CHAPTER 1

# The legal framework: the Mental Capacity Act, the Human Rights Act and common law

Clinical practice involves doing things to, and for, other people. Touching, undressing, examining and medicating another person require some legal authority. Depending on the circumstances, that authority is established in England and Wales within the common law, the Mental Capacity Act 2005 (MCA), the Mental Health Act 1983 (MHA) and, underpinning it all, the European Convention on Human Rights (ECHR) as incorporated into the Human Rights Act 1998.

- **Common law** is judge-made law. It is a body of law made up entirely of principles developed organically from individual court cases on a case-by-case basis. As Lord Donaldson said, 'The common law is common sense under a wig'.[4] Common law cannot be used where there is a statutory alternative, i.e. statute law overrides common law. For those practitioners who worked prior to 2005, this is particularly important. The common law authority to act in the best interests of a person who lacks capacity has been almost entirely replaced by the MCA.
- **Statute laws** are laws passed by Parliament and called Acts.
- **Judicial interpretation of statute law** Judges also interpret the statutes passed by Parliament and make rulings on these.
- **European Law** is a potentially confusing term because there are two distinct types of European law. There is European Law passed by the European Union (EU). These laws tend to make specific requirements of member countries and are binding on those countries. An example is the European Working Time Directive. The other European law, and in relation to clinical decision-making much more relevant, is the European Convention on Human Rights (ECHR). This is incorporated into UK law by the Human Rights Act 1998. The latter makes some specific requirements of UK national laws (which must be compatible with the ECHR) and also sets a framework for the interpretation of national laws and practices both by the UK courts and individual clinicians.
- **State compliance with the ECHR** is determined by the European Court of Human Rights (ECtHR).

- **In relation to consent to medical treatment**, unless a patient is subject to the Mental Health Act, the common law and statutory criminal law determine the rules for clinicians whose patients have decision-making capacity. For patients who lack capacity, the Mental Capacity Act gives the legal framework (the only exception to this is when a person who lacks capacity needs control or restraint in the interests of someone else, e.g. to prevent them hurting another person). That is, the MCA provides a statutory framework for decision-making and the care and treatment of people who lack decision-making capacity. It also introduced substitute decision-making powers in the form of advance refusals of medical treatment, lasting powers of attorney and deputies appointed by the Court of Protection (Court Appointed Deputies). The Act provides safeguards in the form of a new Court of Protection, the Office of the Public Guardian, the Independent Mental Capacity Advocate and a new criminal offence of ill-treating or neglecting a person lacking capacity.

The MCA is underpinned by five key principles:

- **a presumption of capacity** – every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise
- **support in decision-making** – a person must be given all practicable help before anyone treats them as not being able to make their own decisions
- **acceptance of unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision
- **acting in the best interests** – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests
- **taking the least restrictive option** – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

The main provisions of the MCA are:

- **A definition of incapacity** The Act introduced a test for incapacity. First, there must be evidence of an impairment of, or disturbance in the functioning of, the mind or brain. Second, the person must be unable to make a decision because of that impairment or disturbance. The test is decision- and time-specific.
- **Best interests** The Act requires that all decisions in relation to a person lacking capacity must be in their best interests. Decision makers must work through a checklist to establish best interests.
- **Acts in connection with care and treatment** The Act gives a clear legal authority, and protection, for those who make decisions on behalf of, or care for, people who lack capacity in relation to the matter in question, so long as they act in that person's best interests.

- **Restraint** The Act defines restraint as the use of force or the threat of use of force. Restraint is only authorised for the prevention of harm to the person themselves and must be proportionate to the likelihood and seriousness of the harm.
- **Deprivation of liberty** The Act includes a schedule to provide authorisation for depriving a person who lacks capacity of their liberty, so long as it is in the best interests of that person and there are no less restrictive alternatives.
- **Lasting powers of attorney (LPAs)** The person can decide whether to have one or several attorneys (also called donees); if several, how they should act together; and whether they can make decisions regarding property and affairs, or health and welfare, or both.
- **Court Appointed Deputies** The Act gives the Court of Protection the authority to appoint deputies to take decisions on health, welfare and/or financial matters as authorised by the Court.
- **Advance decisions to refuse treatment** The Act allows people to make anticipatory decisions – decisions in advance of losing capacity – to refuse medical treatment should they lack capacity in the future. The Act sets safeguards in relation to advance decisions. Decisions must be both applicable and valid. If the decision relates to the withholding or withdrawing of life-sustaining treatment there are additional requirements.
- **Independent Mental Capacity Advocates (IMCAs)** The Act requires the involvement of an Independent Mental Capacity Advocate in specified circumstances. When the decision relates to serious medical treatment or a change in the accommodation of a person who lacks capacity, and the person has no family member or friend to speak for them, an Independent Mental Capacity Advocate must be appointed.
- **Research** The Act sets out the conditions and requirements governing research involving people who lack capacity.
- **A criminal offence** A person found guilty of ill treatment or neglect of a person who lacks capacity may be liable to imprisonment for a term of up to 5 years.

