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Mental Capacity Policy
Family & Criminal Justice Policy
Ministry of Justice
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13 March 2019

Dear Ms Manage

Thank you for the opportunity to submit evidence to the Ministry of Justice's review of the Mental Capacity Act 2005 Code of Practice. I would like to thank you for extending the deadline for receipt of comments from us. It is greatly appreciated given the importance of the Code of Practice in the working lives of our members.

The British Medical Association is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and helping them to deliver the highest standards of patient care. We represent thousands of doctors working in England and Wales who are involved in making capacity assessments and providing treatment on the basis of best interests on a near daily basis.

In light of the tight timeframe for our response, and due to the fact that we are unable to submit a response through the online portal, I have outlined our main concerns and comments on the Code of Practice below. These include:

- concerns about the over-medicalisation of assessing capacity;
- detailed evidence on the challenges of making a best interests decision for doctors, and the need for the Code of Practice to provide further guidance;
- the importance of clarity in the Code on the circumstances in which the Court of Protection should be involved in medical decision-making; and
- the opportunity for revision of the Code to clarify the relationship between the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA).

If you require any further information or clarification of our comments, please do not hesitate to contact me.

Yours sincerely



Stella Dunn
Head of Professionalism and Guidance



Revising the Mental Capacity Act 2005 Code of Practice: Call for evidence

General comments

The provision of care and treatment to adults lacking relevant decision-making capacity has undergone a quiet but profound transformation since the Mental Capacity Act 2005 (MCA) was passed. We have seen much greater expectations, on the part of the medical and legal professions, and also the general public, of the protection and promotion of the rights and interests of those with mental or cognitive disorders or disabilities. For example, the requirement to maximise the ability of adults to fully participate in decision making, even where they may lack explicit capacity in relation to the decision in question is increasingly acknowledged as both best practice and a legal obligation.

Although the introduction of the MCA and its Code have played a crucial role in achieving this, the UK's ratification of the United Nations Convention on the Rights of People with Disabilities (CRPD) in 2009 has also played a part. Given the importance of the Convention, and its legal underpinning of obligations to involve and support those who lack capacity in decision making, some reference to the CRPD and its implications for those working with people who may lack capacity would be helpful.

Chapter 4: How does the Act define a person's capacity to make a decision, and how should capacity be assessed?

Who can assess capacity?

Our members have expressed concern that since implementation, the assessment of mental capacity has become increasingly medicalised. They report either a mistaken assumption that only doctors can carry out a capacity assessment, or an anxiety on the part of other members of the care team to carry out such an assessment themselves. In many cases other members of the care team will be more closely involved in a person's day-to-day care, and in fact may be better placed to make an assessment of capacity.

The Code of Practice has, at **sections 4.51-4.54**, information on when professionals should be involved. It would be helpful to emphasise, either here or at the outset of the chapter, who can assess capacity, with specific reference to the fact that various people involved in the patient's care may be able, and indeed best placed to do so. This should not preclude the need for professional involvement in some more serious or complex decisions.

What other issues might affect capacity? (Sections 4.26-4.27)

Although the Act and the Code of Practice clearly set out the legal framework for assessing capacity, in practice it can be challenging to follow – especially where a person's capacity fluctuates, so that they have capacity at some times but not at others. The challenges associated with this were highlighted to us in the course of our [research with members on end-of-life care](#). Doctors noted that capacity could fluctuate “by the day, or even by the hour” and that it was immensely challenging to identify and to respond appropriately.

The Code of Practice provides general guidance (in **sections 3.12-3.16**) on how to maximise decision-making capacity and support someone to make a decision. It does not indicate, however, how doctors should approach situations where treatment decisions must be made on

an ongoing basis, but the patient has fluctuating capacity. Continually assessing and reassessing capacity for particular decisions can be labour and resource intensive. We are concerned that the Code of Practice's current approach and guidance on fluctuating capacity fails to capture the realities of practice. It may lead doctors working under-pressure to make a judgment of incapacity in order to proceed on the basis of best interests and rely upon the safeguards in the Act. We believe the revision of the Code of Practice presents an opportunity to address and remedy this situation by providing more detailed guidance.

Chapter 5: What does the Act mean when it talks about 'best interests'?

Based on feedback from our members, making an assessment of best interests is one of the parts of the Act that clinicians find most challenging to apply in practice. We feel it would be helpful to update and amend this section of the Code of Practice to provide more in-depth information about what is meant by "best interests"; what factors should be considered and how they should be weighed; and greater guidance on addressing some of the complexities associated with determining best interests.

