Chapter 5

Best Interests

Chapter 5: Best Interests – a Standard for Decision-making

Chapter 5 is in two sections:

A. The absence of a "best interests" standard for decision-making in the PPPR Act and in the HDC Code.

B. The evolution of the common law and codification of the best interests standard for decision-making under s 4 of the Mental Capacity Act (MCA).

Introduction

5.1 The MCA has a statutory "best interests" standard. It applies where a person takes actions or decisions on behalf of another person who lacks capacity and is "unable to make a decision", as defined in sections 2 and 3 of the MCA.[633] A "checklist" in s 4 provides a process for assessing the person's best interests (the best interests assessment) and sets out matters that the substitute decision-maker (the decision-maker) must consider. These matters include the aim that the person with impaired capacity should participate in determining their best interests, recognising the person's present and past wishes and feelings, and acknowledging the beliefs and values that would have likely influenced their decision if they had capacity.

5.2 Under the MCA, the concept of best interests therefore provides a framework for decision-making on behalf of people with impaired capacity. Previously, the law focused mainly on the autonomy of people *with* capacity, such as their right to refuse medical treatment, rather than on decision-making for people who could not make autonomous decisions.[634] As discussed in Chapter 2,[635] this best interests framework is compatible with supported decision-making because it requires participation by the person with impaired capacity where possible, and it is an appropriate approach to decision-making for people who cannot make decisions for themselves. This approach also recognises that, even if a person is unable to make a legally binding decision with support, their likely will and preferences remain central to the decision-making process: capacity is not an off-switch to a person's rights and freedoms.[636]

5.3 Best interests guides substitute decision-making and is often contrasted to the notion of substituted judgment. While the former has traditionally been viewed as an objective standard, the latter is more subjective because it instructs the decision-maker to make the decision that the person would have wanted if they had capacity to do so. It has been preferred by courts in the United States.[637] It is considered to uphold the person's autonomy to a greater degree. Both approaches have their challenges.[638] The statutory standard in the MCA can be

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633 See Appendix C and Mental Capacity Act, s 4. Section 1(5) states that "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".
634 Buchanan and Brock, above n 34 at 3.
635 See Chapter 2 Supported decision-making.
636 *Wye Valley NHS Trust v Mr B*, above n 171.
637 Donnelly, above n 254 at 176.
638 Donnelly, above n 254 at 177.

regarded as a hybrid approach, as a subjective element was introduced that was previously absent from the common law's approach to substitute decision-making.

5.4 New Zealand's legal framework provides no such comprehensive standard for decision-making where a person has impaired capacity. The PPPR Act refers to decisions being made in a person's "welfare and best interests", and, under Right 7(4) of the HDC Code, decisions can be made in a person's "best interests." However, best interests is not a primary principle of either piece of legislation and there is no guidance on how these best interests decisions are to be made in light of a person's "will, preferences and rights" under the United Nations Conventions on the Rights of Persons with Disabilities (CRPD).[639]

5.5 How best interests is assessed under the MCA, and the case law around it, is considered below. Recommendations are then made for revised legislation to provide a best interests standard in New Zealand based on s 4 of the MCA.

5A: BEST INTERESTS IN NEW ZEALAND LAW

Best interests and the PPPR Act

5.6 Promoting the "best interests" of people with impaired capacity is not a primary objective of the PPPR Act, although it is often assumed that it is. It is not stated as a key statutory principle governing the exercise of the court's jurisdiction, nor as the basis for the appointment of a substitute decision-maker, such as a welfare guardian or an attorney under an EPOA. It is only once a substitute decision-maker has been appointed that the welfare and best interests of a person who lacks capacity becomes a paramount consideration in making decisions on that person's behalf.[640] There is also no clear direction that the court must make decisions in the person's best interests.[641] In practice, the concept of best interests is given considerable weight in judicial reasoning, but the Act provides no guidance as to what best interests means or how this would be operationalised.

5.7 In some sections of the PPPR Act best interests is given priority. For example, in s 18(3), regarding the exercise of a welfare guardian's powers, it is said: [642]

> In exercising those powers, the first and paramount consideration of a welfare guardian should be the promotion and protection of the *welfare and best interests* of the person for whom the welfare guardian is acting, while seeking at all times to encourage the person to develop and exercise such capacity as that person has to understand the nature and foresee the consequences of decisions relating to the personal care and welfare of that person, and to communicate such decisions. [Emphasis added]

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639 Article 12(4) of the CRPD uses the formulation 'rights, will and preferences'.

640 The phrase "best interests" is used in 10 sections of the PPPR Act, primarily to highlight when the Court (or a trustee corporation) should or should not make an order or appoint a manager, for example, ss 30(1)(c), 31(5)(e), 32(3)(b), 105(1)(a) and 125(b). Best interests is not a criterion for personal orders under s 10 or the appointment of a welfare guardian under s 12.

641 Personal and Property Rights Act 1988, ss 12(5)(b), 18(3), 97A(2) and 98A(2).

642 This expression of paramountcy is reiterated in s 36(1) with regard to property managers and in ss 97A(2) and 98A(2) with regard to attorneys in promoting and protecting the welfare and best interests of the donor, whether in regard to use of the donor's property or personal care and welfare.

