Medical treatment for adults with incapacity

Guidance on ethical and medico-legal issues in Scotland

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Summary

Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000 sets out the framework for regulating intervention in the affairs of adults (people over 16) who have impaired capacity. Capacity is assessed in relation to the particular decision that needs to be made.

General principles

Any intervention in the affairs of an incapacitated adult must:

- benefit the adult
- take account of the adult's wishes, so far as these can be ascertained
- take account of the views of relevant others, as far as it is reasonable and practical to do so
- restrict the adult's freedom as little as possible while still achieving the desired benefit; and
- encourage the adult to exercise residual capacity.

Emergencies

In an emergency, doctors may provide medical treatment that is immediately necessary to save life or avoid significant deterioration in a patient's health without issuing a certificate of incapacity.

Certificate of incapacity

Other than in an emergency, where an adult lacks capacity to make health care decisions, a certificate of incapacity must be issued in order to provide care or treatment.

Once a certificate has been issued, doctors may rely on consent from a proxy decision maker or, where there is no proxy, on the general authority to treat.

Proxy consent

Once a certificate of incapacity has been issued, a welfare attorney, person authorised under an intervention order or welfare guardian with powers relating to the medical treatment in question may give consent to medical treatment on behalf of an incapacitated adult.

Proxies may also refuse medical treatment, provided that in doing so they are fulfilling their duty of care to the adult and are abiding by the general principles in the Act.

General authority to treat

Where there is no proxy decision maker, and a certificate of incapacity has been issued, doctors have a general authority to treat a patient who is incapable of giving consent to the treatment in question.

Disagreement

If there is disagreement about an adult's treatment, there are procedures that must be followed, including obtaining a second medical opinion. If disagreement persists, an application may be made to court.

1 Introduction

The Adults with Incapacity (Scotland) Act 2000 (the Act) introduced a statutory framework for the medical treatment of incapacitated adults (aged 16 or over) in Scotland. It acts alongside the common law power to provide treatment in emergencies to people who are unable to give consent. Amendments to Section 5 of the Act relating to medical treatment and research were introduced in 2005 by the Smoking, Health and Community Care Act.

The Act introduces new forms of proxy decision-making, and clarifies the legal basis upon which doctors make decisions about the medical treatment of incapacitated adults. The Act also makes provision for safeguarding the welfare of incapacitated adults, and managing their property and financial affairs. Doctors may become involved in assessing a person's capacity to make decisions about these matters but it is Part 5 of the Act, which regulates medical treatment and research, that will have the biggest impact on medical practice. Its provisions took effect in July 2002.

2 Adults with Incapacity (Scotland) Act

The Act sets down general principles, which must underpin any intervention in the affairs of an incapacitated adult. Interventions must:

- benefit the adult
- take account of the adult's wishes, so far as these can be ascertained
- take account of the views of relevant others, as far as it is reasonable and practical to do so
- restrict the adult's freedom as little as possible while still achieving the desired benefit; and
- encourage the adult to exercise residual capacity.

Acting within these principles, a proxy decision maker who has been appointed to make medical decisions may give consent to medical treatment on behalf of an incapacitated adult. Where no proxy has been appointed, doctors have a general authority to provide treatment. These provisions of the Act may be used once a certificate of incapacity has been issued in relation to the treatment in question. The Act defines medical treatment as including 'any procedure or treatment designed to safeguard or promote physical or mental health'. In addition to treatment of illness and management of symptoms, the BMA believes that this covers preventive medical measures, such as immunisation or screening, in the absence of any discernible symptoms of disease. Incapacitated patients are entitled to benefit from preventive measures available to other patients. Of course, the general principles must be considered, and it is important not to subject incapacitated patients to measures where there is no discernible benefit to them.

2.1 Withdrawing and withholding treatment

The Scottish Executive Health Department (SEHD) has stated that 'generally treatment will involve some positive intervention in the patient's condition' and that 'simple failure to do anything for a patient would not be treatment'.[1] In other words, the focus of the proxy decision-making provisions and the general authority to treat is the authorisation of treatment, not decisions to withhold treatment. These decisions are affected by the legislation, however, since the general principles apply to all decisions on behalf of incapacitated adults. Where a decision to withhold or withdraw treatment that has the potential to prolong life is being considered, doctors should also consult the BMA's *Withholding and withdrawing life-prolonging medical treatment* for advice about decision-making and safeguards.[2]

3 Emergencies

The Act is designed to work alongside the existing common law provisions enabling treatment to be given to an incapacitated adult in an emergency where consent cannot be obtained. This includes interventions designed to prevent serious deterioration in the patient's condition. This is unchanged by the Act and in these circumstances, no certificate of incapacity is needed.