We would like to draw to your attention Appendix One of the BMA and Royal College of Physician's guidance, [*Clinically-assisted nutrition and hydration \(CANH\) and adults who lack the capacity to consent: guidance for decision-making in England and Wales*](#). This appendix sets out detailed practice guidance for best interests decision-making in relation to CANH, which may assist the Ministry of Justice in their consideration of this chapter of the Code of Practice. Further to this piece of work, we are developing separate, standalone guidance for clinicians about best interests decision-making, and would be happy to share an early draft, in confidence, with you if that would be helpful.

A proportionate approach to best interests decision-making

A best interests decision will be required in a wide range of situations and settings. What will be required of a best interests assessment process will depend upon the nature and circumstances of each case. Case law has established that the defence given to decision-makers will be guided by the concepts of reasonableness, practicability and appropriateness (see *Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69).

Section 5.39 sets out what is "reasonably ascertainable" in relation to best interests assessments. We believed it would be helpful to devote more time at the outset of the chapter to what would be considered a proportionate approach to decision making. Best interests decisions are required in a wide range of different scenarios and circumstances, from the mundane (where the appropriate decision will be so apparent that exploring alternatives is unlikely to be meaningful or necessary) to decisions that will have serious and enduring effects on people (where careful and detailed consideration of all competing factors will be required).

What does the Act mean by best interests? (Sections 5.5 – 5.7)

We recognise that it is impossible to provide a single definition of best interests, given the range of individuals, settings, and circumstances the Act covers. It would be helpful to clarify, in the context of healthcare decisions, that best interests decisions are not just about the best clinical outcome for the person. The person's welfare must be considered in the widest possible sense, with reference to their broader preferences, values and interests. Reference to the

decision of the Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James* ([2013] UKSC 67) would help with this.

Section 5.7 highlights that decision-makers must not “act or make a decision based on what they would want to do” if they were the one lacking capacity. We believe it would be valuable to emphasise this even further, by making clear that the focus of a best interests decision must be on reaching the decision that is right for that individual patient – not on what is best for those close to them; what is convenient for their carers; or what most “reasonable” people would choose.

It would also be helpful to clarify that a best interest decision does not mean that doctors can be compelled to offer or provide a treatment they do not believe is clinically appropriate or is simply not available. A person lacking capacity cannot be in a better position than a person with capacity – if the option would not be available for the person even if they had capacity and were requesting it, there is no requirement that it be offered by way of a best interests decision (see for example *Aintree v James*).

It would be helpful for the Code of Practice to emphasise that providing treatment which is not in the best interests of a person who lacks capacity (or which has not been consented to by a person with capacity) is unlawful (*Airedale NHS Trust v Bland*). In the course of developing our guidance on CANH, we came across a number of doctors who were shocked to hear that it would be unlawful to provide treatment in these circumstances. We feel it is important for doctors to understand clearly the importance and the extent of their obligations in providing treatment to patients on the basis of best interests and feel that making this clear would avoid situations where long-term and potentially invasive treatment is continued “by default”, rather than with a clear understanding of what approach would be in the patient’s best interests.

Who can be a decision-maker? (Sections 5.8-5.12)

It would be helpful for the Code of Practice to be more explicit about who the decision-maker is in best interests assessments in medical settings. In our experience, there remains a great of confusion around “next of kin” and what this means in relation to decision-making. Being named as “next of kin” on a GP registration or hospital admission form leads to some family-members assuming they are able to make medical decisions on behalf of the patient. It would be useful, in this section, to clarify this point.

How should the person who lacks capacity be involved in working out their best interests? (Sections 5.21-5.24)

The suggestions provided in **section 5.24** about how to involve a person who lacks capacity in working out their best interests are helpful. Recent case law has placed greater emphasis on the importance of involving those who lack capacity in best interests decisions, and on ensuring their rights and freedoms are protected. It would be useful to emphasise that the views expressed by a person lacking capacity are no less important than views expressed by a person with capacity, and that a conclusion that someone lacks capacity is not an “‘off-switch’ for his rights and freedoms”. (See Peter Jackson J’s judgment in *Wye Valley NHS Trust v Mr V* ([2015] EWCOP 60). We have noted the importance of the United Nations Convention on the Rights of People with Disabilities (CRPD) in this respect at the outset of our response.

