IN BRIEF

- The new Mental Capacity Act 2005 came into full force in October 2007.
- Dental practitioners are required to act under the provisions of the new Act and follow its Code of Practice when treating mentally incapacitated adults.
- Dental practitioners who do not comply with the provisions of the new Act may face legal liability.
- Dentists will be required in most cases to make their own capacity assessments and determine when treatment is in a patient's best interests.

The Mental Capacity Act 2005 and its impact on dental practice

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In 1995, the Law Commission was given the task of investigating 'the adequacy of legal and other procedures for decision-making on behalf of mentally incapacitated adults'. It concluded that the law was fragmented and confusing and called for a single statute to govern decision-making on behalf of mentally incapable adults regarding welfare, healthcare and financial matters. There followed a 15 year period of consultation, resulting in the new Mental Capacity Act 2005 which came into full force in October 2007. Dentists who administer treatment to patients suffering from mental incapacity due to dementia, learning disabilities, depression, brain injury and other forms of mental disorder, need to be familiar with the Act and its accompanying Code of Practice. This article looks at how the new Act impacts upon the treatment of incapable patients by dentists, whether they are in general surgery, community or hospital settings. In particular, this article focuses on the provisions of the Act which relate to how and when capacity should be assessed prior to the dentist carrying out treatment and the consequences of a finding of incapacity for both the dentist and the patient in his or her care.

A 28-year-old male patient (Mr Brown) attends your surgery for emergency dental treatment. He is known to you as a nervous patient who dislikes visiting the dentist. On examination a number of teeth appear badly decayed. You decide that he needs to return for some extractions and further restorative treatment. You explain to Mr Brown why treatment is necessary and what needs to be done. He appears to understand and to agree with the suggested course of treatment. You arrange for him to return to the surgery at a later date.

Mr Brown arrives for his next appointment but seems anxious. You explain again the proposed treatment and he reluctantly agrees that it should be carried out. As you prepare to administer a local anaesthetic he cries out and tells you to stop. He decides he does not want to go through with the treatment. You explain that unless the teeth are extracted the risk of serious problems in the future is high. Nevertheless, Mr Brown insists that you stop treating him and he leaves the surgery.

The same day, another 28-year-old man, Mr Gray, attends your surgery for emergency dental treatment, accompanied by his mother. Mr Gray has been diagnosed as suffering from a moderate learning disability and although he is capable of making certain simple decisions for himself, he still needs help with more complex decisions and has some difficulty making himself understood. You are aware that he lives with and is cared for by his mother. Upon examination, Mr Gray, like Mr Brown, has a number of teeth that appear to be badly decayed and that require extraction. You explain to Mr Gray and his mother why the proposed treatment is necessary and what it will entail. They both appear to understand and agree with the suggested course of treatment.

When Mr Gray and his mother return to your practice the following week, you give another full explanation of what you are proposing to do, and again, Mr Gray and his mother seem to understand and agree to the course of treatment suggested.

As you are about to administer a local anaesthetic to Mr Gray, he cries out 'no!' and pulls away and attempts to get up to leave. You explain again why the treatment is necessary and that unless certain teeth are extracted there will be a serious risk of problems in the future. Because of this, Mr Gray's mother is keen for you to

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press ahead with the treatment, although the patient continues to resist and cry out. You spend the next 20 minutes calming the patient down and eventually, with limited restraint, you manage to administer the local anaesthetic, although Mr Gray is still clearly distressed and resisting. The extractions are carried out without further incident and Mr Gray and his mother leave the surgery.

Keen students of law and medicine will be quick to point out that, on the face of it, there was no apparent reason why Mr Brown and Mr Gray should have been treated differently by the dentist in each case. Both patients were adults and both presented with similar symptoms. Both Mr Brown and Mr Gray demonstrated a fear of needles, or dental treatment, or both, and they clearly withdrew their consent at the same point during treatment. However, unlike Mr Brown, Mr Gray was suffering from a mental disorder and was accompanied by his mother as carer, and perhaps, as all too often happens, the presence of his mental disorder and his carer led to incorrect assumptions being made by his dentist about his capacity to refuse treatment. Perhaps too, his dentist mistakenly believed that his mother could lawfully sanction the proposed treatment as a kind of 'proxy decision-maker' and indeed, her son may have believed that this was the case, causing him to comply with her wishes. Or maybe the dentist thought that because Mr Gray had a mental disorder he therefore lacked decision-making capacity and the proposed treatment which was clearly in his 'best interests' could be carried out without his consent and without the need to assess his capacity.

