Published in final edited form as:
J Soc Welf Fam Law. 2007 June 1; 29(2): . doi:10.1080/09649060701666598.

Constructing and reconstructing ‘best interests’: An interpretative examination of substitute decision-making under the *Mental Capacity Act 2005*

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Abstract

The Mental Capacity Act 2005 (MCA) authorises substitute decision-making in England and Wales, in relation to ‘acts in connection with care or treatment’, for a person lacking the capacity to make an autonomous decision, if it is both necessary and in his or her ‘best interests’. The approach adopted by the MCA is consistent with the common law, but widens both the scope and procedures of a ‘best interests’ determination to allow for a general model of substitute decision-making in everyday health and social care. However, by decontextualising substitute decision-making, the MCA’s procedures relating to ‘best interests’ may prove to be problematic in three ways: first, by failing to resolve adequately certain ethical dilemmas that pervade this area; secondly, by reducing applied substitute decision-making to a series of compulsory generalised instructions; and, finally, by necessitating deliberation but offering little practical guidance to the process of determination. Whilst the codification of five statutory principles in the MCA is designed to foster the empowerment of vulnerable adults, the realisation of these procedural and conceptual problems may have a negative impact on the implementation of the Act.

Keywords

best interests; substitute decision-making; mental capacity; bioethics; social care; health care

Introduction

It is a fundamental legal and ethical principle in democratic countries that adults should make decisions about their own lives. Equally, there is a presumption that all adults have the capacity, or ability, to engage in personal decision-making (*Substitute Decisions Act 1992*, s. 2(2); *Adult Guardianship Act 1996*, s. 3(1); *Mental Capacity Act 2005*, s. 1(2)). Where a person is judged to lack capacity to make one or more decisions for him or herself, there may exist a difficult ethical dilemma between respect for autonomy and the individual’s need for care and protection from harm (Wong et al., 1999).

From a legal perspective, attempts to resolve this ethical dilemma have focused on enabling another individual to make one or more decisions on behalf of the person who lacks capacity. In contrast with England and Wales, in most other jurisdictions such attempts have been based largely on guardianship models developed in mental health law for the management of psychiatric disorder, as mandated by Article 5 of the UN Declaration on the Rights of Mentally Retarded Persons (United Nations, 1971). In South Australia, for example, the *Guardianship and Administration Act 1993* uses Court-issued Guardianship Orders to enable a named person to give consent to healthcare and dental decisions that he or she believes will 'benefit' the person. Similarly, in Ontario, Canada, the *Substitute Decisions Act 1992* and the *Health Care Consent Act 1996* regulate substitute decision-making through Court-appointed guardians for the management of property, healthcare, and personal assistance services. Again, in Scotland the *Adults with Incapacity (Scotland) Act 2000* authorises a general intervention into the affairs of an adult with incapacity if it 'benefits' that person, but only when a Court intervention order is issued, or a guardian or continuing/welfare attorney has been appointed to make an intervention. All these frameworks focus predominantly on the procedures for delegating powers to a substitute decision-maker rather than the procedures through which substitute decision-making should be operationalised; although the authority to intervene is closely regulated, the decisions made upon intervention are not.

In England and Wales, only the property and affairs of a person with incapacity can be managed by others, currently, under mental health legislation (*Mental Health Act 1983*, Part VII). At the present time, substitute health and welfare decisions are authorised under the common law if judged to be necessary and in the 'best interests' of the person for whom the decision is made. In contrast with most other jurisdictions, the identity of the decision-maker is entirely dependent on the nature of the health and welfare decision to be made and no guardian is appointed with a general authority to make a set of defined decisions. The *Mental Capacity Act 2005* (*MCA*), implemented during 2007, brings health, welfare and financial decisions within a unitary framework and codifies 'best interests' as the justification for making decision-specific interventions into the life of an adult judged to lack capacity. This approach is markedly different from current, and proposed, mental health legislation for both the treatment in hospital of mental disorder (Bartlett, 2003), and the enhancement of patient safeguards and welfare through 'nearest relative' procedures (Rapaport, 2004; Mental Health Bill 2006). In light of these disparities, understanding the application of 'best interests' to authorise substitute decision-making merits further examination.

The procedural and conceptual development of 'best interests' derives from its application and determination in the common law. In this paper, we examine the relevant law closely and demonstrate that its development has been inconsistent and idiosyncratic, reflecting very clearly the specific contexts of the cases to which it has been applied. The *MCA*, in contrast, codifies 'best interests' within its statutory framework to enable it to provide a general, decontextualised model of substitute decision-making. Adopting a social scientific perspective, we argue that, by doing so, tensions may be produced between the abstract conceptualisation of substitute decision-making, built around a rigid set of compulsory requirements, and its everyday application in the practical settings of health and social care. Since, potentially, such tensions may have a negative impact on the implementation of the *MCA*, they are considered in detail.

