Appendix 1

Summary of the main differences in the legal framework for decision-making in relation to those lacking capacity in England and Wales and those in Scotland, Northern Ireland (NI) and the Republic of Ireland. Please note that:

i) The key provisions of the Northern Ireland (Mental Capacity Act 2016) are outlined here but this Act is not yet in force at the time of writing. Readers should refer to http://www.legislation.gov.uk/nia/2016/18/contents to keep themselves updated as to developments, including the Code of Practice to be issued to accompany the new Act.

ii) The key provisions of the Assisted Decision-Making (Capacity) Act 2015 in the Republic of Ireland are outlined here but this Act is not yet in force at the time of writing. The Act also introduces new forms of assisted- and co-decision-making that are not covered in this table. Readers are referred to guidance to be issued by the Health Services Executive of Ireland (see http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/AssistedDecisionMaking/) and relevant professional bodies in the Republic of Ireland as to how healthcare professionals should approach questions of consent to medical treatment in the presence of an assisted- or co-decision-making agreement; they are also referred to the same guidance to keep themselves updated as to when the legislation is in force.

	England and Wales	**Scotland**	**Northern Ireland**	**Republic of Ireland**
Key statutes	Mental Capacity Act 2005 (MCA 2005) Family Law Reform Act 1969	Adults with Incapacity (Scotland) Act 2000 (AWI) Age of Legal Capacity (Scotland) Act 1991 (AOLCA) Children (Scotland) Act 1995	Mental Health (NI) Order 1986 Mental Capacity Act 2016 (MCA 2016). (n.b. not yet in force) Enduring Power of Attorney (NI) Order 1987	Health Act 1953 s. 4 Non-Fatal Offences against the Person Act 1997 s. 23 Mental Health Act 2001 Assisted Decision-Making (Capacity) Act 2015 (ADM(C)A). (n.b. not yet in force)
Requirements for valid consent by patient themselves	In the case of person aged ≥ 16, consent given voluntarily by an appropriately informed patient with capacity to give such consent (s.8 Family Law Reform Act 1969) In the case of a child ≤ 15, consent by the child can be given if he/she has sufficient intelligence and understanding to appreciate fully what is proposed: Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 (HL)	In the case of a person aged ≥ 16, consent given voluntarily by an appropriately informed patient with capacity to give such consent (s.1 AOLCA) In the case of a child ≤ 15, consent by the child can be given where, in the opinion of a qualified medical practitioner attending the child, he/she is capable of understanding the nature and possible consequences of the procedure or treatment (s.2 AOLCA)	In the case of a person aged ≥ 16, consent given voluntarily by an appropriately informed patient with capacity to give such consent (Article 4 Age of Majority Act (NI) 1969) In the case of a child ≤ 15, consent by the child can be given if he/she has sufficient intelligence and understanding to appreciate fully what is proposed: Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 (HL)	Full age (i.e. person has reached age of majority (18 years) or is or has been married), and 'soundness of mind', i.e. has decisional capacity and it is voluntarily given and appropriate pre-intervention disclosure has been made A child aged ≥ 16 can lawfully consent to medical, dental or surgical treatment and things preparatory thereto, including the administration of an anaesthetic, without the necessity for the consent of a parent or guardian (Non-Fatal Offences against the Person Act 1997 section 23) As to a child < 16, the status of *Gillick*-competence in the Irish legal order is questionable, and an application for Declaratory relief would probably be necessary – which then must engage consideration of the Constitutional rights of the

