

## LAW, ETHICS AND MEDICINE

# The Mental Capacity Act 2005: a new framework for healthcare decision making

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The Mental Capacity Act received Royal Assent on 7 April 2005, and it will be implemented in 2007. The Act defines when someone lacks capacity and it supports people with limited decision-making ability to make as many decisions as possible for themselves. The Act lays down rules for substitute decision making. Someone taking decisions on behalf of the person lacking capacity must act in the best interests of the person concerned and choose the options least restrictive of his or her rights and freedoms. Decision making will be allowed without any formal procedure unless specific provisions apply, such as a written advance decision, lasting powers of attorney or a decision by the court of protection.

(2)) and a requirement that all practicable steps should be taken to help a person to make a decision (principle (3)).

There is a rather circuitous statutory definition of those who lack mental capacity. A person lacks capacity in relation to a matter, if, at the time, he is unable to make a decision for himself because of an impairment of, or a disturbance in the functioning of, the mind or brain.<sup>5</sup> The Act recognises that “a person is not to be treated as unable to make a decision merely because he makes an unwise decision” (principle (4)). Reference to age, appearance or an aspect of the person’s behaviour is not sufficient to establish lack of capacity.<sup>6</sup> The Act reiterates the current common law test established in the case of *Re C*,<sup>7</sup> in setting out when a person is unable to make a decision for himself.

An inability to

- understand relevant information;
- retain that information;
- use or weigh the information as part of the process of decision making; or
- communicate the decision (this was not specifically a requirement at common law)

leads to the conclusion that a person is unable to make a decision for himself or herself, and therefore lacks capacity. The code of practice elucidates where there may be a need for professional involvement in assessing capacity—for example, where a person repeatedly makes decisions that put him or her at risk or could result in preventable suffering or damage.<sup>8</sup> <sup>1</sup>

### BEST INTERESTS

In providing healthcare to people who lack capacity, and who are therefore unable to make healthcare decisions for themselves, it is important to establish not only who can take such decisions but also the considerations that must be taken into account in making them. A key premise of the Act is that any decision taken on behalf of a person who lacks capacity to make the relevant decision must be made in the best interests of the person. The Act sets out, in section 4, a checklist of factors that must be considered in determining “best interests”. The decision maker must consider, as

**Abbreviation:** LPA, lasting powers of attorney

<sup>1</sup>The Code of Practice also sets out in some detail when a formal assessment of capacity should be carried out, paragraph 3.53.

On 7 April 2005, the Mental Capacity Act 2005 received Royal Assent and it will be implemented on 1st April 2007. The Act “provides the framework for acting and making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves”,<sup>1</sup> and it clarifies and builds on existing principles of common law. It is broad ranging and applies to decision making in respect of the management of property and financial affairs, and healthcare and personal welfare matters. The aim of the Act is to promote autonomy, and this is achieved by “enabling people to make decisions for themselves as far as possible”<sup>2</sup> in day-to-day decisions and also by giving statutory recognition to anticipatory decision making—respect for autonomy exercised at an earlier time. There is also provision for the court appointment of deputies to make decisions for those who lack the capacity to do so. A specialist court will be established, the court of protection, which will have jurisdiction to deal with adults lacking capacity. This paper considers the provisions of the Act, which relate to healthcare decision making and the requirements of healthcare professionals seeking to provide medical treatment for people lacking capacity, and identifies if, and how, it will alter current practice.

### PEOPLE WHO LACK CAPACITY

The Act applies to people >16 years,<sup>3</sup> habitually resident or present in England and Wales,<sup>4</sup> who lack mental capacity. The Act sets out five principles designed to emphasise its underlying ethos, which is that it is intended to support and enable those people lacking capacity. The principles include a presumption of capacity (principle

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far as is reasonably ascertainable, the person's past and present wishes and feelings and his beliefs and values likely to influence his decision.<sup>9</sup> This assessment of best interests looks to what the person lacking capacity would have wanted, which will clearly take account of non-medical issues. This builds on case law, which has clarified that "best interests encompasses medical, emotional and all other welfare issues",<sup>10</sup> and that many non-medical matters form the basis of any decision as to what is in a patient's best interests.<sup>11</sup> However, this is not to play down the input of clinical opinion in determining best interests. Section 4(2) of the Act requires the person determining the best interests to consider "all relevant circumstances" in addition to the checklist. The Code gives the example that where a decision is to be taken about major medical treatment, the relevant circumstances will include "the clinical needs of the patient, together with the potential benefits and burdens of the treatment on the person's health and life expectancy".<sup>12</sup>