The origins of 'best interests': Developments in the common law

'Best interests' has developed through two inter-related contextual elements of the substitute decision-making process: the changing scope of the decision to which it has been applied and the process of its determination in light of this change. Table 1 demonstrates these changes over time.

Scope

The power to make a substitute decision in the 'best interests' of an adult with incapacity was formally established in *Re F (mental patient: sterilisation)* [1990] 2 AC 1 by applying the common law doctrine of necessity. Subsequently, ‘best interests’ was applied to other substitute, and highly invasive, medical decisions, including the provision or withholding of life-sustaining treatment (*Airedale NHS Trust v Bland* (1993) AC 789), tissue donation (*Re Y (mental patient: bone marrow donation)* [1997] Fam 110) and experimental medical treatment for terminal illness (*Simms v Simms and another* (2003) 1 All ER 669).

As the concept of ‘best interests’ became more widely applied, it was invoked in decisions outside the medical domain when such decisions were deemed to impact on the general welfare of an adult with incapacity. Its scope was extended to contact rights with family members (*Re S (adult patient) (inherent jurisdiction: family life)* [2002] EWHC 2278 (Fam)) and residential placement (*Re S (adult’s lack of capacity: carer and residence)* [2003] EWHC 1909 (Fam)).

Assessment and Determination

The adoption of the doctrine of necessity in *Re F* [1990] defined ‘best interests’ as treatment carried out in order to save life, or to ensure improvement or prevent deterioration in health. Early medical treatment decisions conceived ‘best interests’ solely in terms of medical interests, with responsibility for the assessment and application of ‘best interests’ placed upon medical practitioners using their clinical judgement in accordance with the standard of care set out in *Bolam* (*Bolam v Friern Barnet Hospital Management Committee* (1957) 1 WLR 582).

This application of the *Bolam* standard came under much criticism (Fennell, 1996). Carson (1989), for example, commented persuasively that it was unimaginable that a person should have his or her ‘best interests’ restated as merely the right not to have others make negligent decisions on his or her behalf. However, as the scope of decisions to which ‘best interests’ was invoked was extended, so too were its determinative procedures. In line with the Law Commission’s proposals for incapacity law reform (Law Commission, 1995), ‘best interests’ became focused on the individual welfare of the person to whom it was applied and orientated towards providing treatment for patients according to their personal interests.

‘Best interests’ determinations began to move beyond medical interests when declaring treatment not unlawful (*Re MB (medical treatment)* [1997] 2 FLR 426), incorporating broader social, personal and ethical considerations into a general welfare assessment (*Re S (Sterilisation: patient’s best interests)* [2000] 2 FLR 389). As a result, ‘best interests’ became elucidated solely with regard to its determinative procedures. This is clearly observed in *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549, *Simms v Simms* (2003) and *Re S* [2003] EWHC 1909 (Fam), where a ‘best interests’ determination was guided by drawing up a balance sheet of ‘benefits’ and ‘burdens’ for each option available, thus leading to the single decision that would likely result in the ‘best’ outcome.

Anomalous decisions

The changes in the scope and determination of ‘best interests’ have produced a number of anomalous decisions that are both procedurally and conceptually inconsistent. These anomalies are of two types: the application of ‘best interests’ to overrule capacitous decision-making on paternalistic grounds (*Re S* [1992] Fam 123; *Re G* [2004] EWHC 2222), and incoherence about the determination of an individual’s ‘best interests’, where the interests of others are integrally tied up in the outcome of the decision (*Re Y* [1997]).

Both *Re* S [1992] and *Re* G [2004] draw on medical evidence to reinforce a traditional interpretation of medical ethics that constructs beneficence in paternalistic terms and prioritises generalised conceptualisations of risk management and future welfare. Consequently, the capacity to make the specific decision at issue becomes irrelevant. The decisions made by the Courts in these two cases are, therefore, not only anomalous but, arguably, also wrong.

In *Re Y* [1997] the determination of 'best interests' was made more difficult by the interdependent nature of the decision. In this case it was declared that the bone marrow donation from Y, a woman with severe intellectual disability, to her sister was not unlawful. Although Y's 'best interests' are put forward as paramount, the interests of her mother and sister were integral to the judge's deliberations. Where the lives of other people are in danger, isolating individual interests remains an ongoing challenge.

