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Dear Dr Aiken

Ad Hoc Committee on the Mental Capacity Bill

Thank you for the opportunity to submit written evidence on the Mental Capacity Bill. We appreciate your granting a short extension to the deadline for submission.

In the last 12 months our Standards and Ethics team have had two useful meetings with the members of the Bill team. We used this opportunity to explore the policy intentions behind the Bill, and the rationale behind the way particular clauses have been drafted and redrafted during the consultation process. We are supportive of the ambitions of the Bill and keen to be involved in the development of the draft Code of Practice.

Background

The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified. We are independent of government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the *Medical Act 1983*.

Our core guidance, [Good medical practice](#) (GMP), defines what it means to be a good doctor in the UK. This includes doctors' responsibilities to keep up date with, and follow, the law and other regulations relevant to their area of work (paragraphs 11-12); and to work effectively with patients to make decisions about their treatment and care (paragraphs 31-34, 46-49). We also provide [explanatory guidance](#) that gives more detail on how to apply the standards in practice.

Our core guidance [Good medical practice](#) (GMP), and the [explanatory guidance](#) that supports it, describes what is expected of all doctors registered with the GMC.

We see it as important to engage with the development of new legislation, where it may impact doctors' ability to comply with our professional standards, and where we can offer insights based on our interactions with doctors, patients and other key interest groups. The Bill has important implications for doctors' practice and for the standards of care set out in our guidance, including:

- *Consent: patients and doctors making decisions together* (2008)
- *Confidentiality* (2009)
- *Treatment and care towards the end of life: good practice in decision making* (2010)
- *Good practice in research and Consent to research* (2013)
- *Protecting children and young people* (2013).

We are keen to be helpful to the development process by highlighting issues in the Bill where:

- a there may be a conflict with, or the proposals may reinforce, the duties and responsibilities we place on doctors
- b more clarity or specific guidance may be needed to ensure that doctors understand and are able to comply with the provisions of the Bill
- c there is a potential for unintended consequences which may affect the standards of care provided to patients, their families and carers.

General comments on the Bill

The approach set out in the Bill seeks to build on established good practice and we welcome this as helpful to doctors and patients.

Setting out a single set of decision making principles, to apply in all circumstances where an adult's capacity to make a decision is or might be impaired, and in situations where action might be needed to protect an individual from harming

him/herself or others, certainly is a commendable goal. However, we believe that the way the Bill fuses together principles that seek to empower individuals with measures to protect an individual or third parties from harm, may potentially conflict with the standards we set for doctors and impact on the care of vulnerable adults.

We would like to draw the committee's attention to the following areas:

- The criteria for determining whether a particular intervention is in a person's best interests (section 7 (9)) i.e. the question of whether failure to do an act to the adult who lacks capacity (P) is likely to result in to harm to a third party with resulting harm to P.
- The scope for subjective judgements in deciding whether an adult 'appreciates' the relevance of information provided to them, as part of the assessment of their decision making capacity (section 4 (c)).
- Other provisions in the Bill which seem open to interpretation. For example the way that medical treatment with 'serious consequences' for the patient is defined (Section 20).

We understand that by its nature this is a complex piece of legislation; however we have concerns about the ability of doctors and others to navigate through the various clauses. The development of a Code of Practice will be crucially important for doctors in day to day practice.

Comments on clauses

As requested, we have provided comments on successive clauses, set out in the attachment. We have focused on the general principles and their application in healthcare practice. We have not provided comments on the criminal justice provisions.

Next steps

We welcome the opportunity to contribute to the development of the draft Code of Practice. In the longer term we would hope to work with partner organisations to help raise awareness of our professional guidance, including its interaction with the new legal framework.

Yours sincerely

A handwritten signature in black ink that reads "Vicky Osgood". The signature is written in a cursive, flowing style.

