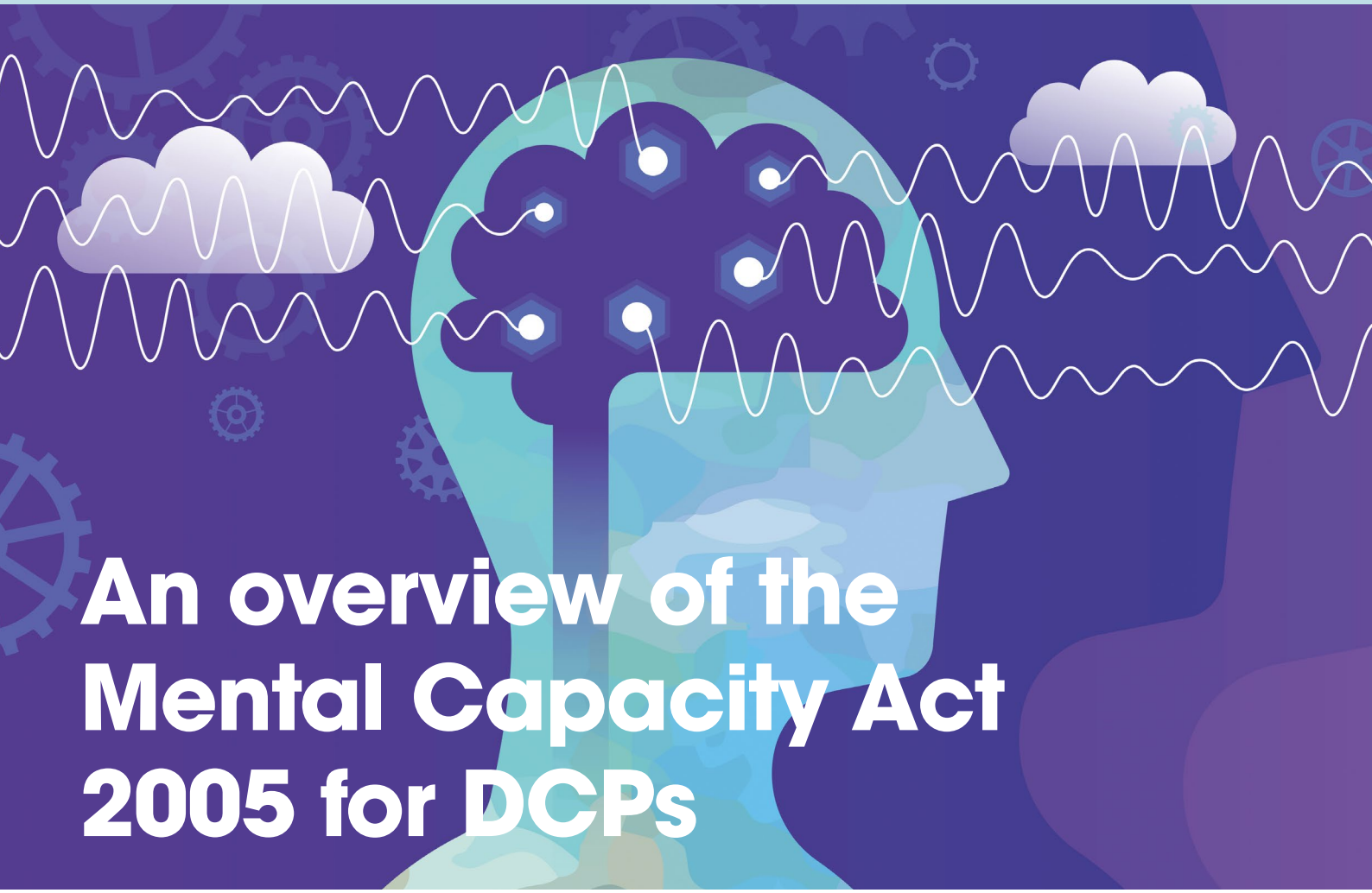

An overview of the Mental Capacity Act 2005 for DCPs

By **Rana Fard**[1] and **Keerut Oberai**[2]

Introduction

Since the Nuremberg trials concluded in 1946, consent and promoting individual autonomy have been the cornerstones of medical and indeed dental ethics. Informed consent has three elements. It must be informed, voluntary and the patient must have capacity. This article will focus on this final condition – capacity. This is an increasingly relevant topic within the UK, with the number of those who lack capacity set to rise dramatically over the next three decades due to an increasingly ageing population.[1] For example, the number of those living with dementia is set to rise from the current figure of 850,000 to 1.6 million by 2040.[2]