Whatever the reason, or combination of reasons, the above scenarios serve to illustrate a number of legal and ethical issues that can arise when patients with mental disorder receive dental treatment. When dentists get it wrong in these situations and treat capable adults without first assessing capacity and without consent, the consequences can be far reaching for both the patient whose autonomous rights are overridden and also for the treating clinician who may face legal liability.

Of course these issues arise not only in general practice but also more commonly in hospital and community settings. Here people with a range of disabilities and complex additional needs are treated by dental clinicians, many of whom have an interest in or are approved specialists in the emerging field of special care dentistry. It is generally recognised that although the oral health of adults and children has improved over the years, vulnerable groups continue to have poorer oral health and health outcomes from care than the general population.[1] Very often the oral health of these groups is compromised by their primary condition or indirectly through medication or poor access to care. Generalists may feel unwilling or unable to treat certain groups because of the lack of skills, facilities, experience and remuneration available to them.[2] Consequently, and in line with the Department of Health's commitment to ensure equality in healthcare,[3] a range of services for people with special dental needs is developing, including improved training to facilitate clinical decision-making[4] and comprehensive special dental care services which are now available in many parts of the country.[5] Yet in spite of this emerging branch of dentistry and an enhanced focus on the treatment needs of this vulnerable section of our community, the laws that govern how and when we assess capacity and treat the incapacitated[6-8] have not always been accessible to those who need them and have often been misinterpreted or misunderstood.

In 1995, the Law Commission was given the task of investigating 'the adequacy of legal and other procedures for decision-making on behalf of mentally incapacitated adults'.[9] The Commission concluded that there was the need for a more coherent and systematic legal framework; a single statute to govern decision-making on behalf of mentally incapable adults who were not detained compulsorily and thus fell outside the provisions of the Mental Health Act 1983. Two years later Lord Irvine, the then Lord Chancellor, made the following observations about the state of our mental incapacity laws:

'As it currently stands, the law affords little protection either to mentally incapacitated adults, or to those who care for them. The law is confusing and fragmented. Many carers in particular are expected to make decisions on behalf of incapacitated adults without a clear idea as to the legal authority for those decisions... The current law lacks coherence because it has developed piecemeal. It is unsystematic and full of glaring gaps. It has many areas of uncertainty, and fails to offer adequate protection either for mentally incapacitated adults or for the people who look after them. The scale of this problem must not be underestimated. The range of people who are let down by the current law is considerable, and includes adults with learning disabilities; victims of accidents, such as road traffic accident victims who develop brain damage; those who lose capacity as a result of a stroke; and those who lose mental capacity later in life (for example those who suffer from dementia).'[10]

This statement was made during a period of increasing awareness of civil liberties and human rights generally. Reforming the law in this area was seen as an ideal opportunity to reflect the new human rights based era that had been developing internationally over the last 50 years. The modern approach to the care and treatment of the mentally disordered would be reflected in the provisions of any new legislation, according recognition and weight to such things as patient autonomy, maximising the potential of those who lack capacity and intervening in the least restrictive way. So, fuelled by the concerns of treating the mental health needs of a progressively ageing population and government policies that have encouraged an increasing number of incapacitated people to be cared for in the community, the Government pressed ahead with some of its most ambitious proposals to reform the laws surrounding mental health and mental incapacity for nearly half a century.

On 7 April 2005, after 15 years of debate and consultation, the Mental Capacity Bill 2004 received Royal Assent. The new Mental Capacity Act 2005 (MCA),[11] which has application in England and Wales, governs the processes for making decisions about financial, welfare and health matters, on behalf of those adults who lack the capacity to decide for themselves. The majority of the Act applies to those aged 16 years and over (section 2(5)). Under its provisions, capable adults aged 18 years and over will be able to make binding 'advance decisions' refusing certain treatments should they lose capacity at some future date. Similarly, they can delegate decisions about health

and financial matters to a designated person called a donee, under a 'lasting power of attorney', so that person can make decisions in their stead should they lose capacity in later life. In addition to these formal decision-making procedures, the Act also includes provisions governing day-to-day decisions and acts carried out on behalf of incompetent people by lay carers and a range of health and social care professionals. It was predicted the Act would come into full force by October 2007.[12]

Dental practitioners, like all other health professionals who routinely administer treatment to mentally incapable adults or those with declining mental functioning will be governed by the Act and will need to be familiar with its relevant provisions and its Code of Practice.[13] The Code of Practice explains how the Act will operate day-to-day and offers examples of best practice to carers and practitioners. A failure to comply with the provisions of the Act may lead to legal liability and a failure 'to have regard to' the Code may be used as evidence in any subsequent legal proceedings.

