Editors


Embedding the Mental Capacity Act into clinical practice in England and Wales

The framework that clinicians used to make clinical decisions relating to the assessment of their patients’ mental capacity changed radically in 2005. Prior to that date decisions were based on a combination of experience, ethics and guidelines that were often discussed and sometimes challenged. Geriatricians awkwardly relied on the legal precedent of Re C (a schizophrenic man who refused amputation of a gangrenous limb) for case law guidance on the criteria of mental capacity [1]. When capacity was in doubt the discussions and challenges became more frequent, sometimes requiring the courts to decide outcomes. The introduction of Living Wills (first proposed in the USA in the late 1960s [2]) offered the promise for clinicians at least to know the wishes regarding treatment decisions of a patient without capacity who is currently ill. However, concerns about their legal standing and relevance in end-of life care decisions remained controversial [3]. The Mental Capacity Act (MCA) for England and Wales [4] has for the first time, created a framework, acceptable to clinicians and carrying the force of law, that provides a solid foundation for clinical decision making when capacity is lacking or can be anticipated to be lost in the future. Some areas of clinical care such as mental health and social work incorporated the MCA into routine practice at an early stage. But despite having been enacted 6 years ago, and despite a clear and well written Code of Practice, its adoption into many other specialties has been slower [5, 6]. In this issue, CJ Bond and K Lowton [7] describe the views of geriatricians when faced with a patient who has an advance decision to refuse treatments (ADRTs). Some of the geriatricians in the survey believed that their views might, in some circumstances, take precedence over a decision made in advance by a patient with capacity. What they may not have realised is that this may put them in breach of the MCA and risk court action.

The MCA sets out five statutory principles:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- 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.
• Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Issues around capacity are common in elderly patients—whether this is a temporary loss of capacity due to a reversible delirium, an anticipated loss of capacity in recently diagnosed dementia or a loss of capacity due to organic brain disease. The MCA compels clinicians to use its criteria in assessing capacity if an impairment or disturbance of mind or brain is suspected. If capacity is lacking, this only applies to a specific decision, so that patients who lack capacity to decide on complex matters (for example, complicated discussions around a treatment plan), may still have the capacity to decide simpler care decisions (for example, that they do not wish to be washed). If capacity is lacking, the decision in question must be made in the patient’s best interests. This no longer means simply what the responsible clinician believes is in the patient’s best interests, but the Act demands a recommended process that:

• encourages participation of the patient;
• identifies all relevant circumstances;
• finds out the person’s wishes, feelings, beliefs and values;
• avoids discrimination;
• assesses whether the person might regain capacity;
• protects the patient insofar that if the decision concerns life-sustaining treatment it shall not be motivated in any way by a desire to bring about the person’s death and does not make assumptions about the person’s quality-of-life;
• consults others;
• avoids restricting the person’s rights;
• takes all this into account in order to work out what is in the person’s best interests.

There are several choices for patients who retain capacity but are suffering from a condition which may cause a lack of capacity in the future. They may speak to their partner, relatives and carers to express their wishes, feelings, beliefs and values. Some may choose to put this in writing in the form of an Advance Statement which only becomes active when they lose capacity. Although such verbal or written statements are not legally binding on clinicians, the MCA requires clinicians to take them into account when applying the best interests process. A second option is that patients may wish to make clear their refusal for specific treatments as an Advance Decision to Refuse Treatment (ADRT). Such advance decisions can be verbal, but if the patient also wishes to refuse life-sustaining treatment, the ADRT must be written and signed and contain the phrase that they refuse the specified life-sustaining treatment, ‘...even if my life is at risk’. A third option is to appoint a partner, relative or friend as an ‘attorney’ in terms of a Lasting Power of Attorney (LPA) order. The Act makes provision for two forms of LPA—one pertaining to property and financial issues and the other to welfare and health issues. These different forms of LPA are distinct and no overlap is possible—an attorney appointed to fulfil the functions in terms of a Property and Financial LPA has no authority to make health or social care decisions, which can only be made by a Personal Welfare LPA. The latter can only make decisions about life-sustaining treatments if the order specifically authorises this power.

If an ADRT is valid and applicable to the clinical situation, it is legally binding on clinicians since it was made by the patient when they had capacity and understood the implications of their decision. Even if the clinician believes the valid and applicable ADRT decision to be unwise, the MCA stipulates that the patient’s wishes should be respected. It is important to recognise this point, since it forms an underlying principle of the Act itself. Some clinicians may find that an ARDT frustrates their sense to do what they believe is ‘right’ for the patient who may appear at that time to be vulnerable and confused. But it should be recognised that interventions that are contrary to a valid and applicable ADRT will in principle bear the same force of censure in law as if it were a battery of a competent patient who refused treatment. It is fair to observe that neither an advance decision nor advance care planning is a replacement for a trusting dialogue between patient and clinician, and ADRTs are not the answer to every clinical decision made in advance. It has been argued that apparently valid and applicable ARDTs will present clinicians with a new set of moral dilemmas arising from the conflict between the principles of respecting the patient’s autonomy and the clinician’s duty to act with beneficence [8]. In addition, decisions based on the MCA have yet to be formally challenged in court and there will always be grey cases where the clinician may benefit from help from their trust’s ethics committee or seek clarification (and indemnity) from the court. However, for most situations the MCA provides clinicians with the best framework when capacity is at issue. It is easily accessible in the Code of Practice [9] and every clinician and health and social services organisation should ensure the MCA is part of everyday policy and practice.

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References