Cases in which a patient lacks capacity can provide a real challenge to dental care professionals (DCPs). For such instances, the Mental Capacity Act (MCA) 2005 was introduced to make it clear how to assess whether a patient has capacity and what steps to take if they do not. The MCA's role is 'to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment'.[3]

Despite its importance, a House of Lords Select Committee on the MCA 2005 found that the 'empowering ethos of the Act has not been widely implemented'.[4] Furthermore, they found that there was a tendency for clinicians to adopt paternalistic and protectionist attitudes in contrast to the Act's goal to promote individual autonomy. The aim of this article is to highlight the key aspects of implementing the Act and to survey relevant case law. In doing so, it is hoped that DCPs will feel more confident in practice when dealing with cases where a patient lacks capacity.

Defining incapacity

The MCA 2005 is based on five core principles. The first principle states that we must assume that all patients have capacity until proven otherwise. To implement this in practice we need to have a clear understanding of what is meant by the term 'capacity'.

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There are two ways to determine whether a patient has capacity:

1. **Status approach:** some individuals will lack capacity due to their status, for example, being below a certain age, regardless of their ability to make a decision
2. **Functional approach:** this focuses on the individual's decision-making capability and does not consider factors such as age.

In the UK, we have a combination of both the functional and status approaches. The MCA 2005 therefore presumes that those over the age of 16 have capacity unless it is proven that they lack the capability to make a decision for themselves.

The Two Stage mental capacity test

The presumption of capacity may be revoked if the patient fails the two-stage mental capacity test set out in Section 2 of the MCA.

Diagnostic test

The first stage of this test, known as the diagnostic test, states that a person lacks capacity 'if at the material time [they are] unable to make a decision for [themselves]' due to 'an impairment of, or disturbance in the functioning of, the mind or brain'.[5] This may be temporary or permanent. The MCA Code of Practice provides examples of what are considered 'impairments or disturbances of the mind or brain' such as dementia, significant learning disabilities and the long-term effects of brain damage.

Functional test

Once the diagnostic test has been carried out, the second limb of the test, known as the functional test, looks at whether the patient has the capacity to make a decision. Crucially, we are just trying to determine whether a patient can make a particular decision (for example about their treatment) at the time of asking.

The Functional test states that a patient cannot make a decision for themselves if they are unable:

a. to understand the information relevant to the decision
b. to retain that information
c. to use or weigh that information as part of the process of making the decision, or
d. to communicate [their] decision (whether by talking, using sign language or any other means).[6]

If a patient fails an aspect of the functional test, then they are deemed to lack capacity. In such cases, we must document specifically which aspect of the test the patient has failed. In addition, it must also be noted what steps have been taken to help the patient make their own decision and how capacity has been assessed by the clinician.

It is vitally important to help and support the patient to make their own decision as much as is practicable. In doing so we implement the second principle of the MCA 2005. This states that a patient should not be treated as lacking capacity 'unless all practicable steps to help [them] do so have been taken without success'.[7] To help patients make decisions for themselves, DCPs must ensure that all the information relevant to the decision is communicated and that this is done in a way that the patient can understand.

This may involve unconventional methods of communication such as using pictures to explain a procedure. The patient should also be made to feel at ease. For example, there may be a certain time of day when they are better able to understand the information provided or specific locations in which they feel more comfortable. Finally, it is worth considering whether someone can help support this process or help the patient communicate effectively with the dental team. This is set out further in the Mental Capacity Act 2005 Code of Practice Chapter 3 (the authors also recommend this as an invaluable resource in understanding the MCA 2005).[8]

The ability to make an unwise decision

The third principle of the MCA 2005 is that a patient must not be treated as lacking capacity 'merely because [they make] an unwise decision'.[9] In other words, even if we disagree with their decision or think that it is not in their best interests, we must still respect it so long as the patient has capacity. This essentially cements in statute the functional test which claims that so long as the conditions set out are met, the patient's wishes should be respected.

