Best interest clinical decision making for care home residents with advanced dementia

THE CHALLENGES

With the ageing population there is a rise in the number of people with dementia, many of whom are cared for in the advanced stages in care homes. There is a growing body of evidence that hospital admission at end of life for people with dementia often has a negative impact on the person,[1] and a palliative care approach within the care home is advocated.[2] McDermott *et al*,[2] recently highlighted that decisions around hospitalisation for this patient group are complex and rely on the GP having sufficient information about the resident's past and recent health status and previous expressed wishes, as well as confidence in the care home staffs' ability to undertake the required treatment and care. In weighing the possible medical benefits of hospital admission against the potential adverse effects for the patient, McDermott *et al* also found that some GPs feel vulnerable to the risk of criticism and conflict with the patient's family or even legal sanction. A clinical decision-making model which incorporates the principles of best interest decision making may assist GPs and care home staff with difficult dilemmas (Figure 1).

LASTING POWER OF ATTORNEY

The care home should hold a copy of the lasting power of attorney (LPA) for health and welfare. To be valid the LPA document has to be registered and stamped by the Office of the Public Guardian. Page 6 of the LPA document details whether the attorney has been given permission by the donee to make decisions about life-sustaining treatment.

PREVIOUSLY-STATED WISHES

The British Medical Association (BMA) has advised the doctor to consider whether a proposed treatment would 'restore the person's health to a level they would find acceptable'.[3] In the case of a best interest decision, this would require the doctor to make a value judgement or substituted judgement about what the person would have wanted if they had the capacity to decide. While the best interest decision maker should consider any previously-stated or written wishes, beliefs, or values about treatment and care, the weight accorded to this in the best interest decision-making process has recently been shown to be unclear from a legal perspective: In W v M [2011] EWHC 2443, the judge stated that prior views must be directed specifically at the issue in hand. It is perhaps better advice to focus on ascertaining the overall benefits and burdens of a proposed treatment option, within the context of the person's life and present situation, rather than to focus on what the person might have wanted if they had capacity.[4]

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WEIGHT GIVEN TO THE VIEWS OF SIGNIFICANT OTHERS

While the views of the person's family and carers should be taken into account, there needs to be awareness of the amount of weight placed on those views in the decision-making process. Taking an ethical perspective, the wishes, or psychological health of relatives should not over-ride the interests of the person who lacks capacity.[5] Taking a legal perspective, GPs will receive protection from the courts if they can provide documentary evidence that they have complied with sub sections 1–7 of section 4 of the Mental Capacity Act, (Table 1), in making the best interest decision and the decision is that which would be endorsed by a responsible body of medical opinion.[6]

ALLOWING NATURAL DEATH

Although the Mental Capacity Act (2005)

Table 1. Mental Capacity Act 2005 Section 4 Subsections 1–7[a]

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of:	(a) the person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.	
(3) He must consider:	(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and (b) if it appears likely that he will, when that is likely to be.
(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.	
(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.	
(6) He must consider, so far as is reasonably ascertainable:	(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 his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.
(7) He must take into account, if it is practicable and appropriate to consult them, the views of:	(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind, (b) anyone engaged in caring for the person or interested in his welfare, (c) any donee of a lasting power of attorney granted by the person, and (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

