

**ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000**

**CODE OF PRACTICE**

**FOR PERSONS AUTHORISED TO CARRY OUT  
MEDICAL TREATMENT OR RESEARCH UNDER  
PART 5 OF THE ACT**

**EFFECTIVE FROM 1<sup>st</sup> JULY 2002**  
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Adults with Incapacity (Scotland) Act 2000

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# 1. INTRODUCTION AND GENERAL BACKGROUND

## **Key points in Part 1**

***Incapacity is not an “all or nothing” concept – it is to be judged in relation to particular decisions.***

***Everyone carrying out functions under the Act must apply the general principles of***  
***BENEFIT***

***MINIMUM INTERVENTION***

***TAKE ACCOUNT OF ADULT’S WISHES AND FEELINGS***

***CONSULT OTHERS***

***ENCOURAGE EXERCISE OF RESIDUAL CAPACITY.***

***Medical practitioners have functions of providing certificates and reports under all Parts of the Act and should be aware of the wider provisions, but this code deals in detail only with Part 5, medical treatment and research.***

***The code is not mandatory, but may be referred to by the courts.***

### The Act

1.1 The law of Scotland generally presumes that adults (those aged 16 or over) are legally capable of making personal decisions for themselves and managing their own affairs. That presumption can be overturned in relation to particular matters or decisions on evidence of impaired capacity. The Adults with Incapacity (Scotland) Act 2000, referred to in this code as “the Act”, sets out a new framework for regulating intervention in the affairs of adults who have impaired capacity, in the circumstances covered by the Act (such an adult being referred to in this code as “the adult”). The framework is underpinned by general principles and provides more flexibility than before to tailor interventions to the needs of particular cases. **In the case of medical treatment and research, it provides a clear statutory framework for the first time regulating what may be done by medical practitioners and others acting with their authority.**

### Incapacity

1.2 “Incapacity” is defined in the Act only for the purposes of the Act. The Act recognises that a person may be legally capable of some decisions and actions and not capable of others.

1.3 The Act allows for intervention in a wide range of property, financial or welfare matters where the adult lacks capacity. But an intervention is only permitted where the adult lacks capacity in relation to the subject matter of the intervention. It is necessary to consider whether the adult lacks capacity in relation to the relevant matter each time a decision or action falls to be taken.

1.4 For the purposes of the Act “incapable” means incapable of acting; or  
making decisions; or  
communicating decisions; or  
understanding decisions; or  
retaining the memory of decisions;

in relation to any particular matter, by reason of mental disorder or of inability to communicate because of physical disability. A person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid.

1.5 The definition of “mental disorder” in the Act follows that in the Mental Health (Scotland) Act 1984. Under that definition, no person shall be treated as suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs. In the 2000 Act, the exemptions from the definition also include “acting as no prudent person would act”.

1.6 For the purposes of the Act, incapacity must be judged in relation to particular matters, and not as an “all or nothing” generalisation. Medical practitioners must be alert to this whenever asked to assess capacity for the purposes of the Act. Guidance on assessment of capacity has been provided in a separate leaflet, and is available on the Chief Medical Officer's website. Normally an assessment under Part 5 should seek to determine whether the adult

- Is capable of making and communicating their choice
- Understands the nature of what is being asked and why
- Has memory abilities that allow the retention of information
- Is aware of any alternatives
- Has knowledge of the risks and benefits involved
- Is aware that such information is of personal relevance to them
- Is aware of their right to, and how to, refuse, as well as the consequences of refusal
- Has ever expressed their wishes relevant to the issue when greater capacity existed
- Is expressing views consistent with their previously preferred moral, cultural, family, and experiential background

It will also be important to investigate whether any barriers to consent are present, such as sensory and/or physical difficulties, undue suggestibility, the possible cognitive or physical effects of alcohol, drugs or medication, possible effects of fatigue, possible effects of pain and mental health status considerations.

1.7 A number of defining characteristics of incapacity clearly relate to communications skills, such as comprehension and expressive skills. Although many health and social care professionals have an awareness and training in human communication, clinical psychologists and speech and language therapists have a specialist knowledge and expertise. Where doubt exists, available

expertise should be called upon to help medical practitioners and others who may require assistance in assessing a person's capacity.

### **The general principles**

1.8 Section 1 of the Act provides that the following principles shall be given effect in relation to any intervention in the affairs of an adult under or in pursuance of the Act.

#### Principle 1 – benefit

1.8.1 There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot be reasonably achieved without the intervention.

So, for instance, if there is a prospect that the adult will regain sufficient capacity to make the necessary decision, and if a decision can reasonable be deferred, then it should be deferred.

#### Principle 2 – minimum intervention

1.8.2 Where it is determined that an intervention in the affairs of an adult under or in pursuance of the Act is to be made, such intervention shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention.

#### Principle 3 – take account of the wishes of the adult

1.8.3 In determining if an intervention is to be made, and, if so, what intervention is to be made, account shall be taken of the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid appropriate to the adult.

NOTE that it is compulsory to take account of the present and past wishes and feelings of the adult if these can be ascertained. (see also 2.27 to 2.29, below.)

#### Principle 4 – consultation with relevant others

1.8.4 In determining if an intervention is to be made, and, if so, what intervention is to be made, account shall be taken, so far as it is reasonable and practicable to do so, of the views of:

- The nearest relative and primary carer of the adult;
- Any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention;
- Any person whom the sheriff has directed should be consulted; and
- Any other person appearing to the person responsible for authorising or effecting the intervention to have an interest in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible.

It will be necessary to consider the individual's right to confidentiality, and any previously expressed wishes about disclosure of information. It will also be advisable to consider any information that is known about the possible financial motives or frictions among family members.

#### Principle 5 – encourage the adult to exercise residual capacity

1.8.5 Any guardian, continuing attorney, welfare attorney or manager of an establishment exercising functions under this Act shall, in so far as it is reasonable or practicable to do so, encourage the adult to exercise whatever skills he or she has concerning property, financial affairs or personal welfare as the case may be, and to develop new such skills. Medical practitioners exercising functions under Part 5 will want to co-operate with guardians or welfare attorneys who are encouraging the adult to participate in a decision on their medical treatment. Furthermore, individuals unable to make a decision about medical treatment may be able to make decisions on other aspects of their care, and should be encouraged to do so. Although the statutory application of this principle is limited to the appointees specified above, this and all preceding principles represent good practice in all matters concerning adults with impaired capacity, and should be applied as a matter of good practice, whether or not in particular circumstances a statutory requirement.

1.9 The general principles will be referred to throughout this code as they apply to the exercise by medical practitioners of their functions under the Act.

#### **Techniques covered by the Act**

1.10 The Act introduces some new or modified techniques for managing the property and financial affairs and taking decisions about the welfare of adults. This code describes briefly below all such techniques because they may impinge at different times on the functions of medical practitioners. It does not however deal with these techniques in any detail. They are covered in other codes of practice and in regulations made under the Act (see Annex 1).

#### Power of attorney

1.11 Under part 2 of the Act an adult may anticipate his or her own incapacity by granting a power of attorney relating to his or her property or financial affairs (**a continuing power of attorney**) or his or her personal welfare. The latter power of attorney is called a **welfare power of attorney**. To be effective a power of attorney must be registered with the Public Guardian (see below). The Public Guardian will only register a power of attorney if it incorporates a certificate in prescribed form to the effect that the granter understood the nature and extent of the power and was not acting under undue influence. This certificate is prescribed in the Adults with Incapacity (Certificates in Relation to Powers of Attorney) (Scotland) Regulations 2001 (Scottish Statutory Instrument 2001 No. 80). A doctor may on occasion be asked by a solicitor for assistance in assessing the capacity of a potential granter. Doctors may later be involved in helping to assess when a specific event, such as the onset of incapacity, has occurred in order to determine at what point a power of attorney becomes effective.

1.12 A welfare power of attorney can only be operated after an adult loses capacity in relation to the welfare decision in question. A welfare power of attorney can include powers to consent to (or to refuse) medical treatment but a welfare attorney may not:

place the granter in hospital for treatment of mental disorder against his or her will;

consent on behalf of the granter to treatment to which Part X of the Mental Health (Scotland) Act (the 1984 Act) applies;

consent to treatment specified under the excepted treatment Regulations.

### Intromission with funds

1.13 Under Part 3, an individual may apply to the Public Guardian for authority to intromit with (have access to) funds held by the adult with a body such as a bank or building society, for the purposes of meeting the adult's living expenses. Medical practitioners will be called upon to certify in connection with such an application that the adult is incapable in relation to decisions about the funds, or incapable of acting to safeguard or promote his interests in the funds. The form of this certificate is prescribed in the Adults with Incapacity (Certificates from Medical Practitioners) (Accounts and Funds) (Scotland) Regulations 2001 (Scottish Statutory Instrument 2001 No. 76). They may also be called on to countersign the application confirming that the applicant is a fit and proper person to have access to the funds (but this would have to be done by a different doctor from the one signing the medical certificate).

### Management of residents' finances

1.14 Part 4 of the Act allows registered establishments to manage the financial affairs of residents with impaired capacity up to a prescribed limit. A medical practitioner must be asked by the managers of a registered establishment to issue a certificate in prescribed form to the effect that the resident in question is incapable in relation to decisions as to, or the safeguarding of his or her interest in, the relevant financial affairs. This part is effective from April 2003.

### Intervention orders and guardianship

1.15 Under Part 6, it becomes possible to apply to the sheriff for an intervention order to deal with clearly defined financial, property or personal welfare matters in relation to an adult on a one-off basis. Guardianship under the Mental Health (Scotland) Act 1984 ("the 1984 Act"), tutors and curators bonis are all replaced with a new form of guardianship order which can include powers over property, financial affairs or personal welfare or a combination of these. In this code a guardian with powers over financial affairs and property is referred to as a "financial guardian" and **a guardian with powers over personal welfare is referred to as a "welfare guardian"**. Persons authorised under an intervention order, and welfare guardians, may be given power by the sheriff to make decisions about medical treatment on behalf of the adult, subject to the same exceptions as apply to welfare attorneys (see paragraph 1.11 above). Part 6 is effective from 1 April 2002.

