The Mental Capacity Act

Introduction

Decisions made by doctors on behalf of patients who lack capacity are currently made according to accepted best practice and common law principles. The Mental Capacity Act 2005 (the Act) sets this approach in statute law, providing protection for incompetent patients and clear legal requirements for those caring for them.

The Act provides a statutory framework for deciding if an individual lacks capacity to make certain decisions for himself and, if so, who can make decisions on his behalf and how to go about this. Generally, the Act will apply to people aged 16 years or over who lack capacity and will cover all decisions made on their behalf, from minor decisions about everyday living to more complex issues such as health, property and financial affairs.

Unless otherwise stated the provisions of the Act discussed in this article will come into force in October 2007.

Principles of the Act

The key principles underpinning the Act are based on an individual's fundamental right to autonomy. A person must be assumed to have capacity unless it is proved otherwise and all practicable steps must be taken to help them to make a decision for themselves, e.g. by providing information in a simple format or involving an expert to help that person to express their views. Just because a person makes an unwise decision does not mean that he should be treated as lacking capacity. Anything done under the Act for a person who lacks capacity must be done in his best interests, and in a way that is the least restrictive on his rights and freedom of action.

Determining capacity

An assessment of capacity is decision specific, and as such a person may have capacity to make some decisions but not other, more complex, ones. In order to determine if an individual has capacity to make a particular decision a two-stage test is applied:

1. Is there an impairment of or disturbance in the functioning of the person's mind or brain? If so,
2. Has it made the person unable to make a particular decision?

The first 'diagnostic' test is intended to cover a wide range of situations which may be temporary or permanent, for example the effects of alcohol or drug use, head injury, delirium, dementia, learning difficulties, mental illness or brain damage. If there is no such impairment or disturbance the individual cannot lack capacity within the definition of the Act.

The second 'functional' test assesses whether a person is able to make a decision for himself. In order to do so he must be able to understand the information relevant to that decision, retain that information, use it as part of the decision-making process and communicate his decision. If there is a failure of any of the above then that person is deemed to lack capacity. It is important to note that only in very rare cases (such as locked-in syndrome) should individuals be considered unable to make a decision through being unable to communicate, given the underlying principle that all practicable steps must be taken to help them to make a decision for themselves.

Best interests

All decisions made on behalf of someone who lacks capacity must be taken in their best interests. Although best interests will vary depending on the individual and the circumstances, the Act sets out a non-exhaustive checklist of factors to consider.

The checklist includes a requirement to consider the person's past and present wishes and feelings as well as their beliefs and values. The decision maker must also take into account, if practicable and appropriate, the views of relevant people such as close relatives or carers. All relevant factors must be considered, not just medical ones, and weighed against each other in order to ensure that the outcome is the best one available for the person concerned.

Restraint

Restraint is defined in the Act as the use or threat of force when an incompetent adult resists, or the restriction of his liberty or movement whether or not he resists. Restraint may only be used if two conditions are satisfied: the person taking action must reasonably believe that it is necessary in order to prevent harm to the person lacking capacity, and the restraint used must be proportionate to the likelihood of the harm and the seriousness of it.

Designated decision-makers

The Act enables individuals to plan ahead for a time when they may lose capacity by introducing lasting powers of attorney, which will replace enduring powers of attorney. A competent adult can nominate a lasting powers of attorney, who, in addition to property and financial affairs, will be able to make decisions on their behalf about their health care and medical treatment once they lose capacity. The lasting powers of attorney can only make decisions about the continuation or withdrawal of life-sustaining treatment if expressly documented by the patient before losing capacity.

In addition, a new Court of Protection has been created under the Act, which will deal with complex decisions, for example irresolvable disputes between doctors and family members about the treatment of an incompetent adult. Authorization of the Court will be required to withdraw artificial nutrition and hydration from patients in a persistent vegetative state and to perform a hysterectomy on an incompetent adult for contraceptive purposes. The Court will also be able to appoint a Deputy to make decisions on behalf of an adult who lacks capacity where there is a need for ongoing decision-making powers.