5.8 In the past, the "welfare and best interests" of the person has been referred to as "the welfare principle".[643] The notion of "welfare" adds little to the concept. "Welfare and best interests"' could be described as a triple tautology as 'best', 'interests' and 'welfare' all have the same purpose.[644] In philosophical literature, the notions of welfare and well-being are viewed as the same, whilst the term "best interests", so important in legal thought, is little analysed.[645]

5.9 As with cases applying the English common law best interests test, a number of the early cases under the PPPR Act were concerned with sterilisation or orders to terminate a woman's pregnancy.[646] In *KR v MR,*[647] where a personal order was sought to terminate the pregnancy of a disabled woman, Miller J considered the correct approach to the welfare principle: [648]

> The welfare principle is capable of being viewed from a range of perspectives. It is susceptible to prevailing social norms and the personal values of the decision-maker. It is not an objective test and its workability depends on informed fact finding and the wise exercise of discretion.… The principal objectives also quite plainly envisaged that there may be 'secondary' objectives, which are unspecified. Nonetheless, from the point of view of the person in respect of whom the decision is being made the principal objectives are a surer guide to the exercise of the decision-maker's discretion than is a general appeal to the welfare principle.

5.10 The participatory model of the PPPR Act requires appointed welfare guardians and property managers to consult with the person subject to the order. It is only when exercising these powers, however, that the "first and paramount consideration" is said to be promoting and protecting the person's welfare *and* best interests.[649] Importantly, this requirement that the welfare guardian or attorney must act in the person's best interests only operates once incapacity has been established and the appointment of a substitute decision-maker made.

5.11 Despite this implied rather than expressed status of the best interests principle,[650] there is now considerable case law, particularly in respect of living arrangements for older adults, where the Court has accepted jurisdiction and made orders considered to be in the person's best interests, albeit against their express wishes. In *Hutt Valley DHB v MJP*,[651] MJP, the person subject to the application, neither wanted nor had any support at home but was unable to look after herself. Personal orders for dementia level care and necessary medical treatment were made despite the express wishes of MJP to return to her own home. The Court held that for its jurisdiction to be governed solely by the least restrictive intervention principle –

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643 *Re H* [1993] NZFLR 225, Judge Inglis.

644 Interview with Dr Dominic Wilkinson, Director of Medical Ethics at the Oxford Uehiro Centre for Practical Ethics (A Douglass, Dunedin, 9 July 2015).

645 Herring and Foster, above n 306 at 484.

646 See for example *Re H*, above n 643, and the decisions based on the *parens patriae* jurisdiction at common law: *Re E v E* [1986] 2 SCR 388; *Re B (a minor, wardship: sterilisation*) [1987] 2 All ER 206; and *Secretary, Department of Health and Community Services v B (Marion's case)* (1992) 175 CLR 218.

647 Above n 52.

648 *KR v MR*, above n 52 at [65]. Miller J noted that whilst the welfare principle is the first and paramount consideration may appear "…self-evident at first blush, this was not necessarily so as a matter of construction under s 10".

649 Personal and Property Rights Act 1988, ss 18(3) and (4) (welfare guardian) and s 98A(2) (attorney in relation to personal care and welfare).

650 The implicit reliance upon best interests by the Court was noted in a review of the implementation of the PPPR Act for people with intellectual disabilities: A Bray and J Dawson *Who Benefits from Welfare Guardianship – A Study of New Zealand Law and People with Intellectual Disability* (Donald Beasley Institute, Dunedin, 2000).

651 *Hutt Valley DHB v MJP* [2012] above n 42. See also, Atkin B and Skellern A "Adults with Incapacity: The Protection of Personal and Property Rights Act" in Dawson and Gledhill, above n 92, at 341.

which is explicit in the Act – would be to limit its application to the most compelling cases of incapacity. Judge Moss said a balancing approach was required:[652]

> It is in this area of fine distinction that meaning must be found to find the difference between an intervention to the least extent possible, which will enable capacity, and what is in the best interests and welfare of the patient.

5.12 The best interests principle tends to be disguised by the court in such a balancing exercise, where, for example, a person's decision to refuse admission to residential care is called into question. This implicit reliance on best interests does not necessarily involve placing weight on the person's current or previous will or preferences, however, but rather goes to the degree of intervention likely to be imposed by the court order.

5.13 The High Court has previously cautioned against adopting an overly legalistic approach when applying the PPPR Act's express principles – to make the least restrictive intervention and maximise the person's participation – to ensure that the welfare and best interests of the person are also taken into account, even if this matter is not expressed as a guiding principle of the Act.[653] The precise role that best interests plays remains unclear, however, as it does not expressly apply to the initial finding that the person lacks capacity, nor is it the stated legal foundation for intervention against the person's express preferences.

