

which can help to negotiate this particular minefield: the danger is that the child's needs may be subordinated to the parent's. Organisations for young carers may be very helpful in this circumstance.

The papers by Cahill and Papageorgiou set the skills of triadic consultation in a scientific context, but it is still an art that has to be learned, and which should be more actively taught from the first year of medical school and throughout any medical career that involves seeing children.

#### Quentin Spender

DCH, MRCP, MRCPsych, FRCPC  
Consultant in Child and Adolescent Psychiatry,  
Wolverhampton Primary Care Trust, and  
member of 'Child in Mind' Project Team, Royal  
College of Paediatrics and Child Health.

#### REFERENCES

1. Healthcare Commission. *Patient Survey Report 2004 — young patients*. Healthcare Commission, 2004. [http://www.healthcarecommission.org.uk/\\_db/\\_documents/04008715.pdf](http://www.healthcarecommission.org.uk/_db/_documents/04008715.pdf) (accessed 9 Oct 2007).
2. Garralda ME, Bailey D. Psychosomatic aspects of children's consultations in primary care. *Eur Arch Psychiatry Neurol Sci* 1987; **236**(5): 319–322.
3. Crossley J, Eiser C, Davies HA. Children and their parents assessing the doctor-patient interaction: a rating system for doctors' communication skills. *Med Educ* 2005; **39**(8): 820–828.
4. Blake K, Vincent N, Wakefield S, et al. A structured communication adolescent guide (SCAG): assessment of reliability and validity. *Med Educ* 2005; **39**(5): 482–491.
5. Eminson D. *Children's consultations in primary care: teaching package development*. The Research Findings Register, 2001. Summary number 598.
6. Howells RJ, Davies HA, Silverman JD. Teaching and learning consultation skills for paediatric practice. *Arch Dis Child* 2006; **91**(4): 367–370.
7. Cahill P, Papageorgiou A. Triadic communication in the primary care paediatric consultation: a review of the literature. *Br J Gen Pract* 2007; **57**(544): 904–911.
8. Cahill P, Papageorgiou A. Video analysis of communication in paediatric consultations in primary care. *Br J Gen Pract* 2007; **57**(544): 866–871.
9. Crossley G, Davies HA. Doctors' consultations with children and their parents: a model of competencies, outcomes and confounding influences. *Med Educ* 2005; **39**(8): 807–819.
10. General Medical Council. *0–18 years: guidance for all doctors*. Manchester: General Medical Council, 2007.

#### ADDRESS FOR CORRESPONDENCE

#### Dr Quentin Spender

Wolverhampton Primary Care Trust,  
The Gem Centre, WV11 1UP.  
E-mail: [quentin.spender@btinternet.com](mailto:quentin.spender@btinternet.com)

## Capacity an Act in force — at last

As the playing field of knowledge between doctor and patient has become more level over the last 100 years, the law's respect for the autonomy of the patient has increased all over the Western world. Buttressed by medical views that patients exercising their autonomy tend to do better, the public have been encouraged to have less faith in the notion that the doctor knows best or that the contents of medication should remain obscure.

In England and Wales, and probably Scotland as well, as a result of the ruling in *Chester vs Afshar*, it is now the law that where a patient is not warned of a risk that should have been mentioned to a patient preoperatively, the surgeon will become the insurer of that risk because the law pretends that it is the failure to mention the hazard that has caused the damage. This legal fiction is there to enforce the autonomy of the patient, even if they would have gone ahead with the operation in any event if the risk had been mentioned. This is a rule that has been fashioned for doctors alone, as we now know it does not apply to barristers, independent financial advisers, or estate agents. Whether it applies also to GPs who prescribe medicines and fail to mention those risks that should have been

mentioned remains to be seen.

In this brave but lonely new world in which we all approach our doctors to exercise our autonomy rather than to be treated for our ailments, there is an awkward anomalous group: the patients who lack capacity to make decisions for themselves. They cannot, by definition, exercise their autonomy. Someone else has to do it for them and the question is who and by what rules.

For this group, 1 October 2007 is a historic day in England and Wales for the Mental Capacity Act 2005 (MCA) comes into force, having given us 2 years to get used to the idea. Many of the provisions are familiar, codifying what has been agreed to be the common law or best practice over the last 10 years. However, there are also some radical new features.

Detailed guidance as to the MCA's provisions is available in several forms. A Code of Practice (which is available at [www.dca.gov.uk/menincap/legis.htm](http://www.dca.gov.uk/menincap/legis.htm)) has been issued by the government. My firm has prepared a more detailed guideline to the law on Consent to Treatment in the light of the new Act which is available to download from [www.hempsons.co.uk](http://www.hempsons.co.uk).

The first crucial point is that every adult

is assumed to be capable until that assumption is displaced. The incapable person is someone who cannot make a decision for themselves because he or she is unable to understand the information relevant to the decision, to retain that information, to weigh the information, and/or to communicate the decision by reason of an impairment or disturbance in the functioning of the mind. Any of these will displace the assumption of capacity. However, the fact that someone wishes to make a decision which is plainly, in the view of their doctor, unwise is not evidence of a lack of capacity. Every person has the right to refuse treatment for good reason, bad reason, or no reason.