1.16 Medical practitioners have formal responsibility for providing reports of incapacity in relation to applications for intervention orders or guardianship. At least two such reports are needed for each application. In a case where the cause of incapacity is mental disorder, one of these reports must be made by a medical practitioner approved for the purpose of section 20 of the 1984 Act.



## Situations where intimation to the adult not required

1.17 Under various provisions in the Act, where intimation or notification to the adult would normally be required by the court or the Public Guardian, such intimation may be dispensed with if intimation or notification would be likely to pose a serious risk to the health of the adult. This will normally require the evidence of two medical certificates. Good practice would suggest that intimation to the adult should only be dispensed with in the most exceptional circumstances.

### **The term “proxy”**

1.18 In this code the term “proxy” is used to mean “welfare attorney, person authorised under an intervention order; or a welfare guardian with powers relating to the medical treatment in question”. There are requirements under Part 5 of the Act to involve such proxies in decision making about medical treatment and to involve guardians and welfare attorneys who have relevant powers in decisions about research. Part 5 also provides a dispute resolution process where proxies and medical practitioners do not agree about a treatment decision, or where the medical practitioner and proxy are in agreement but someone else who has a relevant interest disagrees. These matters are explained further in parts 2 and 3 of this code.

### **Statutory bodies with responsibilities under the Act**

1.19 The statutory bodies given responsibilities under the Act are:

#### The Public Guardian

1.19.1 The Public Guardian (a new office based on the Accountant of Court) registers both welfare and financial powers of attorney, intervention orders and guardianship orders, and has extensive functions and powers in relation to financial provisions and appointments.

1.19.2 The Public Guardian’s contact details are:

Public Guardian  
Hadrian House  
Callendar Business Park  
Falkirk  
FK1 1XR

Tel 01324 678300

Website

[www.publicguardian-scotland.gov.uk](http://www.publicguardian-scotland.gov.uk)

#### The Mental Welfare Commission

1.19.3 The Mental Welfare Commission (MWC) retains protective functions for adults whose incapacity stems from mental disorder. The MWC has a special role in relation to Part 5 of the Act. It is given the duty to establish and maintain a list of medical practitioners whom it can nominate to give an additional opinion in the case of disputes between a medical practitioner and a proxy about treatment under Part 5 (see part 3 of

this code). It also has various powers and responsibilities in relation to welfare matters and appointments under the Act.

1.19.4 The MWC's contact details are:

Mental Welfare Commission for Scotland  
K Floor  
Argyle House  
3 Lady Lawson Street  
Edinburgh  
EH3 9HS

Tel. 0131 226 6111

Fax 0131 222 6112

E-mail: [support@mwscot.org.uk](mailto:support@mwscot.org.uk)

### Local authorities

1.20 Local authorities have a wide range of functions under the Act. As adults coming within the scope of Part 5 will often be in the community, or returning to the community, it is important for medical practitioners to be aware of the functions of local authorities which may impinge on medical treatment. Duties of local authorities will include the following:

*To investigate circumstances where personal welfare of adult at risk*

1.20.1 To investigate any circumstances made known to them in which the personal welfare of an adult seems to be at risk.

*To provide information and advice to those exercising welfare powers*

1.20.2 To provide a guardian, welfare attorney or person authorised under an intervention order, when requested to do so, with information and advice in connection with the performance of his or her functions in relation to personal welfare under the Act.

*To investigate complaints in relation to those exercising welfare powers*

1.20.3 To receive and investigate any complaints about the exercise of functions relating to the personal welfare of an adult made in relation to welfare attorneys, guardians or persons authorised under intervention orders.

*To consult Public Guardian and MWC*

1.20.4 To consult the Public Guardian and the MWC on cases or matters relating to the exercise of functions under the Act in which there is, or appears to be, a common interest.

*To supervise attorneys and guardians*

1.20.5 To supervise a welfare attorney or a person authorised under an intervention order where ordered to do so by the sheriff; and to supervise a guardian appointed with functions relating to the personal welfare of an adult in the exercise of those functions.

*Intervention or guardianship orders*

1.20.6 Where it appears to the local authority that an intervention order is necessary for the protection of an adult, and that no application has been made or is likely to be made for such an order, the local authority is obliged to apply for an intervention order.

1.20.7 Where it appears to a local authority that

an adult is incapable in relation to decisions about, or of acting to safeguard or promote his interests in his or her property, or financial affairs and is likely to continue to be so incapable; and

no other means provided by the Act would be sufficient to enable these interests to be safeguarded or promoted, and

no application has been made or is likely to be made for a guardianship order; and

a guardianship order is necessary for the protection of the property, financial affairs or of the adult;

then the local authority must apply for a guardianship order.

*To provide reports to the sheriff relevant to applications for intervention orders or guardianship orders relating to personal welfare*

1.20.8 The local authority must make a report to the court in relation to applications for intervention orders or guardianship orders with welfare powers. Where the adult's incapacity results from mental disorder, the report must be made by a Mental Health Officer (MHO). But where the adult's personal welfare is in jeopardy only because of the inability of the adult to communicate, this report must be made by the chief social work officer.

*To act as welfare guardian where necessary and no-one else is applying to do so*

1.20.9 Where the guardianship order is to relate only to the personal welfare of the adult, the chief social work officer of the local authority may be appointed as guardian.

## **The role of the courts**

1.21 The sheriff court is the main forum for proceedings under the Act. This also applies to medical treatment matters under Part 5. In particular, a decision by a medical practitioner that an adult is incapable of consenting to a particular form of medical treatment, and a decision to treat the adult, where there is no proxy with power to consent to medical treatment, can be appealed to the sheriff, and thence with leave of the sheriff, to the Court of Session.

1.22 In relation to Principle 4, the requirement to consult, medical practitioners should be aware that under section 4(1) of the Act it is possible for an adult to apply to the sheriff to have the nearest relative displaced, or to have information withheld from the nearest relative. The sheriff may nominate another relative to take the place of the nearest relative or may order that no-one shall exercise the functions of nearest relative. Such applications cannot be made in advance of any incapacity.

1.23 The Court of Session is the forum for appeals in relation to treatment decisions by medical practitioners under section 50 of the Act, where there has been a dispute between the medical practitioner primarily responsible for the treatment of the adult and any proxy with powers relating to the medical treatment in question, or between them and someone else having a relevant interest.

1.24 The sheriff has jurisdiction under section 3(3) to give directions to any person exercising functions under the Act. Anyone with an interest can apply. Directions can be given as to the exercise of functions under the Act and the taking of decisions or action in relation to the adult. A medical practitioner can if necessary use this procedure to obtain a ruling on any matter of significant doubt or difficulty.

## **Status of this code**

1.25 The Act does not impose a legal duty to comply with the code. However, the code is a statutory document and there may, therefore, in certain circumstances, be legal consequences arising from failure to observe the terms of the code. For example someone might raise a legal action for negligence relying on the code as evidence that a medical practitioner did not follow best practice.

1.26 A code cannot foresee all the circumstances that might arise in practice. Should it appear that a detailed requirement of the code conflicts with the application of the general principles to a particular real life situation, the general principles should be followed. If a medical practitioner departs from the code, it is essential that he or she record the circumstances and reasoning behind that departure in a document which should become part of the patient's medical record.

1.27 The Scottish Ministers are obliged by the Act to prepare and review this code. It should therefore be followed unless there are good reasons for not doing so, such as those outlined above. It is likely that the courts will have regard to the code in considering matters put before them under the Act.

## 2. MEDICAL TREATMENT UNDER PART 5

### **Key points in part 2**

***Part 5 of the Act gives a general authority to treat a patient who is incapable of consenting to the treatment in question, on the issuing of a certificate of incapacity.***

***The general principles of the Act must be applied by a medical practitioner issuing such a certificate and giving treatment under it.***

***The common law authority to treat a patient in an emergency situation remains in place.***

***The new general authority may not be used where the consent of a proxy whose powers cover the proposed treatment can reasonably be sought.***

***Treatment under Part 5 is subject to exceptions. It cannot authorise certain treatments and can only authorise others subject to additional requirements.***

### Structure of this part of the code

2.1 This part of the code covers the provisions of Part 5 of the Act in relation to the general authority to treat, apart from dispute resolution which is dealt with in Part 3 of the code. It proceeds so far as possible step by step, following the logical sequence of treatment decisions. It gives the statutory requirements followed by good practice guidance on each step.

### The general authority to treat

2.2 Prior to the Act, to treat a patient without consent other than in an emergency could be considered to be assault. Part 5 means that, if no proxy with relevant powers has been appointed, then provided a certificate of incapacity is issued for the treatment in question and provided the general principles of the Act are observed, the treatment may be given. In deciding whether to issue such a certificate, the medical practitioner must apply the general principles of the Act.

2.3 The Act confers on medical practitioners a general authority to treat patients who are incapable of consenting to the treatment in question. This is a helpful clarification of the law. Common law allows medical practitioners to give immediate treatment (see 2.5, below) to patients who cannot consent. This remains the case and **there is no need to go through the steps in Part 5 of the Act in order to give treatment for the preservation of the life of the adult or the prevention of serious deterioration in his or her medical condition.**

### Emergencies

2.4 It would be contrary to good practice to risk prejudice to a patient's health through any delay in providing necessary treatment, in order to give effect to the procedures under Part 5 of the Act. The Act specifically preserves existing grounds on which treatment may be given without consent. In such circumstances the provisions of the Act are an addition to, rather than a substitute for normal procedures. This is particularly so in the case of emergencies. However, the provisions of the Act were introduced with a view to avoiding the uncertainties which

existed under the law as to the precise circumstances in which treatment could be given. It could therefore offer added confidence to the practitioner and would also be good practice to make use, so far as reasonable and practicable, of the procedures under Part 5 where this is without risk to the patient.