If, in an emergency, a patient refuses treatment and there is doubt about his or her capacity to do so, doctors should take whatever steps are necessary to prevent deterioration of the patient's condition and then consider matters of capacity and consent. These steps should also be taken if a proxy refuses to give consent but the doctor in charge judges that treatment is in the patient's best interests. Once essential treatment has been given, the procedures for resolving disagreement between doctors and proxies must be followed (see section 10). Where it is clear that a patient is competent to refuse treatment, doctors may not provide treatment against the patient's wishes. For information on advance decisions refusing treatment, see section 9.2.1.

4 Assessment of capacity

An assessment of capacity should be decision-specific. The Act stresses that an assessment of capacity should be made in relation to the particular decision that needs to be made at the time it needs to be made. An assessment of capacity is not based on the test 'would a rational person decide as this person has decided?'. Rather, the thought processes behind the decision are relevant to the question of capacity.

A person is incapacitated if he or she is incapable of acting, making decisions, communicating decisions, understanding decisions or retaining the memory of decisions due either to a mental disorder or to a physical disability which prevents communication. Assessments of capacity should not be made on the basis of a specific diagnosis. Not all people suffering from a mental disorder, for example, lack the capacity to make decisions about their care. Capacity is not an 'all-or-nothing' concept but depends on the nature of the decision that needs to be made. Broadly speaking, in order to demonstrate capacity, individuals should be able to:

- understand in simple language what the treatment is, its purpose and nature and why it is being proposed
- understand its principle benefits, risks and alternatives
- understand in broad terms what will be the consequences of not receiving the proposed treatment
- retain the information long enough to use it and weigh it in the balance in order to arrive at a decision.

In cases where patients have borderline or fluctuating capacity, it can be difficult to assess whether the individual can make valid decisions on very serious issues. The BMA has published detailed practical advice about assessing capacity.[3] In many cases there will, of course, be no doubt about a person's capacity. Where there is doubt, a comprehensive psychological investigation may be needed, which would seek to determine whether the adult:

- is capable of making a choice
- understands the nature of what is being asked

- understands why a choice is needed
- has memory abilities that allow the retention of information
- is aware of any alternatives
- has knowledge of the risks and benefits involved
- is aware of the decision's personal relevance to him or herself
- is aware of his or her right to refuse, as well as the consequences of refusal
- is aware of how to refuse
- is capable of communicating his or her choice
- has ever expressed wishes relevant to the issue when greater capacity existed; and
- is expressing views consistent with previously preferred moral, cultural, family, and experiential background.

A patient's abilities can fluctuate because of a range of factors, including medical condition, medication, time of day or mood. The fifth principle of the Act states that doctors have a duty to enhance capacity when it is possible to do so, and should seek to engage patients in decision-making when they are best able to participate.

Doctors constantly assess whether patients have the capacity to make the decision they are faced with. Mental abilities can be influenced by both medical and psychiatric conditions. Any doctor should, however, be able to take a psychiatric history and to conduct a basic mental state examination in order to define straightforward abnormalities irrespective of their cause. Many people can be assessed by their own GP. Indeed, a close, long-term acquaintance with the person being assessed may be an asset, particularly if the person is more relaxed with a familiar doctor. Where the person's capacity is borderline, however, or the treating doctor does not feel able to make an objective assessment, specialist advice should be sought.

5 Adults with capacity

If a patient is found to have the capacity to make a decision about medical treatment, he or she is entitled to decide whether to accept or reject the treatment. Doctors must respect a refusal of treatment if the patient is an adult who has the capacity to make the decision in question, is properly informed and is not being coerced. Patients are entitled to refuse treatment even where doing so may result in permanent physical injury or death. Where the consequences of refusal are grave, it is important that patients understand this. They should also understand that, for clinical reasons, refusing treatment now may limit future treatment options. Decisions about treatment options are best made with ongoing communication and dialogue between the patient and health care team. Doctors should present options to patients, together with information about their purpose, benefits, risks and chances of success. Patients do not have the right to demand that they are given treatment the clinical team thinks is inappropriate, but patients' wishes are taken into account whenever possible. Different considerations may apply where the treatment is for mental disorder and provided under the provisions of mental health legislation (see section 12).

