the outcomes are good in terms of reduced distress and impairment and global improvement (see box). This could be linked to the characteristics that constitute a good doctor in the first place, such as perfectionism and drive. After doctors have accepted they are patients, and fully inhabited the role of the patient, these tools can be called upon to help them recover.

This anthropological approach to the factors that affect doctors when they become patients is by no means true for all doctors, and many doctors successfully negotiate their professional and private lives. It may, however, help explain why some get into difficulty.

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In England and Wales, the law in relation to capacity is based predominantly on the Mental Capacity Act 2005. The Mental Capacity Act is reflected in guidance published in 2008 by the General Medical Council. It contains clear principles that need to be applied in practice and are important for doctors to understand to ensure that they are not practising outside the law.

Understanding the basic legal principles behind the Mental Capacity Act makes it easier to obtain valid consent. However, the Mental Capacity Act should also be viewed within the context of other case law.

The process of assessing capacity has been criticised on the basis that the concept of capacity overlooks the inherent difficulties of comparing judgments about whether a patient is using or weighing information in the decision making process in comparison to an ideal standard or model. Nevertheless, failure to follow this guidance renders a doctor liable to disciplinary proceedings brought by the GMC.

The first principle of the Mental Capacity Act is the presumption of capacity. As with any presumption, this can be rebutted in the presence of evidence supporting a contrary conclusion, but it is important that doctors adopt the mindset of a presumption of capacity.

The adoption of this presumption has effectively lowered the threshold for capacity so that more patients would be expected to be deemed to have capacity. Concerns have also been raised that clinicians are now overestimating patients’ capacity.

Patients should be provided with all necessary assistance, support, and guidance to facilitate the maximisation of their capacity. A doctor should consider whether patients can, in turn, understand, retain, use, and weigh up information provided.

The GMC guidance is explicit about dangers inherent in this process. It states: “You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or the fact that they make a decision [with which] you disagree.”

A patient may have capacity for some decisions but not for others, depending on the complexity of the decision. A decision to take blood, for example, is relatively straightforward. Many patients will have the requisite capacity to give consent for blood to be taken but may not have capacity for more complex decisions, such as those surrounding oncological interventions. It is helpful to give the patient a written record of what has been discussed and agreed. This is useful if any future disputes arise about capacity.

The appropriate legal test as to whether capacity is present in borderline situations is whether it is more likely than not that capacity is present. But more important decisions do not require a doctor to be more certain that capacity is present—the test remains simply whether it is more likely than not that a patient has capacity.

There are a number of situations where problems relating to capacity have a higher risk of occurring by virtue of patient vulnerability. These include patients with neurological conditions, patients residing in a care home, and situations where mental health legislation is engaged or where a patient is in police, immigration, or prison detention.

It is important to differentiate between a patient lacking capacity and a patient’s
CASE LAW

As well as the Mental Capacity Act 2005, the courts have provided a body of case law that assists in understanding the approach of the courts in certain situations. However, care should be taken in applying cases that predate the Mental Capacity Act 2005 unthinkingly to medical practice. There are five key cases in this area. The first is Re C (Adult, refusal of treatment). C had been detained in Broadmoor secure hospital but had refused an amputation to treat a gangrenous leg. The court refused to overrule C’s decision and held that mental health conditions do not axiomaticaly remove capacity. The court’s judgment accords entirely with the Mental Capacity Act 2005, which post-dates it. The court held that understanding, believing, retaining, and weighing the requisite information needed to be present for capacity to subsist.

In Re MB (Adult, medical treatment), the Court of Appeal considered the withholding of consent by MB for a caesarean section on account of her needle phobia. The court held that MB did not have capacity at the time, given her fear and panic. However, this decision should be treated with a great deal of care in practice. Doctors should be slow to make a determination that capacity is lacking given the presumption of capacity contained in the Mental Capacity Act 2005.

In Re B (Adult, refusal of medical treatment), a patient wished artificial ventilation to be terminated. B’s mental capacity was intact and she successfully obtained a declaration from court to switch off her artificial ventilation, even though such a decision would result in her death. Re B is a paradigm case of when legal advice should be sought. This case should be contrasted with the approach of the court to an incompetent patient.

St George’s Healthcare NHS Trust v S is a highly controversial Court of Appeal case. S had been diagnosed as having a condition in which induction of labour was deemed necessary to prevent her unborn child being harmed. The judge at first instance ordered that S should have a caesarean section under the Mental Health Act 1983, and the baby was duly delivered. The Court of Appeal subsequently overturned the decision and held that the Mental Health Act was not appropriate as S had a physical and not a mental condition. This case falls squarely within the principles enshrined in the Mental Capacity Act 2005 that there is a presumption of capacity. Finally, in Re T (Adult), T refused blood transfusions on the basis that she was a practising Jehovah’s Witness. The Court of Appeal adopted an interesting approach and held that T had been placed under duress by her mother. The court also held that T’s consent had been impaired by virtue of the medication with which she was being treated and allowed the blood transfusions to proceed. It would be interesting to know if this case would be decided differently after the Mental Capacity Act 2005. One suspects not.

A patient may have capacity for some decisions but not for others depending on the complexity of the decisions where a patient is vulnerable, the doctor should seek advice from others who may be in more frequent contact with the patient, including nursing staff, carers, and the patient’s family. Doctors should also approach colleagues with specialist skills who may assist, including neurologists, psychiatrists, and speech and language therapists.

If doubts as to a patient’s capacity remain, a doctor must seek legal guidance specifically with a view to obtaining a determination from a court in relation to the patient’s capacity. It is considered good practice to inform the patient, their representatives, and others close to them to enable them to obtain prompt legal representation during such a process.

Patients may have capacity even if the result of their decision is deemed irrational and could result in the loss of life. Even placing the life of an unborn child at risk may not be enough for a patient’s wishes to be over-ridden. Doctors should be especially alert to any possibility of duress being placed on a patient that affects capacity, as well as the effect of any medication being administered.

Competing interests: AD and MG are employed by BPP University, which provides medicolegal courses for NHS organisations across the United Kingdom. AD is a barrister who represents doctors against whom action is being taken by the GMC, represents claimants against the NHS, and prosecutes for the Crown Prosecution Service.

7 Re C (Adult, refusal of treatment) [1994] 1 All ER 819.
8 Re MB (Adult, medical treatment) [1997] 38 BMLR 175.
9 Re B (Adult, refusal of medical treatment) [2002] 2 All ER 469.
11 St George’s Healthcare NHS Trust v S [1998] 3 All ER 673.
12 Re T (Adult) [1992] 4 All ER 649.

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