2.5 The division between cases where treatment is necessary for the preservation of life or to prevent serious deterioration, urgent cases, a necessity to treat and routine matters is not always clear-cut. What underlies the concepts of emergency and necessity is the issue of immediacy. The definition of emergency will vary slightly from specialty to specialty. There will of course be clinical situations where urgent treatment is required to save life – for example in labour wards or Accident & Emergency Departments, or when the patient is found unconscious through illness or injury. In such circumstances a decision must be taken and acted upon within seconds or minutes, if a fatality or severe damage is to be avoided. In other specialties, however, situations can take much longer to develop. An adult could require lifesaving surgery but there may be a period while they are being rehydrated and given antibiotics before they have an anaesthetic and operation. In this time, the medical practitioner responsible should have time to consult and complete the form. What is possible in the way of consultation will vary according to time of day – the opportunities are likely to be fewer at night or during weekends.

2.6 In all normal circumstances, the procedures set out in Part 5 of the Act should be followed. The basic judgement as to whether or not there is time to complete the appropriate form and undertake the processes associated with its completion is essentially a medical judgement in the first instance. Ultimately, however it will be for the courts to decide whether a practitioner has acted improperly in failing to secure the authority provided by a certificate under section 47 of the Act. It will obviously be good practice and potentially a legal necessity to use the new authority in any situation where there is room for doubt. It is recommended that the new authority be used in every case where it is reasonable and practicable to do so.

### **Who may exercise the general authority to treat**

2.7 Medical treatment is defined by the Act to include “any procedure or treatment designed to safeguard or promote physical or mental health”. Authority to do what is reasonable in the circumstances in relation to medical treatment is set out in section 47 of the Act. It applies under subsection (1) to the medical practitioner primarily responsible for the medical treatment of the adult and under subsection (3) to any other person authorised by him or her and acting on his behalf under instructions, or with his or her approval and agreement. This authority is obtained by completion of the certificate of incapacity and its signature by the medical practitioner primarily responsible. A copy of the certificate can be found at Annex 2 of this code.

2.8 The **medical practitioner primarily responsible** is not defined in the Act. It is essentially a practical matter. Who is primarily responsible will depend on the circumstances in any particular situation. In the context of general practice it will normally be the adult’s general practitioner, while in a hospital setting it will normally be the appropriate consultant. The term could include a doctor other than the adult’s GP or the consultant in charge of the case. However, no healthcare worker other than a registered medical practitioner has the power to complete and sign the certificate.

2.9 There will be circumstances where an adult is admitted to hospital at night or at other times when the consultant who is primarily responsible is not present. It cannot be expected that that consultant should attend to make a decision on capacity before treatment can begin. If

in these circumstances treatment has to be authorised under section 47, therefore, the medical practitioner primarily responsible will be the doctor who is in attendance and to whom it is delegated to give treatment in the absence of the consultant. Such a person should be a fully registered medical practitioner competent in terms of the intervention proposed.

2.10 Healthcare is a team effort. The authority granted under section 47 may be exercised by the medical practitioner, himself or herself. It can also be appropriately delegated to another person authorised by the medical practitioner primarily responsible and acting under his or her instructions or with his or her approval or agreement.

2.11 A person acting on behalf of **the medical practitioner primarily responsible** may do so in one of two ways. He or she may act under the instructions of the medical practitioner primarily responsible. Alternatively, he or she may act with the approval or agreement of the medical practitioner primarily responsible. Such a person might include any member of the healthcare team involved in the adult's medical treatment, including other doctors, nurses, physiotherapists, psychologists, occupational therapists, and midwives. It could also include dentists, opticians, podiatrists or other professionals allied to medicine who might be asked at different times to attend to an adult's particular healthcare needs.

2.12 It would not normally include those who do not carry out medical treatment. A husband or wife who assists a spouse to take medication prescribed by a doctor does not need delegated authority to do so. The need for delegation of authority arises in cases where treatment that would normally be carried out by a medical practitioner is carried out by another healthcare professional.

2.13 The Act is not intended to affect the position of doctors' civil liability. Liability for negligent treatment remains with the negligent practitioner. The general medical practitioner unqualified in dentistry cannot be said to authorise a course of treatment given by a dentist. What he or she can do is to certify in accordance with section 47(1) that the adult is incapable in relation to a decision about such treatment.

### **The certificate of incapacity**

2.14 Under subsection 47(1), the general authority to treat is triggered by a certificate stating that the medical practitioner primarily responsible for the medical treatment of the adult is of the opinion that the adult is incapable in relation to a decision about the medical treatment in question.

2.15 Under subsection 47(5), the certificate of incapacity has to be in a prescribed form and must specify the period during which the authority remains valid, being a period which

- a. The medical practitioner primarily responsible for the medical treatment of the adult considers appropriate to the condition or circumstances of the adult; but
- b. Does not exceed one year from the date of the examination on which the certificate is based.

A copy of the certificate is attached at Annex 2.

2.16 To demonstrate that the medical practitioner primarily responsible has fulfilled the requirements of section 47(3), it would be good practice to record such instructions, approval or agreement in the patient's medical record.

2.17 Three matters must be considered before completing the certificate mentioned at 2.14 (above). Firstly, the medical practitioner must have in contemplation some treatment by a health professional, whether acute or continuing. What is meant by "treatment" is outlined in paragraphs 2.32 - 2.36 below. Secondly, the medical practitioner must be satisfied that the adult is incapable in relation to a decision about the treatment in question. Suggestions on how the adult's capacity might be assessed are given below. Thirdly, the proposal for treatment must be consistent with the general principles laid down in section 1 of the Act.

2.18 It would be unreasonable and impractical to issue a certificate of incapacity for every health care intervention in some people. *For example, a person with dementia in a nursing home may have multiple physical and mental health care needs in addition to a requirement for fundamental procedures to ensure nutrition, hydration, elimination, etc.* On the other hand, a single certificate of incapacity is entirely appropriate when a person requires a single procedure e.g. an operation. The Act specifies, under section 47(2), that "the medical practitioner primarily responsible for the medical treatment of the adult shall have ... authority to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult". This could cover not only the operation but also post-operative medical care and pain relief. It is therefore clear that the certificate of incapacity, as designed, will provide an effective and workable means for managing single healthcare interventions but requires careful completion for a person who needs multiple interventions. A possible way to complete the certificate would be by reference to a treatment plan.

### **Use of Treatment Plans**

2.19 For people requiring multiple or complex healthcare interventions, a treatment plan similar to that suggested at Annex 5 could be (but does not have to be) drawn up. The treatment plan could outline the healthcare interventions that can be foreseen over the time specified in the certificate of incapacity and may be attached to the certificate of incapacity and held in the adult's medical case record. The doctor could write in the line *following Consenting to Medical Treatment in the form of...* the phrase "see attached treatment plan". The treatment plan could contain a list of interventions along with a judgement from the medical practitioner regarding the adult's capacity to consent to these interventions. The exact content of the treatment plan will be negotiable. The medical practitioner should follow the general principles of the Act in formulating a plan and seeking the views of other relevant people. The practitioner must strike a balance between a plan that is too broad and therefore at odds with the principles of the Act, and one that is too narrow and might need to be changed on a frequent basis. Examples are shown in Annex 5.

2.20 There are certain healthcare procedures to which all adults are entitled. These need not be listed individually on the form but might be included under a general heading of "Fundamental Healthcare Procedures". This will include nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing, and oral hygiene. If prevention and treatment of infections are not to be included, this should be made clear to the proxy or carer. This would take into account guidance from the Chief Medical Officer that all residents in long-term care should be vaccinated against influenza on an annual basis.



2.21 The treatment plan could include a list of conditions for which treatment is required or foreseen in order to safeguard or promote the physical or mental health of the adult. *For example, a treatment plan for an adult in a nursing home suffering from cerebrovascular dementia may need interventions in the areas of ischaemic heart disease, hypertension, stroke, depression, and sleep.* The interventions would be listed on the treatment plan along with a judgement, in the right hand column, as to whether the adult can or cannot consent to the intervention.

2.22 No treatment plan of this sort can authorise interventions that would normally require the signed consent of the adult. A separate certificate of incapacity will be required for each intervention of this type. *For example, if the adult in 2.21 (above) needs heart surgery, this will not be included in the authority to treat under "ischaemic heart disease" and will require a separate certificate and separate consultation.* Note also that, normally, no treatment specified in regulations as needing special safeguards can be included in the treatment plan. (See 2.58, below).

2.23 During the period specified by the certificate of incapacity, other conditions may come to light requiring healthcare interventions. Where this is a single, time-limited intervention, it may be appropriate to write a separate certificate of incapacity to cover this. However, if a condition requiring continuing intervention occurs, it may be necessary to rewrite a treatment plan, if used.

2.24 The treatment plan may include names and designations of people consulted. These should include a relative of the patient and must include the patient's welfare attorney or guardian or person authorised under an intervention order if such a person exists and where such a person has authority to consent to treatment on behalf of the adult. Where the adult is in institutional care, consultation with a senior member of care staff should be recorded.

*Seek consent of a proxy with welfare powers, where reasonable and practicable*

2.25 The Act requires that even where a proxy has been appointed, a certificate under section 47(1) should be completed. When considering the issue of a certificate, the medical practitioner should ascertain whether it would be reasonable and practicable to seek the consent of a proxy with welfare powers. A proxy may be a guardian, a welfare attorney, or a person authorised under an intervention order. (See also paragraphs 2.66 to 2.72 below for more detailed guidance on this matter.) It will be desirable for any proxy to make himself or herself known during the admission process of a patient into hospital. If the existence of a proxy with powers to consent to treatment on behalf of the adult is suspected but not known, it would be good practice for the medical practitioner to check with the adult's close relatives. Contact can also be made, where practicable, with the Public Guardian who will be able to check his registers and provide the name and contact details of any proxy with welfare powers appointed in terms of the Act. The local authority social work department may also have this information. The details of any proxy with welfare powers appointed prior to the Act will be unknown to the Public Guardian.