6 Certificate of incapacity

Other than in an emergency, in order to provide medical treatment or care to an incapacitated adult, the doctor in charge of the patient's care, normally a GP or consultant, must issue a certificate of incapacity to state that the patient is incapable in relation to a decision about proposed medical treatment. A certificate is needed to allow doctors to act under the general authority to treat or to rely on a proxy's consent to treatment.

Where the doctor in overall charge is not available, a certificate may be issued by a fully registered doctor who is authorised to act on that doctor's behalf.

The certificate must state:

- that the doctor has examined the patient and is of the opinion that he or she lacks capacity for this particular matter
- the nature of the medical treatment in question
- the likely duration of the adult's incapacity; and
- the period for which the specified treatment is authorised. (This will not ordinarily exceed one year, although a certificate can be provided for up to three years where a patient was suffering from either server or profound learning disability, severe dementia or severe neurological disorder.)

Where a person requires a single, one-off procedure such as an operation, it is entirely appropriate to issue a single certificate, which would extend to pre- and post-operative care. Certificates may also cover multiple interventions, which should be described on the certificate. Interventions including the offer of oral nutrition and hydration, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing, and oral hygiene need not be listed separately on certificates, but would be encompassed under a general heading of 'fundamental healthcare procedures'.

To avoid unnecessary bureaucracy, doctors are likely to want to use relatively general wording in the certificate to allow for flexibility. Where there is a treatment plan detailing the adult's care, the plan could be appended and referred to on the certificate. A new certificate is needed, however, if a new treatment is required that is not covered by the initial certificate. A new certificate may also be needed if the patient's condition or diagnosis changes. Detailed advice about completing certificates, with examples, is published by the SEHD. The advice also covers the use of treatment plans which could outline healthcare interventions that can routinely be seen over the period of time covered by the certificate.

There is a standard format for the certificate which must be used. Copies are available from the SEHD. In both primary and secondary care, it is part of doctors' terms and conditions to assess their patients' capacity for medical treatment they are providing. Provision of certificates in other circumstances and for parts of the Act unrelated to medical treatment may attract a fee. Advice on when fees may be charged is available from the BMA offices in Scotland.

7 Proxy decision-making

In this guidance the term 'proxy decision maker' means a welfare attorney, person authorised under an intervention order, or welfare guardian with powers relating to the medical treatment in question (see appendix).

GPs who are aware that a patient has appointed a proxy decision maker should note this in the medical record, together with contact details. Hospitals and other establishments treating patients on an in-patient basis need to ascertain whether there is a proxy decision maker when a patient is admitted. A register of valid proxies is held by the Public Guardian and may be checked, including by telephone during office hours. Contact details are given in section 15 of this guidance. This information might also be available from the patient,

his or her relatives, carers or others close to the patient. Otherwise, the local authority social work department may be able to help.

The roles and responsibilities of proxies are set out in codes of practice.[4] They 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 the Act (see section 9). If it is apparent that a proxy is not fulfilling his or her duties, or is acting contrary to the interests of the patient, this matter should be drawn to the attention of the authorities. Local authorities have a statutory duty to investigate complaints about welfare proxies. Advice is also available from the Public Guardian and Mental Welfare Commission.

7.1 Proxy consent

When an adult lacks the capacity to make a decision, and a certificate of incapacity has been issued, a proxy who has been granted the relevant power may give consent to medical treatment on behalf of the adult. Where a doctor is aware that a proxy decision maker has been appointed, and it is reasonable and practicable to obtain the proxy's consent for treatment, this must be sought. Wherever possible, doctors should postpone treatment until a proxy has been consulted. In all cases, however, it is important to ensure that discussion with a proxy does not introduce delays that jeopardise the patient's care.

Proxies may also refuse medical treatment, provided that they are fulfilling their duty of care to the adult and are abiding by the general principles in the Act (see section 9). If there is disagreement about how to proceed, there are procedures set out in the Act that must be followed (see section 10).

8 General authority to treat

Where there is no proxy decision maker, doctors may issue a certificate of incapacity and act under the 'general authority' to treat. The general authority applies to treatment of patients incapable of giving consent to the treatment in question. It applies to the doctor who has signed the certificate of incapacity and members of the health care team acting on his or her behalf. This general authority may not be used where there is a proxy decision maker (or a pending application) and it is reasonable for that person's consent to be sought. Similarly, if there is an appeal to the Court of Session regarding treatment, only emergency treatment may be provided until the court has ruled (see section 11).

9 General principles

As mentioned above, the Act is based on a set of guiding principles which doctors are legally required to apply to all their interactions with incapacitated patients. The principles describe accepted standards of good practice, and closely reflect the BMA's ethical advice. This section sets out the principles, and what they mean in practice.