A number of matters fall outside the scope of the MCA:

- marriage/civil partnerships
- divorce
- sexual relationships
- placing a child for adoption
- taking over parental responsibility for a child
- consent to fertility treatment
- voting
- detention/treatment of people under the authority of the Mental Health Act.

## Age and the Mental Capacity Act

The MCA applies to people aged 16 and over, with the following exceptions:

- Under the age of 16:
  - if the child is unable to make decisions about property or finances and is unlikely to acquire capacity when they reach 18, then the Court of Protection can make the decision or appoint a deputy to do so (section 18(3))
  - offences of ill-treatment or wilful neglect of a person who lacks capacity (section 2(1)) includes child victims (section 44).
- Under the age of 18 a person cannot:
  - make a lasting power of attorney
  - make an advance decision to refuse medical treatment
  - apply to the Court of Protection.

**Note**

There are some overlaps in legislation. The Code of Practice refers to 'children' as people under the age of 16 and 'young people' as people aged 16–17, whereas in the Children Act 1989 and the law more generally the term 'child' refers to people under 18.

**Note**

The term 'learning disability' is used throughout this book. We recognise that many clinicians, and others, are more familiar with or prefer the term 'intellectual disability'. We are using learning disability because it is the term used and defined in the MHA ('a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning') and used throughout the secondary legislation and Codes of Practice.

An individual carrying out care or treatment of a young person aged 16–17 who lacks capacity to consent will generally have protection from liability provided that they follow the principles of the Act. When assessing best interests, the individual providing care or treatment must consult others involved in the person's care or welfare if it is practical and appropriate to do so, and this may include parents. It is important that in such circumstances, care is taken not to unlawfully breach the young person's rights to confidentiality.

If there is disagreement about the care, treatment or welfare of a young person who lacks capacity to make relevant decisions, then, depending on

the circumstances, the case may be heard in the family courts or the Court of Protection. Cases may be transferred between the Court of Protection and the family courts, depending on what is appropriate for the particular circumstances. For example, if there is a parental dispute about the best place of residence for a 17-year-old with severe learning (i.e. intellectual) disability, it may be appropriate for the Court of Protection to deal with the disputed issues, because orders made under the Children Act 1989 will expire when the young person becomes 18.

## European law and the Human Rights Act

Understanding European institutions isn't easy or, thankfully, necessary here. Our concern is with the European Convention on Human Rights. This was adopted by the Council of Europe (a group of 42 States) in 1951. The UK was one of the first signatories to the Convention. Although before 2000, when the Human Rights Act 1998 came into force, 'public authorities' (the term used to describe 'the State') and private institutions providing public functions were supposedly obliged to comply with the Convention, it was difficult in practice for an aggrieved person to obtain a judgment because they needed to exhaust all domestic legal remedies before they could appeal to the European Court of Human Rights. The Human Rights Act changed this. Parliament is required to ensure that its laws are compliant with the European Convention on Human Rights, and courts and other public authorities are required to interpret Acts in line with the Convention as far as possible. European Court of Human Rights judgments are applicable (although not binding) in UK courts.

