In whose **best interest?**

Lawyer ***Andrew Andrews*** explains the Mental Capacity Act 2005 and how it applies to midwives and decision-making.

THE MENTAL CAPACITY ACT 2005 was a landmark piece of legislation designed to govern decision-making on behalf of adults who lose mental capacity. Although applicable to all patients who may not be able to make their own treatment decisions, the title has led some clinicians to believe it is only used in the mental health field.

The act's underlying purpose was to plug a gap in the law that meant no adult could consent to treatment on behalf of another adult, taking no account of the patient's cognitive ability. Before the act, the NHS adopted a paternalistic approach to patients regarded as not being 'rational'. Hospitals developed a pragmatic approach to determine what was in a patient's best interest, but this left open the possibility of legal liability arising from treating a patient without consent.

The act sets out a test to determine capacity and, providing the practitioner has complied with the procedure, gives protection from liability.

PRINCIPLES OF THE ACT

Section 1 sets out the principles that healthcare professionals should go through when determining whether or not an individual is capable of making the decision in question:

- A person must be assumed to have capacity unless it is established that she lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because she makes an unwise decision.
- An act done, or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in her best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The act creates a presumption in favour of capacity and reflects the principle of a woman's self-determination. If a woman is unable to make her own decision, the starting point will always be to ask: 'Is it likely that the woman will at some time have capacity and, if so, when?'

The test

The act lays down a test for assessing capacity – section 3.

A person is unable to make a decision for herself if she is unable to:

- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decision.

A pre-requisite is that the woman is able to communicate in some way. If a woman is unable to do so, she will be deemed to lack capacity.

It should be noted that the requirement to retain the information need only to be long enough to enable the treatment decision to be reached.

The third requirement is in reality looking at insight – does the woman appreciate the consequences of deciding one way or another?

From the midwife's perspective, there are a wide range of situations that could occur to make the practitioner consider the issue of incapacity. For example, where a woman has a learning disability, where she has been given considerable amounts of medication, or where she is in such pain that she is unable to think clearly.

Capacity is to be assessed in relation to a particular decision at a particular time. If the treatment decision can wait, the best person to make it is the woman. If the decision cannot wait, the practitioner is required to ascertain their wishes, feelings and values to try to make the decision it is believed the woman would have made.

Capacity may vary in the same woman, depending on the decision to be taken or, in other cases, may be a fluctuating condition. When doubt arises as to whether a woman has capacity, the practitioner will apply and record the capacity assessment and reach a decision on the balance of probabilities. Trusts have different ways of recording the decision, so practitioners should ensure they are aware of their trust's method.

If the woman lacks capacity, the practitioner is required to act in her best interest and is able to do anything for her to which she could have consented had she had capacity.

After the capacity decision is made, but before any intervention, capacity must be reassessed to ensure it has not returned in the interim.

Section 5 provides that if treatment is given in this way, there is absolute protection from legal challenge for treating the woman without consent.

Where a person lacking capacity resists treatment that is being given, section 6 allows restraint to be applied. Restraint is described as 'using or threatening to use force' to secure compliance with treatment that a woman resists or imposing a restriction on their liberty, whether or not they resist.

This power can only be used if the treatment is required to prevent the woman coming to harm and the action taken must be the least restrictive option available and proportionate to the likelihood and seriousness of that harm. Practitioners are often reluctant to act in such situations, but the law gives them a tool to do so. Failure to use the power, which results in the woman coming to harm, could constitute negligence.

The act gives statutory recognition to an 'advance decision' made by a client in anticipation that a situation may arise where they will be unable to make a decision and refuse treatment they suspect might be imposed. For example, a devout Jehovah's Witness anticipating severe postpartum haemorrhage refuses blood in the knowledge that this would put her life at risk. A written document that is clear and unambiguous, signed and witnessed, is legally binding.

Advance decisions are unusual, but many women have birth plans. While they have no contractual force, they would be regarded as a statement of wishes to be taken into account when deciding her best interests.

If it is not possible to know what the woman would have decided, the default position will always be to preserve life, prevent deterioration, keep her comfortable and pain free and maintain dignity.

While no other adult can consent on behalf of another adult, the family may help the clinician to ascertain what is in the woman's best interest.

The act enables an alternative approach – the woman may, under a Lasting Power of Attorney, appoint a person(s) to make decisions on her behalf if she should lose capacity in the future. Where such an appointment is made, the attorney stands in the shoes of the woman and can make any decision that she could have made if she had capacity.

As always, the fundamental principle is that the lawyer acts in the woman's best interest and will be bound by any advance decisions that have been made.

Andrew Andrews, lawyer and director of social care, Bond Solon

Supporting women who may lack capacity will be explored further on 7 July at the RCM legal birth conference. See **tinyurl.com/ojmhqbv** for more details or to book your place.

ILLUSTRATION