An example of this in case law is that of *Re C,* in which a 68-year-old patient with paranoid schizophrenia refused a leg amputation, despite the 15% chance of survival without it, on the grounds that he could not imagine living with only one leg. In this case, Thorpe J ruled that C had capacity despite his delusions that he was a world-renowned doctor. He claimed that he 'understood the relevant information,

'To help patients make decisions, DCPs must ensure that all the information relevant to the decision is communicated and that this is done in a way that the patient can understand.'

that in his own way he believes it, and that in some fashion he has arrived at a clear choice'.[10] Therefore, whilst C did have a mental illness, he still had capacity to make decisions regarding histreatment for himself in accordance with the functional test.

The learning points from *Re C* were echoed in the case of *King's College London NHS Foundation v C*. The Court ruled that C did not lack capacity and that their decision ought to be respected even if it was 'illogical or even immoral'.[11] Again, this case highlighted that even if a patient's decision regarding treatment appears unwise or contradicts best practice it must be respected so long as they have capacity.

Best interest decisions

Section 5 of the Act states that a clinician must have a reasonable belief that a patient lacks capacity. In accordance with the MCA 2005 the clinician must take 'reasonable steps' to help them establish this. In addition, they must 'reasonably believe' that the patient lacks capacity, in which case a decision can then be made in their best interests.

In the past, best interest decisions were determined by what the clinician thought was the most appropriate course of treatment for the patient. This paternalistic approach has been replaced by a system which places autonomy and the patient's own interests at the heart of the decision. The MCA 2005, in Section 4, sets out a list of factors which ought to be considered when making a best interest decision on behalf of a patient who lacks capacity. These include encouraging the patient to participate in the process as much as is practicable and considering the patient's 'past and present wishes and feelings' as well as 'other factors that [they] would be likely to consider'.[12]

In the case of *Aintree University Hospitals Foundation Trust v James*, Lady Hale emphasised that best interest decisions ought to be patient centred. Moreover, she added that 'decision-makers must look at [Mr James'] welfare in the widest sense, not just medical but social and psychological'.[13] In keeping with this when making best interest decisions on behalf of a patient we should not only consider their dental or medical best interests but also look at other factors which the patient would consider important and factor into the decision if they had capacity.

It is also important in accordance with Section 4 of the MCA 2005 to consider the patient's current wishes and engage them in the decision-making process. Whilst the eventual treatment decision may not be in accordance with the patient's present views, allowing them to take part in the process helps promote their Article 8 rights to autonomy. This was the view of Peter Jackson J in the case of *Wye Valley NHS Trust v B*, in which he stated, 'where a patient lacks capacity it is accordingly of great importance to give proper weight to [their] wishes and feelings and to [their] beliefs and values'.[14]

The difficulty clinicians and the courts face is knowing how much weight to give to the patient's current wishes and feelings which often conflict with their past wishes and their medical or dental best interests. NICE guidelines on decision making and mental capacity try to help navigate this issue. They advised that when a best interest decision is made in contrast to the patient's current wishes and beliefs that these must be 'clearly documented and an explanation given'.[15] It must also include what steps were taken to ascertain the views of the patient and how they were supported in expressing them.

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Best interest meetings

DCPs will often be required to make best interests decisions on behalf of a patient regarding dental treatment. In these cases, it is advised to convene a best interest meeting. This may involve other members of the patient's dental team, medical team or even their friends and family. The purpose of this meeting is to implement Section 4 of the MCA 2005 by considering what is the best course of action, in terms of treatment, for the patient. As discussed, this will involve considering the patient's past and present wishes and beliefs as well as other factors which they would consider important. It will also involve the patient and trying to ascertain their viewpoint as much as is practicable.

The patient may also have someone who has the authority to make decisions on their behalf. In most cases this will be in the form of a Lasting Power of Attorney (LPA). However, it is important to note that there are two forms of LPAs – a health and welfare LPA and a property and affairs LPA. It is only a health and welfare LPA who can make decisions on behalf of a patient although it may be wise to include the property and affairs LPA in the best interest meeting.

If the patient does not have anyone who can represent their wishes and beliefs at a best interest meeting, an Independent Mental Capacity Advocate (IMCA) may be appointed.

The role of the IMCA is to:

- Support the patient and help them to participate in the best interest process
- Find out what their wishes and feelings are
- Understand what the patient would likely consider important in the decision-making process if they had capacity
- Understand what the alternative treatment options are
- Decide whether the patient would benefit from a second opinion.

Finally, when considering what is in the patient's best interest, we must also consider the final principle of the MCA 2005. This states that the decision made must be the one which is least restrictive of the patient's rights and freedoms. For example, if a patient who lacks capacity attends in pain, a DCP should carry out the least invasive treatment at that initial appointment.

