

Ethics Toolkit

Adults with Incapacity Scotland



January 2024

BMA Medical ethics and human rights

bma.org.uk

Contents

About this toolkit	2
1. Introduction.....	3
2. Capacity and incapacity.....	4
3. Basic principles	5
4. Assessing incapacity.....	6
5. Benefit	9
6. Certificate of incapacity and general authority to treat.....	11
7. Proxy decision makers	13
8. Powers of Attorney.....	15
9. Guardianship and intervention orders	17
10. Advance statements refusing treatment	18
11. Treatment in an emergency.....	20
12. Treatment requiring special safeguards	21
13. Restraint and restrictive practices	23
14. Research.....	25
15. Relationship with the Mental Health (Care and Treatment) (Scotland) Act 2003.....	27
16. Dispute resolution.....	28
17. Confidentiality and information sharing	30

About this toolkit

This guidance covers decision making for adults who lack capacity. It does not address compulsory treatment under mental health legislation. The Adults with Incapacity (Scotland) Act 2000 (the Act) sets out the framework for decision making on behalf of people aged 16 or over who cannot make decisions for themselves. It acts alongside the common law power which allows for treatment to be provided in emergencies to people who are unable to give consent. Amendments to Part 5 of the Act relating to medical treatment and research were introduced in 2005 by section 35 of the Smoking, Health, and Social Care (Scotland) Act.

The purpose of this toolkit is to act as a prompt to doctors providing care and treatment for people in Scotland who lack, or who may lack, the capacity to make decisions on their own behalf. In our view, this is a situation which most doctors are likely to encounter.

The toolkit contains a series of sections relating to specific areas of the Act, such as the Act's basic principles, how to assess capacity, advance statements refusing treatment, research, and powers of attorney. Although each section refers to separate areas of the Act, there is inevitably a degree of overlap.

This toolkit is not intended to provide definitive guidance on all issues surrounding the Act. Each section lists additional sources of guidance that should be used in conjunction with this toolkit. In cases of doubt, legal advice should be sought. The toolkit is designed to raise doctors' awareness of the Act, and to provide an aid for good decision making. This toolkit applies to Scotland. The BMA has separate guidance on decision making for patients who lack capacity in England and Wales, and Northern Ireland.

The toolkit is available on the BMA's website, and Health Boards, medical schools, and individual healthcare professionals may download it and make copies. We welcome feedback on its usefulness. If you have any comments, please address them to:

Medical ethics and human rights department

British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP
Email: ethics@bma.org.uk
Website: www.bma.org.uk



1

Introduction

This guidance covers decision making for adults who lack capacity. It does not address compulsory treatment under mental health legislation. The Adults with Incapacity (Scotland) Act 2000 (the Act) sets out the legal framework for decision making on behalf of adults (people aged 16 or over) who cannot make decisions for themselves. It acts alongside the common law power to provide treatment in emergencies to people who are unable to give consent. Amendments to Part 5 of the Act relating to medical treatment and research were introduced in 2005 by section 35 of the Smoking, Health, and Social Care (Scotland) Act.

Part 5 of the Act confers on healthcare professionals a general authority to treat patients under their care who are incapable of consenting to the treatment in question provided a certificate of incapacity is issued for the treatment in question, and provided the general principles of the Act are observed. The common law allows medical treatment to be given in an emergency to patients who cannot consent. There are limits to these powers. For example, a valid decision by an authorised proxy may take precedence and a valid and applicable advance statement refusing treatment is also likely to be binding.

The Act is accompanied by a statutory Code of Practice providing guidance on how it should be used by healthcare professionals. It is therefore essential that healthcare professionals are familiar with this Code of Practice. The website of the Mental Welfare Commission for Scotland provides resources on all aspects of the Act.



Key resources

[Adults with Incapacity \(Scotland\) Act 2000](#)

Mental Welfare Commission for Scotland – [Advice and guidance](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



2

Capacity and incapacity

What is capacity?

Decision making capacity refers to the everyday ability we possess to make decisions or to take actions that influence our lives, from simple decisions about what to have for breakfast, to complex decisions about serious medical treatment. In a legal context it refers to a person's ability to make and execute a decision, which may have legal consequences for themselves or for other people.

When does a person lack capacity?

For the purposes of the Act a person lacks capacity if, at the time a decision needs to be made, they are incapable of acting, making the decision, communicating the decision, understanding the decision, or retaining the memory of the decision due either to a mental disorder or to a physical disability or neurological impairment which prevents communication and which cannot be made good by human or mechanical aid.

The Act therefore contains a two-stage test:

Stage 1 – Is the individual incapable of acting, making decisions, communicating decisions, understanding decisions, or retaining the memory of decisions?

Stage 2 – If so, is that due to either a mental disorder or to a physical disability or neurological impairment which prevents communication and which cannot be made good by human or mechanical aid?

The assessment of incapacity is 'task specific' – it is not an 'all or nothing' concept. The assessment of incapacity must be made in relation to the particular decision that needs to be made, at the time it needs to be made. A central tenet of the Act is that adults must not be labelled as incapable simply because of a specific diagnosis or other circumstance.



3

Basic principles

What are the Act's basic principles?

The Act contains a set of guiding principles which doctors are legally required to apply to all their interactions with patients with incapacity. Actions or decisions that clearly conflict with these principles are unlikely to be lawful, although there may be occasions where they are in tension, and some balancing will be required. A list of the principles, with brief descriptions, is given below.