'Best interests' under the *MCA*

The flexibility in the application and determination of 'best interests' over a 15-year period challenges the understanding of the concept as a unidimensional legal and ethical principle. Linked to the emergence of 'best interests' through the process of judicial deliberation (the process of reaching the decision) rather than through judicial declaration (the outcome of the decision), common law accounts of 'best interests' are characterised by an inconsistent and non-linear procedural development, and, correspondingly, by a fluid and idiosyncratic conceptual development. The *MCA* aims to resolve the problems associated with these developments in a number of ways. It reflects, but is not the culmination of, the common law (Bartlett, 2005; Greaney *et al.*, 2005). Rather, it establishes a decisive link between a person's lack of capacity to make a particular decision and acting in that person's 'best interests' when making that decision on his or her behalf. In addition, it introduces a framework that clarifies, codifies and regulates substitute decision-making in a person's 'best interests', defining its scope and providing a universal mechanism for determination, applicable regardless of the decision-making context.

Under the *MCA*, the 'best interests' principle is relevant to all substitute decisions involving 'acts in connection with care and treatment' (*MCA*, s. 5), a donee appointed by a personal welfare Lasting Power of Attorney (LPA) or a property and affairs LPA (*MCA*, s. 9) and a Deputy appointed by the Court of Protection (*MCA*, s. 16). Undertaking a 'best interests' determination with regard to 'acts in connection with care or treatment', on which this article focuses, extends only to an adult who is judged unable to make an autonomous decision because of an "impairment of, or disturbance in the functioning of, mind or brain" (*MCA*, s. 2(1); *Code of Practice*, *para*. 4.12) which leads him/her to be unable to understand the information relevant to the decision, retain that information, use or weigh up that information as part of the decision-making process, or to communicate his/her decision (*MCA*, s. 3(1)). This will include more than two million adults who, at any one time, will lack the ability to make one or more decisions about their own lives. It will also include the six million adults who care for them and the provision of legally appropriate procedures across a whole range of health and social care practice in England and Wales (Department for Constitutional Affairs, 2005).

In determining what is in a person's 'best interests', the *MCA* details certain factors to take into account when thinking through the process of making a substitute decision (*MCA*, s. 4). The *MCA*'s *Code of Practice*[1] describes these factors as a 'best interests checklist' (*Code of Practice*, *para*. 5.6). They include:

- Whether capacity will be regained and, if so, when

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[1] The *Code of Practice* referred to in this paper is the final document issued by the Department for Constitutional Affairs on 23rd April 2007.

- Whether the person can be permitted and encouraged to participate in the decision, regardless of their lack of capacity
- Certain special considerations for life-sustaining treatment
- The person's wishes, feelings, beliefs and values
- The views of other people who are deemed practicable and appropriate to consult
- All other circumstances deemed to be relevant

(Adapted from *Code of Practice*, *para*. 5.13)

The 'best interests checklist' bears comparison with the 'welfare checklist' codified in the Child*ren Act 1989*, which is used to guide decision-making concerning the upbringing of a child, or the administration of a child's property or the application of any income arising from it (*Children Act 1989*, s. 1(1)). In the *Children Act 1989*, a child's welfare is paramount. However, although the 'welfare checklist' does incorporate an assessment of the subjective wishes and feelings of the child (*Children Act 1989*, s. 1(3)(a); s. 1(3)(c)), it conceptualises a child's welfare as a process involving, primarily, the capabilities of others in meeting his/her needs, the management of risk, and the avoidance of harm (*Children Act 1989*, s. 1(3)(b); s. 1(3)(d-f)). Additionally, its application is limited to the court setting, and used to inform the report drawn up by a Child and Family Court Advisory and Support Service (CAFCASS) Officer to provide the court with guidance in making certain decisions relating to a child's living or contact arrangements. There is no legal obligation for parents to have regard to the 'welfare checklist' when making all decisions involved in their children's upbringing and its applicability is, therefore, far narrower than that of the 'best interests checklist' to care and treatment decisions made for adults who lack mental capacity.

The impact of the Human Rights Act 1998 (HRA)

The *MCA* does not include an explicit requirement to uphold a person's human rights when undertaking a 'best interests' determination. Common law attempts to do so have not been particularly productive. In *Local Authority v Health Authority* (2004) 1 All ER 480, for example, determining 'best interests' by balancing human rights fails to move beyond, or even necessarily fulfil, the basic duty to uphold a person's rights held by all citizens. Safeguarding a person's human rights should be seen, instead, as the minimum standard when acting in his/her 'best interests', comparable to the doctor's professional duty to adhere to the *Bolam* standard, outlined as the first stage of a two-stage approach to determining a person's 'best interests' in *Re A* [2000]. Protecting a person's human rights does not offer, however, a substantive contribution to maximising the 'best' outcome when determining his/her 'best interests'.