Advance decisions to refuse treatment

The Act enshrines into statute the right to make advanced directives to refuse treatment. An adult aged 18 years or over who has capacity may make an advanced refusal of treatment either orally or in writing which will apply if he subsequently loses capacity. In order to be valid, an advance refusal must be specific as to the treatment that is to be refused and the circumstances in which the refusal will apply. If the advance decision concerns the refusal of

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life-sustaining treatment it must be in writing, signed and witnessed and include the express statement that the decision stands 'even if life is at risk'. An advance decision cannot require doctors to provide a treatment that they consider to be clinically unnecessary, futile or inappropriate.

Research

In order to carry out research involving or relating to a person who lacks capacity, an appropriate body, e.g. a research ethics committee, must agree that the research is safe, relates to the person's condition and cannot be done as effectively using people who have capacity. Any risks or burdens of participating in the research must be outweighed by the potential benefits to that person. If the research aims to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights. The individual must be withdrawn from the research if they show any sign of resistance or reluctance to participate.

Independent Mental Capacity Advocates

Independent Mental Capacity Advocates will support and represent people lacking capacity who have no one else to speak for them when decisions need to be taken about serious medical treatment and long-term accommodation. Independent Mental Capacity Advocates will be operate in England from April 2007 and doctors need to be familiar with those parts of the Act that are relevant to the operation of Independent Mental Capacity Advocates, e.g. assessing capacity and determining best interests.

Conclusions

The Act will provide protection not only for incompetent patients but also for those who make decisions on their behalf. Doctors who follow the principles of the Act and who reasonably believe that a patient lacks capacity will be able to provide care or treatment in that patient's best interests without risk of liability, as long as there is no negligence.

Doctors should document carefully the reasons behind decisions made under the Act and if in doubt should seek advice from their Trust legal department or protection organization. BJHM

Conflict of interest: none.

Department for Constitutional Affairs (2005) Draft Code of Practice. Mental Capacity Act. The Stationery Office, London (http://www.dca.gov.uk/consult/codepractise/draftcode0506.pdf accessed 2 March 2007)

KEY POINTS

- The Mental Capacity Act sets out clear legal requirements for those making decisions on behalf of patients who lack capacity.
- Patients will be able to plan ahead for a time when they may lack capacity.
- The Act will provide protection both for incompetent patients and those who make decisions about their care.

RSM STUDENT MEMBERS' GROUP RESEARCH PRESENTATION

Characteristics of embolic signals detected during the dissection phase of carotid endarterectomy

The* British Journal of Hospital Medicine *is pleased to be publishing some abstracts from the Royal Society of Medicine's Student Members' Group Research Presentation. This is the winning poster presentation. For information about entering this year's prize, please contact young.fellows@rsm.ac.uk

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Abstract

Background and purpose

This study compared the characteristics of embolic signals detected in the dissection phase of carotid endarterectomy (CEA) by transcranial Doppler ultrasound with those previously detected post-CEA from thrombo-emboli to try and better understand their composition.

Method

The characteristics of 673 embolic signals recorded from the middle cerebral arteries of 268 patients during the dissection phase of CEA were analysed. The signals were characterized by their frequency, measured embolus-to-blood ratio (MEBR), signal duration and position in the cardiac cycle.

Results

Dissection embolic signals had a mean MEBR of 9.9 dB (σ=5.4 dB), duration of 25.8 ms (σ=20.8 ms), frequency of 568 Hz (σ=280 Hz) and velocity of 22.0 cm/s (σ=10.9 cm/s). Signals were randomly distributed throughout the sonogram. Postoperative signals had a mean MEBR of 10.2 dB (σ=5.7 dB), duration of 20.9 ms (σ=15.9 ms), frequency of 791 Hz (σ=454 Hz) and velocity of 32.1 cm/s (σ=20.2 cm/s). Signals were twice as likely to be detected at positions between 40 and 80% in the sonogram than elsewhere.

Conclusions

The difference in distribution of emboli through the cardiac cycle suggests that postoperative thrombo-emboli detach from the carotid bifurcation during systole, while dissection emboli detach as a result of surgical manipulation during the dissection phase. It is not possible to differentiate between thrombus and dissection emboli by the interpretation of MEBRs alone. BJHM