Best interests – a different standard to child law

5.14 In contrast to adult guardianship law under the PPPR Act, the Care of Children Act 2004 (COCA) places the welfare and best interests of the child as the first and paramount consideration.[654] The Act provides five principles to assist in this evaluation, with an emphasis on protecting child safety, and on parental and guardian responsibility.[655]

5.15 This difference between the PPPR Act and the COCA stems from fundamental policy differences between the two pieces of legislation. The purpose of the COCA is to promote children's welfare and best interests, with an overall purpose of protecting children. The COCA anticipates that children may be able to participate in decisions about their interests,[656] however, the threshold for state intervention is low.[657] In contrast, the primary objectives of the PPPR Act are to make the least restrictive intervention possible while enabling and encouraging the adult person to exercise and develop their capacity.[658] The aim of the PPPR Act is to "protect and promote" the interests of adults who are unable to manage their affairs. Although there is a protective function, there is a presumption of competence and recognition that intervention is only appropriate where an adult lacks capacity in law.

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652 *Hutt Valley DHB v MJP* above n 42 at [16].

653 *In the Matter of A* [1996] NZFLR 359 (HC) where there was a personal order in addition to a welfare guardian order. The welfare guardian powers were restricted so that the subject person was not to leave the primary care residence without further order of the Court.

654 Care of Children Act 2004, s 4(1). "The welfare and best interests of a child in his or her particular circumstances must be the first and paramount consideration."

655 In *B v K* [2010] NZCA 96 at [37] Arnold J explained how the principles in s 5 of the COCA are to be interpreted: "The answers to the question what is in the best interests of a particular child may differ as between judges. This is not because they involve discretionary decisions but because they involve evaluative assessments, which will not by their nature yield definitive answers".

656 Care of Children Act 2004, s 16(1)(c) uses the term "helping the child to determine questions about important matters affecting the child".

657 It is beyond the scope of this report to consider the competency of children in law to consent to medical treatment under the COCA, for example.

658 Protection of Personal and Property Rights Act 1988, ss 8(1) and (2).

5.16 The ill-defined concept of "welfare and best interests", applying to substitute decisions for adults under the PPPR Act, runs the risk of being confused with the necessarily more protective policy objectives for the care and protection of children under the COCA. What is important is that all welfare tests are subject to limitations, and failure to clearly delineate these limitations risks tipping the balance from welfare and best interests, to protective paternalism.[659]

Best interests and the HDC Code

5.17 Healthcare decisions may be made in a person's best interests under Right 7(4) of the HDC Code.[660] If a "consumer" (person) is "not competent" to make an informed choice or give informed consent and there is no substitute decision-maker, Right 7(4) of the HDC provides legal justification for providing health and disability services without consent. The healthcare provider must, however, take certain procedural steps and act in what they consider to be the person's best interests.

5.18 The Right is based on the common law principle of necessity. As described by Lord Goff in *Re F*,[661] this principle is based on the "need" for the patient to receive treatment, in their own interests, when they are (temporarily or permanently) disabled from giving consent. Read in conjunction with Right 7(1), this Right has the effect of ensuring that the provision of treatment without consent will not infringe the HDC Code in the specified circumstances, whether or not some statutory or common law justification is also applicable.[662]

5.19 The procedural steps in Right 7(4) requires a provider to take reasonable steps to ascertain the views of the person and consider whether there are reasonable grounds to believe that the provision of services would be consistent with the informed choice the person would make if they were competent.[663] If the person's views have not (or cannot) been ascertained, the provider should take into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise.[664]

5.20 There is no definition in Right 7(4) of "other suitable persons". The range of possibilities could extend beyond family and next of kin to the patient's GP (who may have admitted the patient to hospital), or caregivers and social workers who have some knowledge of the patient's preferences and wishes, as well as an interest in their care and welfare. The provider of the services, for example a surgeon seeking consent from a patient for an operation, need only have a reasonable belief, based on their own judgement, as to the person's best interests, to proceed. Right 7(4) may still be satisfied even where the views of other suitable persons cannot be obtained: for example, when it would be unreasonable to delay treatment, for example, and there is no-one available to consult in the timeframe available.

5.21 There is a substituted judgment element in Right 7(4) as the provider must reach a decision that is "consistent with" the informed choice that the person would make if they were

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659 Email from Professor Mark Henaghan, Dean of Otago Law School to A Douglass (Dunedin, 3 May 2016).

660 Right 7(4) of the HDC Code is also set out in full in Appendix C and is discussed in Chapter 3 regarding the common law doctrine of necessity upon which it is based.

661 *F v West Berkshire Health Authority* [1991] UK HL 1 (17 July 1990) Lord Goff of Chieveley at 24. Also cited in *Re F (Mental Sterilisation),* above n 125.

662 Skegg, above n 109, at 300. There is also a defence available to providers under clause 3 of the HDC Code and they will not be in breach of the Rights in the Code in they take reasonable actions in relation to them.

