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The question has arisen regarding the circumstances in England in which clinical decisions relating to withdrawal of 5 treatment should be automatically referred to the court. Mr Y was an active man in his fifties when he had a cardiac arrest and consequent cerebral hypoxia. He never regained consciousness. He was fed through a gastrostomy , and over the following 3 months his doctors concluded that he had a ‘prolonged disorder of consciousness’ (a term that courts have accepted as encompassing persistent vegetative and minimally conscious states). It was also concluded that, if he were to regain consciousness, he would have profound disability , both - physical and cognitive, and remain dependent on others to care for him. This prognosis was confirmed by a second opin - ion. His wife and children told the clinicians that Mr Y would - not have wished to be kept alive if he had received that progno - sis during the time preceding his loss of capacity . Accordingly , the family and clinicians all agr eed that it would be in Mr Y ’ s best interests to withdraw his clinically assisted nutrition and hydration (CANH). - The question for the court was whether a court order must - always be obtained in such situations, or whether, under cer - tain circumstances, these decisions can be taken without the involvement of a court. Twenty-five years earlier, the courts had considered two very di ff erent clinical questions. In re F the question related to - whether sterilisation to prevent pregnancy (rather than to treat 6 disease) could be performed on an incapacitated woman. In Bland it was proposed that CANH in a young man who had been in a persistent vegetative state for 3 years should be with - 7 - drawn. The House of Lords had made it clear in both cases that, as a matter of good practice, a court declaration should be - obtained (that the proposed treatment was in an incapacitated person’s best interests) prior to the actions being taken. In considering Mr Y ’ s case, the Supreme Court noted that decisions on withdrawing CANH are frequent and ubiquitous, best interests of patients with a wide range of neurodegenera tive conditions, notably stroke and dementia. There could be no principled or logical reason to demand a court review of the tiny subset of patients with a ‘prolonged disorder of con sciousness’ while b lithely accepting the commonplace practice of withdrawal in other patients without recourse to the courts. Similarly , since CANH is seen as medical treatment, there can be no reason why its withdrawal should be seen as ‘first among equals’, ther e being no automatic recourse to declarations for withdrawal of antibiotics, ventilation or organ support. For these and other reasons, the Supreme Court held that, provided the provisions and guidance of the MCA 2005 are followed, and that there is agreement as to what is in the patient’s best interests, then life-sustaining treatment, whether this is CANH or any other form of life support, can be with drawn or withheld without needing to make an application to the court. Plainly , if there is any hint of lack of agreement or con flict of interest from any quarter, clinical or family , when the withdrawal of life-sustaining treatment is being considered, an application to court must be made. Equally , if in these circum stances at the end of the decision-making process the clinicians or family remain uncertain, because the conclusions on best interests are finely balanced, an application must be made. This judgement marked a ‘handing back’ to clinicians of responsibility to make some decisions that for the last 25 years have been e xclusively within the control of our courts. This

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