### *The Human Rights Act 1998*

The Human Rights Act incorporated the European Convention on Human Rights into UK law. In clinical practice, references to the Human Rights Act and to the European Convention on Human Rights are interchangeable. The purpose of the Convention is to ensure that governments behave with a proper regard for human rights (it followed the atrocities of the Second World War). It does not apply directly to private companies or citizens unless they are carrying out public functions in the place of the government. It is for governments to legislate to make private bodies and citizens behave properly. It is unlawful for a public authority (the government or its agents) to act incompatibly with the European Convention on Human Rights. If they do, the Convention allows for a case to be brought in a UK court. Clinicians, when treating a National Health Service (NHS) patient or a private patient on behalf of the State, act as public authorities. They do not do so when treating paying private patients. Private hospitals are public authorities when providing services to NHS-funded patients. Professionals must keep the European Convention on Human Rights in mind when

conducting their clinical practice. The Articles of major relevance are the following (that's not to say the others are irrelevant):

- Article 2, the right to life
- Article 3, the prohibition of torture and inhuman and degrading treatment
- Article 5, the right to liberty and security
- Article 6, the right to a fair trial
- Article 8, the right to respect for private and family life.

The European Convention on Human Rights requires all UK legislation to be interpreted, as far as possible, in accordance with Convention rights. If a UK court decides that it cannot interpret an Act in a way that is compatible with the Convention, it has to make a 'declaration of incompatibility' (between UK law and the European Convention on Human Rights) so that the government can ask Parliament to change the law. This does not override Parliament. The Act remains unaltered until amended by Parliament. Parliament has a fast-track method for amending Acts under such circumstances.

The European Convention on Human Rights is said to be a 'living' document. It is expected that the way courts interpret its Articles will change over time, developing in line with the current mores of society. There are three categories of rights under the Convention:

- 'absolute' – no excuses (e.g. Article 3)
- 'limited' – there are specific, explicit circumstances, defined in the Article, when it doesn't apply (e.g. Article 5)
- 'qualified' – interference is permitted in a range of circumstances (e.g. Article 8).

One potential difficulty is that one person's rights may compete with another person's. For example, should there be an absolute right to practise one's religion? Clearly not, if to do so involves sacrificing the lives or freedoms of others. Furthermore, some Articles appear to clash and a balance must be struck. For example, Article 2, which puts a positive duty on the State to preserve life, may conflict with Article 8, which requires the State not to interfere in people's lives. Indeed, there may be a problem even within a single Article. Should, for example, a person with a learning disability who cannot make these decisions for themselves be left with their family (assuming that is the family's wish), or be moved to encourage living an independent life (against the family's wish)? Article 8 is respect for both family and private life and has been used by both sides in support of their argument.

One of the most useful concepts introduced by the European Convention on Human Rights is that of 'proportionality'. This says that any interference with a Convention right must be proportionate to the intended aims and

the aims themselves must be legitimate. How much force can be used in a particular circumstance, for example an interference with a person's physical integrity, depends on the severity of the threat to the person or to others.

Finally, it is perhaps worth noting that only a public authority, including private bodies when exercising public functions, can be sued under the Human Rights Act and only victims can sue. Identifying the victim may not always be obvious. A patient's daughter successfully sued a hospital when her mother, while detained under the MHA, died by suicide (the hospital had breached Article 2, the patient's right to life, by providing care that was not of the required standard).[5]

The following section looks at specific human rights legislation. In an attempt to limit confusion, only the most relevant Articles are reproduced and discussed.

### Convention Articles

**Article 2: Right to life**

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
   a. in defence of any person from unlawful violence;
   b. in order to effect a lawful arrest or to prevent escape of a person lawfully detained;
   c. in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 2 puts a positive duty on the State. An institution will not have breached Article 2 if it has done everything correctly but there is poor practice or negligence by an individual member of staff. Article 2 also covers the clinician's duty to pass on sensitive information about serious risks to others when transferring the care of a mentally disordered patient, including the need to consider the risks to other in-patients (e.g. ensuring an appropriate environment if admitting a very disturbed patient). Other examples include: 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, withdrawal of life-sustaining/prolonging treatments, and arguments about when the State will not fund particular treatments. An interesting example arose in a case concerning conjoined twins. Separating the twins would result in the immediate death of one twin, but not separating them would lead to the death of both. It was argued that one of the twins was interfering in the right to life of the other.[6]

The State's responsibilities are greater in relation to those who are in its custody, such as prisoners. Patients detained under the MHA or the

Deprivation of Liberty Safeguards of the MCA come under this category. Additionally, the right to life and the obligations it puts on clinicians apply at an enhanced level to psychiatric patients, even those admitted informally (voluntarily). As Lady Hale, one of the judges in the case of Rabone[7] explained, voluntary psychiatric patients who have consented to admission to hospital (such as Ms Rabone) may not be in the same position as physically ill patients who have consented, because the former (a) may have impaired capacity, (b) may be consenting because they fear detention and (c) can be detained under section 5 of the MHA.