Benefit

Any action or decision must be necessary and must be likely to be of benefit to the person. There should be a reasonable expectation that the patient will benefit, and that benefit cannot be achieved without the proposed intervention. If the individual is likely to regain capacity in a reasonable time, and the decision can be delayed without causing harm to the patient, it should be. For more information on benefit see section 5.

Least restrictive intervention

Any action or decision taken should be the least restrictive necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Take account of the adult's wishes and feelings

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person as far as these may be understood, and to what is known about their beliefs and values as far as they can be ascertained by any means of communication, whether human or by mechanical aid.

Consultation with relevant others

You must take account of the views of others with an interest in the person's welfare. The Act lists those who should be consulted whenever practicable and reasonable. It includes the person's primary carer, nearest relative, attorney or guardian, if there is one - see proxy decision makers in section 7. This is not an exhaustive list and the views of others who appear to you to have an interest in the welfare of the adult or the intervention should be considered, so far as reasonable and practicable.



4

Assessing incapacity

Who should assess incapacity?

The Act does not specify who should assess incapacity where a patient's ability to make a decision has been called into question. However, anyone who wishes to carry out an action in connection with the care or treatment of an individual, or who wishes to make a decision on their behalf, must have a reasonable belief that they lack capacity. In its guidance on *decision making and consent* at paragraph 82 the GMC states:

'Assessing capacity is a core clinical skill and doesn't necessarily require specialist input (e.g. by a psychiatrist). You should be able to draw reasonable conclusions about your patient's capacity during your dialogue with them. You should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision.'

If you believe that the patient may lack the capacity to make a specific decision, then you must assess their capacity to make the decision in question, as set out below. Where consent to medical treatment is required, the healthcare professional proposing the treatment is responsible for ensuring that the patient has the capacity to consent before proceeding.

The reasons why incapacity is suspected should be recorded in the medical record, as should details of the assessment process and its findings. The more serious the decision, the more formal the assessment of incapacity is likely to be.

If there is doubt about whether the patient lacks capacity and is therefore unable to make a specific decision, it can be helpful to seek support from someone who knows the patient well, for example, another member of the healthcare team or someone close to the patient. Although assessing incapacity is a core clinical skill, in complex cases, where you remain unclear as to whether the patient lacks capacity, you should seek specialist input from colleagues such as psychiatrists and psychologists. You should also seek specialist input if the patient or someone close to them disagrees with your judgement.

How do you assess incapacity?

The law of Scotland generally presumes that adults (those aged 16 or over) are legally capable of making decisions, including treatment decisions, for themselves but that presumption can be overturned where there is evidence of impaired capacity.

If doctors receive requests from other healthcare professionals or those in social care to assess capacity, and insufficient information as to the reason for the request is provided, doctors should ask that the relevant information about the person and the decision(s) in question is provided before carrying out the assessment.

When assessing whether an individual lacks capacity to make a particular decision, doctors should ensure, as far as possible, that any factors likely to affect the patient's ability to decide for themselves are addressed beforehand. These may include medication, medical condition, pain, time of day, fatigue, or mood. Any information must be given as clearly and plainly as possible with communication aids used where appropriate. Those assessing a patient's incapacity are also under an obligation to enhance their ability to make decisions as far as reasonably possible. This will involve seeking to



4

ensure that patients are engaged in decision making when they are best able to participate and are encouraged to participate in decision making to the greatest extent they are able. The Act uses a 'functional' test of capacity. First it must be established that the person is unable to make the decision that needs to be made. Secondly, it needs to be established that this inability to make a decision is the result of a mental disorder (which includes mental illness, learning disability, dementia and acquired brain injury), or severe communication difficulty because of a physical disability or neurological impairment (such as stroke or severe sensory impairment).

Under the Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, they are incapable, even with all practicable support, of:

- acting;
- making decisions;
- communicating decisions;
- understanding decisions; or
- retaining the memory of decisions.

When doctors are involved in assessing a patient's capacity to make a decision about treatment, the Code of Practice (see key resources) states that they need to identify whether the patient:

- 'is capable of making and communicating their choice
- understand 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 previously preferred moral, cultural, family, and experiential background; and
- is not under undue influence from a relative, carer or other third party declaring an interest in the care and treatment of the adult.'

In assessing capacity, family members and close friends may be able to provide valuable background information, although their views about what they might want for the individual must not be allowed to influence the assessment of capacity.

Any decision that a person lacks capacity must be based on a reasonable belief backed by objective reasons. However, difficult judgements will still need to be made, particularly where there is fluctuating capacity, where some capacity is demonstrable but its extent is uncertain, or where impairment may interact with coercion or duress from those close to the individual. More detailed advice on assessing capacity in these circumstances is available from other sources (see key resources).

Where there are disputes about whether a person lacks capacity that cannot be resolved using more informal methods, the Sheriff Court can be asked for a ruling.



4

What do you do when an individual refuses to be assessed?

Occasionally an individual who is suspected to lack capacity to make a decision may refuse to be assessed. In most cases, a sensitive explanation of the potential consequences of such a refusal, such as the possibility that any decision they may make will be challenged later, will be sufficient for them to agree. However, if the individual flatly refuses, in most cases no one can be required to undergo an assessment. In these circumstances, doctors should document the refusal in the medical record, make a decision about capacity based on the information they have available, and document the decision reached and the reasons for it; where the question of capacity cannot be resolved on the basis of existing information, legal advice should be sought.