663 Right 7(4) (b) and (c)(i).

664 Right 7(4)(c)(ii).

competent to do so. Similar principles apply under Right 6, the right to be fully informed. However, Right 7(4) stops short of requiring the provider to act on the "views" of the person, once reasonable efforts have been made to ascertain them. Nor does it specify what the provider should be do where there are conflicting views, or views they disagree with, or how they should weigh the various views to reach a decision.[665]

5.22 Ultimately, Right 7(4)(a) suggests that the person's best interests is the main factor in reaching a decision. Therefore, it seems, a provider could ascertain the views of the person and others but then decide that these views were contrary to the person's best interests, and not follow them. For example, if a person has consistently said they do not wish to receive renal dialysis for their failing kidneys and their family supports this, then it seems the health practitioner, having ascertained their views, could still reach a legally (but not ethically) defensible decision to provide the treatment, based on what they consider to be in the person's best interests.

5.23 Right 7(4) is a pragmatic response to the need for everyday healthcare decision-making for people unable to made decisions that are legally effective. The scope of its application is intended to be narrow. It relies largely upon the notion of "clinical" best interests as judged by the healthcare provider. As such, it provides an unsatisfactory standard for decision-making for people with impaired capacity in a wide range of circumstances. There is also considerable uncertainty about the extent to which Right 7(4) can be relied upon on a continuing basis, rather than in one-off situations or emergencies.[666]

5B: BEST INTERESTS AT COMMON LAW AND UNDER THE MENTAL CAPACITY ACT

The evolution of best interests at common law

5.24 The power to make medical welfare decisions in the best interests of an incapacitated adult was first formally recognised by the courts in England in a 1990 case in the House of Lords. In *Re F*,[667] the issue was whether a profoundly mentally disabled young woman who was living in a hospital setting and having a sexual relationship with a man in circumstances where contraception was considered unsuitable, should have a hysterectomy to prevent her becoming pregnant and having a child. The House of Lords held that the common law doctrine of necessity allowed the medical treatment of adults who were unable to give consent. Treatment or care, which might otherwise be an assault upon a person who lacked capacity to agree to it, was lawful, provided it was in the best interests of the person concerned.

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665 Right 6 provides: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive…"

666 The issue of relying on the doctrine of necessity and Right 7(4) of the HDC Code to make decision that deprive a person of their liberty is discussed in Chapter 3 Liberty Safeguards.

667 *Re F,* above n 125. There were a series of cases involving sterilisation of disabled women at that time, for example, *T v T* [1988] 1 All ER 613 at 625. There was further recognition of the declaratory jurisdiction in a Court of Appeal decision In *Re F (Adult: Court's Jurisdiction)* [2001] Fam 38, Dame Butler-Sloss held that although an 18-year-old mentally handicapped woman did not come within the guardianship principles of the MHA 1983, and was too old for the court's wardship jurisdiction, the court was entitled under the inherent jurisdiction and bests interests doctrine to make declaratory judgments when there was risk of possible harm in respect of an adult who lacked capacity to make decisions.

5.25 This jurisdiction was first limited to declarations of lawfulness related to medical treatment[668] but later was extended to non-medical issues as well, such as a person's residence and contact with others. The resulting body of law is described by Fennell as one of the most dramatic manifestations of judicial creativity in recent years.[669] The COP recently expanded the declaratory jurisdiction to cover the withdrawal of life-sustaining treatment from someone who was in a minimally conscious state, not a permanent vegetative state.[670]

5.26 In *Re F*, the House of Lords, in the same judgment, adopted the *Bolam* test for medical negligence[671] as the standard governing health providers' determinations of best interests.[672] This meant that the task of determining a patient's best interests was effectively delegated to the medical profession, making the question a clinical one to be judged by a narrow "not negligent" test.[673] The adoption of this standard, referred to as the "Bolamisation" of medical law,[674] has been adopted in different areas of medical law besides negligence, including informed consent and when determining "Gillick" competence for consent from children.[675] More recently, the *Bolam* test has been put to rest with regard to the duty of a doctor to disclose information to the patient for the purpose of obtaining informed consent. [676]

5.27 The case law on necessity and best interests continued to evolve after *Re F* and many of these developments were codified in the MCA. The need to have a wider best interests criterion was recognised in English Law Commission reports, culminating in the enactment of s 4 of the MCA.[677] In modern parlance, when applying the MCA both doctors and lawyers refer to "clinical" best interests – that is, what a doctor might think best in the clinical circumstances of a person's case – as a distinct concept. It contributes to decisions about, but remains distinguishable from, a person's best interests as understood under the MCA.

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668 The declaratory jurisdiction has also been exercised for the continuance of artificial nutrition and hydration: *Airedale NHS v Bland*, above n 165.

669 P Fennell "Mental Capacity" in LO Gostin, P Bartlett, P Fennell and others (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, Oxford, 2010) at 168.

670 *M v Mrs N* [2015] EWCOP 76 (Fam) Hayden J. The Court had to consider whether the best interests of Mrs N, who suffered progressive and degenerative impact of multiple sclerosis to receive life sustaining treatment by means of clinically assisted nutrition and hydration (CANH) currently provided by a (PEG) tube.

671 *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582. The *Bolam* test is as follows: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical opinion.

672 *Re F*, above n 125 at 78.