The MCA will affect how and when dental practitioners may treat a range of people who suffer incapacity due to dementia, learning disabilities, depression, brain injury and other forms of mental disorder and for whom treatment, welfare and financial decisions need to be made. It seeks to assist those who lack capacity to make their own independent decisions whilst recognising that they may be vulnerable to abuse and require protection.

To this end, the Act begins by setting out five key Principles. These apply as a point of reference or 'benchmark' for those making decisions under the Act.

The Principles listed at section 1 of the Act are:

- A person is presumed capable until proven otherwise
- 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
- Any act done or decision made under the Act (on behalf of a person lacking capacity) must be carried out in his best interests
- When an act or decision is made, thought must be given to whether the same outcome could be achieved in a less restrictive way.

These Principles will be familiar in that they either flow directly from existing common laws or reflect current rules of good practice. Whenever treatment is carried out or a decision is made on an incapable person's behalf, these Principles need to be considered.

To fall within the provisions of the MCA, the patient being treated must lack capacity. As such, decision-making capacity is a pivotal issue; an adult with capacity may reject treatment regardless of the consequences and, with the exception of statutory treatment for mental illness, will have this right upheld in law. Indeed treating a competent adult patient without his valid consent may amount to a civil trespass (a battery) for which the dentist may face legal liability. If capacity is lacking however, then no-one else (relative, spouse, carer) can give or withhold consent on a person's behalf. Instead, treatment may only be carried out under the MCA if the treatment proposed is considered by the treating clinician to be in the person's best interests. As we shall see, only then will the dentist be afforded a defence against a potential trespass claim. How mental capacity is defined and assessed under the Act is therefore of fundamental importance from both an ethical and legal perspective.

Capacity assessment under the MCA

The assessment and determination of a person's mental capacity will always be required prior to treatment being carried out by a dentist or a decision about dental treatment or care being made on a patient's behalf.

It is usually the responsibility of the attending dental practitioner to assess a patient's capacity to consent to a particular treatment. This will be a matter for clinical judgement, guided by professional practice and subject to legal requirements.[14] Under the Act, the clinician should have a *'reasonable belief'* that capacity is lacking before treatment can be lawfully carried out without a patient's consent. 'Reasonable belief' must be based on objective reasons and the decision-maker must have taken reasonable steps to establish capacity is lacking. A professional clinician is expected to have taken a fuller assessment of capacity than a lay carer, reflecting a higher degree of knowledge and experience (See Code of Practice paragraphs 4.44-45).

The assessment of capacity will inevitably involve discussions with those who are directly involved with the care of the patient (such as family members, lay and professional carers), who may be able to shed light on past behaviour, levels of understanding and capacity for decision-making. Healthcare records may also need to be viewed.

Where a treatment decision is complex, where the treatment proposed has long term effects on the person, or if the capacity of a person is in dispute, it may be appropriate to refer a patient to a consultant psychiatrist or psychologist to carry out the capacity assessment with assistance from other therapists (speech, language or occupational therapists for example) and social care professionals, as appropriate. Ultimately though it is the treating dentist who has to determine capacity and the multi-disciplinary team acts solely in an advisory role.

How do you assess capacity under the MCA?

The starting point when assessing a person's capacity to make a particular decision is always the assumption that the individual does have capacity. This is the first guiding principle of the Act at section 1, and reflects the common law position that people aged 16 and over are assumed to be mentally capable of making their own decisions unless shown otherwise.

The Act introduces a broad *diagnostic* threshold to determine whether a person has capacity to make a particular decision, at section 2. The Act identifies that a person lacks capacity where:

'...at the material time, he is unable to make a decision for himself in relation to a matter because of an impairment of or disturbance in the functioning of the mind or brain' (section 2(1)).