				family (Constitution of Ireland 1937 Article 41) and the Constitutional rights of the child (Article 42A): see, AO & DL v Minister for Justice [2003] 1 IR 1 at 159, McK v Information Commissioner [2004] 1 IR 12, [2004] IEHC 4 (HC) & [2006] 1 IR 260, [2006] 1 ILRM 504, [2006] IESC 2 (SC)
Requirements for informed consent	Healthcare professional must provide all material risks to the patient, judged on the basis whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it (Montgomery v Lanarkshire Health Board [2015] UKSC 11)	Healthcare professional must provide all material risks to the patient, judged on the basis whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it (Montgomery v Lanarkshire Health Board [2015] UKSC 11)	Healthcare professional must provide all material risks to the patient, judged on the basis whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it (Montgomery v Lanarkshire Health Board [2015] UKSC 11)	Normally, the healthcare professional must inform the patient if there is a significant risk that would affect the judgement of a reasonable patient (not dissimilar from the requirement enunciated in Rogers v Whitaker (1992)175 CLR 479. 'Significant risk' and 'material risk' are interchangeable; 'materiality' involves consideration of both (a) the severity of the consequences and (b) the statistical frequency of the risk; a risk may be seen as material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it. Where the practitioner may be aware that the particular patient, if warned of the risk, would be likely to attach significance to it where another patient might not, the authorities suggest a duty to disclose (Fitzpatrick v Whyte [2008] 3 IR 551 relying on Lord Woolf MR in Pearce v United Bristol Healthcare NHS Trust [1999] 48 BMLR 118) A warning must in every case be given of a risk, however remote, of grave consequences involving severe pain continuing into the future and involving further operative intervention (Walsh v Family Planning Services & ors [1992] IR 496 not departed from in Fitzpatrick v Whyte [2008] 3 IR 551).
Consequence of treating without consent	Crime and tort of assault/battery. Potential claim for negligence where consent not properly informed and operation causes suffering/loss to patient Claim under Human Rights Act 1998 for breaches of ECHR rights where healthcare professional acting on behalf of public body Disciplinary action by professional	Crime of assault Potential claim for negligence where consent not obtained, or not properly informed, and procedure causes suffering/loss to patient Claim under Scotland Act 1999 or Human Rights Act 1998 for breaches of ECHR rights where healthcare professional acting on behalf of public body	Crime and tort of assault/battery. Potential claim for negligence where consent not properly informed and operation causes suffering/loss to patient Claim under Human Rights Act 1998 for breaches of ECHR rights where healthcare professional acting on behalf of public body Disciplinary action by professional	Criminal offences of assault and assault causing harm Liability in trespass for battery (and assault) – where no consent was sought or obtained and it was feasible to do so or consent was obtained by fraud Liability in Negligence for negligent pre-intervention non-disclosure of material risks Breach of Constitutional rights (Constitution of Ireland 1937 Article 40.3.1) – largely unenumerated rights but , potentially, also the named right to the person: see Article 40.3.1) Claim for damages for

	regulatory bodies	Disciplinary action by professional regulatory bodies	regulatory bodies	breach of Convention Rights where 'State body' involved Disciplinary action by professional regulatory bodies
Presumption of capacity to consent to/refuse medical treatment	Statutory presumption of capacity to consent to/refuse medical treatment, applying to all those aged 16 and over (s.1(1)) MCA 2005)	Implicit presumption of capacity to consent to/refuse medical treatment, applying to all aged 16 and over (s.1 AOLCA, read alongside Part 5, AWI)	At present there is a common law presumption of capacity which applies until the contrary is proven and then it is presumed that the person is mentally incapable until the contrary is again proven. Burden of rebutting the presumption of capacity rests on the respondent IHM's Application No [2014] NIQB 43) A medical professional should presume that a patient is competent unless there is evidence that he/she is not (R v Sullivan [1984] AC 156) If the case comes to court the burden is on the doctor to demonstrate that the patient lacks capacity on the balance of probabilities (R (N) v Dr M, A NHS Trust [2002] EWHC 1911) MCA 2016 introduces a statutory presumption of capacity to consent to/refuse medical treatment for all those > 16 years (Section 1(1))	Statutory presumption of decisional capacity where capacity is, or may shortly be, in question (s.8 ADM(C)A 2015 section 8) More generally, there is a common law presumption of capacity to consent/refuse consent (Fitzpatrick v FK [2009] 2 IR 7)
Test for capacity to consent to/refuse medical treatment	Decision-specific test contained in s.2 MCA 2005: whether patient is able to understand, retain, use and weigh the relevant information, and communicate his/her decision. Where patient unable to do one or more of the above, the functional inability must be because of an impairment or disturbance in the functioning of his/her mind or brain. NB: (i) all practicable steps must be taken to support a patient to take the decision without success before he/she can be treated as lacking	Decision-specific test of *incapacity* contained in s1 AWI: whether patient is incapable of (a) acting; (b) making decisions; (c) communicating decisions; (d) understanding decisions; or (e) retaining the memory of decisions ...by reason of mental disorder or inability to communicate because of physical disability: but a person is not incapable by reason only of a lack or deficiency in a faculty of communication if that lack of deficiency can be made good by human or mechanical aid (s1(6)	At present, common law test. Judicial decisions on the issue of mental capacity emphasise the need for a 'functional' or 'decision specific' approach, focusing on the decision itself and the capacity of that person to understand the nature of the decision required and its implications as in the leading case of Re C (adult: refusal of medical treatment) [1994] 1 All ER 819) Leading case at common law (Re C [1994] 1 All E.R. 819): 3 stage test: i) Can the patient understand and retain the treatment	<u>At common law</u>: Issue and time specific test. Is the patient's cognitive ability impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made? (Fitzpatrick v FK [2009] 2 IR 7 approving In re C (Adult: refusal of medical treatment) [1994] 1 WLR 290) Under s.3 ADM(C)A, <u>generally</u> capacity is to be assessed on the basis of the person's ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made in the context of the available

