Best Interests, the Power of the Medical Profession, and the Power of the Judiciary

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Abstract

This paper is a response to a paper by John Coggon 'Best Interests, Public Interest, and the Power of the Medical Profession'. It argues that certain legal judgements in relation to best interests seek to change and curtail the role of the medical profession in this arena while simultaneously extending the jurisdiction of the courts. It also argues that we must guard against replacing one professional standard, that of the medical profession, with another, that of the judiciary in this area.

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Introduction

In this paper I give a short response to a particular issue raised by John Coggon's paper 'Best Interests, Public Interest, and the Power of the Medical Profession'. While he was concerned with best interests and the power of the medical profession, I briefly raise some concerns about the power of the judiciary in this area. Traditionally, the standard for decision-making in the health care arena with regard to the incapacitated patient has been that of the medical professional. Jonathan Montgomery has highlighted the fact that in the past "legal scholars have attacked the reluctance of legislators and the judiciary to wrestle from the grip of doctors the authority to determine ethical issues".[9, p.185] I argue that this reluctance is no longer present. Certain judgements in relation to best interests seek to change and curtail the role of the medical profession in this arena while simultaneously extending the jurisdiction of the courts. In relation to decision-making which uses the best interests standard, Coggon asks what we are to do "to prevent despotic value depositing, or even simple officious moralism, by medical professionals".[5, p.000] A brief look at the development of best interests in English law leads me, in this paper, to ask what we are to do to prevent the 'despotic value depositing' or the 'officious moralism' of the judiciary. Coggon argues that the best interests standard entreats medical professionals to think carefully before acting, I argue that it entreats us all to do this, including the judiciary.

Best Interests: A Professional Standard

'Best interests' was established as the standard for medical treatment involving the incapacitated patient in *Re: F.*[11] Here Lord Brandon's judgement echoed that of Wood J in *T v T.*[14] In the latter Wood J declared:[14 at 625]

> . . . where the patient is suffering from such mental abnormality as never to be able to give such consent, a medical practitioner

> is justified in taking such steps as good medical practice 'demands'.

While in the former Lord Brandon determined that it would be lawful to administer treatment to an incapacitated adult "provided that the operation or other treatment concerned is in the best interests of the patient".[6 at 551]

These early judgements essentially employ the professional medical standard as the one for deciding on best interests. Little direction is given for the consideration of the wider aspects of the patient's welfare nor for the consultation by the healthcare team of any other parties save from Lord Goff who said that "it must surely be good practice to consult relatives and others who are concerned with the care of the patient".[6 at 567] Effectively these judgements applied the *Bolam*[1] test in the determination of best interests. As Margaret Brazier has commented, the effect of this was that the medical profession acted as the patient's proxy. [2, p.100][1] The concern with this approach as Coggon pointed out in his article is that this "might permit the doctor to do what he wants, unhindered because of the application of the notoriously troublesome *Bolam* test and an excessively deferential judiciary".[5]

However, the deference of the judiciary to the medical profession has been somewhat tempered in more recent cases with a move away from *Bolam* and 'best interests' as the professional medical standard. The cases of *Re A*[10]and *Re S*[12] saw the Court assert that the assessment of a patient's best interests should be separate from the physician's duty of 'reasonable care'. In *Re A* Butler-Sloss echoed her judgement in *Re MB*[13 at 555] stating that "best interests encompasses medical, emotional and all other welfare issues".[10 at 200] Following that in *Re S* Thorpe J maintained that while:

> [T]he *Bolam* test is relevant to the judgement of the adult patient's best interests. . . regard to the patient's welfare [i]s the paramount consideration. That embraces issues far wider than the medical.[12 at 30]

In the past Brazier has called best interests 'a pious fiction'.[3, p.138] This is because she doubted whether it is "ever possible to divorce the interests of the individual entirely from the interests of the carer".[3, p109] As such the decisions that are made regarding incapacitated individuals cannot be made in isolation from the interests of other people in their life. Brazier would like us, and the courts, to recognise this fact and to do so openly. Arguably this has been achieved in these recent developments in the case law surrounding best interests. In these 'best interests' seems to be constructed in a manner which focuses on the patient and their interests, needs and wants. This approach seems to allow room for the interests of the people involved in that individual's care to be taken into account, recognising that the interests of the patient and those who care for her are "inextricably intertwined".[3, p.139] This wider concept of best interests is

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[1] This was the practical effect, however, legally this proxy status had no standing.[3, p.130]

likely to come closer to what might actually be best for an individual given their particular circumstances.