**Article 3: Prohibition of torture and inhuman and degrading treatment**

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 3 is an absolute right. A person can argue that their care and/or treatment is incompatible with Article 3 and its protection of fundamental human dignity without having to point to (or be capable of pointing to) any specific ill-effects arising from it. For example, tying an elderly patient to a bed may breach Article 3 even though the patient isn't physically harmed. Equally, neglect of a person that leads to death may be a breach of Article 3 rather than Article 2. The threshold for Article 3 is high. In the case of *Herczegfalvy v Austria*,[8] a patient complained that he had been forcibly administered food and antipsychotics, isolated and attached to a security bed with handcuffs. The European Court of Human Rights held that 'as a general rule a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading'. The medical intervention must, of course, be 'a necessity'. As was pointed out by Lady Hale, the judge in a case from Broadmoor hospital, 'Forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading'.[9]

Furthermore, the UK has breached Article 3, for example in the case of a man taken to a police station under section 136 of the MHA. He was kept in a cell for four days although he was clearly seriously mentally ill: shouting, taking off all his clothes, banging his head on the wall, drinking from the toilet and smearing himself with food and faeces. The European Court of Human Rights said 'Even though there was no intention to humiliate or debase him, the Court finds that the conditions which the applicant was required to endure were an affront to human dignity and reached the threshold of degrading treatment for the purposes of Article 3'.[10]

**Article 5: Right to liberty and security of person**

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
   a. the lawful detention of a person after conviction by a competent court;
   b. the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
   c. the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
   d. the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
   e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants;
   f. the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.
2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
3. Everyone arrested or detained in accordance with the provisions of paragraph 1c. of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.
4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.
5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

Article 5 is central to issues relating to the Deprivation of Liberty Safeguards (DoLS) of the MCA (discussed in Chapter 7) and the MHA. Paragraph 1 (e) of Article 5 allows for 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants'. What is meant by unsound mind and who decides that a person is so suffering? In a pivotal case, *Winterwerp v The Netherlands*,[11] the European Court of Human Rights said:

> 'A person cannot be detained as being of unsound mind unless he or she is reliably shown to be so as demonstrated by objective medical expertise and the nature or degree of his or her mental disorder is such as to justify the deprivation of liberty. The detention ceases to be valid when the relevant mental disorder disappears or ceases to be such as justifies the deprivation of liberty.'

This is important because it means that a detained patient's mental state must be kept under constant review by the clinician responsible for their care and the patient must be discharged from detention under the MHA, or MCA Deprivation of Liberty Safeguards, if they are deemed no longer to be suffering from any mental disorder.

**Article 6: Right to a fair trial**

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.
2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.
3. Everyone charged with a criminal offence has the following minimum rights:
   a. to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;
   b. to have adequate time and facilities for the preparation of his defence;
   c. to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
   d. to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
   e. to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

Article 6 is important not only in relation to civil and criminal cases but also, for example, in tribunals (e.g. disability, employment, mental health), General Medical Council and other professional body hearings, and employment and disciplinary procedures.

**Article 8: Right to respect for private and family life**

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The notion of private life in Article 8 is broad and covers an individual's right to personal autonomy and to physical integrity. Doing anything to a person's body, such as giving a medicine or injection without consent, is a potential Article 8 breach. It is a qualified right. It can be overridden, if necessary, on the grounds given. Consequently, patient confidentiality can be overridden in certain circumstances (e.g. in informing the Driver and Vehicle Licensing Agency about a patient who may be unfit to drive, or informing the police about a patient who may pose a danger to others). In such situations, the patient's consent to release information should always be sought, if possible. Article 8 was used in a case arguing that it was unlawful to ban smoking in hospitals that are effectively patients' homes and that the patients cannot leave (the maximum-security hospitals). The court decided that the exceptions within Article 8 were met and upheld the smoking ban.[12] Seclusion, restraint, strip-searching, access to medical records, family visiting rights, same-sex accommodation and so on are all issues that come within the bounds of Article 8. Indeed, 'even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will'.[13]

**Article 9: Freedom of thought, conscience and religion**

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

**Article 12: Right to marry**

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

**Article 13: Right to an effective remedy**

Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

In relation to Article 13, compensation has, for example, been paid to patients when their Tribunal hearing has been significantly delayed and to the family of a detained patient whose right to life was violated when poor standards enabled her to take her own life.[5]

**Article 14: Prohibition of discrimination**

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Article 14 does not give a free-standing right to non-discrimination but requires the exercise of the other rights to be carried out in a non-discriminatory way. So if there is a distinction between the way people with mental disorder are treated compared with the treatment of those with a physical disorder, the Article might apply.