[a] *Reproduced under the Open Government Licence v3.0.*

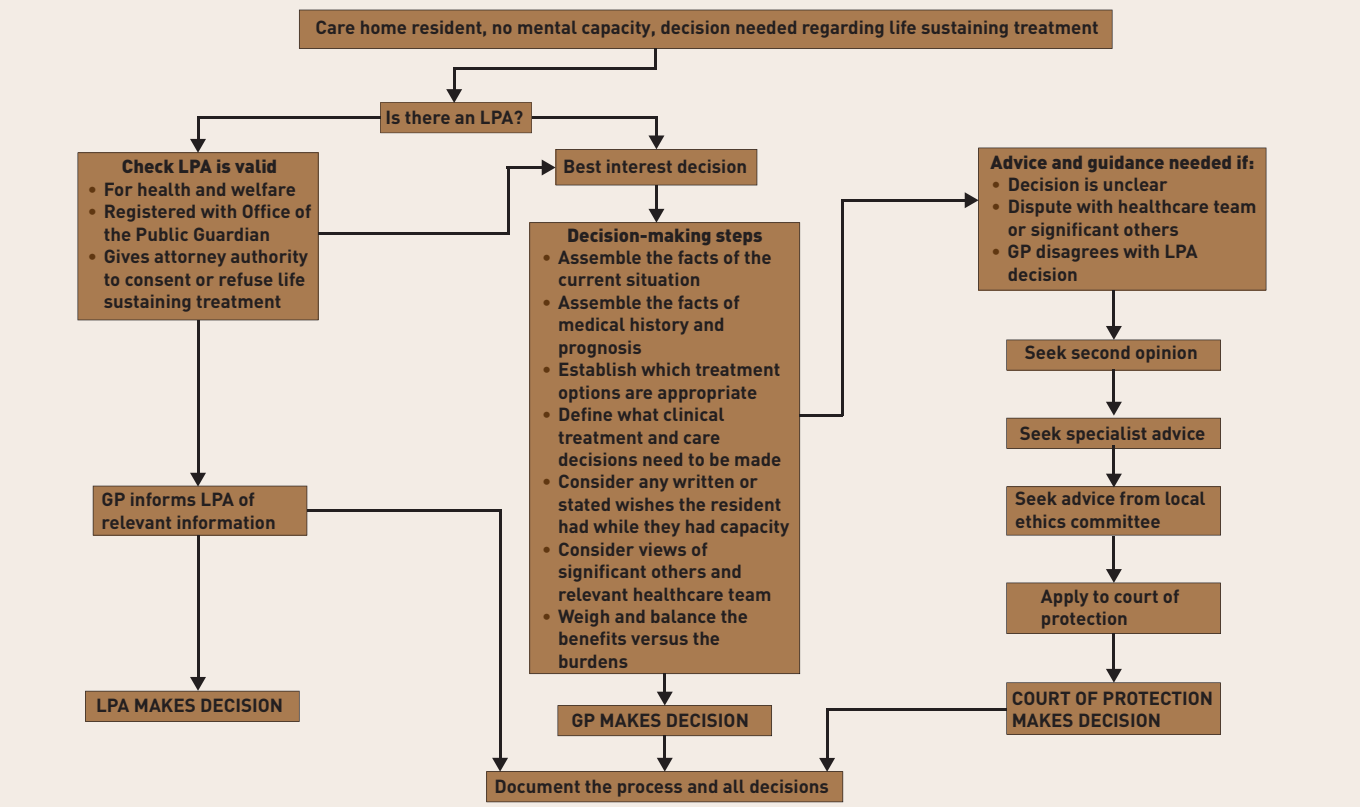

Figure 1. Best interest clinical decision making model. LPA = lasting power of attorney.

advises clinicians to assume that it would always be in the person's best interests for their life to continue, it has been recognised by law that there are circumstances where letting someone die can also be seen to be in a person's best interests (see Airedale NHS Trust v Bland [1993] AC 789). It has been argued that the distinction between withdrawing and withholding a treatment is morally irrelevant as both can be justified depending on the circumstances. It can also be argued that letting someone die is morally appropriate when the burdens and risks of the treatment outweigh the benefits of the treatment for that particular patient. Thus the balance between medical goals and dignity in care for patients who are vulnerable and potentially at end of life, also needs to be considered.

BENEFITS VERSUS BURDENS

If there is uncertainty about the balance of benefits versus risks, a trial of treatment with regular review and subsequent withdrawal if the treatment proves ineffective or too burdensome could be considered.[3] If the GP is uncertain at any point in the decision-making process, or if there are any disputes within the healthcare team or with relatives, then a second opinion or specialist advice should be sought. The GP can also seek advice from a local ethics committee or apply to the court of protection for advice or decision making if the dispute cannot be resolved locally.

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Provenance
Freely submitted; not externally peer reviewed.

Competing interests
The author has declared no competing interests.

DOI: 10.3399/bjgp15X686293

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