GPs manage the care of increasingly large numbers of patients often living at home or in shared accommodation and who, in many cases, would not be found by a court to have capacity to consent to treatment. In the future, as in the past, GPs may be able to trade upon the general assumption of capacity. However, if things go awry and patients suffer complications of treatment wherein it is found that they have not given their informed consent, the doctor is being placed in an increasingly uncomfortable position. Where the patient

has no capacity to consent a course of treatment with medication, under the ruling in *Chester vs Afshar*, their passive assent will be invalid.

Where a person lacks capacity to make a decision, it remains the case that the doctor is entitled to treat the patient on the basis of what is in the patient's best interests. However, what is new under Section 4 of the Act is a list of things that a doctor must consider in this situation. Obviously, the doctor must consider the relevant circumstances but these are now defined.

- You should consider whether your patient will regain capacity and, if so, when. This will be particularly relevant to patients who may have more capacity at one time of the day rather than another, or whose condition fluctuates for some other reason. A GP who visits a home in the afternoon after surgery may have to consider whether the patients lack the capacity they would have in the morning to decide whether to accept advice.
- You should also enable the person to participate as far as possible in decisions concerning them, and there may be circumstances in which patients will have capacity to make their own decision if enough time and care is taken to enable them to do so.
- You must also consider the person's wishes, feelings, beliefs, and values. This has not been spelled out before, but suppose we have a patient with a fractured neck of femur whose niece refuses to agree to it being fixed surgically when the orthopods can plainly see that it is in the patient's best interests medically, because without surgery, the prognosis is grim. Before the MCA we would advise the surgeon that to consult the relative as a matter of good practice, but ultimately the surgeon had to act in the best interests of the patient as seen by the surgeon. However, now we advise doctors to find out why the niece is objecting, to talk to her more carefully. If it turns out that the niece knows that the patient has refused surgery when the doctors thought it was overwhelmingly indicated on other occasions earlier in

the patient's life; and that the niece is opposing the operation because she is confident that the patient would refuse if she could speak for herself, then our whole view of the case is altered and we advise against going ahead.

- Next you have a statutory obligation to consider any other factors that the patient would take into account if the patient were able to do so. I am not sure what that means: the government's Code of Practice provides a series of suggestions, such as the effect of the decision on others.
- Finally, you have an obligation to take account, if you think appropriate, of the views of anyone that the patient has said should be consulted on the matter, or anyone providing care to the person or interested in the patient's welfare, or any Attorney appointed under a Lasting Power of Attorney and any Deputy appointed by the Court of Protection who have a statutory power to make a binding decision.

We have had Enduring Powers of Attorney for 30 years. These enable competent people to empower other people to deal with their business affairs and endure after they have lost capacity. They are short, one page statutory forms. Lasting Powers of Attorney, which have been introduced, are quite different. These authorise other people to act in a wide range of matters, including consenting to medical decisions. They may well be extremely useful in these circumstances. Unfortunately, they are going to be much longer and far more expensive to prepare than Enduring Powers.

So, as a result of the Act, the doctor looking after the incapable patient owes them exactly the same duty to act in their best interests as was owed before 1 October 2007. Fortunately or otherwise, there is now a coded series of steps that have to be taken.

Before the Act we were certainly advising doctors to take account of all of the circumstances that were known when we were consulted. We were also aware that most GPs were being confronted on a

daily basis with a need to treat patients whose capacity to make decisions was in doubt and who did not trouble their lawyers. Despite the statutory assumption of capacity, we are now advising doctors that they have a duty to consider whether the patient has capacity when they are embarking on many courses of treatment far removed from the operating theatre.

When patients encounter complications of therapy, we do envisage that claims will be made on their behalf to the effect that they did not have capacity to give consent to the treatment. If it is found that they did not and that any reasonable doctor would have recognised that the statutory assumption was displaced, then the doctors will need to demonstrate that they have considered the factors defined in Section 4 of the Act. A rough and ready assertion that: 'I thought the medication was in her best interests because it was clinically indicated', will no longer be enough. It is true that a doctor who had a reasonable belief that a patient had capacity will be covered by Section 5(1), but in many cases that will be scant protection.

The MCA marks a further stage in the formalisation of medicine. An increasing number of decisions that used to be made intuitively are now made according to protocols and guidelines, usually based on an authority claimed to emanate from the best evidence of nature. Here we see a protocol based on an appeal to the authority of the law. In many cases practitioners will find it of assistance to see the way in which things should be done set down in black and white; however, it is important to appreciate that it is there whether they find it helpful or not.

#### **Bertie Leigh**

*Senior partner of Hempsons, solicitors specialising in medical law.*

#### **ADDRESS FOR CORRESPONDENCE**

#### **Bertie Leigh**

*Hempsons House, 40 Villiers Street,  
London, WC2N 6NJ.  
E-mail: mamsi@hempsons.co.uk*