If there are reasonable grounds to believe that the refusal of assessment results from coercion or undue influence by a third party, for example if there is a history of abuse, advice should be sought from the local authority under adult support and protection arrangements.



Key resources

General Medical Council – [Decision making and consent](#)

Scottish Government – [Adults with incapacity \(Scotland\) Act 2000 Code of Practice](#)

Scottish Government – [Adults with incapacity: guide to assessing capacity](#)



5

Benefit

What is meant by benefit?

Doctors have a general duty to provide treatment that benefits their patients. There should be a reasonable expectation that the patient will benefit from any proposed intervention and that benefit cannot be achieved without the intervention. 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 also encompasses avoiding harming the individual by infringing their rights. The Supreme Court has said that decision makers must put themselves in the place of the individual patient and ask what their attitude to the treatment is or would be likely to be.

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. Depending on the powers they have been given, proxies may have the authority to decline treatment if they believe that would benefit the patient, although this decision can be challenged (see section 7). In complex cases where the assessment of benefit is difficult or agreement cannot be reached, it may be necessary to take legal advice (see section 16).

What should you consider when assessing benefit?

Lacking capacity should not exclude an individual from participating in the decision-making process as far as possible. The decision maker must also consider whether the person will regain capacity. A decision should be delayed if it can reasonably be left until the individual regains the capacity to make it without unduly disadvantaging the patient.

When determining whether an intervention would benefit an adult with incapacity, assumptions must not be made merely on the basis of the individual's age or appearance, their medical condition or any disability, or an aspect of their behaviour – this is the principle of equal consideration and non-discrimination.

In most circumstances it will be clear where the individual's best interests lie, and a decision as to care or treatment will not be challenging or time-consuming – but this is not always the case. Whether to provide analgesics for someone in pain is likely to be a straightforward question; a decision about whether to continue providing life-sustaining treatment is less so. Where a decision is likely to have grave consequences for a person it will require greater consideration, wider consultation with those close to the patient, and more detailed documented evidence about the decision reached and the reasons for it.

Relevant factors to consider are likely to include (so far as they are reasonably ascertainable):

- the person's past and present wishes and feelings, including any relevant written statement made when they had capacity;
- the person's wishes, beliefs, or values where they would have an impact on the decision; and
- other factors the person would have considered if able to do so.



5

For significant decisions, a crucial part of assessing benefit involves discussion with those close to the individual, including family, friends, or carers, where it is practical or appropriate to do so, bearing in mind the duty of confidentiality (for more on information sharing, see section 17). It should also include anyone previously nominated by the person as someone to be consulted. The BMA has a toolkit about how to make decisions for those who lack capacity, including taking account of the individual's wishes, beliefs and values to reach a decision. Although this is based on the legislation in England and Wales, it contains a lot of practical information and guidance that may be helpful for those practising in Scotland (see key resources).

Where there is a proxy with the authority to make treatment decisions on behalf of the individual (see section 7), they should be provided with as much information as is necessary for them to make the decision in question.

Can it ever benefit a patient to be given medication covertly?

The Code of Practice for Part 5 of the Act (see key resources) states that the use of covert medication is permissible in certain, limited circumstances, that is to safeguard the health of an adult who is unable to consent to the treatment in question **and** where other alternatives have been explored and none are practicable. Healthcare staff should not give medication except in accordance with the law, and even where the law allows, it should not be given in a disguised form unless the adult has refused, and their health is at risk because of this. Where covert medication is given, healthcare staff are required to record this in the patient's records. Detailed advice and guidance on the use of covert medication has been published by the Mental Welfare Commission – see key resources.

Are there any exceptions to the benefit principle?

There are two circumstances to which the benefit principle may not apply. The first is where someone has previously made a valid and applicable advance statement to refuse treatment while they had capacity, which the Code of Practice says, at paragraph 2.30, is 'potentially binding'. In such circumstances, the advance statement, should normally be respected, even if you or others think that the decision does not benefit the patient. For more information on advance statements see section 10. The second exception relates to the enrolment of adults with incapacity in certain forms of research - see section 14.



Key resources

British Medical Association – [Best Interests decision making for adults who lack capacity](#). Although this is based on the legislation in England and Wales, the practical information may also be useful for doctors working in Scotland.

Mental Welfare Commission for Scotland – [Covert Medication - a legal and practical guide](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



6

Certificate of incapacity and general authority to treat

When should a certificate of incapacity be completed?

Other than in an emergency (see section 11), in order to provide medical treatment or care to a patient who lacks capacity the healthcare professional primarily responsible for the patient's care, normally a GP or consultant, must complete a section 47 certificate of incapacity (Certificate).

The Certificate is to state that the patient lacks capacity in relation to a decision about the proposed medical treatment, and authorising treatment that other healthcare professionals will provide (under the instructions of the doctor, or with their agreement). A Certificate is needed to allow healthcare professionals to rely on a proxy's consent to treatment (see section 7), or in the absence of a proxy decision maker, to act under the general authority to treat – see below.

What information should the Certificate include?

The Certificate must state:

- that the doctor has examined the patient and is of the opinion that the patient 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.