'The impairment may be temporary or permanent' (section 2(2)).

At section 3 of the Act, a person is unable to make a decision if he is unable:

- *'To understand the information relevant to the decision*
- *To retain that information*
- *To use or weigh up that information as part of the process of making the decision*
- *To communicate his decision.'*

Relevant information in this context would include information about the foreseeable consequences of deciding one way or another or failing to make a decision.

Practitioners will already be familiar with this 'test' as it is similar to the existing common law capacity test first laid down in the legal case of *Re C* in 1994[15] and later refined in 1997 by the Court of Appeal in *Re MB*[16] where Lady Justice Butler-Sloss stated:

'...a person lacks capacity when some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse treatment...'

Where the patient is:

- *'...unable to comprehend and retain information which is material to the decision, especially the likely consequences of having or not having treatment*
- *'The patient can't use the information and weigh it in the balance as part of the process of arriving at the decision'.*

For dentists who have previously assessed capacity under these common law principles, the new statutory process at sections 2 and 3 may not look very different. However, it is important to remember that when documenting the assessment process, the section of the Act, together with the guiding Principles of the MCA in section 1 will be relevant and regard must also be had to the guidance contained in Chapter 4 of the Code of Practice.

It is suggested that the following should be borne in mind when carrying out the assessment process:

- An adult person is presumed capable unless proven otherwise (Principle section 1(2))
- A capacity assessment should not be based on any preconceptions surrounding a person's age, appearance or behaviour. Just because a person has a mental disorder, has difficulty with speech, has one or more physical disabilities, or is perhaps old and frail, does not mean he or she automatically lacks capacity
- The assessment of capacity should be 'decision specific' so just because a person lacks capacity to make some decisions, this does not mean that he or she lacks capacity in respect of all decisions to be made
- For capacity to be present a person needs only to retain the information about the treatment for a short period of time, but long enough to enable him to make a decision. Patients with Alzheimer's disease for example, may only be able to hold a thought for a brief period, but long enough to enable them to understand and weigh up the treatment information presented. In such cases they will not be found to lack capacity as long as the relevant information is retained for the time it takes for the decision to me made
- Capacity may fluctuate, allowing a person a so-called 'lucid interval' in which certain decisions may be made. The Act makes clear in its second Principle (s1(3)) that everything should be done to enable a person to make an unaided decision, and this would include ensuring that if a person is prone to have lucid intervals then this is when the capacity assessment and the decision-making should preferably take place, if given a choice. Where acts or decisions are of a serious nature, then any decision made when the person has capacity during a lucid interval should be documented and confirmed by medical evidence
- If there are communication or language problems, consider using a speech therapist or interpreter, or consult family members on the best methods of communication
- Be aware of any cultural, ethnic or religious factors which may have a bearing on the person's way of thinking, behaviour or communication
- Consider whether or not a friend or family member should be present to help reduce anxiety. But in some cases the presence of others may be intrusive
- The capacity assessment carried out by the dentist (with advice from a multi-disciplinary team of specialists, as appropriate) should be recorded in the patient's clinical notes.

There is a reminder at section 1(4) that irrational or eccentric decisions made by a patient do not necessarily render that patient incapable – even if the decision is not considered by others to be in the patient's best interests.

In 1993, Lord Donaldson confirmed the common law position in the Court of Appeal case of *Re T* when he said:

'Every adult is presumed to have that capacity, but it is a presumption which can be rebutted ... the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent.'[17]

Thus a treatment refusal that is considered unwise does not necessarily indicate the patient lacks capacity, but it may put the treating dentist on notice that the patient's capacity requires further investigation. After all, many of us take decisions every day that are undoubtedly illogical or unwise and are not in our best interests, yet our capacity to make such decisions is rarely called into question. What drives some people and not others to make particular choices is often bound up in their own personal belief systems, values and social mores, which may run contrary to what society as a whole considers rational or wise.

Equally, the gravity of the decision should be borne in mind when the assessment of capacity is carried out; some decisions requiring a higher level of capacity than others, due to the nature and importance of the decision being made.[18]

When a person's capacity to consent to medical treatment is being assessed and up until the point it is determined, the person being assessed should continue to receive any emergency care which is considered to be necessary and in his or her best interests.

How much and what type of information to give when assessing capacity?