*Apply the general principles to the treatment in contemplation before the certificate is issued*

2.26 In deciding to certify the adult's incapacity, the medical practitioner must apply the general principles to the situation. The medical practitioner must be satisfied that the treatment would:

2.26.1 **Benefit** the adult, and that the benefit cannot reasonably be achieved without treatment; and

2.26.2 Be the **least restrictive option** in relation to the freedom of the adult, consistent with the purpose of the treatment. This should include, among other things, considering the duration of the certificate. The maximum duration is a year but it will often be appropriate to set down a shorter period. The duration should be related to the expected duration of the incapacity **and** of the treatment in prospect. **Treatment without legal authority is not an option.**

*Take account of the wishes of the adult*

2.27 The medical practitioner must also **take account of the present and past wishes and feelings of the adult in so far they can be ascertained by any means of communication.** This is an unqualified obligation. Guidance on communicating with the adult is given below under the heading of *Assessment of capacity*. The best person to give an account of his or her wishes or feelings is the adult him or herself. However if verbal communication is impossible, or the patient's ability to comprehend information and respond to it appropriately is found to be very limited, other sources of information will have to be used. Non-verbal communication may be taken into account, for example if the patient shows unusual distress at the mention of a particular kind of treatment or the sight of particular apparatus or instruments, even after attempts to reassure have been made.

2.28 Medical records may record the past wishes of the adult from earlier contacts with the medical profession. It will be essential to try to ascertain the adult's past wishes and feelings from those who know him or her. While these reports should be taken into account, the medical practitioner should guard against taking at face value everything that relatives or carers say about the adult's past wishes and feelings, in case these have been misunderstood or are being misrepresented. If time allows and it is feasible to do so, it may be appropriate to contact the patient's solicitor, member of the clergy or other adviser to ascertain whether the patient at any time in the past expressed wishes or feelings on the subject of his or her medical treatment.

2.29 A competently made advance statement made orally or in writing to a medical practitioner, solicitor or other professional person would be a strong indication of a patient's past wishes about medical treatment but should not be viewed in isolation from the surrounding circumstances. The status of an advance statement should be judged in the light of the age of the statement, its relevance to the patient's current healthcare needs, medical progress since the time it was made which might affect the patient's attitude, and the patient's current wishes and feelings. An advance statement cannot bind a medical practitioner to do anything illegal or unethical. An advance directive is a document which specifically refuses particular treatments or categories of treatment. Such documents are potentially binding. When the medical practitioner contemplates overriding such a directive, appropriate guidance should be sought.

2.30 The medical practitioner will also need **to take account of the views of the nearest relative or anyone nominated by the sheriff and primary carer, in so far as it is reasonable and practicable to do so, and of anyone else with an interest in the welfare of the adult.** This does not require the medical practitioner to go to undue lengths to seek out such people. It would be good practice to make enquiries of the adult's visitors, social work officer or other personnel currently involved with the adult and make such contacts with relatives as are

reasonable and practicable in the circumstances, (distinguishing between the personal views of such people, and light they are able to shed on the adult's own views).

2.31 A welfare attorney, and a welfare guardian, have responsibility for **encouraging the adult to exercise residual capacity**. This does not mean that a patient who is very unwell must be encouraged to decide things for him or herself at all costs, but it does mean that if a medical practitioner consults an existing proxy about medical treatment, that proxy has a duty to encourage the adult to participate in the medical decision. Medical practitioners exercising a general authority to treat under section 47(2) do not have this obligation but should try to do so as a matter of good practice. They should be alert to the legal obligation on a proxy who is involved in a medical decision to do so, and it will be good practice for the medical practitioner to give appropriate co-operation.

### Meaning of “treatment”

2.32 Under subsection 47(4), “medical treatment” **includes any procedure or treatment designed to safeguard or promote physical or mental health**. Under subsection 47(2), subject to certain exceptions discussed below, the medical practitioner primarily responsible for the treatment of the adult shall have, during the period specified in the certificate, authority to **do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult**. A single certificate may cover multiple treatments (see 2.19 – 2.24, above).

2.33 The rule for a patient with incapacity is the same as for a patient who has capacity to consent. Treatment should depend on clinical need. The only relevant difference between a patient with incapacity and a patient with capacity is the ability to consent. There is nothing in the Act that would justify discrimination of any form between a patient with and a patient without capacity. The Act is designed to ensure that as far as possible adults with any incapacity have equity of treatment and choice with adults with capacity. The mechanism under section 47 allows for the medical practitioner to proceed without the consent of the patient or a proxy where this consent is not available. The certificate authorises the treatment to proceed in the absence of the consent that a capable patient would have given.

2.34 Generally treatment will involve some positive intervention in the patient's condition. Simple failure to do anything for a patient would not be treatment. However a decision not to do something is still an intervention in terms of section 1 principles, and must accord with those principles. It is difficult to conceive of circumstances in which a medical practitioner would take no steps at all in relation to a patient.

2.35 It would therefore be good practice to make an assessment and complete a certificate of incapacity where the conditions in section 47(1) apply, whatever the treatment contemplated.

2.36 Treatment includes any procedure designed to promote or safeguard physical or mental health. Where the patient is unable to consent and there is no proxy with the necessary authority to do so, healthcare professionals will be unable to administer the treatment without instructions from, or the approval or agreement of a medical practitioner who has issued a certificate of incapacity. Good liaison will be needed between medical practitioners and others providing healthcare at local level to ensure that such certificates are requested and issued at the appropriate times. Patients themselves and their carers should be made aware of the need for

such a certificate by the provision of appropriate information by NHS Boards and Trusts, through all appropriate outlets.

### **Change of circumstances**

2.37 Subsection 47(6) provides that if, after issuing a certificate, the medical practitioner primarily responsible for the treatment of the adult is of the opinion that the condition or circumstances of the adult have changed, he may

- a. Revoke the certificate
- b. Issue a new certificate specifying such period not exceeding one year from the date of revocation of the old certificate as he considers appropriate to the new condition or circumstances of the adult.

2.38 This could apply if the adult's capacity changes, for example a person with learning difficulties develops dementia. Or it could happen if the adult's medical condition changes or the diagnosis changes. A change of circumstances could include a significant difference between the type or duration of treatment contemplated when a certificate was first signed, and the treatment that subsequently turns out to be clinically indicated. If this happens, it would be good practice to revoke the first certificate and make out a new certificate covering the new treatment. Good practice would indicate that if a capable patient would have been asked for consent to a change in treatment owing to a new diagnosis or developing knowledge of his or her medical condition, then an incapable patient ought to be subject to a new certificate. The issue of any new certificate would require a fresh assessment of the patient, just as revocation would. There will, however, be cases where a relatively general wording in the certificate will be the most appropriate action. This will obviate developing a multiplicity of certificates where the patient's condition or diagnosis develops rapidly or is complex. It will of course be essential to keep the adult's condition and capacity to consent under regular review.

#### *Change of medical practitioner*

2.39 Where the medical practitioner who has signed a certificate of incapacity ceases to be primarily responsible for the adult's treatment (for instance, if the adult moves elsewhere, or the doctor retires or moves to another post) and another doctor takes over responsibility, the new practitioner should review the adult's circumstances. If these have not changed, the certificate may continue to apply. If the adult's circumstances have changed, the new practitioner can revoke the original certificate and, if necessary, issue a new one.

### **Assessment of capacity**

2.40 The Act stresses an approach to the assessment of capacity that is decision or action-specific. It is not an all or nothing condition.

2.41 An adult does **not** have impaired capacity simply by virtue of

- being in community care
- having a psychotic illness

- having dementia, particularly in the early stages
- having difficulties with speech or writing
- having an addiction
- disagreeing with the treatment or those offering it
- having learning difficulties or disabilities
- being vulnerable or at risk from him or herself or others
- behaving irrationally
- being promiscuous
- having a brain injury
- having a physical disability
- having a history of offending
- having an acquired or progressing neurological condition.

It is central to the Act that adults must **not** be labelled as incapable because of some other circumstance or condition. The assessment of capacity must be made in relation to the particular matter or matters about which a decision or action is required. An adult assessed as incapable in relation to one matter should not, without proper assessment, be assumed to be incapable in relation to other matters.

2.42 Medical practitioners looking to assess capacity for the purposes of section 47(1)(a) should bear in mind that they are assessing capacity in relation to a decision about the medical treatment in question. Every possible assistance must be given to the adult to understand his or her own medical condition and the decision that is required in relation to treatment.

2.43 Medical practitioners should be on guard for signs that the adult, although apparently participating in decision-making, is unduly suggestible, as others may have a vested interest in asserting that the adult is, or alternatively is not, capable of taking decisions on medical matters. Carers and relatives will have valuable information about the patient's present and past wishes and feelings but care should be taken not to let them simply answer for the adult, or put words into his or her mouth. They should be asked to differentiate between expression of their own views, which may be relevant, and reporting known views of the adult.

2.44 It is a statutory requirement to take account of the present and past wishes and feelings of the adult, so far as they can be ascertained by any means of communication appropriate to the adult. Such communication includes human communication or communication by mechanical aid. It will be reasonable to use the help of the adult's relatives, friends, social worker, clergy, or others who may be available and in a position to assist. A multidisciplinary approach is commended, utilising particularly the services of clinical psychologists, neurologists,

speech and language therapists and of qualified and experienced interpreters, where it is reasonable and practicable to do so.

2.45 In assessing whether capacity has been impaired, it can often be useful to consider what is “normal” for that adult. This will assist in cases where there may be incapacity linked to a psychotic illness, dementia, acquired brain injury or a progressive disease which can involve deteriorating capacity in its later stages. In acquired conditions, what is normal for the adult should be the baseline for assessment of capacity, not any societal norm. The medical practitioner should draw on his or her own knowledge of the patient, as well as information from relatives, carers and other professionals, to assess whether there has been a deterioration in the patient’s capacity, and the likely duration of that deterioration. Ultimately, however, the central issue is whether the person retains adequate capacity to take the decision or decisions in question. Patients with fluctuating capacity (for example resulting from delirium or hypomanic conditions) will present particular issues. In such cases, it may be best that a certificate of incapacity should be of short duration to ensure that the patient’s freedom is not restricted more than necessary. If a decision can reasonably be deferred until the adult is likely to regain sufficient capacity then in accordance with section 1 principles, it must be deferred.