For routine healthcare needs, multiple treatments can be covered on one Certificate. However, a separate Certificate is required for any intervention that would normally require the signed consent of the adult, such as surgery. A treatment plan may be completed and attached to the Certificate – see below. There is a standard format for the Certificate which must be used. Detailed advice about completing Certificates, with examples, is published by the Scottish Government (see key resources).

How long does a Certificate last?

A Certificate can be issued with a duration of up to one year, but can authorise treatment for up to three years if, in the view of the doctor, no curative treatment is available, and the patient's capacity is unlikely to improve, and the patient has at least one of the following conditions:

- severe or profound learning disability
- severe dementia
- severe neurological disorder.

The doctor should keep the patient's capacity to consent to treatment under review at appropriate intervals during the duration of the Certificate. Where a new Certificate is issued, doctors must consult any proxy decision maker. The guidance from the Scottish government on s 47 Certificate of Capacity states that it is also good practice where reasonable and practicable to discuss it with the patient's nearest relative or carer (see key resources).

When should a new Certificate be completed?

A new Certificate is needed 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.



6

When should a treatment plan be completed?

Where there are multiple or complex ongoing healthcare needs the use of a treatment plan is recommended. Certain basic healthcare procedures can be authorised under a single entry on the treatment plan for 'fundamental healthcare procedures' (if the patient is incapable of consenting to any of those procedures). These include nutrition, hydration, hygiene, skin care and integrity, elimination or relief of pain and discomfort, mobility, communication, eyesight, hearing, and oral hygiene. Interventions that fall outside of these fundamental healthcare procedures should be listed separately, with a note made of whether or not the patient is capable or incapable of deciding on each intervention.

As with the Certificate, the treatment plan should be completed by the clinician with overall responsibility for the patient and should be reviewed regularly. Detailed advice on the use of treatment plans is published by the Scottish Government (see key resources).

When can a doctor act under a general authority to treat?

Where there is no proxy decision maker, doctors may issue a Certificate and act under the 'general authority' to treat. This applies to the doctor who has signed the Certificate and members of the healthcare team acting on their behalf. This general authority may not be used where there is a proxy decision maker and it is reasonable for that person's consent to be sought, but this has not been done. Nor can it be used where a pending application has been made to the sheriff for an intervention or guardianship order with powers that cover the medical treatment in question (see section 9), or if there is an appeal to the Court of Session regarding treatment. In these cases, only emergency treatment may be provided until the court has ruled.

Can doctors charge a fee for completion of a Certificate of incapacity?

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.



Key resources

Scottish Government – [Section 47 Certificate of Incapacity](#)
 Scottish Government – [Adults with incapacity: code of practice for medical practitioners, Annex 5 Treatment plan for patients](#)



7

Proxy decision makers

Who are proxy decision makers?

A proxy decision maker can be a:

- welfare guardian or welfare intervener (appointed by the Sheriff Court – see section 9), or
- welfare attorney (appointed by the patient under a power of attorney – see section 8)

GPs who are aware that a patient has a proxy decision maker should note this in the medical record, together with their contact details. Hospitals and other establishments treating patients on an in-patient basis need to make reasonable enquiries to ascertain whether there is a proxy decision maker when a patient is admitted. A register of valid proxies is held by the Office of the Public Guardian and may be checked, including by telephone during office hours. This information might also be available from the patient, their relatives, carers, or others close to the patient. Otherwise, the local authority social work department may be able to help.

What are the responsibilities of a proxy decision maker?

The roles and responsibilities of proxies in relation to medical treatment are set out in the Code of Practice (see key resources). 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 3). If it is apparent that a proxy is not fulfilling their 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.

What is the role of a proxy decision maker?

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, if they are fulfilling their duty of care to the adult and are abiding by the general principles in the Act (see section 3).

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 under a duty 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 themselves. This means healthcare professionals need, independently, to have their own view as to what would benefit the patient, so that they can engage with the proxy on an informed basis. If any doubt or disagreement about what would benefit the patient cannot be resolved locally, legal advice should be sought.



7



If there is disagreement about how to proceed, there are procedures set out in the Act that must be followed - see dispute resolution in section 16.

Key resources

[Mental Welfare Commission for Scotland](#)

[Office of the Public Guardian, Scotland](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



8

Powers of Attorney

What is a power of attorney?

A power of attorney is a document appointing someone to act and to make decisions on their behalf. The person who grants the power is known as the 'granter' and the person appointed is the 'attorney'. A power of attorney can be useful both for someone anticipating permanent incapacity or to deal with periods of temporary, or fluctuating incapacity.

GPs who are aware that a patient has a welfare power of attorney should note this in the medical record, together with their contact details. Hospitals and other establishments treating patients on an in-patient basis need to make reasonable enquiries to ascertain whether there is a valid welfare power of attorney when a patient is admitted.

Is there more than one type of power of attorney?

Yes. Powers of attorney can deal with financial and/or welfare matters. A welfare power of attorney covers personal, welfare, and healthcare decisions, including decisions relating to medical treatment. Although a power of attorney in relation to property and affairs (a continuing attorney) can be used while the granter still has capacity, a power of attorney dealing with health and welfare can only come into effect at the onset of incapacity. The granter can appoint the same person to deal with financial and welfare matters, or different people.

What are the requirements for making a valid power of attorney?