Nevertheless, the *MCA* is entirely consistent with the HRA. The substitute decision made in a person's 'best interests' must be the least restrictive alternative and it must involve considering whether there is a need to act or make a decision at all (*MCA*, s. 1(6); *Code of Practice*, *para*. 2.14). Equally, acts involving restraint are only in that person's 'best interests' if, first, the use of restraint is necessary to prevent harm to the person, and, secondly, the restraint is proportionate to the likelihood of the person suffering harm and to the seriousness of that harm (*MCA*, s. 6(2); s. 6(3)(a-b)). Using restraint should involve the minimum force, or least intrusive intervention for the shortest possible time, and restraint that restricts a person's liberty is unlawful if it amounts to a deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights (*Code of Practice*, *para*. 6.44; 6.49; *HL v The United Kingdom* [Application no. 45508/99]).

The discursive (re)construction of ‘best interests’

Judicial deliberations about ‘best interests’ have no role to play in guiding substitute decision-making in general, although judges have occasionally taken it upon themselves to attempt to provide such guidance (see Munby L.J. in *R (Burke) v General Medical Council* (2004) EWHC 1879 (Admin)). As such, there is no reason to assume that statutory procedures for determining ‘best interests’ will be the culmination of specific common law decisions.

Nevertheless, the *MCA*’s ‘best interests’ procedures do reflect those in the common law, though in a general and decontextualised way, and the drafting of the Act acknowledges the discursive interplay that characterises the judicial deliberations that take place within specific cases. Under the *MCA*, ‘best interests’ symbolises the reconstruction of these discourses, necessarily codifying them in a manner that grants the concept statutory authority yet renders it flexible enough to be applied to substitute decision-making in general. We outline three discourses: objective and subjective accounts of ‘best interests’, the role of evidence, and the nature of relevant interests, and argue that considering the implementation of ‘best interests’ in everyday practice requires these to be examined further, both in the constructive setting of the common law and in the reconstructive setting of the *MCA*.

Objectivity and subjectivity

There is a clear distinction between objective and subjective accounts of ‘best interests’. Objective accounts propose that the ‘best’ decision can be assessed objectively and predicted regardless of the person for whom it is made by referring to the consequences of all possible outcomes. The ‘best’ outcome is then the one bringing the most good to the person (Buchanan and Brock, 2004). In contrast, subjective accounts operationalise substitute decision-making with regard to all of the features of a person’s life that make a positive contribution to it going well. Drawing on a subjective account, a competent person’s choices will always equate with his/her ‘best interests’, whilst for an incompetent person a substitute decision is based on what the person would be likely to choose if able to do so, in light of his or her individual beliefs, values and past decisions. Accordingly, subjective determinations of ‘best interests’ draw heavily on personal context and the outcome, whilst not necessarily consistent with an objective account of a person’s ‘best interests’, will be judged to be best for that person.

The difference between objective and subjective accounts of ‘best interests’ has supported an ethical argument that rejects subjective determinations of ‘best interests’ for very young children and adults judged to be permanently lacking capacity (Dawson, 2005; *Airedale NHS Trust v Bland* (1993): Lord Goff at p.58). In theory, this approach seems consistent: examining the subjective wishes, beliefs and values of a newborn baby, or an adult with a lifelong and profound intellectual disability, is difficult, or, arguably, impossible (though for challenges to this point of view, see, for example, Goode, 1994; Caldwell, 2005). However, it is in stark contrast to that adopted in most American courts, where substitute decisions are determined through the application of the ‘substituted judgement’ test. Under this test, a substitute decision made on behalf of an adult with incapacity is based on the decision that the adult would have made if he or she had been competent to do so (see, for example, *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *In Re Spring*, 380 Mass. 629 (1980)). This subjective approach to substitute decision-making requires a detailed inquiry into the way in which the adult leads his or her life in order to elucidate his or her values as judged relevant to the decision at hand. Through this undertaking, a third party’s best guess about the wishes of the incompetent adult could be substituted for that which was impossible to obtain directly (Hoefler, 1994). Following judicial declarations in England and Wales that have, in fact, drawn upon both objective and subjective accounts of ‘best interests’ in these contexts, the *MCA* attempts to integrate these two accounts within a unitary framework. In doing so, the conceptualisation of ‘best interests’ in the *MCA* incorporates a ‘substituted judgement’ approach, and demonstrates that ‘best interests’ and ‘substituted judgement’ need not be conceived as incompatible, or oppositional, models of substitute decision-making.

Incorporating subjective interests into a ‘best interests’ assessment raises questions about the nature of personal welfare and the means by which acting in a person’s ‘best interests’ will maximise his or her welfare. *Re F* [1990] and *Re T* [1992] Fam 95 adopted a medical approach, operationalised through the *Bolam* standard of care, as being determinative of ‘best interests’ in its own right. In the ‘doctor-patient’ relationship, the medical practitioner preserved and enhanced a patient’s medical interests. However, as the scope of ‘best interests’ has been extended to non-medical decisions, subjective factors have become increasingly relevant. In *Re S* [2000], for example, Thorpe L.J. stressed that:

> In deciding what is best for the disabled patient the judge must have regard to the patient’s welfare as the paramount consideration. That embraces issues far wider than the medical (*Re S* [2000]: Thorpe L.J. at p. 403).