How should someone’s best interests be worked out when making decisions about life-sustaining treatment? (Sections 5.29-5.36)

Section 5.31 states that “all reasonable steps which are taken in the person’s best interests should be taken to prolong their life” and goes on to say that there may be some circumstances in which treatment is futile, overly burdensome, or where there is not prospect of recovery. We propose a number of changes to this section which would help clarify the responsibilities of doctors in relation to making best interests decisions about life-sustaining treatment:

- Rather than talking about “all reasonable steps”, this section should make clear that decision-makers should start from the “strong presumption” (*Aintree v James* [2013] UKSC 67, Lady Hale at para. 35) that it is in a patient’s best interests to receive life-sustaining treatment (noting that this presumption can be rebutted in some circumstances).
- This section also refers to a conclusion about it being in the best interests of the patient “to withdraw or withhold life-sustaining treatment”. It should be made clear that the correct question to ask is whether it is in the best interests of the patient to provide, or continue to provide, life-sustaining treatment, not whether it is in the best interests of the patient to withdraw it. (See *Aintree v James* [2013] UKSC 67)
- As per the Supreme Court’s decision in *Aintree v James*, it would also be helpful to clarify what “futile, overburdensome...or no prospect of recovery” means. This should make clear that this refers to a recovery and quality of life that the person themselves would value, not what others or doctors would find acceptable.

Sections 5.33 and **5.36** refer to the involvement of the Court of Protection in best interests decisions about life-sustaining treatment. It would be helpful to clarify the precise circumstances in which court involvement is required, with reference to the language used by the Supreme Court in *An NHS Trust v Y*: that the Court of Protection should be involved where there is “disagreement about best interests or the decision is finely balanced”. Please see our comments below, in relation to Chapters 6 and 8, for more information on this issue.

How do a person’s wishes and feelings, beliefs and values affect working out what is in their best interests? (Sections 5.37-5.46)

Section 5.38 notes that the person’s wishes and feelings, beliefs and values will not necessarily be determinative, and that the decision must be based on what is objectively in the best interests of a person. We note that neither the Act nor the Code provides a guide for decision-makers on how much weight to give to the person’s wishes and feelings, beliefs and values. We note in particular that there appears to be a discrepancy between the priority given to the person’s wishes and feelings, beliefs and values by the courts and by healthcare professionals: this was highlighted by the House of Lords post-legislative scrutiny of the Mental Capacity Act 2005 in 2014, and more recently by the Law Commission’s 2017 report on mental capacity and deprivation of liberty.

Broadly, the person’s wishes and feelings, beliefs and values, appear to take priority over other considerations in many of the judicial decisions post-*Aintree* (see, for example, Charles J in *Briggs* ([2016] EWCOP 53) who noted that, in the context of life-sustaining treatment, where it

is clear what decision the person would have taken had they had capacity, this will almost always give the answer as to what is in their best interests). The Law Commission highlighted that in practice, the person's wishes and feelings, beliefs and values, are often not prioritised in the same way. We would welcome more discussion about how much weight is to be given to the patient's own wishes, and how this could be reflected in the Code of Practice to provide clearer guidance for decision-makers.

More generally in these sections, it would be helpful to provide information to illustrate what counts as "wishes and feelings, beliefs and values", and what constitutes evidence of these. We believe this would assist in developing understanding that best interests are broader than just medical interests. This may be something that could be brought out more in some of the scenarios in this chapter.

Actions that benefit other people (Section 5.48)

It would be helpful to update this section of the Code of Practice to have clarity on best interests and needlestick injuries sustained by health professionals. During the passage of the Mental Capacity Act through Parliament, we sought amendments to confirm that it would be lawful to test a patient who lacks capacity for blood-borne viruses in the event of a health professional sustaining a needlestick injury. The Minister rejected these amendments on the basis that they were unnecessary, because "it would always be in the patient's best interests to know if they were affected by a blood-borne virus". We had been assured that the issue would be clarified in the Code of Practice, but the example used on testing for the benefit of others (genetic testing) is not directly comparable and so does not provide the reassurance we had been seeking.

Further discussions took place with the Department of Health after the Code was published and it was agreed that another route would be found to provide this reassurance. The intention at the time was to make regulations under the Human Tissue Act, authorising the testing of existing samples in these limited circumstances. This failed because the tests are carried out on serum, not blood, and serum does not meet the definition of "relevant material" in the Human Tissue Act.