The following statutory requirements apply to the creation of a power of attorney:

- it must be in a written document;
- the document must be signed by the granter, and state clearly that the powers are continuing, or welfare, or a combination of both;
- it must contain a statement to the effect that the granter has considered how their incapacity should be determined where the authority of the attorney commences on incapacity;
- it must incorporate a certificate in the prescribed form by a practising solicitor, a practising member of the Faculty of Advocates, or a registered and licensed medical practitioner which certifies that they:
 - have interviewed the granter immediately before the granter signed the document;
 - are satisfied, either because of knowledge of the granter or because of consultation with another person who has knowledge of the granter, that at the time of granting the power, the granter understands its nature and extent;
 - have no reason to believe that the granter is acting under undue influence.



8

A power of attorney must be registered with Office of the Public Guardian before it can be used. It does not give the attorney any legal power to make decisions before it is registered or before the individual loses capacity. Whether or not the powers can be exercised will depend on the terms of the power of attorney, and whether the granter has included a clause specifying an event that must happen before the attorney can act, for example an assessment of incapacity by a medical practitioner.



Key resources

Office of the Public Guardian Scotland – [What is a power of attorney?](#)
Scottish Government – [Continuing and welfare attorneys: Code of Practice](#)



9

Guardianship and intervention orders

What are guardianship and intervention orders?

Guardianship and intervention orders provide legal authority for someone to make decisions and act on behalf of a person who lacks capacity in order to safeguard and promote their interests. The powers granted under an order may relate to the person's money, property, personal welfare, and health.

A guardianship order gives authority for the guardian(s) to act and make certain decisions over the long term. An intervention order is appropriate where there is a need for a 'one-off' decision or action. An application can be made for a financial and/or welfare order depending on the needs of the individual.

An application for a guardianship or intervention order is made to the Sheriff Court. The Sheriff decides if the adult needs a guardian and if the person who wishes to be the guardian is suitable. Once granted, the order is registered with the Office of the Public Guardian and is operational. Doctors who are aware that a patient has a guardianship or intervention order should note this in the medical record, together with their contact details.

What are the limits on the powers of a welfare guardian or intervener?

A guardian or intervener does not have powers to:

- consent to specific treatments regulated under the Adults with Incapacity Act (see section 12 on treatments requiring special safeguards);
- consent on behalf of the adult to certain medical treatments covered under the Mental Health (Care and Treatment) Act 2003; or
- place an adult in a hospital for the treatment of mental disorder against their will. If the adult resists treatment for a mental disorder, then an application will need to be made by a mental health officer for an order under the Mental Health (Care and Treatment) (Scotland) Act 2003.



Key resources

Office of the Public Guardian Scotland – [What is a guardianship order?](#)
 Office of the Public Guardian Scotland – [What is an intervention order?](#)
 Scottish Government – [Guardianship and Intervention Orders](#)



10

Advance statements refusing treatment

Are advance statements refusing treatment legally binding?

Advance statements are not covered by the Act, or case law in Scotland. There is, however, provision in Sections 275 and 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 which enables a patient to make an advance statement setting out how they would wish to be treated, or not to be treated, should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder.

Where advance statements are not covered by the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003, paragraph 2.30 of the Code of Practice states:

'A competently made advance statement made orally or in writing to a 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 practitioner to do anything illegal or unethical. An advance statement which specifically refuses particular treatments or categories of treatment is called an 'advance directive'. Such documents are potentially binding. When the practitioner contemplates overriding such a directive, appropriate legal and ethical guidance should be sought.'

When assessing the validity of an advance statement it is important to remember the general presumption of capacity in Scottish law. Doctors should always start from the assumption that a person who has made an advance statement had the capacity to make it, unless there are reasonable grounds to doubt the person had the capacity to make the statement at the time they made it. In cases of genuine doubt about the existence or validity of an advance statement, doctors can provide treatment that is immediately necessary to stabilise or to prevent a deterioration in the patient's condition until the existence, and the validity and applicability, of the advance statement can be established. If doubts cannot be resolved locally, and time permits, legal advice should be sought about approaching the court for a decision.

Advance requests for future treatment, or statements about matters other than medical treatment, are not legally binding, although they can be a useful indication of a patient's wishes and feelings when making decisions that benefit them.

Are there limits to advance statements refusing treatment?

Although any written or oral statements of patients' future wishes are clearly a vital part of decision making, there are limits to patients' ability to influence their future care. Nobody can authorise or refuse in advance procedures they could not authorise or refuse contemporaneously. They cannot, for example, insist upon treatment that is not clinically indicated. In the BMA's view, it would also be inappropriate for patients to refuse in advance the provision of all forms of 'basic care' such as hygiene and interventions designed solely for the alleviation of pain or distress. This also includes the offer of oral food and water (but not clinically assisted nutrition and hydration).



10

Is there a specific format for advance statements refusing treatment?

There is no specific form in which an advance statement refusing treatment needs to be made. Oral advance statements can potentially be binding, particularly when supported by appropriate evidence, although a note should be made of any such oral decision in the medical record. It is worth bearing in mind that advance statements can also be recorded, for example on smart phones, although patients have to take appropriate steps to ensure relevant people are made aware of their existence.

Patients wishing to make an advance statement that is likely to have serious consequences for them, including any decision relating to life-sustaining treatment, should ideally put their wishes in writing. In the BMA's view, patients making a written advance statement refusing treatment should include the following:

- full details of the person making the advance decision including their name and address;
- the name and address of the person's GP and whether they hold a copy of the document;
- a statement that the document should be used if the person ever lacks capacity to make treatment decisions;
- a clear statement of the decision, the treatment to be refused, and the circumstances in which the decision will apply;
- the signature of the person making it and any person witnessing the signature; and
- the date the document was written or subsequently reviewed.