	capacity: s.1(3) MCA 2005; and (ii) a patient is not to be treated as lacking the capacity to make a decision merely because the decision is unwise: s.1(4) MCA 2005.	AWI)	information? ii) Can the patient believe it? iii) Can the patient weigh it sufficiently to make a choice? MCA 2016 introduces a statutory two stage process to determine a lack of capacity: whether the patient is able to understand, retain, appreciate the relevance of and use and weigh the relevant information, and communicate his/her decision. The MCA 2016 includes similar, but more developed, provisions to those in MCA 2005 as to the steps that must be taken to support a person to take his/her own decision, including provision of information in an appropriate fashion, raising the matter at an appropriate time/times and involving those able to support the person	choices at that time, i.e. an issue and time-specific test. A person lacks decisional capacity where (s)he is unable to understand, retain use or weigh the relevant information (including information about the reasonably foreseeable consequences of (a) each of the available choices at the time the decision is made, or (b) failing to make the decision) or communicate the decision A person is not to be regarded as unable to understand the relevant information if (s)he is able to understand an explanation of it given in a way that is appropriate to his/her circumstances. The fact that a person: i) is able to retain the relevant information for a short period only does not prevent him/her from being regarded as having capacity to make the decision, ii) lacks capacity in respect of a decision on a particular matter at a particular time does not prevent him/her from being regarded as having capacity to make decisions on the same matter at another time. Specifically, where capacity is, or may shortly be, in question, a person is not to be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help him/her to do so or merely by reason of making, having made, or being likely to make, an unwise decision (s.8 ADM(C)A)
Basis upon which healthcare professionals may lawfully proceed without valid consent of patient themselves	Patient aged ≥ 16: reasonable belief that patient lacks the capacity to consent to the proposed treatment/procedure and reasonable belief that the actions taken are in the patient's best interests (s.5 MCA 2005); certain serious medical treatment cases require order from Court of Protection; Patient aged 16 or 17 with capacity to but refusing to consent, on the basis of consent of person with	Patient aged ≥ 16: where doctor certifies in prescribed form that adult is incapable of making treatment decision in question (s.47 AWI). N.B. cannot be used to authorise placing adult in hospital for treatment of mental disorder against patient's will; or actions inconsistent with decision by competent court; or force or detention, unless immediately necessary and only for so long as	Patient aged ≥ 16: at present addressed by common law. Treatment can be could be lawfully administered in patients' best interests by virtue of doctrine of necessity. Re F [1990] 2 A.C. 1. MCA 2016 provides for treatment on basis of reasonable belief that patient lacks the capacity to consent to the proposed treatment/procedure and reasonable belief that the actions taken are in the patient's best	Patient aged ≥ 16 and above: common law defence of necessity (n.b. when ADM(C)A comes into force, modified by requirement that healthcare professionals follow principles in s.8 ADM(C)A; Patient aged 16 or 17 with capacity to but refusing to consent, unlikely that consent of parent/guardian would provide authority. Possible that High Court would make order, but only in extreme case Patient < 16, on the basis of consent of parent/guardian, but subject to uncertainty as to the status of Gillick-competence in the Irish legal order At present, when authorised by the High Court,