The inability of a person to understand, retain and weigh information is central to the test to determine whether a person is unable to make a decision for himself and therefore lacks capacity under the Act. The way in which information is presented and explained to the patient by the dental practitioner is therefore of the utmost importance and, in cases of borderline capacity, may well tip the balance in favour of a finding of capacity.

When providing information to the person, in line with current good practice,[19] thought must be given to whether the information is presented in an accessible form, whether there is too much information or whether it can be reduced or simplified. The Code tells us at paragraphs 3.7 to 3.9, that all relevant information to the decision must be provided

to allow the person to make a choice. In terms of dental and other forms of medical treatment, this will include specific information about what is involved in the proposed course of treatment, why the treatment is necessary, any alternatives to the treatment, and the consequences of consenting and refusing treatment – ie the risks and benefits.

The Authority to Act on Behalf of an Incapacitated Person (section 5)

Only when the dental practitioner has:

5(1) (a) *'taken reasonable steps to establish that the person lacks capacity in relation to the matter in question'*

and

5(1) (b) *'reasonably believes that the person lacks capacity and it is in the best interests of that person for the act to be done'*

will they be afforded the protection of section 5.

Section 5 enables health carers who perform acts in relation to the treatment and care of a person and who follow the requirements of the MCA, to be protected from liability for committing such acts without consent, in the same way the common law doctrine of necessity has afforded protection in the past.[20] The Act does not however provide a defence to negligent acts and a dentist who performs a procedure negligently can still be sued in the tort of negligence.

Section 5 is one of the most important provisions in the Mental Capacity Act 2005 in the context of medical treatment and healthcare due to the protection it affords. It is important to note that only *reasonable belief* is needed after *reasonable steps* have been carried out and, if it later transpires that capacity is present and best interests were determined incorrectly, this will not affect the protection afforded to the treating dentist under section 5 of the Act.

So before any act is carried out, the dental practitioner must have first carried out all practical steps to assess capacity under sections 2 and 3 and have acted in accordance with the guiding principles of the Act. Once reasonable grounds are established for believing that a patient lacks capacity, then the dentist must determine whether the proposed act is in the person's best interests. This will fall to a consideration of the guiding provisions of the Act and the best interests checklist at section 4.

The Best Interests checklist (section 4)

There is no specific definition or criteria of what is in a person's best interest under the Act. Instead the Act gives assistance to clinicians by providing an open-ended statutory checklist at section 4.

As with section 5, section 4 is an important section for practitioners in that it provides protection for treating clinicians who carry out procedures in the 'reasonable belief' that they are acting in the best interests of the patient. The protection is gained by the compliance with the best interests checklist. So even if a challenge is subsequently made in the courts and there is a later judicial finding that the treatment is not in the patient's best interests, protection will be given so long as the dentist had a 'reasonable belief' and has evidence that he or she has followed the statutory steps. Compare this with the previous common law position that suggested protection would only be afforded if best interests were correctly determined, then this is an altogether softer approach. Nevertheless, it highlights the importance of detailed record keeping, as thorough and well-documented notes will evidence that the dentist has acted lawfully if faced with any future legal challenge.

As with the assessment of capacity, best interests and the availability of treatment must not be determined merely on the basis of a person's appearance, age or behaviour.

The dentist should:

- *Consider whether the person is likely to regain capacity in the future and if so, when* (see section 4(3))
- *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* (see section 4(4))
- *Consider, as far as reasonably ascertainable the past and present wishes and feelings, beliefs and values and other factors.* It is worth noting that this, by definition, will include the patient's incompetent wishes. So, if a patient clearly finds a treatment traumatising and is refusing the proposed treatment – this should be taken into account
- *Take into account and if appropriate and practicable consult the following for their views on the treatment proposed:*
  - *Anyone named by the person as person to be consulted*
  - *Any carer or person interested in their welfare.* It is important however that the treating dentist is not influenced by the personal wishes of family, friends and carers and that it is the best interests of the incapable patient that is in question and not those of the family or carer (Code of Practice para. 4.49)
  - *Any donee of a lasting power of attorney*
  - *Any court 'deputy' appointed by the Court of* Protection to make person welfare decisions on behalf of the incapable patient
  - *Any Independent Mental Capacity Advocate (IMCA) if applicable.* So where serious treatment (as defined by The Mental Health Act 2005 (independent Mental Capacity Advocates) (General) Regulations 2006)[21] is to be carried out on a person who lacks capacity by an NHS body and it is satisfied that there is no person other than the paid carer treating the person in a professional capacity to determine what would be in his/her best interests, then the NHS body has a duty to appoint an IMCA and 'take into account any submissions made' by the advocate.[22] The IMCA Service came into effect on 1 April 2007 and now all staff at NHS hospitals (including dentists) are under a statutory duty to instruct an IMCA when an incapable patient meets the eligibility criteria.