2.46 It is important to note that an adult with learning difficulties may also experience deteriorating capacity as a result of ageing or illness. Many such patients will be capable of consenting personally to medical treatment given proper explanations and support and it will be important to be alert to the possibility that their capacity may also change over time.

2.47 A medical practitioner should bear in mind that issuing a certificate of incapacity is a potential restriction of the freedom of the patient. If a patient was capable of consenting to treatment previously there will need to be very careful assessment of why the patient is no longer deemed to be capable of doing so. It will be essential to involve relevant others in reaching that assessment and obtain if possible their agreement that this is the correct way forward. A doctor’s assessment of incapacity for the purpose of the certificate may be challenged in court and will have to be well grounded in the Act.

#### **Matters not covered by the general authority to treat**

2.48 There are several exceptions to the general authority to treat. These are discussed below.

##### *Treatments falling under the Mental Health (Scotland) Act 1984*

2.49 It is not necessary to detain an adult formally under the 1984 Act because they are unable to consent to treatment for mental disorder. If an adult with incapacity who is not formally detained under the 1984 Act requires treatment for a mental disorder, this may be given under the 2000 Act. If the adult resists that treatment, this should be taken as an indication of the adult’s wishes, which must be taken into account in terms of section 1 of the 2000 Act. Consideration should be given to whether it would be appropriate that they should be formally detained under the 1984 Act in order that they might benefit from the added protections which that Act offers. Advice may be sought from a psychiatrist or mental health officer. In difficult cases, the Mental Welfare Commission may be able to advise.

2.50 With regard to patients liable to detention under the Mental Health (Scotland) Act 1984, section 48(1) of the 2000 Act provides that treatments dealt with in Part X of the 1984 Act are not covered by the general authority to treat under the 2000 Act. Part X applies to patients subject to long term (6 month) or short term (28 day) detention under the 1984 Act, and parallel

forms of mental health detention imposed under the Criminal Procedure (Scotland) Act 1995. Part X of the 1984 Act covers treatment for mental disorder generally. It also provides additional safeguards for the following treatments:

- neurosurgery for mental disorder and surgical implantation of hormones to reduce sexual drive (where the adults' consent AND the opinion of a doctor and 2 lay person's appointed by the Mental Welfare Commission is required) and
- ECT and drug treatment for mental disorder over 3 months (where the adult's consent OR a second opinion by a doctor appointed by the Mental Welfare Commission is required).

2.51 Where an adult is formally detained under the provisions of the 1984 Act any treatment for mental disorder must be authorised under that Act rather than by the 2000 Act. Treatment which is authorised to be given without consent under Part X of the 1984 Act may be given where the patient is assessed as being unable to consent due to incapacity. However, the treatment provisions in the 2000 Act cannot override the need for a detained patient's consent and/or a second opinion under sections 97 and 98 of the 1984 Act.

2.52 Part X of the 1984 Act does not apply to treatments for physical conditions unrelated to the mental disorder. Therefore, if a patient who is detained under the 1984 Act requires treatment for a physical condition they should be assessed for their capacity to consent to such treatment and, if appropriate, treatment considered under the provisions of the 2000 Act. There are some situations where the 1984 Act authorises detention, but does not authorise treatment for mental disorder. In such cases, treatment for mental disorder may be given under Part 5 of the 2000 Act where the adult is assessed as being unable through incapacity to consent to such treatment. However, these situations essentially relate to emergency detention for short periods. If treatment is required during these periods, it is likely to be on an emergency basis, and may require to be carried out using the common law (see paragraph 2.3). The relevant provisions are:

1984 Act

section 24 or 25(1) – patient detained by virtue of an emergency recommendation

section 25(2) – nurse's holding power

section 117 or 118 – removal to a place of safety

section 64(2) or 68(2) – patient conditionally discharged and not recalled to hospital

Criminal Procedure (Scotland) Act 1995

section 58(9) – detention pending admission to hospital

2.53 A certificate authorising such treatment under the 2000 Act should only be made out for the shortest possible period. It would not be good practice to continue to treat a patient detained under the above provisions for longer than absolutely necessary. For someone who is no longer formally detained, but who is not objecting to remaining in hospital, or who can be treated in the community, Part 5 of the 2000 Act can continue to be used.

2.54 This guidance relates to current mental health legislation, the 1984 Act. The guidance on the interaction of the two Acts will be reviewed when new mental health legislation is implemented (which is unlikely to occur before 2004).

### *The use of force or detention*

2.55 Subsection 47(7) prohibits the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances. The interpretation of this will depend on the particular circumstances of each case, but the principles set out in section 1 of the Act must be applied. So, for example, the *degree* of force applied must be the minimum necessary. Where an adult shows continued resistance to treatment for mental disorder consideration should be given to detaining the adult under mental health legislation.

2.56 It may be helpful to refer to the Mental Welfare Commission's guidance "Principles and Guidance on Good Practice – Restraint of residents with mental impairment in care homes and hospitals" which is available on the MWC's website at [www.mwscot.org.uk/publications.htm](http://www.mwscot.org.uk/publications.htm). Useful guidance may also be found in the Scottish Commission for the Regulation of Care's National Care Standards, which can be obtained from The Stationery Office.

2.57 Placing the adult in hospital for treatment for mental disorder against his or her will can only be carried out by making an application formally to detain the adult in hospital under the 1984 Act. However, where it is not against the patient's will, treatment by way of admission to hospital may be permitted under the 2000 Act.

### *Treatments regulated under section 48(2)*

2.58 Under the provisions of section 48(2) of the 2000 Act certain irreversible or hazardous treatments may not be given with the authority of one medical practitioner under section 47(2). The administration of these treatments is subject to regulations made under section 48 of the Act. Such treatments or types of treatment may not be given to any patient who is unable to consent to them except in the specific circumstances and with the specific approvals detailed in the regulations. The treatments specified by regulations under section 48 of the Act are the subject of separate guidance, in the form of a supplement to this code of practice.

### *Welfare guardians and attorneys*

2.59 Welfare guardians and attorneys may not consent on behalf of the patient to any treatment which is regulated under section 48(2). However, the views of the welfare guardian or attorney should be taken into account when considering treatment for the adult.

### *Where there is a criminal law prohibition*

2.60 The Act introduces a new criminal offence. Under section 83 it shall be an offence for any person exercising powers under the Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult. The penalties are on summary conviction up to 6 months imprisonment or a fine of up to £5000 or both and on indictment up to 2 years imprisonment or a fine or both. A medical practitioner who issued a certificate of incapacity under the Act and then ill-treated or wilfully neglected the adult would be liable to prosecution for this offence, as would anyone acting on his or her instructions or with his or her approval or agreement.

2.61 The Act does not affect the existing criminal law whereby anybody who acted in such a way towards another person as to unlawfully cause or hasten his or her death would be guilty of a criminal offence. Neither does the Act change the law in relation to euthanasia, which remains a criminal act under Scots Law.



2.62 The criminal law and the general principles of the Act are consistent on this point. Part 5 only authorises the issuing of a certificate, and the provision of medical treatment under it, if it will benefit the adult and there is no reasonable way of achieving the benefit without the intervention. Nothing in the Act authorises acts or omissions which harm, or are intended to bring about or hasten the death of a patient. During Parliamentary debate on the Act there was extensive discussion of this matter. Ministers made it absolutely clear that the Act does not permit any form of euthanasia, which remains a criminal act under Scots Law. As the then Deputy Minister for Community Care, Iain Gray, said in the Scottish Parliament,

“Any health professional, like any individual, who acted by any means – whether by withholding treatment or by denying basic care, such as food and drink – with euthanasia as the objective, would be open to prosecution under the criminal law.”

All interventions under the Act (including some omissions to act) must comply with the general principles that all interventions must benefit the adult, and that any intervention must be the least restrictive option in relation to the freedom of the adult. Clearly, an intervention under Part 5 of the Act which adversely affects the well-being of an adult or causes harm or even death to that adult cannot be described as bringing a benefit to that adult. Section 47 of the Act only allows intervention to “safeguard or promote the physical or mental health of the adult”. This does not impose a duty to provide futile treatment or treatment where the burden to the patient outweighs the clinical benefit.

*Where there is or could be a conflicting court decision*

2.63 Section 47(7)(b) provides that the general authority does not cover action which would be inconsistent with any decision by a competent court. This could cover questions about the medical practitioner’s authority, and questions about whether the treatment itself should be given.

2.64 Section 47(9) provides that where any question as to the authority of any person to provide medical treatment under the general authority is subject to an application to the court (other than in the case of a specified treatment) and that application has not been determined, the treatment shall not be given. However it is still possible to give treatment where it is necessary to preserve life or prevent serious deterioration in the adult’s medical condition. This would include circumstances where a deterioration would not be immediate but the need for treatment to prevent such deterioration is immediate. It is less clear whether action taken to prevent circumstances arising in which patients’ prospects of a full or more complete recovery are inhibited, would be covered by the concept of “prevention of serious deterioration” in all cases. Where practicable the view of the court in question should be taken. It is thought, however, that conventional treatment designed to maintain the patient’s prospects of full recovery may, in many circumstances, be considered to be for the prevention of serious deterioration in the adult’s medical condition.

2.65 Section 47(10) and section 49(3) provide that nothing shall authorise the provision of any medical treatment where an interdict has been granted and continues to have effect prohibiting the provision of such medical treatment.

*Where there exists or there is an application to appoint a proxy with powers to consent*

2.66 Section 49 prevents treatment, except for the preservation of life or the prevention of serious deterioration, if there is an application before the sheriff for an intervention order or

guardianship order with power in relation to the treatment and that application has not yet been determined. Medical practitioners should have early discussions with the applicants for such powers where possible, with regard to any potential treatments which would or would not require consultation with them.