The UK is also a signatory to other important international conventions, including the United Nations Convention on the Rights of Persons with Disabilities (2008) and the United Nations Convention on the Rights of the Child (1989). Although both conventions have been ratified, neither has been incorporated into UK law.

## Common law

### *Consent to medical treatment – adults*

Clinicians are familiar with seeking and obtaining consent for treatment from patients. If the patient has the capacity to make the required decision(s), then the patient is the legal authority for the clinician to proceed with treatment. The validity of that authority depends on whether the practitioner has established consent within the framework of common law and documented it appropriately. So proper consent to treatment protects both the patient from treatment they do not want and the clinician from liability for wrongdoing. The MHA Code of Practice defines consent as:

> '[the] voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.'[14]

Consent may take different forms. It may be stated or implied but need not be expressly declared or written for it to be legally valid. For example, a patient holding out their arm for a clinician to measure their blood pressure may imply consent to this investigation even if the patient cannot speak.

Understanding the principles that underpin consent by patients who are able to make decisions is essential for understanding the legal framework for those who lack capacity. The case law relating to consent to medical treatment follows two themes. The first is the right of the capacitous patient to refuse treatment and the second is defining the duty of the practitioner to provide appropriate information to help the patient in making the decision.

### The principle of autonomy

Every human being of adult years and sound mind has a right to determine what shall be done with their own body. A clinician who performs an operation or other medical procedure on such a person without their consent is not merely negligent. This is trespass of the person (a tort or civil wrong for which damages may be liable) and an assault (i.e. a criminal act which may lead to a criminal conviction). This, of course, doesn't apply in an emergency if the patient is unable to consent and it is necessary to operate or carry out the procedure before consent can be obtained.

Lord Donaldson, considering a case in which clinicians sought authority to administer a blood transfusion to a patient who had refused a transfusion stated that 'Every adult has the right and capacity [*sic*] to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death […] it matters not whether the reason for the refusal were rational or irrational, unknown or even non-existent'.[15]

In another case, medical staff were required to switch off the patient's ventilator, leading to her death, because she had capacity and refused the treatment. Dame Butler-Sloss used almost identical words to Lord Donaldson, 'A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death'.[16]

In a recent case, the judge, Justice Jackson, could not have made the legal position clearer: 'The freedom to choose for oneself is a part of what it means to be a human being. For this reason, anyone capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. In the absence of consent any invasion of the body will be a criminal assault. The fact that the intervention is well-meaning or therapeutic makes no difference'.[17]

These judgments assert the principle of autonomy. The influence of these cases can be found in the principles of the MCA that recognise an assumption of capacity and the freedom to make unwise decisions. The judges' language is somewhat unhelpful, however, as an irrational refusal of medical treatment may constitute evidence of incapacity. Indeed, the apparently irrational refusal of medical treatment may alert a practitioner to a difficulty with decision-making capacity. This is not to suggest that the principle that people have a right to make unwise decisions is wrong or

that making an unwise decision is synonymous with lack of capacity. The provisions of the MCA and its Code of Practice[2] may provide authority and guidance in these circumstances.

### Providing information to patients

*Bolam v Friern Hospital Management Committee*[18] is a case familiar to most clinicians. The case concerned a patient who suffered a fracture of the hip during electroconvulsive therapy (ECT) conducted without a muscle relaxant or restraint. The standards of practice at issue in Bolam were not only anaesthetic practice and restraint in relation to ECT, but also the information given to the patient before the procedure. In relation to all these issues it was held that the practitioner had not been negligent as his practice had been in accordance with a responsible body of opinion (a legal construct subsequently known as the Bolam test), i.e. a group of clinicians acted in a way that would be thought reasonable practice by a group of their peers. While this test (what would a group of similar professionals do?) remains important, the decision does have to be capable of withstanding logical analysis and the judge is entitled to hold that the body of opinion is not reasonable or responsible.[19]