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Comments on clauses

GMC comments	Mental Capacity Bill clause(s)
<p>In the <u>section on Capacity</u>: the Bill specifies at 1(3) a number of prohibitions intended to protect an adult (P) from unwarranted assumptions based on factors such as their physical appearance, health condition or disability, or the fact that they are making a decision that someone else considers unwise. This is a helpful provision in line with the goal of 'equal treatment'.</p> <p>We have a concern that, where the definition of "unable to make a decision" includes the requirement that P can "appreciate" the relevance of information provided to him/her - in 4(1)(c) - this may leave scope for subjective judgements that undermine section 1(3), unless additional guidance is available in the proposed Code of Practice.</p> <p>We understand that 4(1)(c) is primarily intended to ensure that the law extends to adults who may be delusional or lack insight but may not strictly speaking have impaired function of the brain/mind. It seems possible that a decision maker could come to regard an individual as delusional or lacking in insight because of the 'unwise' choices that the person was making. Evidence presented to the House of Lords Select Committee on the Mental Capacity Act suggested that, despite similar legal requirements, the burden nevertheless may fall on patients with particular disabilities or illnesses or 'unwise' preferences to demonstrate capacity before their decisions and choices are given due weight.</p>	<p>Sections 1 (3)(5) and 4(1)(c)</p>
<p>In the <u>Best interests section</u>: the Bill specifies that, in effect a checklist of factors that must be considered in order to reach a view about whether a proposed action is in the best interests of an adult (P) who lacks capacity. We understand that the intention is that no one factor is on its own determinative, although there is a specific requirement for the decision maker to '<i>have special regard to</i> P's wishes, feelings, beliefs and values, and other matters that P might want to be taken into account - at 7(6).</p> <p>We have a specific concern about the requirement the decision maker must "have regard to whether the failure to do the act is likely to result in harm to other persons with resulting harm to P" – at 7(9).</p> <p>We understand the policy aim here is to set out a principle that can apply to decisions about whether to:</p> <ul style="list-style-type: none"> • provide a treatment for a physical health condition • provide assessment or treatment for a mental health condition (including to patients who have mental capacity) • intervene for other purposes to do with P's welfare or the protection of third parties • restrict P's freedom for any of the above health or care or public protection purposes <p>The 7(9) requirement seems to permit highly subjective considerations to influence these decisions. A decision maker's view of the possible harms to possible third parties from P's possible action might be heavily influenced by prevailing social attitudes that work against the empowerment and equal treatment aims of the Bill. For example we</p>	<p>Section 7(1)-(11) in particular 7(6) and 7(9)</p>

GMC comments	Mental Capacity Bill clause(s)
<p>know that some people may hold a view that people with disabilities should be prevented from making unwise choices or taking actions that may risk them coming to harm, in circumstances where there would be no concerns about a person with capacity following the same path.</p> <p>We have been advised that the expectation is that decision makers will apply a rising scale of harm. The explanation as we understand it is that:</p> <ul style="list-style-type: none"> • Failure to treat a particular physical health condition (eg a broken leg) might not present a risk of harm to a third party (even if it risked serious harm to P), or it might risk harm to a third party but not such that it would result in any harm to P. In these circumstances, section 7(9) would not apply. • Failure to provide for example appropriate social care for P, or to treat a mental health condition, might present a risk of harm to a third party and resulting harm to P. The harm would need to be assessed in terms of its seriousness, before section 7(9) could be relied on. • The possibility of P being sectioned or imprisoned after causing (serious) harm to another person is treated as self-evidently a serious harm to P that would justify action under section 7(9). • Before proceeding, if the proposed intervention with P can be classified as 'treatment with serious consequences' (as described in sections 19-23), then additional safeguards apply and must be acted on. <p>It seems a significant departure from precedent to incorporate protection of the interests of third parties into considerations of what is in the best interests of an individual, except where there is a significant personal relationship and the third party interests intersect directly with the interests of the person who lacks capacity (eg organ donation for a close family member).</p> <p>If this approach is retained, it would seem appropriate to set the level of risk at 'serious harm' to a third party and serious harm to P.</p> <p>It will also be essential to provide substantial guidance for practitioners on how to apply the section 7(9) criteria to the variety of circumstances that might realistically arise, in a way that ensures day to day practice does not undermine the empowerment and equal treatment aims of the Bill. We found it helpful to have the additional information about the 'scale of harm' approach, as a starting point. We would want to look at this again when the Code of Practice and case study examples are available.</p>	
<p>It is not clear whether a risk of self-harm by a person who has or lacks capacity but who is not willing to undergo voluntary mental health assessment could be dealt with under the best interests test as set out in this section. Section 21 seems the most relevant but does not seem to reference back to the best interests criteria</p>	<p>Section 7 and section 21</p>
<p>Protection from liability section: it is helpful to try to bring together in one section all of the steps that must be taken including safeguards before a decision maker can rely on the protection offered by the Bill. It is not easy to follow the structure, and some confusion may arise</p>	<p>Section 9</p>