2.67 The prohibition only applies where this is within the knowledge of the medical practitioner primarily responsible. There is no need to make disproportionate effort to find out whether there is such an application but it would be good practice for the medical practitioner to check with the adult's close relatives and social work officer, if any, whether they are aware of such an application. The code of practice for guardians and intervenors makes clear that applicants for relevant powers should make themselves known to the adult's medical practitioner.

2.68 Subsection 50(2) disapplies the general authority where there is a proxy (guardian, welfare attorney or person authorised under an intervention order) with powers in relation to the medical treatment **and** the medical practitioner primarily responsible is aware of the appointment **and** it would be reasonable and practicable to obtain the proxy's consent but the medical practitioner has failed to do so.

2.69 Again, the code of practice for guardians and intervenors makes clear that guardians and intervenors with relevant powers should make themselves known to the adult's medical practitioner. However, it would be good practice to check with close relatives and/or the adult's social work officer (if any) whether such an appointment is known to them. Details of proxies should be systematically recorded in relevant medical records. If the medical practitioner primarily responsible considers that some further steps should be taken to ascertain whether there is such a proxy, this can be done most readily by contacting the Public Guardian, for those appointed after the Act came into effect (after 2 April 2001 for attorneys, and after 1 April 2002 for guardians and intervenors). There may be pre-Act guardians and attorneys whose existence is not known to the Public Guardian.

2.70 If the existence of a proxy or an application for the appointment of a proxy is identified, the medical practitioner should consider whether it would be reasonable and practicable to postpone the treatment until it has been possible to obtain the proxy's consent. It would be reasonable to do so if the proxy is visiting the adult in hospital regularly, or regularly accompanies the adult to outpatient or GP appointments. If the proxy is not someone with whom the medical practitioner otherwise has contact, he or she should ascertain whether the proxy can be readily contacted to discuss the matter face to face. The proxy could be asked to attend an appointment or if the proxy has difficulty in doing this, a domiciliary visit could be considered.

2.71 Attorneys may be individuals or professionals such as solicitors. Welfare guardians and persons authorised under an intervention order may be individuals, professionals or social work officers exercising guardianship powers delegated by the chief social work officer. Proxies who are acting in a professional capacity should be prepared to make time to discuss the adult's treatment even if they do not have day to day contact with the adult. For private individuals, much will depend on their accessibility. It is reasonable to expect that proxies with power in relation to medical treatment will make themselves available to consult with medical practitioners. Although there will be times that the proxy is unavailable, simple failure to respond should be reported to the appropriate authorities. Everything will depend on the particular circumstances of the case, but it is expected that proxies will have a continuing interest in and knowledge of the adult, and should be contacted.

2.72 It may emerge in the course of seeking a proxy's consent that the adult is not receiving the attention he or she should from that proxy in terms of the proxy's duties (see Annex 1 for reference to relevant codes of practice). In such circumstances it would be good practice for the medical practitioner to take some action to draw this to the attention of the authorities. Local authorities have a statutory duty to investigate complaints received about welfare proxies, and the medical practitioner should contact the local authority for the area in which the adult normal resides if he or she considers that a proxy is not acting properly. If in doubt, the medical practitioner may also be able to receive guidance from the Public Guardian, the Mental Welfare Commission or a range of voluntary bodies (see contacts list in Annex 3).

### 3. DISPUTE RESOLUTION

#### ***Key points in part 3***

***It is best to proceed with consensus on medical treatment matters; but consensus is not always attainable.***

***In the event of a dispute with a proxy, the medical practitioner primarily responsible has recourse to the MWC's list of Nominated Medical Practitioners.***

***Proxies have a right to be consulted by, and to choose their own nominee to be consulted by, the Nominated Medical Practitioner.***

***If the Nominated Medical Practitioner agrees with the medical practitioner primarily responsible, the treatment may be given.***

***If the Nominated Medical Practitioner agrees with the proxy, the medical practitioner primarily responsible may appeal to the Court of Session.***

***Anyone having an interest may apply to the Court of Session for a determination as to whether the treatment should be given or not.***

#### **Procedure under section 50**

3.1 Section 50 envisages that a proxy with welfare powers should be given the opportunity to consent to the proposed medical treatment wherever reasonable and practicable.

3.2 Even after discussion, proxy decision-makers will not always agree with the medical treatment proposed by the doctor in charge of the case. Others close to an adult may also disagree with the doctor and, indeed, with the opinion of the proxy. Section 50 of the Act sets down a procedure for resolving such disagreements. The procedure applies only in cases where a proxy decision-maker has been appointed, but it gives rights not only to the proxy, but also in certain circumstances to "any person having an interest in the personal welfare of the adult". Such a person may be a close relation of the adult, or a person who has lived with, or cared for or about them, over a significant period. The term does not extend to those whose interest is that of an onlooker, such as interested pressure groups, uninvolved neighbours, or those seeking to achieve objectives which are of wider import than the welfare of the particular adult. It should be noted that, while proxies can legitimately object to particular courses of medical treatment, they may not act unreasonably by, for example, refusing fundamental care procedures. Proxy decision-makers have a duty of care to the adult on whose behalf they act, and a duty to abide by the general principles set out in section 1 of the Act.

#### **What if delay will put the adult at risk**

3.3 Treatment in emergencies is specifically exempted from the scope of the Act. There is already a common-law authority for a doctor to treat a patient for the preservation of the life of the adult or the prevention of serious deterioration in his or her medical condition, which is not

superseded by the Act. There should be no question, therefore, of consultation putting a patient's life at risk. What is meant by "reasonable and practicable" will vary from situation to situation. It will normally be reasonable and practicable to consult relatives, proxies or carers, where these people are present or easily contactable.

#### Where there is no disagreement between the medical practitioner primarily responsible and the proxy

3.4 Where there is no disagreement as to medical treatment between the medical practitioner primarily responsible and the proxy decision-maker, medical treatment as proposed may normally be given. The exception to this is where a person having an interest in the personal welfare of the adult (as described above) is of a different opinion. In such circumstances, the Act gives such a person the right to appeal to the Court of Session on the question of medical treatment. Where an appeal is initiated, further treatment must not be given, except for the preservation of the life of the adult or the prevention of serious deterioration in his or her medical condition. It will obviously be preferable for the medical practitioner to take account at an early stage of the views of such persons in terms of section 1 (4) (d) of the Act, rather than have the courts involved.

#### Nominated Medical Practitioners

3.5 As part of the procedure for resolving disagreements, the Act requires the Mental Welfare Commission to establish and maintain a list of medical practitioners. From this list, the MWC can nominate a doctor from the appropriate specialty (the "Nominated Medical Practitioner") to give an opinion as to medical treatment which is independent of that of the medical practitioner primarily responsible for treatment.

#### Where there is disagreement between the medical practitioner primarily responsible and the proxy

3.6 In situations where a disagreement arises between the doctor and the proxy decision-maker, the doctor must request the Mental Welfare Commission to provide a "Nominated Medical Practitioner" to give a further opinion as to the medical treatment proposed. The Nominated Medical Practitioner must, in such circumstances, have regard to all the circumstances of the case and must consult the proxy about it. The Nominated Medical Practitioner must also consult any other person nominated by the proxy, if it is reasonable and practicable to do so. Such a person may be the GP of the adult, a consultant in a relevant speciality, or a relative, a carer, an independent advocate or someone else who knows the adult well.

#### Where the Nominated Medical Practitioner agrees with the medical practitioner primarily responsible

3.7 If, after taking these steps, the Nominated Medical Practitioner certifies an opinion that the proposed medical treatment should be given, then the medical practitioner primarily responsible may give the treatment in spite of the disagreement with the proxy, unless an

application to the Court of Session is initiated. The opinion of the Nominated Medical Practitioner in such circumstances must be confirmed in writing in the patient's medical notes.

#### Where the Nominated Medical Practitioner does not agree with the medical practitioner primarily responsible

3.8 Where a disagreement still exists after the Nominated Medical Practitioner has certified an opinion, the medical practitioner primarily responsible may ask the Court of Session to determine whether the proposed treatment should be given or not. The same right to apply to the Court is also extended to any person having an interest in the personal welfare of the adult (as described above). In such a case, further treatment must not be given, except for the preservation of the life of the adult or the prevention of serious deterioration in his or her medical condition.

#### The need for full and careful discussion and documentation

3.9 It will be seen from the foregoing paragraphs that the Act requires detailed consultation with proxies and, if necessary, with the Nominated Medical Practitioner. It is the responsibility of the medical practitioner primarily responsible for treatment to ensure that such consultation is carried out and fully documented. The Nominated Medical Practitioner has an additional duty to consult a person nominated by the proxy if reasonable or practicable, and should ensure that an agreed record of such consultation is kept with the patient's medical notes. It will be necessary in terms of section 1 of the Act for the medical practitioner primarily responsible and the Nominated Medical Practitioner to consult also relatives or carers who express a strong opinion. Consideration and discussion of such opinions at this stage are likely to reduce the chances of lengthy and costly court action at a later stage.

#### Where an action is taken to the Court of Session

3.10 Where action in the Court of Session is initiated by the medical practitioner primarily responsible or by any person having an interest in the personal welfare of the adult, the general authority to treat is withdrawn until the Court of Session has determined the matter. The only exception to this is the common-law authority to give emergency treatment, that is, treatment for preservation of life or prevention of serious deterioration in the patient's condition. Such emergency treatment can be given, so long as there is no interdict in force prohibiting the giving of such medical treatment.

### **Appeals on decisions as to medical treatment**

3.11 All decisions taken on medical treatment under Part 5 of the Act are open to appeal to the courts. Section 52 of the Act establishes a comprehensive appeals procedure which may be used by any person having an interest in the personal welfare of an adult with incapacity. Appeals may be heard by the sheriff, and may be taken further, by leave of the sheriff, to the Court of Session. It is important to note that this section extends to all provisions for medical treatment under Part 5 – with the exception of decisions made by doctors under section 50, which are appealed direct to the Court of Session. The process of appeal will of course be

made easier if medical practitioners and others making decisions under Part 5 have recorded their decisions and, where relevant, the reasons for those decisions at the time they are made.

