Scottish Council on Human Bioethics
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Consultation response to the Scottish Executive

Adults with Incapacity (Scotland) Act 2000: Review of the Code of Practice for part 5 (Medical Treatment and Research) and related issues

Proposals for Changes to the Code

Arising from the experience of the operation of Part 5 so far, a number of doctors have expressed concern about the extra workload implications which the Act brings, with particular reference to the assessment and certification procedures. Reflecting these concerns, the British Medical Association (BMA) and Scottish General Practitioners Committee (SGPC) have suggested that:

Point 1

The principle of proportionality might be incorporated in the Code to reflect the implications of treatment and interventions of greater or lesser gravity. For example, is it necessary to carry out the full assessment procedures recommended in the Code of Practice where, say, an intervention such as the administration of a flu immunisation or prescription of aspirin is concerned? They suggest therefore that the Code might indicate that an extensive multi-disciplinary assessment would not be expected where the treatment proposed is either a continuation of existing treatment for the ongoing management of, eg raised blood pressure or the annual administration of the flu vaccine.

Scottish Executive:
Views are sought on whether it would be possible to have a variable assessment procedure which reflected the scope and degree of the intervention or treatment proposed. If so, suggestions on how the Code might be amended would be welcome.

Scottish Council on Human Bioethics Response:
The SCHB agreed that a variable assessment of capacity procedure proportional to the scope and the degree of the intervention being proposed should be considered. The extensive multi-disciplinary assessment could then be simplified if the envisaged intervention did not require a comprehensive appraisal and appropriate co-operation existed between healthcare professionals. However, the SCHB was of the opinion that no intervention should ever take place without some form of assessment of capacity. Furthermore, a full and extensive assessment should remain a requirement for invasive health care interventions.

Point 2

At present, the Section 47 certificate states that the examination has "today" been carried out, thus potentially diminishing the relevance of earlier, and possibly still valid, assessments. The BMA therefore propose that "today examined" be dropped from the certificate and replaced by eg "Based on my considered opinion ...". This would allow still current assessments and other relevant information to inform the certification process. Such a change could be achieved by subordinate legislation and would not need amendment to the 2000 Act.

Scottish Executive:
Views are invited on this suggestion.

Scottish Council on Human Bioethics Response:
The SCHB agreed with the proposal of the BMA that "today examined" should be dropped from the certificate and replaced by a wording which would allow current assessments and other relevant information to inform the certification process. This would enable the medical practitioner primarily responsible for the medical treatment of the adult to take account of all the relevant multidisciplinary assessments which would be necessary for him or her to form an expert opinion.

Point 3

At present the Code of Practice states, at paragraph 2.25, that a certificate of incapacity under section 47 is needed even where a proxy exists.

Scottish Executive:
It would be useful to have your views on this point and on whether or not this requirement has had an adverse impact on services to patients.

Scottish Council on Human Bioethics Response:
The SCHB was of the opinion that, prior to a medical intervention on the incapable adult taking place, a certificate of incapacity should be required even when a proxy has been appointed. In other words, a certificate of incapacity should never be dispensed with, except in emergency circumstances. This is because proxies may not always have the appropriate medical experience to be able to decide, on their own, whether or not a specific intervention should be undertaken. In addition, the certificate of incapacity would prevent any proxies acting for their own ends and against the best interests of the patient when a treatment is being considered.

For these reasons and in order to protect the person with incapacity it is essential that both the medical practitioner primarily responsible for the medical treatment and the proxy of the patient agree to the intervention. If this does not happen then the provisions for the resolution of disputes between proxies and medical practitioners listed in paragraph 50 indent (4) to (6) should be applied.

Point 4

Experience of Part 5 so far may have suggested other ways in which its operation could be streamlined, without encroaching on the principles of the Act.

Scottish Executive:
The Executive would be very grateful to receive any further suggested changes to the Code of Practice.

Scottish Council on Human Bioethics Response:
Not addressed.

Proposals for changes to the Act

Point 5

At present, the duration of a certificate cannot exceed one year. This upper limit was set when the legislation was going through the Scottish Parliament and was an increase from the original period of 3 months proposed at an earlier stage. The suggestion is that the upper limit should be raised from one year to 3 years. This would be consistent with other parts of the Act, and would be appropriate, eg where some long-term conditions were concerned, in which there was little or no prospect of capacity being regained.

Scottish Executive:
Views are invited on this proposal

Scottish Council on Human Bioethics Response:
The duration of the certificate of incapacity should be directly related to the expected duration of the incapacity and to the envisaged treatment.

The SCHB considered that the suggestion to increase the upper limit of duration of the certificate of incapacity to 3 years would only be appropriate under specific circumstances and for named and well defined disorders for which it was certain that no capacity could be regained. In addition, a review of the treatment plan should be undertaken on an annual basis.