This nuanced interpretation of a person’s general welfare was developed further in *Re A* [2000], where a balance sheet approach was used to provide an objective welfare appraisal within which all factors deemed relevant to the decision can be outlined, including, of course, those factors based on subjective evidence. This appraisal was outlined in *Simms v Simms* (2003) as being potentially infinite in scope:

> In my judgement, I have to assess the best interests in the widest possible way to include the medical and non-medical benefits and disadvantages, the broader welfare issues of the two patients, their abilities, their futures with or without treatment, the views of the families, and the impact of the refusal of the applications. All of these matters have to be weighed up and balanced in order for the court to come to a decision in the exercise of its discretion (*Simms v Simms* (2003): Butler-Sloss L.J. at *para*. 60).

These cases illustrate how subjective interests have been incorporated into an objective framework within which a person’s overall ‘best interests’ might be determined. The appropriation of an objective accounting approach by subjective considerations firmly grounds the assessment of ‘best interests’ in the lived realities of the person for whom the decision is made. In these contexts, it is not surprising that subjective measures of quality of life, personal development and individual opportunity have become central to a ‘best interests’ assessment.

The assessment of a vast range of subjective evidence within an objective framework, in a manner consistent with the maximisation of personal welfare, remains the major stumbling block in person-centred substitute decision-making. The ‘best interests checklist’ stresses that relevant interests are only substantive when linked to the context in which they are based. In a recent case where a ‘best interests’ determination was made in the context of child welfare rather than substitute decision-making for an adult with incapacity, counsel for all parties were instructed to draw up a ‘benefits/burdens’ list to assess the likely impact of the withdrawal of life-sustaining treatment. Equivalent to a ‘best interests’ balance sheet, this list was used by the judge to assist in the process of ‘weighing up’ varied and conflicting evidence (*An NHS Trust v B and others* (2006) EWHC 507 (Fam)).

The centrality of evidence

The incorporation of a subjective account of ‘best interests’ within an objective framework of assessment is based on an approach to substitute decision-making that treats evidence as being, first, central to the specific determination and, secondly, personal and contextual in nature. The application of the *Bolam* standard to the determination of a person's 'best interests' rested not on the context in which the treatment is delivered, but on the nature of the treatment itself. In contrast, recent subjective accounts of 'best interests' incorporate a broad range of personal evidence that must be 'weighed up' in the process of making the 'best' decision.

The need for pragmatism in identifying and assessing relevant evidence is emphasised in the *MCA* and its Draft Code of Practice (*MCA*, s. 4(2); *Code of Practice*, *para*. 5.13). Upon consideration in the House of Commons, amendments seeking to specify 'best interests' were rejected on the grounds that a general framework would better ensure wide and effective application (Hansard, HC Committee Stage, 21st October 2004, Column 77). The *MCA*'s statutory checklist provides such a framework.

The nature of interests

Regardless, a decision-specific approach to determining 'best interests' is complicated by considering what a person's 'interests' might actually be, in the context of that decision. First, relevant interests can be distinguished by being current or future-orientated (Buchanan and Brock 2004). Considering future-orientated interests in medical contexts will likely lead to more weight being assigned to considerations beyond the decision at hand (Dawson 2005). Indeed, future-orientated 'best interests' have been used to justify paternalistic intervention, specifically where the life or future health of a person is at risk (see, for example, *Re S* [1992] and *Re G* [2004]). In other cases, however, future-orientated interests have been excluded on the grounds that the declaration is limited to the immediate circumstances of the decision. In *Re A* [2000], for example, the court was not convinced by the argument that sterilisation would be in the 'best interests' of a man with intellectual disability in the context of his intention to move from the 'protective environment' of his mother's home into residential care; his future interests were deemed irrelevant.

There is also an important distinction to be made between 'experiential' and 'critical' interests, both of which impact differently on the ways in which autonomous decisions are made (Dworkin 1993). 'Experiential' interests reflect decisions we make because of the pleasure that is gained from them, whilst 'critical' interests involve decisions we make because we genuinely believe they make for a good life – we make these decisions because we *should*.