GMC comments	Mental Capacity Bill clause(s)
<p>from the requirement (at 9(4)-(5)) to refer back to section 1. Professionals working in services where they are time poor will need easy to digest guidance or other resources to navigate the complexities of the Bill.</p>	
<p>The Bill refers to “effective advance decisions to refuse treatment” consistent with the common law. We would want to see guidance in the Code of Practice or elsewhere that summarises the current common law position as it stands in Northern Ireland. We know from our interaction with doctors that they find it helpful to have access to such summaries.</p> <p>We do of course give advice about advance statements and advance decisions to refuse treatment in our guidance <i>Treatment and care towards the end of life</i>. This might be of interest to the Committee.</p>	11(1)-(2)
<p>Safeguards for serious interventions: we welcome the provision at section 16(1) which sets a requirement for a second opinion to be obtained for treatments with serious consequences where the question of whether the treatment is in P’s best interests is finely balanced. This seems particularly relevant to situations towards the end of a patient’s life involving judgements about the provision of artificial or clinically assisted nutrition and hydration. Our guidance on <i>Treatment and care towards the end of life</i> addresses this at paragraphs 119-122. It is a challenging area of decision making and providing clarity about the need for second opinions may prove helpful to doctors and patients and their family and carers.</p> <p>We have some concern to understand how the patient confidentiality aspects of the provisions at section 18(1) and (4) will work in practice. The role of the RQIA in holding certificates that contain confidential information about a patient’s health condition and treatment plan is not clear. Certificates will relate to patients who are not being treated for mental health conditions or being treated under restrictions on their liberty where external review and monitoring is required. There seems to be scope for considerable flow of confidential patient information in circumstances where a person with capacity would be able to exercise control over what is shared with external organisations.</p> <p>We are advised that certain legal provisions that apply within mental health will be ‘read into’ this area of practice. It would be helpful to see the details of what is envisaged.</p>	13, 14, 15, 16, 17, 18 especially 16(1) and 18(1) and (4)
<p>It may help to make clear, in the Code of Practice or elsewhere, whether Do not attempt CPR (DNACPR) decisions are covered under the concept of ‘serious interventions’ and treatment with ‘serious consequences’. This seems likely based on section 16(6). However, we know that there can be debate in the medical community about whether a decision not to offer/provide CPR at a future date because it won’t work can rightly be called a decision about treatment.</p>	Section 13,14, 15, 16(6)
<p>The concept of “treatment with serious consequences”, as set out in section 19 and 20, helpfully makes clearer now that any pain, distress or side effects associated with treatment must be ‘serious’ to fall within the definition. However the definition still has the potential to draw in a large volume of day to day decisions, if the person who lacks capacity demonstrates serious pain or distress or the arguments in favour of the treatment are finely balanced.</p>	Section 19, 20

GMC comments	Mental Capacity Bill clause(s)
<p>Once treatment is categorised as having serious consequences, the professional/carer would have to take the escalation steps required in the Bill to “authorise” that treatment.</p> <p>This could create a steady flow of requests for authorisations and lead to otherwise avoidable delays to providing appropriate care for patients. This could be more significant a risk if considered alongside the definition of ‘serious intervention’ at section 60(1)-(2) which states that any deprivation of liberty is also a serious intervention.</p>	
<p>Given the philosophy underpinning the Bill; we wonder whether there would be benefit in providing an explanation in the Code of Practice about how the research framework relates back to the “best interests” framework.</p>	130 (1)