We were receiving increasing numbers of enquiries from our members who found themselves in this situation and not knowing whether, and if so when, they could test a sample from the source patient. Guidance from the GMC and the defence bodies simply said that testing could only take place when it was "in the best interests" of the source patients but did not provide any advice about how best interests should be assessed or interpreted in this situation. In 2016, the BMA therefore produced [guidance to fill this gap](#). This work was overseen by our Medical Ethics Committee, reviewed by a QC, and approved by BMA Council.

Who should be consulted? (Sections 5.49-5.55)

This section could be updated to provide more detail on the different types of people who should be consulted in working out someone's best interests, in particular emphasising a multi-disciplinary team approach (MDT) to decision-making and the importance of hearing from all members of the care team.

It would also be helpful to note that for more significant decisions it is important to ensure that attempts are made to identify all relevant people who should be consulted about best interests.

In some circumstances this will go beyond immediate family and friends. It is for the decision-maker to make and justify the judgment as to how widely to consult.

Using and weighing the information

We believe that an additional section should be developed between **Sections 5.55** and **5.56**, which sets out how information about a person's wishes, feelings, beliefs and values should be used and weighed. **Section 5.62** notes that some more complex decisions will require the decision-maker to balance the pros and cons of all relevant factors. We feel it would be helpful to mention this earlier on, and to set out how a balance sheet approach – as advocated by the courts – can assist decision-makers in complex cases where a number of competing factors must be weighed against one another.

This section should make clear that all the information and evidence gathered about a person's wishes, feelings, beliefs and values should be carefully assessed in relation to the clinical options and their associated risks and benefits. It should make clear that the exercise is not a numerical one, and it is the weight of the arguments rather than the number on each side which will assist in identifying what is in the person's best interests – see, for example, McFarlane LJ in *Re F (A Child) (International Relocation Case)* ([2015] EWCA Civ 882). It should also clarify how to identify “factors of magnetic importance” (*Crossley v Crossley* [2007] EWCA Civ 1491) which may be of overriding importance to the decision. Please also see our comments, above, on the importance of clarifying how much weight should be given to a person's wishes and feelings, beliefs and values as part of this exercise.

What problems could arise when working out someone's best interests? (Sections 5.62-5.69)

These sections clearly set out some of the problems that might arise when working out someone's best interests, mainly in relation to the potential for disagreement and how to resolve it. It could benefit from addressing the following two scenarios, in relation to decisions about serious medical treatment:

- A situation where, despite consulting with those close to a person and collecting relevant information, there is no clear evidence of consistently and reliably expressed wishes, feelings, beliefs and values. It is important to emphasise that decision-makers should not speculate or make assumptions about what the individual's views might have been in the absence of reliable evidence. Where uncertainty persists, an application to the Court of Protection is necessary.
- A situation where a person's previously expressed capacitous views appear to be in conflict with their current attitude or feelings – for example, someone who had previously expressed a wish for treatment to be stopped should they reach a certain stage of their illness, but who now appears to be content. This is a very tricky issue, and it may be helpful for the Code of Practice to elucidate on how these situations should be approached.

Medical education and training and adults who lack capacity

Where an adult has capacity, their consent will be required before they can be involved in a teaching exercise with a medical student or doctor in training. It would seem, therefore, that a

best interests assessment would be required before an adult who lacks capacity could be involved in a teaching exercise. Although the majority of teaching can be undertaken involving adults with capacity, some specialties – such as psychiatry, geriatrics, or the provision of treatment and care to individuals with learning disabilities – may require the involvement of patients who lack capacity. It is not clear that such teaching can always be said to be in the best interests of the person who lacks capacity. We would welcome greater consideration of this issue, and a suggested way forward, in the revised Code of Practice.

Reviewing best interests decisions

The Code of Practice is clear throughout that capacity is decision-specific. It would be helpful to emphasise in this chapter that best interests decision-making is a process and not a one-off event, and that best interests decisions should be kept under review in order to ensure that a person continues to receive appropriate care and treatment, with adjustments made if necessary.

Chapter 6: What protection does the Act offer for people providing care or treatment?

What type of actions might have protection from liability? (Sections 6.4-6.19)

Section 6.5 outlines some of the actions that might be covered by section 5 of the Act. These are divided between acts of personal care and acts of healthcare and treatment. In the course of developing our own guidance on decisions about clinically-assisted nutrition and hydration (CANH) and adults who lack capacity, we found that some people view CANH as part of basic care, despite the law being clear that it is a form of medical treatment (*Airedale NHS Trust v Bland*). The Code of Practice notes that help with eating and drinking is part of personal care but does not note the difference between that and CANH, which would fall under healthcare and treatment. We ask that you consider whether it would be helpful to make this distinction more clearly.