It is advisable for patients to review their advance statements regularly, particularly where there are any material changes in the individual's condition or treatment options, and at least every five years.

How should advance statements be stored?

The storage of advance statements, and the obligation to ensure that relevant healthcare professionals are aware of them, are the responsibility of those who make them. A copy of any written advance statement should be given to the patient's GP for storage in the medical record. A copy of the document should be provided to another healthcare professional involved in the patient's care on request. It is good practice for anyone who makes an advance statement to draw it to the attention of anyone who may be called upon to assist in making decisions on their behalf, such as friends, family, or any proxy decision maker. The patient or family members should draw it to the attention of hospital staff before an episode of care.



Key resources

Law Society Scotland – [Advance choices, and medical decision making in intensive care situations](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



11

Treatment in an emergency

Can emergency treatment be provided to adults with incapacity?

It is clearly established under the common law 'principle of necessity' that, in an emergency, where consent cannot be obtained doctors should provide treatment that is immediately necessary either to preserve life or to prevent a serious deterioration in the patient's condition. The only exception to this is where there is clear evidence of a valid and applicable advance statement refusing the treatment in question (see section 10).

In some emergency situations a section 47 certificate may be required. Paragraph 2.41 of the Code of Practice gives the following example '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 practitioner responsible for the treatment could have time to consult and complete the certificate.' It goes on to say 'The basic judgement as to whether or not there is time to complete the appropriate certificate 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 (as amended) of the Act. It is recommended that the authority be used in every case where it is reasonable and practicable to do so.'

Where decisions can reasonably be delayed until such time as the adult is likely to regain capacity, or to permit an assessment of incapacity and discussion with those close to the patient, and any proxy decision maker, then they should be.

What should you do if in an emergency, a patient refuses treatment and there is doubt as to their capacity?

If, in an emergency, a patient refuses treatment and there is doubt about their capacity to do so, doctors should take whatever steps are immediately necessary to preserve life or prevent serious 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 would benefit the patient. Once essential treatment has been given, the procedures for resolving disagreement between doctors and proxies must be followed (see section 16).



Key resources

Law Society Scotland – [Advance choices, and medical decision making in intensive care situations](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



12

Treatment requiring special safeguards

What treatments require Court approval in Scotland?

There are certain safeguarded treatments that cannot be undertaken on the basis of the general authority to treat, or proxy consent provisions of the Act. These treatments are set out in the Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002. 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;
- neurosurgery for mental disorder.

What other treatments may require additional safeguards?

In England, case law (including Supreme Court case law) and Court of Protection guidance have made clear that certain categories of cases are ones where legal advice should be sought to determine whether an application to court is required. Given that these are cases where there is doubt or disagreement about the correct course of action, or where it is considered that the proposed treatment would involve serious interference with the person's human rights, the BMA recommends that doctors in Scotland seek legal advice in cases where:

- at the end of the decision-making process:
 - the decision is finely balanced;
 - there is a difference of medical opinion;
 - there is a doubt or dispute that cannot be resolved locally (see section 16) about whether a particular treatment will benefit the patient; or
 - there is a conflict of interest on the part of those involved in the decision-making process;
- the procedure is for the purpose of donation of an organ, bone marrow, stem cells, tissue, or bodily fluid to another person;
- the action proposed involves a procedure for the covert insertion of a contraceptive device or other means of contraception;
- it is proposed that an experimental or innovative treatment be carried out; or
- the case involves a significant ethical question in an untested or controversial area of medicine.



12

What treatments require approval by the Mental Welfare Commission?

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); and
- any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

These requirements do not affect doctors acting in an emergency where treatment is necessary to preserve life or prevent serious deterioration in health (see section 11).



Key resources

Law Society Scotland – [Advance choices, and medical decision making in intensive care situations](#)



13

Restraint and restrictive practices

What is restraint?

There may be occasions when healthcare professionals need to consider the use of restraint in treating an individual lacking capacity. Restraint is the use or threat of force, to make someone do something they are resisting, or restricting a person's freedom of movement, whether they are resisting or not. Section 47(7)(a) of the Act states that the use of force or detention is not authorised, 'unless it is immediately necessary and only for so long as is necessary in the circumstances'. Healthcare professionals therefore have the right to use proportionate restraint to prevent the immediate risk of harm to the patient or others.

Where relevant, any use of restrictive practices, including the use of restraint, should comply with the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (the Regulations), and the Mental Welfare Commission's guidance on rights, risks, and limits to freedom (see key resources).

What are the types of restraint?

Restraint can be overt, such as the use of bed rails. It can also be covert and indirect such as having doors that are heavy and difficult to open or putting patients in low chairs from which they find it difficult to move. The Mental Welfare Commission in its guidance states '...restraint is taking place when the planned or unplanned, conscious or unconscious actions of care staff prevent a resident or patient from doing what he or she wishes to do and as a result is placing limits on his or her freedom'. The National Care Standards define restraint as 'Control to prevent a person from harming themselves or other people by the use of:

- physical means (actual or threatened laying of hands on a person to stop them carrying out a particular action);
- mechanical means (for example, wrapping someone in a sleeping bag or strapping them to a chair);
- environmental means (for example, using cot sides to prevent someone getting out of bed); or
- medication (using sedative or tranquillising drugs for the symptomatic treatment of restlessness or agitated behaviour)'.