In all other instances, the SCHB was of the opinion that the upper limit for the validity of the certificate should remain at one year.

Point 6

Currently only a registered medical practitioner can sign a certificate of incapacity. There have been representations that other members of the healthcare team should be allowed to sign certificates. In particular, dentists are concerned that the need for them to obtain a certificate from a doctor before dental interventions - which often involves the treatment of patients in acute pain or with potentially serious infection - can be carried out is time-consuming and can delay the administration of appropriate treatment.

Scottish Executive:
Views are invited on whether more flexibility should be given in Part 5 of the Act to allow other health professionals to sign the certificate of incapacity, including other professions eg dentists and opticians. If so, it would be helpful to have views on which health professionals should be allowed to sign and why this would be appropriate in relation to incapacity to decide about treatment, when all other certificates and reports relating to incapacity under the Act require to be signed by a medical practitioner.

Scottish Council on Human Bioethics Response:

The SCHB was of the opinion that a good collaboration and co-operation between health care professionals was important and should be reflected in the preparation of certificates of incapacity which may include a treatment plan covering such matters as dental care according to the principle of proportionality. In other words, the treatment plan should envisage these eventual interventions and state whether or not the patient has the capacity to consent to them.

The SCHB concurred, however, that it would be preferable that a single healthcare professional have overall responsibility and oversight of any medical interventions being considered and that the medical practitioner primarily responsible for the adult with incapacity was the best person to do so since he or she had the competence to assess the capacity and the needs of the person concerned. Thus, the SCHB agreed that it would be inappropriate, at present, for other healthcare professionals to be able to sign certificates of incapacity.

It did point out, however, that other healthcare professionals could maybe be considered in the future as being entitled to sign a certificate of incapacity if they had undergone specialist training in (a) the assessment of capacity and (b) the follow-up, overall care and multidisciplinary needs of adults with incapacity.

Point 7

The definition of "medical treatment" in the Act as set out in paragraph 9 above, has been criticised as too broad and potentially precluding the access of incapacitated adults to routine treatment without formal assessment and certification under Section 47. It has been suggested, therefore, that it might be possible to refine the definition to exclude certain forms of treatment eg general care such as oral hygiene, nursing care, blood pressure recording, thus simplifying the assessment and certification process.

Scottish Executive:
Views are invited on whether medical treatment can be redefined in such ways and, if so, how this might be achieved.

Scottish Council on Human Bioethics Response:
The SCHB was of the opinion that it would be preferable for the definition of a "medical treatment" in the Act which includes "any procedure or treatment designed to safeguard or promote physical or mental health" to remain unchanged.

Furthermore, the SCHB noted that the assessment and certification process may be simplified if the principle of proportionality was incorporated into the assessment of capacity procedure (see Point 1) in the Code of Practice in order to reflect the implications of interventions of greater or lesser gravity.

In addition, the SCHB would like to emphasise that the reasons for a new definition of "medical treatment" would no longer be pertinent if a treatment plan was prepared covering "Fundamental Healthcare Procedures" which included "nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing, and oral hygiene".[1]

Point 8

Scottish Executive:
Any other points consultees might wish to make in relation to Part 5 would be welcome.

Scottish Council on Human Bioethics Response:
The SCHB noted, first of all, that the workload for doctors had increased following the enactment of Part 5 which requires them to follow the recommended procedures in the Code of Practice, in particular the process relating to the completion of certificates under Section 47. This was especially the case for primary care physicians who seemed, as yet, unaccustomed and uncomfortable with the different new procedures. Difficulties may also exist where general practitioners have a number of patients in care homes, with the assessment and certification process making substantial demands. However, the SCHB recalled that the Act was drafted with the primary aim of promoting and safeguarding the interests of incapable adults and that any amendments to this document, therefore, should not be driven by the workload of physicians when they may erode the protection due to patients.

Secondly, the SCHB was of the opinion that the present consultation exercise to review Part 5 of the Code of Practice and to amend the Act itself was somewhat premature. Indeed, having made its own enquiries with concerned healthcare professionals, it was informed that a greater familiarisation with the provisions of the Act was still necessary. In other words, not all healthcare professionals are, as yet, accustomed to all the intricacies (and some of the possible simplifications) of the provisions.[2] Thus, the SCHB concurred that it was impossible, at present, to draw solid conclusions as to whether or not the provisions being examined should be considered for

review.

The implementation of new legislation takes time and it would have been preferable for the consultation to take place at a later date when healthcare professionals were better accustomed with all the procedures enshrined in the Act.

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[1] Paragraph 2.20 of the Code of practice of the Adults with Incapacity (Scotland) Act 2000.

[2] This was underlined in the BMA's submission to the public petition committee on the adults with incapacity (Scotland) act 2000 which states that there has been a "notable lack of training or publications advising GPs on how to make appropriate assessment", www.bma.org/ap.nsf/Consent/publicpetitionawi