will involve consideration of the proposed medical treatment, the prospects of success and the likely outcome. That is all very well; how should we achieve this? A case decided in 2017 provided us with clear, specific guidance concerning Mrs P , who was 72 years old when she suffered the intracranial bleed that left her in a minimally con 4 scious state. It was agreed that there was no prospect of her regaining the capacity to make decisions relating to her health, and it was speculated that her potential life expectancy was in the region of 3–5 years. Nonetheless, she was otherwise relatively healthy and the hospital wished to insert a gastrostomy for hydration and nourishment. She would not tolerate a nasogastric tube, the presence (and frequent replacement) of which distressed her . Mrs P’s daughters disagreed with this proposal, explaining that their mother had previously expressed a wish mental function was severely affected. Because of this disagreement, the court was approached, the hospital seeking a declaration that the proposed treatment was lawful. The judgement was centred on the notion that, when considering best interests, those making the decisions must try and put themselves in the place of the individual patient and ask what her attitude to the proposed treatment is likely to be. And they must consult those who befriend or look after the patient, in particular to obtain a view on what her attitude to the treatment might be. Factors that should be taken into account would include the views of those who had a close - relationship with the patient when she had capacity , and the impact of the patient’s fate on those who were closest to her. The court nevertheless made it crystal clear that what the patient would have done in the circumstances (if her capacity had been preserved) would not automatically be reg arded as to be in her best interests. While courts (and clinical decision mak - ers) will strive to recognise and comply with what the patient is likely to have wanted, acting in her best interests remains the paramount objective.

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