When is restraint lawful?

Restrictive measures should be a last resort and alternatives to restraint must always be considered. Anybody proposing to use restraint must have objective reasons to justify that it is necessary. They must also be able to show that the patient is likely to suffer harm unless proportionate restraint is used. A proportionate response means using the least intrusive type and the minimum amount of restraint for the smallest amount of time to achieve the objective, to the benefit of the patient. The use of restraint must also be proportionate to the likelihood and seriousness of harm. If these conditions are met, it is permissible to restrain a patient to provide necessary treatment. It also follows that in such circumstances there would be no liability for assault.



13

Where a healthcare professional working in a registered care service is using restraint, either as a direct intervention or a safety measure, the Regulations provide that they must undertake a comprehensive risk-benefit assessment and document the outcomes and actions. Any actions should make clear that they are the only practicable means of securing welfare and detail the exceptional circumstances.

The Regulations also state that where restraint or control has been used, details of the form of restraint or control, the reason why it was necessary and the name of the person authorising it must be documented.



Key resources

Mental Welfare Commission for Scotland – [Rights, Risks and limits to freedom](#)
[The Regulation of Care \(Requirements as to Care Services\) \(Scotland\) Regulations 2002](#)



14

Research

Can patients who lack capacity participate in research?

Yes. Under the Act, adults who lack the capacity to consent can be enrolled in research provided the following conditions are met:

- the research will provide a direct benefit to the adult with incapacity or, exceptionally, where the research is likely to improve scientific understanding of the adult's condition and contribute to the attainment of real and direct benefit to persons suffering from the same form of incapacity;
- the research cannot be undertaken involving adults with the capacity to consent to it. This condition is binding – it is not sufficient to say that it has not been possible to identify participants with capacity;
- the research presents little or no foreseeable risk or discomfort to the adult with incapacity;
- the adult does not object to involvement in the research;
- consent has been obtained from a person with authority to provide it, such as a guardian or welfare attorney. If no such person exists, consent must be sought from the person's nearest relative; and
- the research has been approved by the Ethics Committee established in Scotland for that purpose (see key resources).

These conditions, which are in no order of priority must all be met before the research can proceed.

More information about research can be found in the Adults with Incapacity Code of Practice (see key resources).

Can adults with incapacity participate in 'emergency' research?

'Emergency' research other than clinical trials of investigational medical products (see below) requires consent. It follows therefore that the inclusion of adults who cannot consent for themselves in research other than clinical trials requires consent from either a welfare attorney, welfare guardian or, if neither are appointed, the adult's nearest relative.

In December 2006, an amendment to the 2004 Clinical Trials Regulations introduced provisions enabling patients to be enrolled in clinical trials of pharmaceutical products without prior consent in emergency situations where the research is approved by an appropriate research ethics committee.

Given the potential vulnerability of adults with incapacity who are enrolled in research, it is important that doctors undertaking such research are familiar with the substantial body of guidance reflecting international standards for research involving adults who lack capacity.



14

Can doctors provide innovative treatment to patients lacking the capacity to consent to it?

Doctors have always modified methods of investigation and treatment in light of experience and so innovative therapy is a standard feature of good care. There are occasions however where innovative treatment may involve exposing patients to significant risk. Where adults lack the capacity to consent to innovative treatment, any such treatment must be governed by the Act, in particular it must benefit the person. Where any proposed treatment differs significantly from existing practice and involves unknown or significant risk, considerable care must be taken as innovation can give rise to legal and ethical uncertainty. In these circumstances, it is advisable to seek both expert clinical scrutiny and legal advice.



Key resources

[The Adults with Incapacity \(Ethics Committee\) \(Scotland\) Regulations 2002](#)

Scottish Government – [Adults with incapacity. Code of Practice for Medical Practitioners](#)



15

Relationship with the Mental Health (Care and Treatment) (Scotland) Act 2003

What happens where treatment may be possible under both mental health and mental capacity legislation?

This guidance covers decision making for adults who lack capacity. It does not address compulsory treatment under mental health legislation. However, questions will sometimes arise as to whether it is appropriate to provide treatment to a patient using mental capacity or mental health legislation.

This is a complex area of law and in cases of uncertainty, advice should be sought from the Mental Welfare Commission. As a general rule, if the patient retains capacity with regard to the treatment or intervention, mental capacity legislation cannot be used. Where the treatment is for a physical condition unrelated to the patient's mental disorder, mental health legislation cannot be used.

Where a patient who lacks capacity's physical disorder arises as a 'consequence' of their mental disorder, it is possible that treatment can be provided under either mental capacity or mental health legislation. In relation to the choice as to which legislative framework to use in these circumstances, the Mental Welfare Commission advises that where there is resistance or objection to treatment, either for a mental disorder or for a physical disorder that is a consequence of the mental disorder, mental health legislation should be used. In the absence of resistance or objection from the patient, mental capacity legislation can be used, provided the patient meets the relevant criteria.



Key resources

Mental Welfare Commission – [Right to treat? Delivering physical healthcare to people who lack capacity and refuse or resist treatment](#)



16

Dispute resolution

When can disputes occur?