This is not a finite list of factors and it is important for the treating clinician to consider *all* relevant circumstances of which s/he is aware or which would be reasonable to regard as relevant when determining best interests, not just those listed in section 4. It is envisaged that the approach taken – although more prescriptive and robust than the previous common law guidance - will not significantly alter current practice as much of section 4 simply replicates current good practice which has been adopted by clinicians in the past. Clearly the dentist will need to alter the recording process to reflect the new statutory requirements, and to ensure that s/he has considered or complied with the section 4 criteria in order to prove s/he has acted lawfully should any later challenge arise.

The section 4 factors seek to achieve a delicate balance between objective best interests and autonomous rights. For practitioners this may lead to difficulties in knowing how to weight or prioritise the various objective and subjective criteria. It would seem that this will depend largely upon the circumstances of the patient and the importance or severity of the decision to be taken or act to be carried out. For example, if an incompetent patient has previously made a competent objection to the proposed treatment, this would, presumably, be an important subjective factor in any final best interests determination compared with a person who has never had capacity, and who makes an incompetent refusal of treatment where a more objective approach would be adopted.[23]

The Court of Protection

Historically, where major healthcare decisions taken on behalf of incapable adults involve, for example, withdrawal of life-sustaining treatment from PVS patients, invasive surgery with irreversible effects such as non-therapeutic sterilisation or organ donation, there has been a clear precedent for such cases to be referred to the High Court for a declaration as to their lawfulness prior to treatment being carried out. The High Court also had jurisdiction to make declarations as to the lawfulness of any proposed treatment and to declare whether an individual had capacity when disputes arose between carers and clinicians. Under the MCA, a new 'Court of Protection' will take on this role and have extended jurisdiction to provide directions and determinations relating to best interests and capacity in complex cases and when disputes arise. Given that most routine dental care is uncontroversial by nature, it is envisaged that applications to the Court of Protection would be rare, although there may be occasions when disputes arise between the treating dental clinician and carer, or a donee acting under a lasting power of attorney or IMCA, as to whether the capacity exists and whether treatment is in an incapable person's best interests. Similarly, there may be genuine doubt or disagreement about an advance decision refusing certain procedures (such as the refusal of anaesthesia or blood products) which may have an effect on dental treatment and the Court's intervention may be necessary. However, for most minor interventions it would be extremely cumbersome for the Court to become involved and such decisions are usually made by the treating dentist on a 'best interests' basis with disputes being resolved through informal channels. The Code of Practice gives guidance on how to resolve disputes that arise at Chapter 15.

Physical intervention/restraint

If restraint is necessary in order to carry out dental treatment in an incapable patient's best interests under the Act, section 6 states that the defence afforded by section 5 will *only* apply if the person treating the patient believes that the restraint is *necessary* to prevent harm to the incapacitated person in their care, and (2) the restraint *is proportionate* to the likelihood and seriousness of harm.

So any restraint or force used must not exceed what is necessary in order that the proposed procedure is carried out and must be weighed against any potential mental or physical harm to the patient brought on by the use of restraint.[24] For example, where it is possible to use moderate intervention such as physically restraining someone's hands or by orally administering anti-anxiety medication or sedatives, this may obviate the need for a general anaesthesia in certain circumstances.

CONCLUSION

By bringing the various common law strands together under one statute and by providing one single point of reference for practitioners, with a detailed Code of Practice to aid interpretation it is hoped that the Mental Capacity Act 2005 will alleviate many of the past difficulties practitioners have had with interpreting and applying the laws in this area. Indeed, had our treating dentist been familiar with the provisions of the Mental Capacity Act, the outcome for Mr Gray in our initial scenario may have been very different. On assessment, Mr Gray may have been found to possess decision-making capacity in spite of his mental disorder, his autonomous rights would not have been overridden and like Mr Brown he could have refused the treatment proposed should he have so wished, regardless of the consequences.