There is also a requirement that, if it is practicable and appropriate, others—for example, a carer, an attorney appointed under a lasting power of attorney (LPA) or a deputy appointed by the court—should be consulted as to what would be in the person's best interests. However, the Code states that "the interests of the person who lacks capacity should prevail; not the views or convenience of those caring for that person".<sup>13</sup> It is also recognised that "the decision maker may not be in a position to make exhaustive enquiries to investigate every issue which may have some relevance".<sup>14</sup>

The Act thus establishes that primacy is given to the best interests of the person lacking capacity and this forms the basis for any treatment decision. But who can make such decisions on behalf of that person? Autonomy is promoted where possible and the person lacking capacity should be both allowed and encouraged to participate in the decision-making process. However, this cannot be sufficient to give valid consent to treatment. Consent can be obtained from the person himself or herself before loss of capacity by virtue of an advance directive; the Act gives statutory effect to advance decision making not only in the format of an advance directive but also through the appointment of an attorney under an LPA. The Act also gives protection to those who carry out acts in connection with the care or treatment of a person lacking capacity.

### ACTS IN CONNECTION WITH CARE OR TREATMENT

An incompetent adult is not able to give valid consent, and at common law no person may give valid consent to treatment on behalf of an adult patient lacking capacity.<sup>15</sup> The doctrine of necessity has provided a justification for treatment, including a wide range of actions undertaken for the general care of the person, such as routine medical or dental treatment.<sup>16</sup> The provisions of section 5 of the Act are based on the common law doctrine of necessity. It gives statutory protection<sup>ii</sup> to carers (both paid and family members), and social and healthcare professionals for acts performed in connection with the personal care, healthcare and treatment of those who lack capacity. There is no requirement to obtain formal authority to act and "section 5 acts" are stated widely—those acts carried out in connection with the care or treatment<sup>17</sup> of a person who is believed to lack capacity in respect of the issue in question. The action undertaken must be in the person's best interests. There need only be a reasonable belief of this, but health professionals will be adjudged by normal professional and clinical standards.<sup>18</sup> Section 5 applies to acts in connection with healthcare and treatment, and this includes major treatment, although the code states that in such a situation "particular consideration" will need to be given to ensure a careful determination of best interests and that the choice of treatment is the least restrictive option. Clearly, section 5 only applies

where the patient lacks capacity and therefore cannot give valid consent. However, the Act provides that decision-making powers may be formally vested in an attorney, appointed under an LPA, or a deputy appointed through an order made by the court of protection. If such appointments have been made, it is the attorney or deputy who, if they are acting within the scope of their powers, can provide consent on behalf of the person lacking capacity. Section 5 would no longer be necessary because consent can be obtained, and indeed "anyone acting contrary to a decision of an attorney or deputy acting within the scope of his/her powers will not therefore have protection from liability" under section 5.<sup>19</sup>

### LASTING POWERS OF ATTORNEY

An LPA is a legal document whereby a person (the donor), aged  $\geq 18$  years, appoints a proxy (the attorney or donee; more than one attorney can be appointed<sup>20</sup>) to take decisions on his or her behalf. In January 2006, the Department for Constitutional Affairs launched a 3-month consultation on the forms and guidance for making an LPA. The aim is to produce "clear, easy to follow processes and simple and effective forms".<sup>2</sup> Nevertheless, certain formalities must be complied with, and the proposed LPA for personal welfare runs to nine pages. The LPA must be written, witnessed and lodged with the Office of the Public Guardian. It must also include a certificate stating that the donor understands the purpose of the LPA and that no undue pressure has been used to persuade the donor to make the LPA. This is completed by an independent third party.