The responsibility of the clinician is to act in consideration of what information a 'reasonable patient' might expect. If a treatment carries a significant risk that might influence the decision of a reasonable patient, then in the normal course it is the responsibility of the clinician to inform the patient of that risk, so that the patient can determine for themselves whether or not to consent.[20]

The General Medical Council recognises that information-giving and consultation are central to the doctor–patient relationship and that the justification for medical paternalism is diminishing. It has issued detailed guidance for doctors, emphasising partnership between doctors and patients and participation in decisions about treatment.[21] The guidance proposes a basic model for establishing consent that includes the following steps:

- Assessment of the patient's condition.
- An explanation of the condition, the options available, the risks and benefits of each option, and the effect of no intervention, covering:
  - the diagnosis and prognosis
  - any uncertainties about the diagnosis or prognosis, including options for further investigations
  - options for treating or managing the condition, including the option not to treat
  - the purpose of any proposed investigation or treatment and what it will involve
  - the potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if available, about whether the benefits or risks are affected by which organisation or doctor is chosen to provide care

  - whether a proposed investigation or treatment is part of a research programme or is an innovative treatment designed specifically for the patient's benefit
  - the people who will be mainly responsible for and involved in the patient's care, what their roles are, and to what extent students may be involved
  - the patient's right to refuse to take part in teaching or research
  - the patient's right to seek a second opinion
  - any bills the patient will have to pay
  - any conflicts of interest that the clinician, or their organisation, may have
  - any treatments that the clinician believes have greater potential benefit for the patient than those they or their organisation can offer.
- The patient weighs up the options and decides. A capacitous patient may refuse the intervention.
- If the patient chooses investigations or treatment that the clinician believes are inadvisable, the clinician is not obliged to provide them but should explore the reasons for the request, explain their position and consider referring for a second opinion.
- Clinicians need to tailor their decision-making approach to the patient, taking into account:
  - the patient's needs, wishes and priorities
  - their level of knowledge about, and understanding of, their condition
  - their prognosis and the treatment options
  - the nature of their condition
  - the complexity of the treatment
  - the nature and level of risk associated with the investigation or treatment.

***Coercion and consent***

In the case mentioned above (p. 13) of the patient who refused a blood transfusion, it was suggested that the patient's mother, a Jehovah's Witness, had exercised undue influence over her daughter's decision.[15] Lord Donaldson noted that the test in relation to duress is: 'Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?'.[15]

***Common law doctrine of necessity***

For many years this was the authority clinicians used when treating patients who lacked the capacity to make treatment decisions for themselves. The MCA, in sections 5 and 6, has generally replaced the doctrine of necessity as the authority for treating patients who lack capacity. A judge in a case

involving a man with severe autism who was restrained by the police clarified the legal position in the following way: 'For my part I am satisfied that where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application'.[23] For the sake of completeness it is also worth noting that in a different case the judge said 'Part II of the Mental Health Act 1983 provides a comprehensive code for compulsory admission to hospital for non-compliant incapacitated patients such as the Claimant. The common law principle of necessity does not apply in this context'.[24]

So when, if ever, is the common law doctrine of necessity still relevant? One might suggest that it is still applicable when a person who lacks capacity presents a risk solely to others, i.e. when the intervention cannot be said to be in that person's best interests because, under that circumstance, the intervention cannot be under the authority of the MCA.

#### Summary of common law in relation to consent for adults

Practitioners who can demonstrate that they have provided the appropriate information for a patient to make a decision and give consent to an investigation or treatment will not be found liable for trespass. The authority to investigate or treat comes from the patient.

It is worth mentioning that above the age of 18, age itself, in law, does not affect a person's ability to make a decision. It has been suggested that, in practice, older people (like those with disabilities) are sometimes treated as if they do not have mental capacity – solely on the basis of their age. To do so is, of course, wrong.

### *Consent to medical treatment – minors*

The age of majority (that is the age at which the law recognises someone as an adult) has varied markedly over the centuries. It is currently 18 in the UK. This means that until the age of 18, young people (minors) may still be subject to the jurisdiction of the courts. Over the years, legislative and other changes, including European and UK case law, have made the subject of consent relating to minors very much more complex than that relating to adults. Only a brief outline is within the scope of this book.

Overarching all other legal provisions for minors is the Children Act 1989. Its provisions apply to all people under 18. It has been amended several times (most significantly by the Adoption and Children Act 2002, the Children Act 2004 and the Children and Adoption Act 2006), but the 1989 framework remains intact.[25] It established that the welfare of children is of paramount importance. It also introduced the concept of parental responsibility.