There may be occasions in relation to the care and treatment of a person who may lack capacity where disagreements with the proxy decision maker, or others close to the patient arise. These may relate to:

- whether an individual retains the capacity to make a decision;
- whether a proposed decision or intervention will benefit a person with incapacity; or
- whether the decision or the intervention is the most suitable of the available options.

It is clearly in everybody's interests that disagreements are resolved as soon as possible, and with as much consensus as possible. Broadly speaking, disputes can be resolved either informally or formally. Some disputes will be so serious that it may be necessary to make an application to court.

How should a dispute be approached initially?

Many disputes can either be avoided, or settled rapidly, by using good communication and involving all relevant individuals. Where healthcare professionals are involved in a dispute with those close to a person who lacks capacity, it is a good idea to:

- set out the different options in a way that can be clearly understood;
- invite a colleague to talk the matter over and offer a second opinion;
- consider enrolling the services of an advocate; and
- arrange a meeting to discuss the matter in detail.

When should mediation be considered?

Where the methods outlined above do not successfully resolve the dispute, it may be a good idea to involve a mediator. Any dispute that is likely to be settled by negotiation is probably suitable for mediation. A mediator is an independent facilitator. It is not the role of a mediator to make decisions or to impose solutions. The mediator will seek to facilitate a decision that is acceptable to all parties in the dispute.

What happens if the dispute cannot be resolved informally?

Where the doctor who signed the Certificate of incapacity (see section 6) and a proxy disagree about a treatment (or non-treatment) decision, the doctor can obtain a second opinion from a medical practitioner nominated by the Mental Welfare Commission. 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 the proxy makes an application to the Court of Session. If the nominated medical practitioner disagrees with the treating doctor, legal advice should be sought.



16

What role does the court have?

Appeal to the court should be very rare. In all cases of disagreement that cannot be resolved, doctors should seek legal advice. All decisions about medical treatment, under the general authority to treat, 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. 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 (see section 11).

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

Going to court can be distressing for those concerned. However, the benefits are that a court can give rulings very quickly when necessary, and it can provide a protective role for both patients and the healthcare team in cases where there is a disagreement that cannot be resolved.

What if a complaint is made?

It may be that as part of the dispute resolution process, those acting on behalf of an adult with incapacity might wish to lodge a complaint about the services they have received. Healthcare professionals should be able to provide information about the formal NHS complaints process.



17

Confidentiality and information sharing

Is a duty of confidentiality owed to patients who lack capacity?

Yes. Healthcare professionals owe the same duty of confidentiality to all their patients whether or not they lack capacity. Healthcare professionals may therefore usually only disclose information where it will benefit the patient.

What is the role of welfare attorneys, and proxy decision makers?

Welfare attorneys and other proxy decision makers whose authority extends to medical decisions have the right to give or withhold consent to treatment and so must be involved in treatment decisions, although where emergency treatment is required, this may not always be possible or practicable.

The healthcare team must provide the proxy decision maker with all the relevant information including the risks, benefits, side effects, likelihood of success and level of anticipated improvement if treatment is to be given, the likely outcome if treatment is withheld and any alternatives that might be considered. While it will therefore be necessary for proxy decision makers to have information that will enable them to act or make decisions on behalf of the patient, it does not mean that they will always need to have access to all the patient's records. Only information relevant to the issue in question should be disclosed.

What role do relatives, carers and friends have?

If a patient lacks capacity, healthcare professionals may need to share information with relatives, friends, or carers to enable them to provide information to help assess whether the proposed intervention will benefit the patient. Where a patient is seriously ill and lacks capacity, it would be unreasonable always to refuse to provide any information to those close to the patient on the basis that the patient has not given explicit consent. This does not however mean that all information should be routinely shared. Where the information is particularly sensitive, for example sexual health, a judgement will be needed about how much information the patient is likely to want to be shared and with whom. Where there is evidence that the patient did not want information shared, this must be respected.

Is there a role for 'next of kin'?

Despite the widespread use of the phrase 'next of kin' this is neither defined, nor does it have formal legal status in relation to decision making about medical treatment. A 'next of kin' has no rights of access to a patient's medical records or to information on a patient's medical condition. On the other hand, if, prior to losing capacity, a patient nominates an individual and gives authority for their condition to be discussed with them, they can provide valuable information.

There are no rules about who can and cannot be nominated as someone to be consulted. A patient may nominate their spouse, partner, member of their family or friend. In the absence of a named individual, the healthcare team should consult with people who are close to the patient; depending on the seriousness and implications of the decisions to be made, this may be a group of people rather than one individual.



17

When should disclosures be made to protect adults who lack capacity?

In the absence of a legal requirement, where adults lack the capacity to make a decision about whether or not to disclose information relating to harm or abuse, decisions need to be made on their behalf. Healthcare professionals can make a decision based upon an assessment of what would benefit the individual. When considering a disclosure of information, any assessment of benefit will ordinarily involve discussion with those close to the individual. However, care must be taken to ensure that anyone consulted who is close to the individual is in fact acting in the person's interests. Healthcare professionals must disclose information to the appropriate authority where there is a belief that an adult lacking capacity is at risk of abuse or other serious harm, unless it is not in the overall benefit of the patient to do so.



Key resources

BMA – [Confidentiality and health records toolkit](#)

Mental Welfare Commission for Scotland – [Good Practice Guide Carers and Confidentiality](#)



British Medical Association
BMA House, Tavistock Square,
London WC1H 9JP
bma.org.uk

© British Medical Association, 2024

BMA 20230629