Attorneys can be appointed to make decisions on personal welfare, including healthcare and consent to medical treatment.<sup>iii</sup> Personal welfare LPAs can only be used when the donor loses capacity to make the decision. The authority of the attorney may be limited to specific matters or it can apply generally in respect of all matters relating to the personal welfare of the donor. It does not authorise an attorney to consent to or refuse life-sustaining treatment (which in the view of the person providing healthcare is necessary to sustain life)<sup>21</sup> unless there is express provision to this effect in the formal document. Where the attorney has the authority to make the relevant healthcare decision, the "healthcare professionals must consult the attorney and seek his/her consent in the same way as they would with a patient who had the capacity to consent".<sup>22</sup> There will be a searchable register of LPAs.

The decision taken by the attorney must always be in the donor's best interests. The attorney is, in a sense, the voice of the incapacitated patient and should represent what he/she would have wanted. Thus, the proposed guidance suggests that "you should make sure that the person you are choosing is someone you know well and someone you trust to make decisions in your best interests".<sup>23</sup> The best interests checklist includes the requirement that, if it is practicable and appropriate to do so, the views of the attorney should be sought as to what would be in the person's best interests. If the treating doctor disagrees with the attorney's view as to what treatment would be in the patient's best interests and the matter cannot be resolved by discussion, then an application can be made to the court of protection and in the interim the doctor can

<sup>ii</sup>Section 5 only offers protection against liability in battery, if the action is itself carried out negligently it does not offer protection to the health professional.

<sup>iii</sup>Under the Enduring Powers of Attorney Act 1985, an attorney could be appointed to act in relation to property and financial affairs. The Mental Capacity Act 2005 repeals the Enduring Powers of Attorney Act and provides a new regime for the appointment of attorneys to deal with property and financial matters.

continue to treat to prevent a serious deterioration in the patient's condition.

The benefit of appointing an attorney is that he or she can respond to healthcare needs as they arise and hence is more flexible than an advance directive. The attorney can consent to and refuse treatment (although, as is true of patients with capacity, an attorney cannot demand specific treatment that the doctor does not consider to be clinically necessary or in the patient's best interests), whereas advance decisions only operate to refuse a specified treatment. If an LPA is created after making an advance decision then the attorney's decision would take precedence in respect of the treatment specified in the advance decision.

## ADVANCE DECISIONS

Advance decisions are "nothing more than a refusal of consent given much earlier than in other circumstances".<sup>24</sup> The courts have recognised<sup>25</sup> that an advance refusal of treatment (known as a "living will", "advance statement" and "advance directive") is as valid as a contemporaneous refusal of treatment, although it could be argued that advance decisions lack the moral force of contemporaneous treatment choice as the patient is unable to engage in discussion about treatment at the time the decision is taken.<sup>26</sup> The Act uses the terminology "advance decisions" and sets out a statutory framework which is complemented by a code of practice. The Department for Constitutional Affairs launched a 3-month consultation on a new draft code issued on 9 March 2006.<sup>1</sup>

The Act provides that an advance decision can be made by adults aged  $\geq 18$  years who have the capacity to do so. The Act does not require a record of assessment of capacity, but the code of practice states that it would be good practice to do so.<sup>27</sup> There is no particular format for an advance decision and no requirement that it is made in writing, except where life-sustaining treatment is refused, although this would provide proof that it exists (if it can be identified at the time the treatment decision is to be taken).<sup>28</sup> An advance decision only applies in respect of refusal of treatment—the Act does not provide that a patient can request treatment. However, a request for specific forms of treatment made in an advance decision should be taken into account in deciding what treatment would be in that person's best interests and this was clarified by the Court of Appeal in *R (Burke) v GMC*.<sup>29</sup> The treatment to be refused must be specified, although this need only be described in layman's terms. An advance decision is not applicable to life sustaining treatment unless the person making it verifies that it applies to a treatment, even if "life is at risk" and it must be written, signed and witnessed.<sup>30</sup> Life-sustaining treatment "means treatment, which, in the view of the person providing healthcare, is necessary to sustain life".<sup>31</sup> However, basic care, including the offer of oral food and water, warmth and hygiene measures, may not be refused by an advance decision.<sup>32</sup>

An advance decision is not relevant if the person still has capacity to make the decision. It must be valid at the time at which it is to take effect, and section 25(5) sets out events that would render an advance decision invalid. These are where the person has withdrawn the decision when he or she had capacity; has later appointed a person under an LPA, with power to refuse the treatment to which the advance decision relates; or has done something clearly inconsistent, with the advance decision remaining his or her fixed decision. If an

<sup>i</sup>Paragraph 8.36 of the draft Code of Practice states that storage and notification of an advance decision are primarily the responsibility of the maker.