3.12 Section 14 of the Act allows a decision taken by a medical practitioner as to the incapacity of an adult to be appealed by the adult. It may also be appealed by any person claiming an interest in the adult's personal welfare for the purposes of Part 5 of the Act.

What if the court decision conflicts with the principles of the medical practitioner primarily responsible

3.13 The great majority of decisions on medical treatment under Part 5 of the Act are likely to be resolved with no difference of opinion between the doctor and proxy decision-maker. Only a very small number of cases are likely to go to court for decision. Having heard the evidence, the court will be able to make a ruling on whether or not a patient should have a particular course of treatment. Courts will not be able to instruct a particular doctor to give a certain type of treatment against his or her principles - merely to instruct that the patient should receive that form of treatment.

## 4. AUTHORITY FOR RESEARCH

### ***Key points in Part 4***

***Research on adults incapable of consenting is authorised under the Act provided that***

***It will further knowledge;***

***It is of benefit to the adult or others in a similar condition;***

***It entails little or no risk or discomfort;***

***the adult is not objecting;***

***consent has been obtained from a person with relevant powers; and***

***the research has been approved by The Ethics Committee.***

### **Authority for research**

4.1 Section 51 sets out the circumstances and conditions which must apply when research involving adults with incapacity is undertaken. Subsection (1) of that section specifies that the term 'research' embraces surgical, medical, nursing, dental or psychological research. Subsection (2) provides that the purpose of involving adults with incapacity in research is to gain knowledge of the causes, diagnosis, treatment and care of the adult's incapacity or the effect of any treatment or care given to the adult while he or she is incapable.

4.2 One of the overriding conditions attached to involving adults with incapacity in research is that similar research cannot be done by involving adults who can consent. This condition is paramount. It is not sufficient to say there are no capable volunteers.

4.3 The other conditions which must be fulfilled are in section 51(3) (a) to (f):

(a) The research must be of direct benefit to the adult involved. (There are circumstances in which this qualification can be waived. These are discussed below.)

(b) The research must not be carried out if the adult indicates unwillingness.

(c) Ethical approval for the research must be obtained from The Ethics Committee. The Ethics Committee, specifically established by regulations made by Scottish Ministers, has the discretion to attach conditions other than those listed, when granting ethical approval. Local Research Ethics Committees have no power to grant approval for research on adults with incapacity, or to consent to it.

(d) The research involves no foreseeable risk or only minimal risk to the adult and should impose no or only minimal discomfort. These conditions should be seen in the context of the adult's standard treatment, if that is appropriate.



(e) Before any research involving the adult is undertaken consent must be obtained from a guardian or welfare attorney of the adult who has powers to consent in relation to participation in research. If none has been appointed, the consent of the adult's nearest relative is required.

4.4 These conditions, which are in no particular order, must all be fulfilled before an adult who cannot consent can be involved in research.

#### Where no direct benefit to adult exists

4.5 The first of the conditions set out above is that the research must be of real and direct benefit to the adult involved. However, subsection 51(4) of the Act provides exceptionally for the possibility that research may be carried out even where it is not likely to produce real and direct benefit to the adult. This is where the research is likely to improve the scientific understanding of the adult's condition and the attainment of real and direct benefit to the patient or persons suffering from the same incapacity. Were such research to cease altogether, there could be serious consequences for future prevention and treatment of serious conditions (e.g. into the treatment of stroke, serious head injuries, and Alzheimer's disease). It is still necessary in these circumstances to comply with subsections (1), (2), and (3) (b)-(f) of section 51 of the Act.

#### The Ethics Committee

4.6 Section 51 enables the Scottish Ministers to make regulations to establish The Ethics Committee and prescribe those matters which that Committee must take into account when approving research. This is not an exclusive list and The Ethics Committee may examine such other matters as are relevant and appropriate to the applications for ethical appraisal submitted to them.

## List of codes of practice and regulations under the Act

**ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000****CODES OF PRACTICE**

[Code of practice for local authorities exercising functions under the Act](#)

[Code of practice for persons authorised under part 3 to access funds of an adult](#)

[Code of practice for continuing and welfare attorneys](#)

[Code of practice for persons authorised under an intervention order and guardians](#)

**Still to be published:**

Code of practice for managers of authorised establishments

Code of practice for supervisory bodies

**REGULATIONS**

[The Adults with Incapacity \(Scotland\) Act 2000 \(Commencement No. 1\) Order 2001 \(SSI No.81\)](#)

[The Adults with Incapacity \(Public Guardian's Fees\) \(Scotland\) Regulations 2001 \(SSI No.75\)](#)

[The Adults with Incapacity \(Certificates from Medical Practitioners\) \(Accounts and Funds\) \(Scotland\) Regulations 2001 \(SSI No.76\)](#)

[The Adults with Incapacity \(Supervision of Welfare Attorneys by Local Authorities\) \(Scotland\) Regulations 2001 \(SSI No.77\)](#)

[The Adults with Incapacity \(Countersignatories of Applications for Authority to Intromit\) \(Scotland\) Regulations 2001 \(SSI No.78\)](#)

[The Adults with Incapacity \(Evidence in Relation to Dispensing with Intimation or Notification\) \(Scotland\) Regulations 2001 \(SSI No.79\)](#)

[The Adults with Incapacity \(Certificates in Relation to Powers of Attorney\) \(Scotland\) Regulations 2001 \(SSI No.80\)](#)

[Guidance Note for Signatories](#)

[The Civil Legal Aid \(Scotland\) Amendment Regulations 2001 \(SSI 2001 No.82\)](#)

[The Adults with Incapacity \(Supervision of Welfare Guardians etc by Local Authorities\) \(Scotland\) Regulations 2002 \(S.S.I. 2002/95\)](#)

[The Adults with Incapacity \(Reports in Relation to Guardianship and Intervention Orders\) \(Scotland\) Regulations 2002 \(S.S.I. 2002/96\)](#)

[The Adults with Incapacity \(Recall of Welfare Guardians' Powers\) \(Scotland\) Regulations 2002\(S.S.I. 2002/97\)](#)

[The Adults with Incapacity \(Non-compliance with Decisions of Welfare Guardians\) \(Scotland\) Regulations 2002 \(S.S.I. 2002/98\)](#)

[Civil Legal Aid \(Scotland\) Amendment Regulations 2002 \(S.S.I. 2002/88\)](#)

**Certificate of Incapacity under Section 47 of the Adults**

**with Incapacity (Scotland) Act, 2000**

I.....(name)

of..... (address)

being the medical practitioner primarily responsible for the medical treatment of

.....(name)

of.....

.....(address)...../...../.....(date of birth)

for whom the guardian/welfare attorney/person appointed by intervention order/nearest relative/carer is.....

have today examined the patient named above. I am of the opinion that he/she is incapable in terms of the Adults with Incapacity (Scotland) Act 2000 because of (nature of incapacity)

.....

in relation to a decision about the following medical treatment.....

.....

.....

This incapacity is likely to continue for.....months. I therefore consider it appropriate for medical treatment to be authorised by this certificate until...../...../.....(a date not more than one year later than the date of the examination on which this certificate is based) or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the Act.

Signed..... Date...../...../.....

## Contacts list

### Documents

- For copies of the Act, the Explanatory Notes and any Regulations, and also for any other related legislation:  
Stationery Office Bookshop  
71 Lothian Road  
Edinburgh EH3 9AZ  
Tel 0870 606 5566  
Fax 0870 606 5588  
[www.scotland-legislation.hmso.gov.uk/](http://www.scotland-legislation.hmso.gov.uk/)
- For copies of the codes of practice relating to the Act:  
Scottish Executive  
Justice Department  
Civil Law Division  
Floor 2 West (Rear)  
St Andrews House  
Regent Road  
Edinburgh EH1 3DG  
0131 244 2193

All documents may be downloaded from the Website  
[www.scotland.gov.uk/justice/incapacity/](http://www.scotland.gov.uk/justice/incapacity/)

### Statutory authorities under the Act

- Public Guardian  
Hadrian House  
Callendar Business Park  
Falkirk FK1 1XR  
Tel: 01324 678300  
[www.publicguardian-scotland.gov.uk](http://www.publicguardian-scotland.gov.uk)

Mental Welfare Commission for Scotland  
Argyle House  
3 Lady Lawson Street  
Edinburgh EH3 9SH  
0131 222 6111  
[www.mwscot.org.uk](http://www.mwscot.org.uk)

- Local authority

To contact your local authority on matters relating to the Act you should ask for the social work department or community services department at your own local council offices. Their address is in your phone book.

You can also get information about your own local authority from the Convention of Scottish Local Authorities, at the address below.

Convention of Scottish Local Authorities

Rosebery House

9 Haymarket Terrace

Edinburgh EH12 5XZ

0131 474 9200

[www.cosla.gov.uk/](http://www.cosla.gov.uk/)

- Courts  
Scottish Court Service  
Hayweight House  
23 Lauriston Street  
Edinburgh EH3 9DQ  
0131 229 9200

[www.scotcourts.gov.uk/](http://www.scotcourts.gov.uk/)

The address and telephone number of your local sheriff court should be in your telephone directory.

#### Contacts on specific issues referred to in the code

- Advocacy

For copies of “Advocacy a guide to good practice” which contains details of advocacy projects across Scotland and “Independent Advocacy: A Guide for Commissioners”

Scottish Executive Health Department

Health Planning and Quality Division

St Andrew’s House

Regent Road

Edinburgh EH1 3DG

Tel: 0131 244 2839

For information on independent advocacy and on projects active in Scotland:

Advocacy 2000

134 Ferry Road

Edinburgh EH6 4PQ

0131 554 7878

- Education

Your local education authority will provide information.

For copies of “Enquire- the parents’ guide to special educational needs” and “Your Future Needs Assessment”:

Children in Scotland  
5 Shandwick Place  
Edinburgh EH2 4RG  
0131 228 8484

- Health

You can find addresses for your local health services in your phone book or from the local library or Citizen’s Advice Bureau.