673 M Donnelly "Best Interests, Patient Participation and the Mental Capacity Act 2005" (2009) 17 Med Law Rev 1 at 3.

674 M Brazier and J Miola "Bye-bye Bolam: A Medical Litigation Revolution?" (2000) 8 Medical Law Review 85 at 90.

675 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. See also, M Dunn, I Clare, A Holland and others "Constructing and reconstructing "Best Interests": an Interpretative Examination of Substitute decision-making under the Mental Capacity Act" (2007) J Soc Welf Fam Law 117.

676 *Montgomery v Larnarkshire* [2015] UKSC 11. This case concerned a pregnant diabetic patient who was not warned by her consultant about the risk that her baby, being relatively large size in relation to the mother's pelvis, would have shoulder dystocia. The doctor thought the mother would opt for a caesarean section, which the doctor considered to not be in her best interests.

677 Szerletics, above n 209.

Best interests under the MCA

5.28 The MCA therefore now provides the framework for the application of the best interests test and the Court of Protection provides important guidance on its interpretation. Although a comprehensive definition of a person's "best interests" is deliberately not provided by the MCA, it sets out a number of rules which must be followed. These require that a decision-maker must consider all relevant circumstances, and in particular:[678]

- *Equal consideration and non-discrimination*: Determinations must not be made merely on the basis of the person's age or appearance, or on the basis of unjustified assumptions from the person's condition or behaviour;

- *Regain capacity*: Consider whether the person is likely to regain capacity and, if so when that is likely to occur;

- *Permitting and encouraging participation*: Encourage the person to participate as fully as possible in the decision before making it for the person;

- *Best interests decisions in relation to life-sustaining treatment:* These decisions must not be motivated by a desire to bring about the person's death;

- *Person's past and present wishes, feelings, beliefs and values*: This includes consideration of written statements, the person's beliefs and values, and any other factors that the person would be likely to consider if they were able; and

- *The views of other people*: Consult a number of people including carers, holders of lasting powers of attorney, deputies and anyone else named by the person.

Constructing decisions

5.29 Assessing best interests (or "benefit" under Scottish law) is described by Adrian Ward, a Scottish lawyer, as a process of "constructing decisions" on behalf of the person who cannot make the decision themselves.[679] Neither the MCA nor its Code of Practice provides an indication of the relative weight to be given to the various factors.[680] For example, it is possible for two individuals conscientiously to apply the s 4 "checklist" and come to different views as to where the person's best interests lie, but both views could be "reasonable". Under s 5 of the MCA, both could then act on their beliefs to carry out routine acts of care and treatment safe in the knowledge that they were protected from liability.[681] The duty to consult the person

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678 The factors listed here in s 4 of the MCA are set out in the Law Commission Report at 160. See Appendix C for s 4 of the MCA.

679 The methodology for assessing benefit under the Adults with Incapacity Act (Scotland) is set out in A Ward above n 128 at Chapter 17 (A Douglass, Interview with Adrian Ward, Edinburgh, 29 May 2015).

680 See, for example, *MCA Code of Practice*, above n 285 at 86 [5.5] to [5.7]. Note that the framework under the MCA creates the role of a best interests assessor. The design of the Act is that if a person is a decision-maker whether the person making the decision is acting as a family carer, a paid care worker, an attorney, a court appointed deputy or a health professional. As long as these acts or decisions are in the best interests of the person who lacks capacity to make the decision for themselves, or to consent to acts concerned with their care or treatment, then the decision-maker or carer will be protected from liability under ss 5 and 6.

681 Example given in Ruck Keene and Butler-Cole, above n 201. In the *ZH v Commissioner of Police,* above n 415 at [40], the Court of Appeal emphasised that the defence afforded to health and social care

and others is wide. In *Winspear v City Hospitals Sunderland NHS Foundation Trust,*[682] the Court emphasised that, where the duty to consult under s 4(7) of the MCA has arisen and has not been complied with, there will be no defence available under s 5 of the MCA.[683] While the duty to consult is not absolute, the person carrying out an act in connection with care and treatment will not be able to proceed as if they had the consent of the individual lacking capacity.

5.30 In weighing the factors under s 4 of the MCA, the Courts have endorsed a "balance sheet" approach whereby the relevant benefits and burdens of a particular course of action are listed and, only where the "account" can be said to be in "significant credit" can a decision be said to be in a person's best interests.[684] Although case law has confirmed that there is no hierarchy between these factors, in that the weight attached to each will vary in the circumstances of each case, certain factors can become "magnetic" and tilt the balance.[685]

The person's wishes, feelings, beliefs and values

5.31 Section 4(6) requires the decision-maker:

> So far as is reasonably ascertainable to consider –
>
> (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 the decision if he had capacity, and
>
> (c) The other factors that he would be likely to consider if he were able to do so.

5.32 The practical effect of s 4(6) is to require the decision-maker to attempt to ascertain what the person's subjective preferences would have been, had they been able to express them. This does not require the decision-maker to make a formal substitute judgement, by trying to put themselves in the shoes of the person, as the matters itemised in subsection (6) are merely considerations when deciding what the person would have wanted. Therefore, although there is an element of substituted judgement involved, the MCA represents a compromise between the objective and subjective approaches to decision-making for people with impaired capacity.