Assigning different weight to 'critical' and 'experiential' frames 'best interests' declarations in different ways. *Re F* [1990] drew on 'experiential' interests to assess the positive impact of sterilisation on sustaining her ability to gain pleasure and freedom from an active sexual relationship while avoiding the risk of pregnancy. Interestingly, by giving primacy to 'experiential' rather than 'critical' interests, the assessment failed to raise the question of the legality of the relationship. This was surprising, given F's apparent 'general mental capacity of around a 4 or 5 year old', which was accepted at all levels of legal review (see, for example, *Re F* [1990]: Neill L.J. at p. 24; Lord Brandon of Oakbrook at p. 46) and the legislation then in place prohibiting sexual activity with a (in the pejorative language of the time) 'defective' (*Sexual Offences Act 1956*, s. 7).

As subjective evidence has been integrated into an objective assessment of 'best interests', holistic welfare appraisals have increasingly focused on 'critical' interests. Where the decisions involve long-term and decisive interventions into the life of a vulnerable adult, this is, perhaps, unsurprising. In decisions relating to changes of residence, 'best interests' has been conceived in terms of abstract notions of human potential and human flourishing, rather than by prioritising the direct impact of the decision on the person's immediate life experiences. In *Re S* [2002] EWHC 2278 (Fam):

> Both Ms MD and Ms AE report him as becoming more confident, more independent and interacting more with everybody since he moved to RM. He has, says Ms AE, 'made great strides' and 'has a greater sense of himself' (Munby L.J. at *para*. 110) … The much greater risk to S is of the avoidable and increasing emotional damage he will continue to suffer if he lives at home, socially isolated and not afforded the full opportunity he deserves to develop his potential (*Re S* [2002]: Munby L.J. at *para*. 122).

The *MCA* attempts to tie up the complex relationship between differing interests by instructing the decision-maker to take into account all factors deemed relevant to the decision. By opening up the assessment to wide consultation it is designed to elucidate *all* the person's interests in a way that is most likely to lead to the 'best' outcome.

Reflections on the implementation of 'best interests' and the *MCA*

The *MCA*'s pragmatic and holistic approach imposes a rigid, yet rigorous, framework onto the common law's discursive engagement with 'best interests', allowing for a general model of substitute decision-making that is applicable in health and social care contexts far wider than those covered by the common law. In doing so, the *MCA*'s reconstruction of 'best interests' gives rise to three conceptual and procedural issues which may prove problematic when considering its implementation.

1. The pervasiveness of ethical dilemmas

Despite the rigorous procedures outlined in the 'best interests checklist', and the clear and concise guidance offered by the *MCA* and its *Code of Practice*, the ethical dilemmas posed by certain substitute decisions remain highly emotive and controversial, and it is likely that inconsistencies in the ways in which 'best interests' is conceptualised and determined will continue. When considering such decisions, people with strongly held religious beliefs and/or strongly held moral positions might consider 'best interests' as wholly inappropriate as a means for justifying a decision that they believe should not be made in any circumstances, or totally inadequate in reaching the right decision if that decision involves life or death. The adoption of a 'best interests' test to guide medical decision-making in protecting the welfare of a child in recent cases (see, for example, *Portsmouth NHS Trust v Wyatt & Wyatt* (2004) EWHC 2247 (Fam) and *An NHS Trust v B* (2006)) resulted in large-scale media and public interest and has demonstrated that, for some people, the application of 'best interests' to end-of-life decisions for infant children is not an acceptable means to engage with these kinds of substitute decision-making dilemmas.

In addition, the potential persistence of ethical dilemmas is linked to the individualised conception of 'best interests' in the *MCA* (*Code of Practice*, *para*. 5.7), consistent with the principles of the Act (*MCA*, s. 1(5)), and a 'principlism' approach within medical ethics (Beauchamp and Childress, 2001; Gillon, 2003). The *MCA* reflects the common law in conceiving substitute decision-making within an individual relationship, specifically the doctor-patient relationship, or in a detached, consultative setting, such as a case conference. However, this conceptualisation of 'best interests' potentially gives rise to tensions, not only when other people's interests are integrally connected with the outcome of the decision (see *Re Y* [1997]) but also when 'best interests' determinations are made in social settings, such as family or group homes. Maximising the 'best interests' of one individual in these settings may not be beneficial to, and may even impact negatively on, the 'best interests' of others in the same setting.

2. The tension between a general framework of ‘best interests’ and the specificity of applied substitute decision-making

While the principles of the *MCA* and its provisions for fostering empowering and informed substitute-decision making are to be commended, by providing for substitute decision-making in general the ‘best interests checklist’ loses its sensitivity to the realities of health and social care provision. There are two elements to this: first, the potential for generalisation in everyday practice, and, secondly, the relevance of the ‘best interests checklist’ to practitioners.