<sup>v</sup>Such care may be provided under the provisions of section 5.

advance decision is valid, it must next be determined whether it applies to the situation. Section 25(4) states that an advance decision is not applicable if the proposed treatment is not the treatment specified in the advance decision, if circumstances specified in the decision are absent or if there are reasonable grounds for believing that circumstances have arisen that the person did not expect and that would have affected his decision had he expected them.

Although the courts have recognised advance decisions at common law, they are seemingly reluctant to give effect to them where there is any doubt about validity or applicability,<sup>33</sup> and "the continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence".<sup>34</sup> The code of practice provides that an advance decision is more likely to be valid and applicable if the maker had ongoing discussions with a healthcare professional about the practical aspects and consequences of treatment. Perhaps then, an advance decision made before the onset of illness or before a new stage in a progressive illness and without discussion with a healthcare professional may be unlikely to be upheld. If a healthcare professional provides medical treatment contrary to a valid and applicable advance decision then he or she may be liable to a claim for damages in battery; however, where there are genuine doubts, based on a reasonable belief, treatment can be provided without incurring liability,<sup>35</sup> and a declaration can be sought from the court of protection.

## DEPUTIES AND THE COURT OF PROTECTION

The court of protection is a specialist court that has jurisdiction to deal with decision making for adults lacking capacity.<sup>vii</sup> It will deal with decisions about healthcare and personal welfare matters that have up to now been dealt with by the High Court under its inherent jurisdiction. Applications for a declaration that proposed action is lawful for certain serious decisions relating to the provision of medical treatment should be made to the court of protection. Examples include cases involving the withholding or withdrawal of artificial nutrition and hydration of patients in a permanent vegetative state, and organ or bone marrow donation by a person lacking capacity. The code of practice also suggests that other cases likely to be referred are "those involving ethical dilemmas in untested areas, or where there are otherwise irresolvable conflicts between professionals, or between professionals and family members".<sup>36</sup>

The court of protection can make a single order, or where there is a need for ongoing decision-making powers (and where no attorney has been appointed under an LPA), it may appoint a deputy to make decisions on behalf of a person who lacks capacity. A deputy can be any person at least 18 years of age who has agreed to act, but paid carers should not be appointed because of the potential for conflict of interests. Usually a single order will be preferred and only in difficult cases will a deputy be needed to make healthcare decisions.<sup>37</sup>

<sup>vii</sup>A young woman made an advance directive when she was a practising Jehovah's Witness refusing blood products. Her father questioned the validity of the advance decision as she had recently become engaged to a Muslim man. The court stated that where life is at stake, the evidence must be scrutinised with especial care. The advance directive was considered invalidated by this change of circumstance.

<sup>viii</sup>Cases involving 16 and 17-year olds who lack capacity may be dealt with by the Court of Protection or in a court dealing with family proceedings.

<sup>iii</sup>Paragraph 7.39 of the draft Code of Practice gives examples of cases where there is a history of acrimonious and serious family disputes or where the person's best interests are resolved by a deputy consulting everyone concerned.

## CONCLUSION

The extent to which the Mental Capacity Act will build on current good practice relies on the proper assessment of capacity and the understanding and implementation of the Act's principles. All appropriate help must be given before anyone concludes that a person cannot make his or her own decisions, and anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms. The Act provides that the basis for any decision to be taken on behalf of a person lacking capacity is in the best interests of that person and it provides a checklist of factors that decision makers must work through in deciding what is in a person's best interests. The person can put in writing his or her wishes and feelings, and carers and family gain a right to be consulted. The Act provides welcome clarification to those providing care and treatment to patients who lack capacity, with statutory protection against liability in certain circumstances. The Act creates two new public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity. A new court of protection will be the final arbiter for capacity matters. It will have its own procedures and nominated judges. A new public guardian will be the registering authority for LPAs and will supervise deputies and work with other agencies such as the police and social services. Further provisions of the Act provide for the appointment of an independent mental capacity advocate and it will be a criminal offence if anyone is found guilty of ill-treatment or neglect of a person lacking capacity. Whether the provisions of the Act will alter current practice will depend to a large extent on the way they are interpreted by clinicians, and ultimately, by the courts.

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