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professionals delivering routine acts of care and treatment is "pervaded by the concepts of reasonableness, practicality and appropriateness".

682 [2015] EWHC 3250 (QB).

683 The provisions of MCA s 5 are based on the common law doctrine of necessity as set out in *Re* F, above n 125. See *MCA Code of Practice*, above n 285 at Chapter 6: "What protection does the Act offer for people providing care and treatment?" In addition, s 6 places clear limits on the use of force or restraint by only permitting restraint to be used for example, to transport the person to their new home, where this is necessary to protect the person from harm and is a proportionate response to the risk of harm. It is beyond the scope of this report to consider whether statutory protection for carers and health practitioners, as provided for in ss 5 and 6 of the MCA would be appropriate or necessary in New Zealand's medico-legal environment under the no-fault treatment injury provisions of the Accident Compensation Act 2001.

684 *Re A: (Mental Patient: Male Sterilisation)* [2000] 1 FCR 193 at 206, Thorpe LJ.

685 *Re M* [2009] EWHC 2525 (FAM) At [35] Munby J lists the relevant factors, including: the degree of the person's incapacity, for the nearer to the borderline the more weight should be attached to their wishes and feelings; the strength and consistency of the person's view; and the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the Court's overall assessment.

5.33 Where the person's reliably identifiable wishes and feelings suggest a course of action that would be profoundly risky for them, the relative weight to be given to the person's wishes and feelings has been contentious,[686] as the statute does not set out a hierarchy of these considerations.[687]

Conflict between past and present wishes and feelings

5.34 Nor does the MCA expressly indicate whether it is the *present* or the *past* wishes and feelings of a person that should be given priority, and neither are determinative. There may be situations where there is a conflict between the person's own views pre- and post-incapacity. A person's past preferences may not be relevant if their present circumstances have changed radically. Ward suggests that a person should "not be treated as irrevocably 'owned' by the past adult, and … present wishes and feelings should prevail".[688] For example, under an advance directive,[689] a person, while capable, may express a strong preference that they would not wish to live with profound disabilities but when in that situation may appear to be contented.[690]

5.35 Such conflicts are an inevitable feature of the hybrid, participatory approach taken to best interests by the MCA and do not diminish the value of its approach.[691]

Whose best interests?

5.36 Although there is a general obligation to consult certain people during the course of a best interests assessment, the overall aim is to have a better understanding of what would be in the individual's best interests.[692] The court has accepted, however, there are certain situations where the interests of others are inseparable from the interests of the protected person and therefore seem to carry moral relevance when making decisions on the person's behalf. In the case of *Re Y,*[693] a woman with severe disabilities was deemed to be the best suitable donor for her sister who suffered from a bone marrow disorder. The Court held that the required operations were in Y's best interests as she would tend to prolong her sister's life and Y would continue to receive emotional, psychological and social support from her sister in return.

5.37 There have also been cases of substituted "financial altruism". In *Re G (TJ)*,[694] Morgan J directed the court-appointed deputy of an elderly woman who lacked capacity, to make maintenance payments from her funds to her daughter on the basis that the payments were in the best interests of Mrs G. The approach taken in this case was a substituted judgment

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686 A Ruck Keene and C Auckland "More presumptions please? Wishes, feelings and best interests decision-making" (2015) Eld LJ 293.

687 *MCA Code of Practice*, above n 285 at 81 [5.38].

688 A Ward *Greens Essential Legislation: Adults with Incapacity Legislation* (Thomson Reuters/W Green, London, 2008) at 15.

689 The requirement to take account of the person's past wishes in s 4(6) of the MCA may be conflict with the advance refusal provisions provided for in ss 24-26 of the MCA.

690 M Donnelly "Determining Best Interests under the Mental Capacity Act 2005" (2011) 19 Med Law Rev 304 at 311; *Re Martin* (1995) 538 N.W n.99.

691 Donnelly, above n 673 at 2.

692 Mental Capacity Act 2005, s 4(7).

693 *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam 110.

694 *Re G (TJ)* [2010] EWHC 3005 (COP) Morgan J.

approach. Both the previously expressed wishes of Mrs G, as well as the hypothetical wishes and feelings that she would express if she were able, were considered.[695]

5.38 The impact of the best interests decision on others is considered relevant regarding the court's power to make gifts. In *David Ross v A*,[696] Senior Judge Lush authorised the payment of A's brother's school fees from A's clinical negligence award in circumstances where it was clear that A's well-being depended in large part upon the well-being of her family as a whole. A, who was severely disabled at birth, will never have the capacity to make or contribute to a decision of this kind and reliance was placed on the views of the professional deputy who managed her funds and knew her family well.

Best interests and "the patient's point of view"

5.39 *Aintree University Hospital NHS Foundation Trust v James*[697] was the first decision of the Supreme Court of the United Kingdom under the MCA. It concerned a seriously ill man who lacked capacity to make decisions about his medical treatment. The hospital sought a declaration that it would be in the best interests of Mr James to withhold specified life-sustaining treatments should they be needed. His family opposed the application. The High Court declined the application and the Court of Appeal reversed that decision. Mr James died following a cardiac arrest but in view of the importance of the issues and the different approaches taken in the lower courts, the Supreme Court gave Mr James's widow leave to appeal. The Supreme Court was unanimous in rejecting the widow's appeal but disagreed with the Court of Appeal's reasoning, preferring the approach adopted by the High Court.