The whole process of the mental capacity test is summarised in Figure 1.

Conclusion

The MCA 2005 was introduced to promote the autonomy of patients who lack the capacity to make their own decisions. This contrasts with the previously paternalistic measures that were in place in the past. The Act highlights that it is important to ascertain whether a patient lacks capacity and to support them as much as possible in making their own decisions. In cases where patients lack capacity, DCPs must document the steps taken to assess capacity and which aspect of the two-stage mental capacity test the patient has failed. Following this a decision should be made on behalf of the patient in their best interests following the guidance set out in Section 4 of the MCA 2005 and in a manner

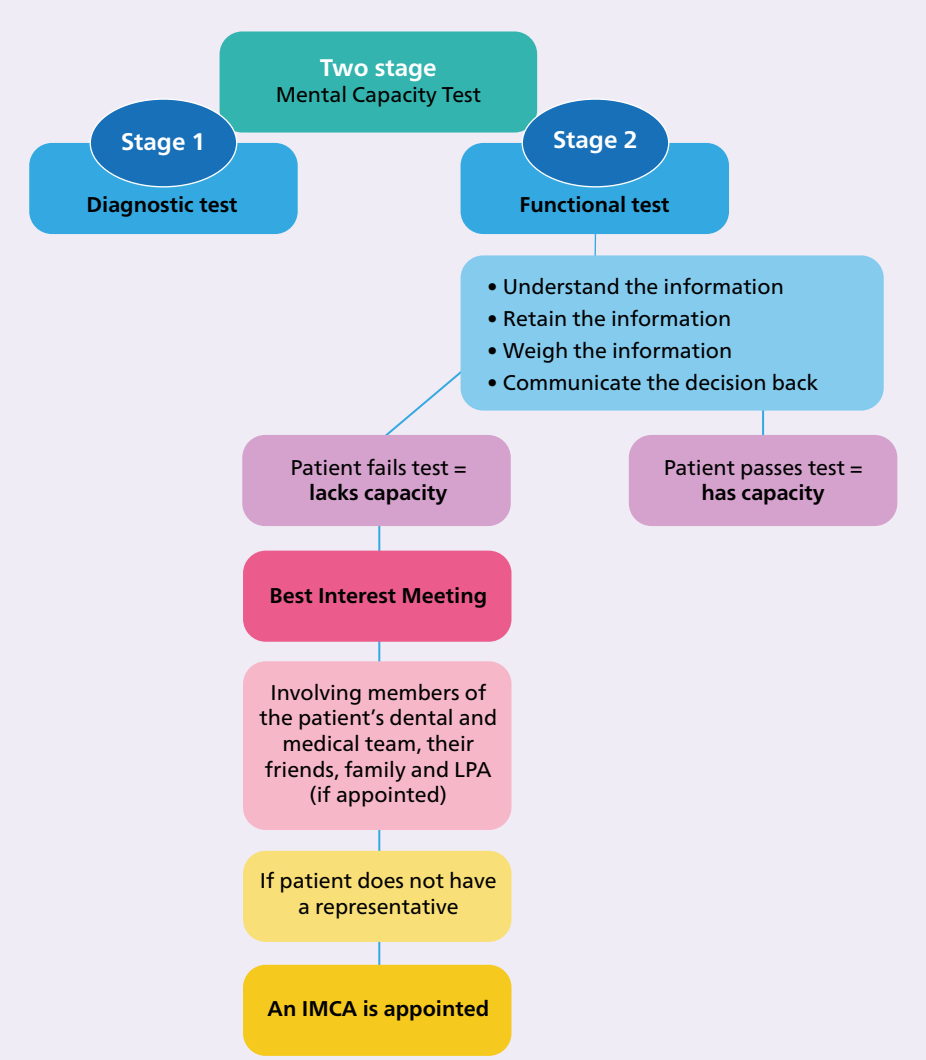

Fig. 1 Two Stage Mental Capacity Test flow chart

'Dental care professionals will often be required to make best interests decisions on behalf of a patient regarding dental treatment.'

which is least restrictive of the patient's rights and freedoms.

It is of course challenging to deal with cases where a patient lacks capacity. It is advised that DCPs have good knowledge of the MCA 2005 to help them manage such cases confidently and competently. Furthermore, support and help can be gained from senior colleagues and indemnity providers. With an increased number of patients likely to be lacking in capacity as set out at the outset of this article this is an even more important topic to be aware of.

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