It would be helpful to update **Sections 6.15 – 6.19**, with reference to *Winspear v City Hospitals Sunderland NHS Foundation Trust*, to emphasise that Act provides protection from liability only where the correct decision-making process has been followed: it is not just the decision reached that determines liability. It is essential that doctors are aware of this fact, and therefore of the importance to carefully record the decision made, how this was reached, and the reasons for it.

Section 6.18 must be updated to clarify the circumstances where the Court of Protection must be asked to decide – particularly, removing the reference to the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (following *An NHS Trust v Y*). The status of decisions about withholding or withdrawing CANH, as set out in the Code of Practice, created a huge amount of confusion for doctors about their role and responsibilities in relation to decision-making. Now that this has been clarified by the Supreme Court in *Y*, it is essential that this opportunity of the revision of the Code is taken to ensure similar problems do not arise in relation to other treatment decisions. Please see our comments, below, in relation to Chapter 8 for further information.

Chapter 7: What does the Act say about Lasting Powers of Attorney?

Checking the existence of an LPA

The information in this chapter could be improved for healthcare professionals by including information on how decision-makers should check and confirm whether there is in fact an LPA with the relevant powers. In the course of developing our guidance on decisions about CANH, we heard concerning reports that if a family member claimed to have power of attorney in relation to health and welfare decisions, this was often taken at face value. It may be helpful to include a section (possibly after **section 7.17** about registering an LPA; or alternatively, after **section 7.29**) which provides guidance on how decision-makers should check the existence and validity of an LPA – e.g. asking to see the original document (with the embossed Office of the Public Guardian logo) or a certified copy. This is particularly crucial for confirming that the LPA expressly authorises the attorney to consent to or refuse life-sustaining treatment.

Chapter 8: What is the role of the Court of Protection and court-appointed deputies?

Serious healthcare and treatment decisions (Sections 8.18-8.24)

As has been noted in our response to Chapter 6, the Code of Practice must be updated to reflect the decision of the Supreme Court in *An NHS Trust v Y*, which held that there is no requirement for decisions about the withdrawal of CANH to go to court, providing that the provisions of the Mental Capacity Act have been followed; the relevant guidance has been observed; and there is agreement as to what is in the best interests of the patient.

In addition to removing the reference to CANH, these sections of the Code of Practice must be updated to clarify the circumstances in which a decision about serious healthcare and treatment decisions must go before the Court of Protection. In the context of decisions about CANH, the Code of Practice created a huge amount of confusion for doctors about their precise responsibilities and obligations, which in turn impacted on the care and treatment of patients, and the experience of their families. It is essential that similar problems are not created for other healthcare decisions for patients who lack capacity. We would like to offer to provide our expertise and evidence on how decisions are made in clinical practice as part of any process to agree these sections.

Following clarification of the circumstances in which a healthcare or treatment decision must go before the court, it may be helpful to develop a scenario for this chapter to illustrate how that might work in practice.

Initiating and funding court applications

Where a decision from the Court of Protection is required in cases of serious healthcare and treatment decisions, it would be helpful to clarify who is responsible for initiating and funding such an application (**section 8.8**), particularly seeing as public legal funding is not always available to families. In the course of developing our own guidance on CANH we came across a number of cases where family members had been forced to start proceedings and fund them themselves.

Chapter 9: What does the Act say about advance decisions to refuse treatment?

The information included in this chapter could be improved by clarifying some of the terminology associated with making an advance decision to refuse treatment (ADRT). We have been made aware of some confusion about “proxies” in relation to ADRTs. In making an ADRT, people are often asked to name a “proxy” on the form, with many doctors and family members believing that that named person therefore assumes decision-making powers. It may be helpful (perhaps in **sections 9.18 – 9.21**) to be explicit that anyone named as a “proxy” in an ADRT will be consulted as part of a best interests assessment but does not have any legal powers and is not the decision-maker.

Chapter 10: What is the new Independent Mental Capacity Advocate service and how does it work?