5.40 In *Aintree*, the Supreme Court addressed the question of how doctors and courts should decide when it is in the best interests of the person to be given, or not given, treatments necessary to sustain life. The Court held that the question for the Court is whether it is in the patient's best interests to receive the treatment, rather than in their best interests to have it withheld or withdrawn. Where there is complete agreement among clinicians that life-sustaining treatment should not be offered and their stance is confirmed by an independent expert who would also be unwilling to provide such treatment, there is, in effect, no best interests decision to be taken, as there is no treatment option available to the patient. Lady Hale corrected the Court of Appeal's suggestion that the test for considering a patient's wishes and feelings is an objective one of what a reasonable patient would think. As Lady Hale noted: [698]

> The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his wishes were in the past, they may well have changed in light of the stresses and strains of the current predicament.

5.41 Lady Hale confirmed that "the preferences of the person concerned are an important component in deciding where his best interests lie." She went on to state:[699]

> … in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical, but social

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695 *Re G (TJ),* above n 694, at [35].
696 [2015] EWCOP 46.
697 *Aintree*, above n 164.
698 *Aintree,* above n 164 at 18 [45].
699 *Aintree,* above n 164 at 15 [36].

> and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; *they must try and put themselves in the place of the individual patient* and *ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view on what his attitude would be.* [Emphasis added]

5.42 Some cases have suggested that, in certain circumstances, the person's wishes and feelings will be determinative. In *Re S,*[700] Hazel Marshall QC J accepted that the person's views are not ordinarily paramount, but went on to say that where a person's wish is not irrational (in the sense of being a wish that a person with full capacity might reasonably have), is not impracticable as far as its physical implementation is concerned, and is not irresponsible, having regard to the extent of the person's resources, then a presumption arises in favour of implementing their wishes, unless there would be some sufficiently detrimental consequence for the person to outweigh this.

Best interests and proposed law reform under the MCA

5.43 It has been argued that the Supreme Court judgment in *Aintree* has given a new impetus to the centrality of the person at the heart of the best interests process.[701] However, the recent House of Lords' report on the operation of the MCA notes that one of the problems was that the wishes and feelings of the person lacking capacity were not routinely prioritised in best interests decision-making and, instead, "clinical judgements or resource-led decision-making predominate".[702]

5.44 Moreover, for pragmatic reasons, it will not be possible for every decision by a person lacking capacity to be the subject of a best interests determination under the MCA.[703] The House of Lords report found that "the best interests principle is widely praised but its implementation is problematic".[704] There have been a number of cases where insufficient recognition has been given to the person's wishes and feelings when making a best interests decision, as well as to the presumption that living or contact with family is in the person's best interests.[705]

5.45 The Law Commission has now proposed that the MCA should be aligned, as far as possible, with the CRPD. However, the UN Committee has effectively rejected best interests decision-making, saying national laws must ensure that the person's "rights, will and preferences" are respected, rather than decisions being based on an objective assessment of their best interests.[706] While the MCA refers to "wishes and feelings" in this context, the CRPD adopts the term "will and preferences".[707] The Law Commission did not consider that there was any substantial difference between these phrases, although they are deployed for different

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700 [2008] EWHC (16) FAM.

701 House of Lords Select Committee, above n 3 at [99].

702 House of Lords Select Committee, above n 3 at [104].

703 *IM v LM,* above n 591 at [77].

704 House of Lords Select Committee, above n 3 at [90].

705 Cases include: *Hillingdon v Neary,* above n 462, (which was referred to extensively in the House of Lords report). In *G v E and others* [2010] EWHC 621, although a Local Authority's decision to remove a mentally incapacitated adult from a continuing placement with a person who had fostered him as a child breached his rights under Article 5 and 8 of the European Convention on Human Rights, it would be in his best interests to continue at the residential care unit to which he had been transferred until there was a final hearing to consider whether he might be returned to the foster carer.

706 CRPD General Comment No. 1, above n 242 at [20]-[21].

707 Article 12(4) of the CRPD uses the formulation 'rights, will and preferences'. The ALRC formulation follows the spectrum of decision-making based on the will and preferences of a person, through to a human rights focus in circumstances where the will and preferences of a person cannot be determined. See Chapter 2 Supported Decision-making.

purposes.[708] The Law Commission has recommended that there should be a presumption that the person's wishes and feelings will be followed, to make the best interests standard more compliant with the CRPD.[709] In *Wye v Mr B* Peter Jackson J defended the existing provision in the MCA and questioned this proposal: [710]

> … my respectful view is that the Law Commission proposal would not lead to greater certainty, but to a debate about whether there was or was not *"good reason"* for a departure from the assumption. To elevate one important factor at the expense of others would certainly not have helped the parties, nor the court, in the present case. All that is needed to protect the rights of the individual is to properly apply the Act as it stands.