The ‘best interests checklist’ is designed to be universally applicable. In contexts where rich, subjective evidence is available (for example, the social care provided for an adult with progressive dementia), the checklist should go a long way to resolving any decision-making dilemmas that arise in the provision of that care. In this situation, it is likely that family and friends will be available for consultation and that the person’s beliefs, values and past decisions, prior to incapacity, will either be relatively easy to obtain or will have been formally codified by that person before the onset of the illness, through an advance decision to refuse treatment (which must be followed if valid and applicable, *MCA*, s. 24) or a written statement (which outlines preferences to guide a ‘best interests’ determination, *MCA*, s. 4(6)(a)). But, in the context of the provision of, for example, residential social care for adults with a lifelong and profound intellectual disability, the potential lack of evidence relating to personal welfare makes determinations of ‘best interests’ more provisional. Here, interpersonal health and social care relationships may lead to decisions characterised by generalisations founded on the carer’s values, those of the family, and/or social stereotypes of disability, gender, age or race. Although the *MCA* specifically legislates against such discrimination (*MCA*, s. 4 (1) (a-b)), the nature of the decision-making context, and our continuing difficulty in thinking about men and women with severe and profound intellectual disabilities in terms of the supports they need (American Association on Mental Retardation 2002), rather than in terms of their impaired development (see, for example, the original, Appeal Court and House of Lords judgements in *Re F* [1990]), remains a potential, and unsettling, reality.

Similarly, the codification of ‘best interests’ as a statutory legal principle requires all substitute decision-makers to approach decision-making with primary regard to their legal obligations. The implementation of the *MCA* is based on the assumption that the ‘best interests checklist’ approach will be entirely compatible with the personal and professional identity of those involved in its operationalisation and to their relationship with the person for whom they are making the decision. In fact, there are no empirical data to support this. The personalised nature of social care provision is built around professional codes of practice that stress a duty of care. But, as argued, the assessment of ‘best interests’ goes far beyond the performance of this basic duty. Empowering substitute decision-making must be based within the personal and interdependent relationship between the decision-maker and the person for whom the decision is being made, yet this relational element forms no substantive part of the *MCA*’s provisions. Instead, a ‘best interests’ determination is a detached and reflective procedure that is potentially incompatible with the situated and embodied nature of the relationship within which the ‘best’ decision could be based. This disembodiment may not only produce an outcome that fails to reflect a robust determination of a person’s ‘best interests’, it may also act to produce a general loss in the personalised quality of the care relationship – a qualitative reduction in good practice.

3. The ‘best interests checklist’ aids deliberation not determination

Given that ethical dilemmas are ubiquitous in health and social care practice (for example, enhancing autonomy will be balanced against risk management; guaranteeing a person’s ongoing health may sometimes require paternalistic intervention), the ‘best interests checklist’ only ensures that evidence is provided to uncover and scrutinise these dilemmas, without offering specific guidance for their resolution.

The checklist requires wide consultation and clearly acknowledges that decision-making in health and social care is a multi-faceted and contextual activity within which a range of conflicting facts, values and opinions exist (Fulford, 2004). This is admirable but makes conflict between consultees likely. Whilst the checklist should operate to make these conflicting opinions and values explicit, it offers little means to resolve conflict other than recourse to the Court of Protection for judicial review. In the context of everyday health and social care, what is to be done if there is disagreement between the decision-maker and those providing evidence? To what extent should priority be given to particular evidence or evidence from a particular person? The *MCA* fails to offer a definitive solution. The *Code of Practice* advises the decision-maker to reach a consensus with everyone involved in the consultation process (*Code of Practice*, *para*. 5.64), although, rightly, it states that “an agreement in itself might not be in the person’s best interests” (*Code of Practice*, *para*. 5.64). Approaches to resolving disputes through mediation, advocacy and complaints procedures are considered (*Code of Practice*, *para*. 5.68 – 5.69; *para*. 15.7 – 15.13), but these appear inadequate for the everyday decisions that arise in these settings.

In contrast with recent common law declarations, the *MCA* offers no guidance to draw up a balance sheet. By not assigning priority to the elements that constitute the checklist (*Code of Practice*, *para*. 5.13), the decision-maker must only assess ‘best interests’ with reference to the relevant circumstances in which he or she is making a determination (*Code of Practice*, *para*. 5.18). This is a correct and commendable approach, but very little practical advice is given to the actual *process* of this undertaking. Instead, the view is taken that a determination will almost always be possible if attention remains focused on the task (*Code of Practice*, *para*. 5.62).

In light of this, the ‘best interests’ principle may become defensively orientated, only drawn upon, post hoc, to defend decisions already made rather than to guide substantive substitute decision-making in advance. After all, determinations that are not in the ‘best interests’ of the person for whom they are made are only deemed to be negligent if the decision-maker fails to demonstrate that he or she has adhered to the requirements of s. 4 (*MCA*, s. 4(9)).