It may be helpful to note, as part of the information about when an IMCA is required (**sections 10.40-10.58**), that the involvement of an IMCA can aid in decision-making, even where there are others available and positively engaged in the discussion. In the course of developing our guidance on CANH, we heard from families who reported finding it helpful to have an advocate to help them navigate through the system and to ensure that the patient’s voice was heard. It would be helpful to highlight this use of IMCAs, where that resource is available.

Chapter 13: What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

This is an area that has been – and remains – challenging for health professionals. It is clear from speaking to our members that considerable confusion remains in relation to the choice of legal regime, particularly where some deprivation of liberty for the patient may be involved. There is also anecdotal evidence to suggest that the choice of regime may at times depend more on clinical preference, health care setting or familiarity rather than a focus on the legal instrument most likely to promote the rights and interests of the patient. We recognise that there may also be a risk that a decision maker may “shop” between the different regimes to provide treatment he or she thinks appropriate, rather than considering the best interests of the patient. The fact that the Deprivation of Liberty Safeguards (DoLS) were introduced after the MCA, and have their own Code of Practice, may have further contributed to confusion in this area. The forthcoming replacement of the DoLS regime with the Liberty Protection Safeguards may create a further opportunity to clarify the relationship between the two regimes.

In revising this chapter of the MCA Code of Practice, we would suggest you consider:

- Parity of choice between regimes such that the question is which is the least-restrictive way of achieving the proposed outcome (see Charles J in *AM v (1) South London & Maudsley NHS Foundation Trust (2) Secretary of State for Health* [2013] UKUT 0365 (ACA)). The focus has to be on the patient’s needs and interests.
- Combining the Codes of Practice for the MCA and the replacement for DoLS.
- The use of scenarios involving choice between the Mental Health Act (MHA) and the Liberty Protection Safeguards.

- The importance of identifying those who lack decision-specific mental capacity even where the choice of regime is the MHA – this will enable the use of the MCA for relevant decisions, and facilitate supportive decision making.
- Providing guidance on best practice in relation to those who may be deprived of their liberty inadvertently. These will include compliant incapacitated patients who are being treated in psychiatric hospitals informally, or general hospital patients who are deprived of their liberty but whose lack of relevant decision-making capacity is not identified. Guidance on establishing an appropriate balance between a presumption of capacity, and the obligation to identify those whose capacity may be challenged would be helpful.

Chapter 15: What are the best ways to settle disagreements and disputes about issues covered in the Act?

We support this chapter of the Code of Practice and welcome the emphasis on seeking to resolve disagreements before they become serious, using local dispute resolution processes. We would like to see reference to the use of medical mediation to resolve disputes emphasised, as it becomes more widespread in clinical practice. We recognise that such dispute resolution solutions are not universally available and believe that any revision of the Code of Practice must be supported by further investment in mediation services.

Chapter 16: What rules govern access to information about a person who lacks capacity?

We have received some queries from members regarding requests from the Office of the Public Guardian (OPG) to the medical records of patients who lack capacity. Our advice has been that the OPG has statutory powers under s.58(5) of the MCA to “examine and take copies of any health record” when it is to enable him to carry out his functions, and that this would provide a lawful justification for the disclosure of information.

It has not been confirmed whether, in the event that the patient has appointed a health and welfare attorney, consent from the attorney is required when the OPG is seeking access under s.58. It would be helpful if the Code of Practice could clarify this point.

Key words and phrases used in the Code

The following should be removed or amended:

- **Artificial nutrition and hydration (ANH):** in-line with GMC guidance, this should now refer to clinically-assisted nutrition and hydration (CANH). CANH is a more accurate description of the use of a drip, a nasogastric tube, or a surgically implanted tube in to the stomach, to provide fluid and nutrition, and supports its designation as a form of medical treatment.
- **Permanent vegetative state (PVS):** this should be referred to more generally as “vegetative state” or “VS” – clinical guidelines from the Royal College of Physicians highlight that two states of “persistent” or “permanent” VS can exist on the continuum.

Annex A

The literature mentioned under the British Medical Association is now out-of-date. Please refer to the 4th edition of the BMA/Law Society publication, which was published in 2010. Please note that a 5th edition is currently being prepared for publication.

It would be helpful to also list the following resources, available from the BMA website at www.bma.org.uk/ethics:

- *Decisions about clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent: guidance for decision-making in England and Wales.* (2018) BMA/Royal College of Physicians: London.
- *Mental Capacity Act Toolkit* – please note this is currently under review, but we would be happy to share an updated link to the document once it has been finalised.