9.1 Benefit

Be satisfied that the proposed treatment is needed to benefit the patient.

Doctors have a general duty to provide treatment that benefits their patients. Benefit in this context has its ordinary meaning of an advantage or net gain for the patient. It is broader than whether the treatment simply achieves a physiological goal. It includes other less tangible advantages such as respecting the patient's known wishes and values. It encompasses avoiding harming the individual by infringing his or her rights.

The health care team, proxy decision makers, and people close to the patient should discuss what might benefit the patient, taking into account the patient's past and present wishes. Competent patients may choose for themselves whether to accept or decline further treatment. Similarly proxies should be able to decline treatment if it is believed to be what the individual would have chosen. In complex cases it will be necessary to take legal advice, or even take a case to court, where the assessment of benefit is difficult or agreement cannot be reached.

The law recognises that there may be circumstances in which continuing to provide life-prolonging medical treatment to a patient does not provide a benefit. The SEHD has stated that the Act 'does not impose a duty to provide futile treatment or treatment where the burden to the patient outweighs the clinical benefit'.[5] The courts have also confirmed that it is sometimes not in a patient's interests to continue to provide artificial nutrition and hydration.[6] The BMA issues detailed advice about decisions to withhold or withdraw potentially life-prolonging treatment.[7]

9.2 Past and present wishes and feelings

Take account of the past and present wishes and feelings of the patient, using whatever means of communication are appropriate.

Doctors must consider a patient's past wishes and values when deciding on treatment, as far as they can be ascertained, and a written, witnessed advance statement, made when the patient was competent and informed, can be important evidence of these.

9.2.1 Advance directives

Advance directives are not covered by the Act, nor by case law in Scotland. There has, however, been case law in England that has confirmed that people may refuse, in advance, procedures that they do not want if they become incapacitated. This case law has been codified in the Mental Capacity Act 2005. The BMA believes that there is no reason to assume that the courts in Scotland would take a different approach to the English courts. The relevant code of practice states that valid advance refusals of treatment 'are potentially binding', and, in the BMA's view, doctors should comply with an unambiguous and informed advance refusal when the refusal specifically addresses the situation that has arisen.[8] Emergency treatment should not normally be delayed in order to look for an advance directive if there is no clear indication that one exists. Detailed advice about advance decision-making is available in the BMA's book *Advance statements about medical treatment.*[9]

9.3 Views of others

Consultation with relevant others.

When considering whether an intervention should be made, consultation with proxies and others close to the patient is essential, and should be well documented. Where reasonable and practicable, consideration should be given to the views of:

- the nearest relative and primary carer
- any guardian, continuing attorney or welfare attorney who has powers relating to the proposed intervention
- any person whom the sheriff has directed should be consulted
- anyone with a reasonable interest in the welfare of the adult.

Consensus about the patient's interests is the aim. In consulting others, doctors must bear in mind their duty of confidentiality to the patient, and disclose information about their patient's health only where this is in keeping with the patient's past and present wishes, and not contrary to his or her interests.

The role of a proxy or other person close to the patient is not to decide what he or she would want in the patient's position. Proxies are only entitled to make decisions that benefit the patient, that are really needed, that are in keeping with the patient's past and present wishes, and that the patient cannot make for him or herself. Proxies' views may not override a valid and applicable advance statement.

9.4 Minimum intervention

Be satisfied that the proposed treatment is the least restrictive option in relation to the patient's freedom, consistent with the purpose of the intervention.

Doctors should consider the available alternatives when deciding what treatment is appropriate for a patient. The Act is based on a principle of 'minimum intervention', so that regard must be paid to how much a proposed treatment restricts the patient's freedom. The treatment chosen should be the option that achieves the aim while restricting the patient's freedom as little as possible.

9.5 Enhance capacity

Enhance the patient's capacity and encourage him or her to exercise any residual capacity.

Some patients' capacity can fluctuate with their condition, medication, mood or the time of day. There is a statutory duty on any guardian, continuing attorney, welfare attorney or manager of an establishment exercising functions under the Act to encourage patients to use their existing skills and develop new ones. Health professionals caring for incapacitated patients should do the same. The BMA publishes advice on enhancing capacity in its book *Assessment of mental capacity*.[10]

10 Disagreement

It is obviously best to proceed with consensus on medical treatment. Where everybody is in agreement over proposed treatment, generally it may proceed with a proxy's consent or, where there is no proxy, under the doctor's general authority to treat. Disagreement about treatment should be rare. Discussion and ongoing consultation can help doctors to understand the patient's priorities, and help proxies and others close to the patient to understand the reasoning behind clinical decisions. If agreement cannot be reached, however, the Act puts in place procedures for resolving disputes.