Conclusions

The *MCA*’s codification of ‘best interests’ provides for a general model of substitute decision-making in England and Wales that differs markedly from the frameworks adopted in many other jurisdictions. For an adult lacking capacity to exercise his or her right to make one or more autonomous decisions, the *MCA* aims to ensure that all interventions into the personal life of that individual take place in an empowering, personal and decision-specific way. A determination of ‘best interests’ must be centred objectively on the interests of the person for whom the decision is made and that decision must be entirely focused on fostering an outcome that maximises his or her welfare. Accordingly, making a decision in a person’s ‘best interests’ should not only aim to achieve the best outcome for that person, it should also emphasise the ethical principle that decision-making is a vital component in the lives of all adults and should, therefore, be respected, regardless of whether or not such decisions are made autonomously. Notwithstanding the potential problems highlighted above, the codification of ‘best interests’ in the *MCA* must be seen as fostering a more ethically defensible approach to substitute decision-making than the comparable, guardianship-based, models present in many other legal jurisdictions.

However, applying ‘best interests’ to substitute health and welfare decision-making does not solve all decision-making dilemmas; by giving general guidance, problems may arise when specific substitute decisions are made in practice. Three potentially problematic elements to the implementation of the *MCA* have been discussed with reference to the discursive construction and reconstruction of the concept and procedures of ‘best interests’ in a range of legal documents. Empirical research is required to explore these problems further.

If the conflict between a general ‘best interests checklist’ and substitute decision-making in the applied context of health and social care provision is realised upon implementation, and the problematic elements highlighted above materialise, the *MCA*’s success may depend on refining its Code of Practice and/or initiating more focused training programmes for staff making practical substitute decisions.

Acknowledgments

This paper forms part of an ongoing project on the legal, ethical and practical aspects of substitute decision-making for adults with incapacity in England and Wales. We would like to thank the other members of the project’s Steering Group: Dr Jennifer Clegg, Dr Marcus Redley and, particularly, Dr John McMillan, for their contributions to the ideas presented here. We would also like to acknowledge the support of the Wellcome Trust, which funds the project through a Biomedical Ethics Studentship (Grant Ref: GR077905AIA), awarded to the first author.

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TABLE 1

Summary of the application of ‘best interests’ to substitute decision-making for adults with incapacity in the common law in England and Wales

Case and Year	Decision	Scope	Reason for invoking ‘best interests’	Assessment and Determination
Re F [1990] 2 AC 1	Non-therapeutic female sterilisation	Medical treatment	Incapacity due to intellectual disability	Bolam standard
Re S [1992] Fam 123	Caesarean section	Medical treatment	Welfare of mother and unborn child	Survival of mother and unborn child
Re T [1993] Fam 95	Blood transfusion	Medical treatment	Invalid refusal of consent due to undue influence	Bolam standard
Airedale NHS Trust v Bland (1993) AC 789	Withdrawal of Artificial Nutrition and Hydration (ANH)	Medical treatment	Incapacity due to Persistent Vegetative State (PVS)	Bolam standard
Re MB [1997] 2 FLR 426	Caesarean section	Medical treatment	Incapacity due to needle phobia (mental illness)	Welfare assessment
Re Y [1997] Fam 110	Tissue donation	Medical treatment	Incapacity due to intellectual disability	Welfare assessment
Re S [2000] 2 FLR 389	Non-therapeutic female sterilisation	Medical treatment	Incapacity due to intellectual disability	Welfare assessment
Re A [2000] 1 FLR 549	Non-therapeutic male sterilisation	Medical treatment	Incapacity due to intellectual disability	Best interests balance sheet
Re S [2002] EWHC 2278 (Fam)	Contact with father	Family contact	Incapacity due to intellectual disability	Best interests balance sheet
Re S [2003] EWHC 1909 (Fam)	Place of residence	Place of residence	Incapacity due to intellectual disability	Best interests balance sheet
Simms v Simms (2003) 1 All ER 669	Experimental medical treatment for vCJD	Medical treatment	Incapacity due to neurological disease	Best interests balance sheet
Re G [2004] EWHC 2222 (Fam)	Contact with father and place of residence	Family contact/Place of residence	Protection from mental illness and future incapacity	Enhancing mental health and protection from future incapacity
Local Authority v Health Authority (2004) 1 All ER 480	Restraint on publication of official inquiry report	Restraint on publication	Vulnerable adults / incapacity for undeclared reason	Human Rights balance sheet
R (Burke) v GMC (2004) EWHC 1879 Admin	Continuation of ANH	Medical treatment	Incapacity due to neurological disease	Provision of a general model for best interests
R (Burke) [2005] EWCA Civ 1003	Continuation of ANH	Medical treatment	Incapacity due to neurological disease	Best interests balance sheet