While the term itself is not actually defined, it is this understanding of the function of best interests that has become enshrined in the Mental Capacity Act 2005. The Act binds those making decisions on behalf of the incompetent or incapacitated individuals to do so in that individual's best interests.[8, Section 1(5)] In doing so, it requires them to consider the past and present wishes and feelings of the person, any beliefs and values, and any other factors which may be important.[8, Section 4(6)] Additionally it requires them to take into account the views of carers and other persons as may be relevant.[8, Section 4(7)] This framework recognises that more often than not there is a whole host of people involved in, and affected by, the care of the incapacitated. Recognition of this allows decisions about an individual's best interests to be placed in the appropriate context.

While there are undoubtedly criticisms that could be made of the 2005 Act, we must also acknowledge the strides forward that it has made. It puts the patient themselves centre stage, while simultaneously recognising the difficulties and conflicts that decision-makers might face. The provisions of the Act, in particular section 4, in my view make significant headway towards requiring medical professionals to give due and proper consideration to what course of action might actually be in the best interests of a particular patient. Doing this will necessarily involve consultation with, and regard for, other people involved in the care of the patient. This ensures that decisions that are made in the relevant context and are practically tenable.

Whose Professional Standard?

While the developments that these judgements and the provisions of the 2005 Act are to be welcomed they have been accompanied by some more worrying ones as well. In particular, alongside the refinement of the best interest standard in the *Re A* and *Re S* judgements, there seems to be a change in opinion amongst the judiciary about who is best suited to take decisions regarding the best interests of patients. The judgements in these cases suggest that the judiciary is no longer happy to let the medical professional standard dictate play with regard to best interests. It seems that they are seeking to redefine the role of the medical professional in the decision-making process, deeming them no longer suitable as decision-makers in cases involving best interests considerations. This is worrying because they seem merely to be substituting one professional standard for that of another: their own. There appears to be an attempt by the judiciary to broaden the categories of decisions that come within the jurisdiction of the courts.

This change is evident if we look at the declarations of the judges in *Re A* and *Re S*. In *Re A* Butler-Sloss says that:

> [I]t is the judge, not the doctor, who makes the decision that it is in the best interests of the patient that the operation be performed.[10 at 200]

She confirms this again in *Re S* saying:

> In these difficult cases where the medical profession seeks a declaration as to the lawfulness of the proposed treatment, the judge, not the doctor, has the duty to decide whether such treatment is in the best interests of the patient.[12 at 27]

Later she added:

> The Bolam test was, in my view, irrelevant to the judicial decision, once the judge was satisfied that the range of options was within the range of acceptable opinion among competent and responsible practitioners.[12 at 28]

Thorpe LJ followed in a similar vein asserting that the *Bolam* test, and therefore medical opinion, is only relevant to in assessing the proposed treatment for the incapacitated individual. He proceeds to say that:

> . . . the judge must in certain circumstances either exercise the choice between alternative treatments or perhaps refuse any form of treatment.[12 at 30]

He goes on to say:

> In my opinion the Bolam case [*and here I read medical opinion*] has no contribution to make to this second and determinative stage of the judicial decision.[12 at 30]

The implication of these judgements is that the role of doctors in determining the best course of treatment for incapacitated patients is to limit themselves to suggesting a range of reasonable options, and that it is for the Courts to decide which of these is in fact 'best'. If this is what Dame Butler-Sloss and Lord Justice Thorpe did in fact mean then it is objectionable on two counts.

Firstly, one has to question how the medical profession is meant to interpret the judgements in these cases. Do the judges mean for every decision regarding incapacitated patients to be referred to the Courts for a judge to decide the best course of action? This is unlikely. Such a dictate would be practically untenable, and I am sure that even Lord Justice Thorpe and Butler-Sloss P would not like to see every decision involving the medical treatment of an incapacitated patient to appear before the Courts for them to act as the final arbiters. A more probable reading of the judgements would be that it is for the judge to decide amongst the range of options once a case ends up at the door of the Court. This, however, leads me to my second concern.

It is unclear to me why the judiciary is better suited to determine the best course of treatment for incapacitated patients in these cases. It seems, especially given the provisions of the 2005 Act, that medical professionals are equally capable of taking into account the range of factors (medical, emotional, social) which could have a bearing on the decision. Indeed consultation with carers and proper reflection on the circumstances and the context in which such decisions are being made are not just good medical practice but simply good practice whoever the decision-maker might be. In

this respect medical professionals are surely better placed than the Courts to make these decisions. Medical professionals will have built a relationship with both the patients and the patients' carers and are, therefore, likely to be acutely aware of the context in which the decision needs to be made and the factors influencing it. The same cannot be said of the Courts.