Where the doctor who signed the certificate of incapacity and a proxy disagree about a treatment (or non-treatment) decision, the doctor must obtain a second opinion from a medical practitioner nominated by the Mental Welfare Commission.[11] The nominated medical practitioner must consult the proxy. He or she must also consult anybody else nominated by the proxy (so far as is reasonable and practicable). If the nominated medical practitioner agrees with the treating doctor, the treatment may be given notwithstanding the proxy's refusal, unless there is an application to the Court of Session (see section 11).

If the nominated medical practitioner disagrees with the treating doctor, legal advice should be sought. An appeal may be made to the Court of Session by the treating doctor to determine whether the treatment should be given or not. In the interim, only emergency treatment may be provided (see section 3).

11 Appeal to the court

Appeal to the court should be very rare. In all cases, doctors should seek prior legal advice.

All decisions about medical treatment, under the general authority or where there is a proxy, are open to appeal to the courts. Any person with an interest in the personal welfare of an adult with incapacity may challenge a decision by appealing to the sheriff and then, by leave of the sheriff, to the Court of Session.[12] This person may be the treating doctor, another member of the clinical team caring for the adult, a proxy decision maker, or a close relation or person who has lived with, and cared for, the adult over a significant period. It does not include 'onlookers' such as interested pressure groups, uninvolved neighbours or those seeking to achieve objectives, which are of wider significance than the welfare of the particular adult.

While an appeal is pending, doctors may provide only emergency treatment.

The courts can instruct that the patient should receive the treatment in question, but cannot instruct a particular doctor to provide treatment contrary to his or her professional judgement or conscience.

12 Mental Health (Care and Treatment) (Scotland) Act 2003

The provisions of the Adults with Incapacity (Scotland) Act include the option to provide treatment for a patient's mental disorder. If the patient is resisting treatment for a mental disorder, however, this should be taken as an indication of the adult's wishes, and consideration should be given to whether it is appropriate to detain the patient under the Mental Health (Care and Treatment) (Scotland) Act. In this way, the patient benefits from the added protection that the Act offers. Where a patient is detained, the Mental Health (Care and Treatment) (Scotland) Act procedures must be followed. Doctors must also follow the provisions of the Adults with Incapacity (Scotland) Act where a detained patient needs treatment for which he or she is incapable of giving consent and which falls outwith the scope of mental health legislation.

13 Special safeguards

Regulations have been made specifying irreversible or hazardous treatments that require safeguards in addition to those set out in the general principles.[13] The additional safeguards must be applied and these treatments may not be provided under the general authority to treat or proxy consent provisions of the Act. The Regulations do not affect doctors acting in an emergency where treatment is necessary to preserve life or prevent serious deterioration in health.

The following treatments require approval by the Court of Session:

- sterilisation where there is no serious malformation or disease of the reproductive organs
- surgical implantation of hormones for the purpose of reducing sex drive.

The following treatments require approval by a practitioner appointed by the Mental Welfare Commission:

- drug treatment for the purpose of reducing sex drive, other than surgical implantation of hormones
- electro-convulsive therapy for mental disorder
- abortion (in addition to meeting the provisions of the Abortion Act 1967)
- any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

13.1 Young people

None of the regulated treatments for mental disorder may be provided to an incapacitated patient who is 16 or 17 unless either the doctor in charge of care has a qualification, or special experience, in child and adolescent psychiatry or that doctor has sought and obtained an opinion in writing from a doctor who does. In addition, the practitioner appointed by the Mental Welfare Commission must have a qualification, or special experience, in child and adolescent psychiatry or another specialism appropriate to the treatment of the patient.

13.2 Use of force or detention

Force or detention may only be used where immediately necessary, and only for as long as is necessary to achieve the aim. In addition to being difficult to achieve in practice, imposing treatment on incapacitated adults where they refuse could damage relationships with health care providers and undermine trust in carers. It is important that force or detention is used only as a last resort, and with continual support and explanation for the patient. This is an area where doctors should consider the impact of the Human Rights Act on their decisions. Article 5 of the European Convention on Human Rights protects patients against arbitrary detention.[14]

14 Research

The Act regulates the involvement of incapacitated adults in research.[15] It permits involvement where the purpose is to gain knowledge of the causes, diagnosis, treatment and care of the patient's incapacity, or the effect of any treatment given to the patient while he or she is incapable and similar research cannot be undertaken involving adults who can consent. The research may aim to provide direct benefit to the patient concerned. Research that does not have this aim is also permitted in exceptional cases, where it is likely to improve the scientific understanding of the patient's condition and the attainment of real and direct benefit to the patient or others suffering from that incapacity.