The Family Law Reform Act 1969 gave 16- and 17-year-olds the authority to consent to medical treatment:

> 'The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment […] shall be as effective as it would be

> if he were of full age; and where a minor has […] given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.'

However, unlike with adults, the refusal of a competent 16- or 17-year-old could be overridden by either an individual with parental responsibility or a court.[22] This has changed since the introduction of the MCA. As with adults, the law now requires the presumption of capacity for anyone aged 16 and over, and so if a 16- or 17-year-old has capacity, they can consent to or refuse medical treatment. However, a 16- or 17-year-old may be unable to make a decision because 'they are overwhelmed by the decision'[2] or because 'they find themselves in an unfamiliar or novel situation' or they 'find the decision too difficult to make.[14] These young people do not lack capacity within the meaning of the MCA and are not covered by the provisions of the MCA.

If a clinician is considering treatment of a child and needs to obtain consent, they must first assess whether or not the child has capacity. The General Medical Council guidance[26] regarding individuals from birth to 18 years of age states that 'at 16 a young person can be presumed to have the capacity to consent' and 'a young person under 16 may have the capacity to consent, depending on their maturity and ability to understand what is involved' (para. 25).

If it is decided that a child does not have capacity, then consent must be sought from someone with parental responsibility.

### 16- and 17-year-olds who lack capacity

Parental responsibility is the right of a parent (or legal guardian) to consent to treatment if the child doesn't have capacity and the treatment is in their best interests.

A person with parental responsibility is outlined in the Children Act 1989 as:

- the mother
- the father, if he is married to the mother at the time of birth; or (from December 2003) if not married to the mother, the birth was jointly registered with the mother and his name is on the birth certificate; or if he has a parental responsibility agreement with the mother or a parental responsibility order made by the court
- a legally appointed guardian
- a person to whom the court has made a residence order concerning the child
- a designated local authority in a care order for the child (except if the child is 'accommodated' or in 'voluntary care' – section 20 of the Act)
- a local authority or authorised person who holds an emergency protection order in respect of the child.

To further complicate matters, if a 16- or 17-year-old doesn't have capacity to consent to treatment, a person with parental responsibility can make a decision only if it falls within the scope of parental responsibility.

This 'zone' has derived from the European Court of Human Rights case law and is difficult to define. The MHA Code of Practice[14] provides some guidelines, and the Department of Health and National Institute for Mental Health in England[25] recommend that in such cases the following are considered:

- Would the decision usually fall within parental decisions?
- Are there any indications that the parent may not be acting in the best interests of the child?
- Does the parent have the capacity to make the particular decision?

General Medical Council guidance[27] relating to children under 18 years of age advises that they should be involved as much as possible in decision-making even if they are not able to make decisions on their own. It stresses that competence is situation-dependent: 'it is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made'.

It also advises that where children lack capacity to consent, parents can consent for them, but if the parents cannot agree and the dispute cannot be resolved, legal advice should be sought.

### 16- and 17-year-olds who withhold consent

An individual with parental responsibility does not have authority to consent on behalf of a capacitous 16- or 17-year-old who is refusing to do so. Possible options for gaining consent in such circumstances include common law, the MHA and the Court of Protection.

Even though 16-year-olds are presumed to have capacity (be competent) in law to give their own consent to treatment, it is good practice to encourage young people to include their families in decisions unless this is not in their best interests.[23]

It is important that doctors respect a competent child's request to maintain confidentiality unless significant harm may result.

General Medical Council guidance on refusal states that respect for young people's views about their treatment is important and points out that 'Parents cannot override the competent consent of a young person to treatment that you [the doctor] consider is in their best interests', but 'the law on parents overriding young people's competent refusal is complex'.[26] The GMC suggests that legal advice be sought if a competent young person refuses treatment that is considered to be in their best interests. It stresses the potential harm that might be done if the refusal is overridden and notes this must be weighed against the benefits of treatment.

It is important to note that the Court of Protection can overrule the capacitous refusal of a minor, including 16- and 17-year-olds, and authorise medical treatment.[28]

### Children under 16 years of age

The MCA is not applicable to young people under the age of 16 and so the legal provisions for their medical treatment are outside the scope of this book.