However, despite the declarations in these cases the judgements did still accord with medical opinion on the matter. This situation has led Montgomery to suggest that:

> Although the cases now tend to emphasise the importance of the courts considering the interests of patients rather than merely accepting medical opinion, it is hard to find evidence of them departing from professional proposals.[9, p.204]

The suggestion is that the judiciary are less deferential in process only, rather than in the decisions that they actually make. He does, however, point to signs that this is changing, in particular citing the judgements of Justice Munby. Montgomery sees Justice Munby as exemplifying a new type of judge who "rejects deference to the health professions, sees healthcare as equivalent to other (commercial) enterprises and, therefore, to be regulated from outside without any trust in industry values and without any special rules for healthcare."[9, p.206] Montgomery sees this, along with other developments, as 'demoralising' medicine and medical law.[9, p.206]

Munby's judgement in the recent case of *SA*[7] was outlined earlier in this issue by Coggon. He was concerned by the broad scope that the judgement in the case now appears to give the jurisdiction of the courts in relation to vulnerable adults.[5, p.000] The wide definition of 'vulnerable' given in the case leaves it opens to the Courts to override the decisions of those who might be considered competent in medical terms.[7 at 82] Coggon points out that this opens us up to the "real danger that the state can rob decision-making authority from individuals".[5, p.000] This in itself is worrying but equally concerning is the question of what the role of the medical profession is to be in all this. While doctors have recently only had to worry about the best interests of their patients in cases where the patient themselves did not have the capacity to make their own decisions, the implication of Munby's judgement is that we now might have to take them into consideration even where the patient appears to be competent.

Munby's judgement harks back to a time in medicine where decisions were made in a strongly paternalistic fashion. With such judgements decision-making in the medical arena is in danger of a backward regression rather than a forward evolution. Whatever worries we might have about the bad decision-making of a minority of medical professionals regarding a patient's best interests can only by intensified by the bad decision-making and overt moralising of the judiciary. Whereas a bad decision by a particular health care professional will only affect his patients, bad judgements by the courts legally bind all doctors to make bad decisions. All the work that has taken place in order to move away from the value-laden 'doctor knows best' model could potentially be rendered futile if it is simply substituted with a 'judge knows best' model.

Who Knows Best

Coggon asked in his paper what we are to do "to prevent despotic value depositing, or even simple officious moralism, by medical professionals".[5, p.000] Here I ask what we are to do to prevent this in both the judiciary as a whole and in the judgements of particular members of the judiciary. The key to the good implementation of the best interests standard cannot simply be a shifting of power from the medical profession to the judiciary. Proceeding from a position of either 'doctor knows best' or 'judge knows best' can only lead us back down the path to a narrow interpretation of best interests. It is certain that this was not the intention of the Mental Capacity Act 2005.

Coggon maintains that what best interests does is ask "medical professionals to think".[5, p.000] This seems like theoretical and practical good advice. If we proceed from a position of actively thinking about what might be best for the patient, the focus is shifted away from the decision-maker, be it doctor or judge, and onto the patient. Decision-makers are less likely to act in a paternalistic fashion, acting only on their own values and knowledge, when trying to determine the best course of action. Doing this leaves it open for a wider interpretation of 'best interests' to be applied. What is best here need not be based in the values of the physician or the judiciary but can encompass a wide range of elements all of which will have a bearing on the course of action taken. It will necessarily include medical considerations regarding the patient but will place them in the wider context of family and carers. It is the kind of care of process that must become enshrined as good practice both for medical professionals and the judiciary.

Conclusion

In striving to implement best interests as a useful construction we must guard against simply replacing one professional standard, that of the medical profession, with another, that of the judiciary. Neither is in a position to make isolated judgements regarding the best interests of the incapacitated or incompetent individual. Each should give more than a superficial reading to provisions of the Mental Capacity Act 2005 and the stipulations regarding best interests contained therein. It should entreat decision-makers, whether medical professionals, legal professionals, or otherwise, to think carefully before acting. In doing this it might go someway to ensuring that best interests as a standard is not simply the despotic value depositing of medical or legal professionals and that it becomes more than a 'pious fiction'.

References

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[5] Coggon J. (2008) Best Interests, Public Interests, and the Power of the Medical Profession. *Health Care Analysis*.

[6] *F v west Berkshire Health Authority* (1989) 2 All ER 545.

[7] *In the Matter of SA* [2005] EWHC 2942 (Fam).

[8] Mental Capacity Act 2005

[9] Montgomery, J. (2006) Law and the demoralisation of medicine. *Legal Studies* 26:2, 185-210

[10] *Re A* (medical treatment: male sterilization) (2000) 1 FCR 193

[11] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, sub nom *F v west Berkshire Health Authority* (1989) 2 All ER 545 (HL n).

[12] *Re S* (Adult Patient: Sterilisation) (2001) 3 Fam 15

[13] *Re MB* (an adult: medical treatment) (1997) 2 FCR 541.

[13] *T v T* (1988) All ER 613.