The Local Health Council will also be able to direct you to information available from the Local Health Education Board. Or you may contact:

Health Education Board for Scotland  
The Priory  
Canaan Lane  
Edinburgh EH10 4SG  
0131 536 5502

Health Service Commissioner for Scotland (Ombudsman)  
28-38 Thistle Street  
Edinburgh EH2 1EN  
0131 225 7465

- Social security

Contact your local Benefits Agency office (details in your phone book)

There is also a free Benefit Enquiry Line for People with Disabilities on 0800 88 2200 (textphone users 0800 24 33 55).

- Housing

Local authority housing departments or units

Scottish Federation of Housing Associations  
38 York Place  
Edinburgh EH1 3HU  
0131 556 5777  
[www.sfha.co.uk](http://www.sfha.co.uk)

- Legal Aid

Scottish Legal Aid Board  
44 Drumsheugh Gardens  
Edinburgh EH3 7SY  
0131 226 7061  
[www.slab.org.uk](http://www.slab.org.uk)

- Solicitors

Law Society for Scotland  
26 Drumsheugh Gardens  
Edinburgh EH3 7YR  
0131 226 7411  
[www.lawscot.org.uk](http://www.lawscot.org.uk)

Other useful contacts:

- Alzheimer Scotland- Action on Dementia  
22 Drumsheugh Gardens  
Edinburgh EH3 7RN  
0131 243 1453  
[www.alzscot.org](http://www.alzscot.org)  
  
Dementia Helpline  
Freephone 0808 808 3000
- ENABLE  
6<sup>th</sup> Floor  
7 Buchanan Street  
Glasgow G1 3HL  
0141 226 4541  
[www.enable.org.uk](http://www.enable.org.uk)
- Capability Scotland  
22 Corstorphine Road  
Edinburgh EH12 6HP  
0131 337 9876  
[www.capability-scotland.org.uk](http://www.capability-scotland.org.uk)
- Scottish Association for Mental Health  
Cumbrae House  
15 Carlton Court  
GLASGOW G5 9JP  
Tel: 0141 568 7000  
[www.samh.org.uk](http://www.samh.org.uk)
- Sense Scotland  
5<sup>th</sup> Floor  
45 Finnieston Street  
GLASGOW G3 8JU  
Tel: 0141 564 2444  
[www.sensescotland.org.uk](http://www.sensescotland.org.uk)
- Citizens Advice Bureau  
Address in your local phone book or from  
Citizen's Advice Scotland  
26 George Square  
Edinburgh EH8 9LD  
0131 667 0156  
[www.cas.org.uk](http://www.cas.org.uk)

- Criminal Injuries Compensation Board  
Tay House  
300 Bath Street  
Glasgow G2 4LN  
0141 331 2726  
[www.cica.gov.uk](http://www.cica.gov.uk)
- Royal College of Speech and Language Therapists  
2 White Hart Yard  
London SE1 1NX  
Tel : 020 7378 1200

Contacts within the Scottish Executive

Health Department  
Community Care Division  
St Andrews House  
Regent Road  
Edinburgh EH1 3DG  
Tel: 0131 244 5389

Health Department  
Public Health Division  
St Andrews House  
Regent Road  
Edinburgh EH1 3DG  
Tel. 0131 244 3457

Health Department  
Community Care Inspectorate  
St Andrews House  
Regent Road  
Edinburgh EH1 3DG  
Tel : 0131 244 3752

Justice Department  
Civil Law Division  
St Andrews House  
Regent Road  
Edinburgh EH1 3DG  
Tel : 0131 244 2193



**Treatment plan for patients**

receiving ongoing treatment under the terms of Part 5 of the Adults with Incapacity (Scotland) Act 2000.

Name of patient..... Date of birth...../...../.....

Address.....

.....

I have today examined the above patient and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention.

<b>Disorder/intervention</b> (See note A)	<b>Capacity</b> C = capable I = incapable
1. Fundamental healthcare procedures (see note B)	

I have consulted the following people over this treatment plan and over the patient's capacity (see note C):

Name..... Designation.....  
 Address.....

Name..... Designation.....  
 Address.....

Signed.....

## Notes on completion of treatment plan

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

A. Under the Act, you can only intervene if it will benefit the patient. Your intervention must be the least restrictive in relation to the patient's freedom in order to achieve the required benefit. You must take the patient's views into account and you must consult other relevant people, where reasonable and practical.

**Include** all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B). You should consider the patient's capacity to consent to each intervention. Under the Act, the patient is incapable if he/she is incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions. **Exclude** all interventions that would ordinarily need the signed consent of the patient. Interventions of this sort need a separate certificate of incapacity. *For example, if you write "Ischaemic heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, treat disease with anti-hypertensive drugs but not operate to bypass blocked arteries.*

**You may not include on this form any treatment regulated under section 48 of the Act. Please consult the regulations and separate guidance issued on these treatments.**

B. Fundamental healthcare procedures include all measures to promote or safeguard the following: nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

C. The Act requires you to take the views of others into account when deciding on an intervention. You should discuss this plan with professional carers and relatives of the patient. Any person with an interest in the welfare of the patient may appeal a treatment decision to the Sheriff. If the patient has a Welfare Attorney or Guardian with the authority to consent to treatment, you must consult this person where reasonable and practical. You can find out if your patient has a Welfare Attorney or Guardian by contacting the Public Guardian on 01324 678300. If this person disagrees with any element of your plan, you must obtain a second opinion from a Nominated Medical Practitioner appointed by the Mental Welfare Commission for Scotland, tel. 0131 222 6111.

You may find that you need to treat a condition that is not specified in your treatment plan. If this is a short lived condition, a separate certificate in relation to it might suffice. If it is a condition that is likely to need ongoing intervention, you should consider rewriting the treatment plan.

This treatment plan is only valid for the period specified in the certificate of incapacity.

## ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

Treatment plan for patients receiving ongoing treatment under the terms of Part 5 of the Act

Name of patient...Mary Smith..... Date of birth...1/...1/...21

Address...1 Suilven Road.....  
 .....Edinburgh.....

I have today examined the above patient and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention.

Disorder/intervention (See note A)	Capacity C = capable I = incapable
1. Fundamental healthcare procedures (see note B)	I
2. Iron deficient anaemia	I
3. Coronary artery disease	I
4. Cerebrovascular disease	I
5. Osteoarthritis	I
6. Behaviour disturbance associated with dementia <i>except for treatment with conventional neuroleptic drugs</i>	I
7. Prevention and treatment of infection <i>except for treatment with penicillin</i>	I

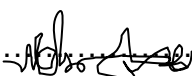
I have consulted the following people over this treatment plan and over the patient's capacity (see note C):

Name...Christine Smith.....  
 Designation.....Daughter.....

Address.....As above.....

Name.....Sarah Jones..... Designation.....Ward  
 Manager.....

Address.....Cairngorm Nursing Home, Edinburgh.....

Signed.......... Print name...John Foster.....

Address...Grampian Hospital..... Designation...Consultant Physician.....  
 .....Edinburgh..... Date .....1/4/02.....

## ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

Treatment plan for patients receiving ongoing treatment under the terms of Part 5 of the Act

Name of patient.....Jack Green..... Date of birth...1../...1../..80...

Address.....22 Ochil Road.....

.....Aberdeen.....

I have today examined the above patient and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention.

Disorder/intervention (See note A)	Capacity C = capable I = incapable
1. Fundamental healthcare procedures (see note B)	C
2. Psychological treatment for aggression	I
3. Epilepsy (Except for barbiturate drugs and phenytoin)	I
4. Treatment for mood disorder <i>except for lithium</i>	C

I have consulted the following people over this treatment plan and over the patient's capacity (see note C):

Name.....Harriet Green.....Designation.....Mother.....

Address.....As above.....

Name.....Chris Black.....Designation.....Psychologist.....

Address.....Sidlaw Centre, Aberdeen.....

Signed ..... Print name...Clare Goodfellow.....

Address.....Eildon Surgery..... Designation.....General Practitioner....

.....Aberdeen..... Date .....1/4/02.....

## Notes on worked examples

Example A: Mrs Smith is an elderly lady in hospital continuing care. She has been suffering from stroke disease, dementia and has other medical conditions. She now has an advanced degree of dementia and her physical condition is very poor. She can be aggressive and uncooperative with simple interventions, including bathing and hygiene. She is incontinent and her mobility is declining. She has suffered from recurrent chest infections and should have annual influenza vaccination.

The Consultant reviews the treatment plan as part of an annual review and discusses the future with the ward manager and the patient's daughter. The plan allows for all fundamental healthcare to be given despite her resistance as she is agreed to be incapable in relation to many of these interventions. **It would not be reasonable or practical to decide on capacity in relation to each individual aspect of fundamental care.** The other aspects of the treatment plan reflect present and predicted interventions. Discussion reveals that she is allergic to penicillin and has reacted badly to certain classes of medication for behaviour disturbance in the past. The daughter insists that these are listed as exceptions in the treatment plan. This is recorded on the treatment plan and on separate documentation in accordance with Trust policy.

Example B: Mr Green suffers from learning disability and epilepsy. He lives with his parents and receives input from the Community Learning Disability team. He has some problems with behaviour and has been treated for episodes of bipolar mood disorder. He has no need for interventions listed under "Fundamental Healthcare procedures" except for speech therapy. He is judged to be capable in relation to this procedure. A case review is held to discuss the rest of the treatment plan. All agree that he needs a psychological approach to his behaviour problems but that he lacks the capacity to fully understand what this procedure involves. He also does not appreciate that he has epilepsy and sometimes refuses his medication. The treatment plan gives his carers more authority to try to get him to take medication when he is reluctant. However, he knows that his mood can be unstable and agrees that he needs treatment for this. He was treated with lithium once and had severe side effects. All agree that he is capable of deciding that this treatment should be excluded and this is recorded on the treatment plan. **If he actively resists other treatment for mental disorder, treatment under the Mental Health Act should be considered.**

These examples illustrate the importance of following the general principles of the Act. They also show how the Act can help to reinforce good medical practice in making decisions in consultation with other relevant parties.