In these cases, and with consent from a proxy or nearest relative, the patient may participate in research provided that:

- the patient does not object
- the research is approved by the Ethics Committee established by Regulations to fulfil this function
- the research involves no or only minimal risk to the patient; and
- the research imposes no or only minimal discomfort.

There is no guidance on how to interpret 'minimal risk' in this context. Doctors are referred to the substantial body of published guidance reflecting internationally accepted standards for research involving incapacitated patients.

15 Contacts

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Appendix: Definitions

Adult
An adult is someone who is age 16 years or over.

Mental disorder
A mental disorder is defined in the Act as mental illness, including personality disorder, or mental handicap however caused or manifested. The Act states that a person shall not be treated as suffering from mental disorder 'by reason only of promiscuity or other immoral conduct, sexual deviancy, dependence on alcohol or drugs, or acting as no prudent person would act'.

Welfare attorney
A power of attorney is a deed by which one person (the granter) gives another person (the attorney) the authority to act in the granter's name and on his or her behalf. Where the authority relates to decisions about personal welfare, this is called a welfare power of attorney. To grant power of attorney, a person needs to understand the nature and extent of the power, and be free from undue influence. Doctors may be asked to assess capacity to grant power of attorney. The power comes into effect when the granter loses capacity in relation to the welfare decision in question. Doctors may also be involved in assessing this. The power must be registered with the Public Guardian to have effect.

A welfare power of attorney can include powers to consent to medical treatment. It may not, however, grant the power to:

- place the adult in hospital for treatment of mental disorder against his or her will
- consent on behalf of the granter to certain treatments under the Mental Health (Care and Treatment) (Scotland) Act 2003; or
- consent to treatment specified under regulations (see section 13).

Intervention orders and guardianship
Where an adult lacks the capacity to make welfare decisions, a sheriff may make an intervention order or appoint a guardian to take action or decide on behalf of the adult.

A sheriff may give somebody authorised under an intervention order, and a welfare guardian, the power to give consent to medical treatment on behalf of an adult. The power is limited in the same way as that of a welfare attorney.

Primary carer
Primary carer in relation to an adult, means the person or organisation primarily engaged in caring for him or her.

References

1 Scottish Executive Health Department (2007) *Code of practice for persons authorised to carry out medical treatment or research under Part 5 of the Act* (2e). Edinburgh: SEHD. Available in full at http://www.scotland.gov.uk/Resource/Doc/227589/0061536.pdf. Para 2.37.
2 British Medical Association (2007) *Withholding and withdrawing life-prolonging medical treatment* (3e). London: Blackwell.
3 British Medical Association and Law Society (1995) *Assessment of mental capacity: Guidance for doctors and lawyers*. London: BMA. Ch 12. The legal sections of the book address only England and Wales but the practical aspects of assessment of capacity are relevant to Scotland. A revised edition is expected in 2009.
4 These are available from the Scottish Government's website: http://cci.scot.nhs.uk/Publications/Recent.
5 See ref 1: para 2.67.
6 Law Hospital NHS Trust v Lord Advocate (1996) SLT 848.
7 See ref 2.
8 The Millan Committee has recommended that 'service users should be entitled to make advance statements, setting out their wishes in relation to future care and treatment, but these should not be legally binding when the relevant treatment is authorised by the Mental Health Act'. Millan Committee (2001) *New directions. Report on the review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Executive.
9 British Medical Association (2008) *Advance statements about medical treatment* (2e). London: BMA. Available in full at www.bma.org.uk/ethics.
10 See ref 3.
11 The nominated medical practitioners fees are paid by the Mental Welfare Commission.
12 The only exception is where a treating doctor disagrees with the nominated medical practitioner (see section 10). In such a case, the treating doctor may appeal direct to the Court of Session. Legal advice must be sought.
13 The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (SSI 2002/275).
14 For discussion of the impact of the Human Rights Act on detention of patients see British Medical Association (2008) *The impact of the Human Rights Act 1998 on medical decision making*. London: BMA.
15 Research includes surgical, medical, nursing, dental and psychological research.

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