Equally, the dentist may have determined that Mr Gray lacked capacity, so allowing lawful treatment to be given without consent if the dentist had a 'reasonable belief' that capacity was lacking and the treatment proposed was in the patient's best interests. The treating dentist would need to refer to the section 4 best interests checklist and relevant guidance contained in the Code of Practice and would need to carefully record the steps taken during the assessment process. It would also be good practice to consult with Mr Gray's mother to determine whether her son had reacted similarly to medical or dental intervention in the past and if so, whether any alternative forms of treatment should be considered. Although consultation with Mrs Grey would give a useful insight into her son's level of understanding and past treatment preferences, her own personal wishes would certainly not rule the day and the ultimate decision to proceed with the proposed treatment would rest with the treating dentist.

So what is apparent is that legislating for change is not effective unless accompanied by effective training and education and dental clinicians, whether they are specialists in the field of special care dentistry or whether they are in general dental practice, will need to familiarise themselves with the Act and the Code. Only then will we hope to begin to see patients like Mr Gray afforded the legal rights and protection they are entitled to under the law.

1. Fiske J, Griffiths J, Jamieson R *et al.* Guidelines for oral health care for long stay patients and residents. *Gerodontology* 1999; **16:** 204-209.
2. Fiske J, McGeoch R J, Savidge G F, Smith M P. The treatment needs of adults with bleeding disorders. *J Disability Oral Health* 2002; **3/2:** 59-61.
3. Tackling health inequalities, a programme for action, 2003. London: Department of Health Publications, 2003.
4. Joint Advisory Committee for Special Care Dentistry. *Training in special care dentistry.* London: JACSCD.
5. BSDH Commissioning Tool for Special Care Dentistry. BSDH, 2007. Available at www.bsdh.org.uk.
6. Henwood S, Wilson M A, Edwards I. The role of competence and capacity in relation to consent to treatment in adults. *Br Dent J* 2006; **200:** 18-21.
7. Bridgman A M, Wilson M A. The treatment of adult patients with mental disability. Part 1: consent and duty. *Br Dent J* 2000; **189:** 66-68.
8. Bridgman A M, Wilson M A. The treatment of adult patients with mental disability. Part 2: assessment of competence. *Br Dent J* 2000: **189:** 143-146.
9. Law Commission Report no. 231. Mental incapacity. 1995. Available at www.lawcom.gov.uk.
10. The Lord Chancellor, Lord Irvine of Lairg, Statement to the House of Lords, 10 December 1997. Available at www.dca.gov.uk.
11. Mental Capacity Act 1995. London: The Stationary Office. Available at http://www.opsi.gov.uk/acts/acts2005/20050009.htm.
12. Written Ministerial Statement on the implementation timetable for the Mental Capacity Act:

December 2006, Department of Constitutional Affairs. Available at www.dca.gov.uk.
13. Mental Capacity Act 2005, Code of Practice, 2007. London: The Stationary Office.
14. *Assessment of mental capacity, guidance for doctors and lawyers*, 2nd ed. UK: BMJ Publishing, 2004.
15. Re C (Adult Refusal of Medical Treatment) (1994) 1 All ER 819 per Thorpe J at 824.
16. Re MB (medical treatment) (1997) Med LR 217 per Butler-Sloss LJ at 224.
17. Re T (Adult Refusal of Treatment) (1992) 4 All ER 649.
18. Re MB (medical treatment) (1997) Med LR 217.
19. Department of Health Publications. Good practice in consent implementation guide: consent to examination or treatment, 2001. Seeking Patients Consent: The Ethical Guidelines. GMC, 1998.
20. F v West Berkshire HA and another (1998) 2 All ER 545.
21. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations, SI 2006/1832. London: The Stationary Office.
22. Lee S. *Making decisions: the Independent Mental Capacity Advocate (IMCA) Service. Helping people who are unable to make some decisions for themselves.* London: The Stationary Office, 2007.
23. Bartlett, Sandland. *Mental health law policy and practice*, 3rd ed. p 553. Oxford: OUP, 2007.
24. Nunn J, Greening S, Wilson K *et al.* Principles on intervention for people unable to comply with routine dental care - a policy document, April 2004. British Society for Disability and Oral Health.