Summary

5.46 In New Zealand, the phrase "best interests" is found in both the PPPR Act and in Right 7(4) of the HDC Code, but it cannot be regarded as a specified legal standard for decision-making of the kind codified in the MCA.[711] Nor does New Zealand law actively encourage supported decision-making as envisaged in the CRPD, and in the case law of the COP applying s 4 of the MCA.[712]

5.47 The UK Supreme Court decision of *Aintree*[713] provides some insights into how the best interests test might apply to end-of-life decision-making under the court's inherent jurisdiction in New Zealand.[714] However, withdrawal or withholding of treatment type cases rarely come before the High Court under the inherent jurisdiction in New Zealand. Most "best interests" decisions in respect of a person's care and welfare and property are made by those substitute decision-makers appointed under the PPPR Act or the Family Court under that jurisdiction. Or, they do not come before the courts at all, such as treatment and healthcare decisions that need to be made for people who lack capacity under Right 74) of the HDC Code. The net result is that the decision-making process for reaching "best interests" decisions – where the decisions are made by others – is largely invisible.

5.48 The scheme of the MCA and its Code of Practice is pragmatic as it allows the great majority of decisions to be made in the person's best interests by informal decision-makers, such as carers and family without recourse to the court or for the appointment of formal decision-makers at all.[715] It is also consistent with supported decision-making principles under the CRPD, to provide reasonable accommodation of support measures that are tailored to an individual's needs.[716] To this end, New Zealand should develop a decision-making standard that is similarly consonant with both human rights obligations and the need to ensure there is a clear and transparent process for decision-making that takes into account a person's will and preferences.

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708 Law Commission, above n 199 at 165.

709 Law Commission, above n 199 at 164.

710 *Wye Valley v Mr B,* above n 172 at [17].

711 There has been limited discussion about the meaning of "best interests" in the New Zealand context within the *parens patriae* jurisdiction, see *Re G* [1997] 2 NZLR (HC) and *Auckland Healthcare Services v L* [1998] NZFLR 998 (HC).

712 See *Re M (Best Interests)* and *Wye Valley v Mr B*, case examples discussed in Chapter 2E Supported decision-making in practice and in English case law.

713 Above n 164.

714 N Peart "Withholding Treatment" [2014] NZLJ 117 at 119.

715 Interview with Lady Brenda Hale, Deputy President, Supreme Court of the United Kingdom (A Douglass, London, 6 May 2015).

716 B Hale, discussing discrimination on the grounds of not providing reasonable accommodation (Toulmin Lecture, Kings College London, 12 March 2015).

RECOMMENDATIONS FOR BEST INTERESTS AS A STANDARD FOR DECISION-MAKING

1. Best interests should be codified as a standard for decision-making which should include:

   a) taking into account the person's will and preferences, and all relevant circumstances, largely modelled on the best interests framework in s 4 of the MCA.

   b) in determining what is in the person's best interests, the decision-maker would be required take a series of steps, including, so far as practicable, supporting the person to participate as fully as possible in the determination of what would be in their best interests.

   c) consideration given to the establishment of a presumption in favour of the person's will and preferences in respect of a decision, where their preferences can be reasonably ascertained, unless there is compelling evidence that following their preferences would have serious adverse consequences for them.[717]

   d) a general principle of proportionality should apply: the greater the departure from the person's reasonably ascertainable will and preferences, the more compelling must be the reasons for such a departure.

2. The best interests standard would have to be followed by those required to make decisions for others. It would apply across the operation of revised adult guardianship legislation (a reformed PPPR Act), as well as in the operation of Rights 5, 6 and 7 of the HDC Code, where a person lacks capacity to consent to, or refuse health or disability services.

3. Appointment of health and disability advocates to provide support to the person who lacks capacity to assist them to participate as fully as possible in any relevant decision. This would complement the consultative aspect of supported decision-making.[718]

4. An accompanying Code of Practice with guidance for decision-makers on the best interests standard, including how to assess a person's best interests in accordance with their rights, will and preferences, and how to support the person and their involvement in any decision that affects them.[719]

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717 *S v S (Protected Persons)* [2009] WTLR 315, Hazel Marshall QC presumption test and proposal by the English Law Commission (see Ruck Keene and Auckland, above n 686 at 295), currently under consultation. Amendments to the 2015 Northern Ireland Mental Capacity Bill were proposed by researchers associated with the Essex Autonomy Project (University of Essex, England), in conjunction with its ongoing "three jurisdictions" study of approaches to capacity legislation in England and Wales, Scotland and Northern Ireland. The amendments were prepared by W Martin (Director of the Essex Autonomy Project) and A Ruck Keene (Thirty Nine Essex Chambers).

718 See for example, the Independent Mental Capacity Advocates (referred as "IMCAs") appointed under s 36 of the MCA and accompanying regulations. This would be an expansion of the current role of health and disability advocates under the Health and Disability Commissioner Act 1994.

719 See for example, *MCA Code of Practice*, above n 285 at Chapter 3: How should people be helped to make their own decisions?