	parental responsibility (if consent within the scope of parental responsibility) or order of High Court; Patient < 16, on the basis of consent of person with parental responsibility (if consent within the scope of parental responsibility) In relation to medical treatment for mental disorder, patient of any age, pursuant to compulsory treatment provisions of Part IV Mental Health Act 1983 (e.g. anaesthetic ancillary to ECT).	necessary. Certain serious procedures (drug treatment to reduce sex drive, ECT, abortion or therapeutic procedure resulting in sterilisation) require independent medical authorisation; and others (non-therapeutic sterilisation and implantation of hormones to reduce sex drive) require approval of Court of Session Patient < 16: consent of person with parental rights and responsibilities (if child not sufficiently mature to take decision on own behalf) (s.2 Children (Scotland) Act 1995, s2 AOLCA) In relation to medical treatment for mental disorder, patient of any age, pursuant to compulsory treatment provisions of Part 16 of Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCTA) Emergency treatment under common law where patient unable to give/refuse consent	interests Patient aged 16 or 17 with capacity but refusing to consent, on the basis of consent of person with parental responsibility (if consent within the scope of parental responsibility) or order of High Court Patient < 16, on the basis of consent of person with parental responsibility (if consent within the scope of parental responsibility) In relation to medical treatment for mental disorder, patient of any age, pursuant to compulsory treatment provisions of Art. 68 Part IV Mental Health (Northern Ireland) Order 1986	whether exercising its inherent or Wardship jurisdiction – by the making of a permissive order which enables non-consensual treatment to be administered if considered clinically indicated. High Court's jurisdiction will be limited when ADM(C)A comes into force but will still apply to those < 18 who are not covered by the Act Where the court has made a declaration that the person lacks decisional capacity, either pursuant to an order of the court (in urgent circumstances) or the consent of a court-appointed decision-making representative, (s.38 ADM(C)A). Where a designated healthcare representative, under a health care directive, has been conferred with the power to consent on the person's behalf (s. 88 ADM(C)A) N.B.: Nothing in the ADM(C)A authorises any person to give consent for a non-therapeutic sterilisation procedure to be carried out on a person who lacks capacity (s.4 ADM(C)A) For treatment of mental disorder in patients who are involuntarily detained, and incapable of giving consent, extending to the taking of blood samples (Mental Health Act 2001 Part IV)
Status of advance decisions made by patient	Only relevant to those ≥ 18. Except in relation to treatment under Part 4 of the Mental Health Act 1983., Binding if valid and applicable and (if relating to life-sustaining treatment) in writing, witnessed and state knowledge of consequential risk to life .	Law not totally clear in Scotland. May be same as England/Wales – see Scottish Law Commission Report on Incapable Adults (1995) para 5.46. Would apply to those aged ≥ 16 For treatment for mental disorder under MHCTA, advance statement in proper form can be overridden, but doctor must justify reasons for doing so (ss.275-276 MHCTA)	MCA 2016 requires an effective advance decision to be complied with but will not codify the law as to the creation of an advance decision as was the case with MCA 2005.	Only relevant to those ≥ 18. It must comply with the statutory formalities and is binding. Applies only where the person lacks capacity to consent, the treatment to be refused is clearly identified, and the circumstances in which the refusal of treatment is intended to apply are clearly identified. Not applicable to life-sustaining treatment unless this is substantiated by a statement in the directive by the directive-maker to the effect that it is to apply to that treatment even if his or her life is at risk. Not applicable to the administration of basic care. Advance decisions will not be complied with if, at the time it is proposed to carry out treatment, the person's treatment is otherwise regulated under the Mental health Act 2001 or (s)he is subject to a conditional discharge order under the Criminal Law (Insanity) Act 2010, unless the refusal relates to the

				treatment of a physical illness not related to the amelioration of a mental disorder Special provisions apply in relation to pregnant women (s.85 ADM(C)A)
Power of proxy decision-maker	Only relevant to those ≥ 18. Attorney under health and welfare Lasting Power of Attorney may consent/refuse to treatment (including life-sustaining treatment if expressly authorised). Only relevant to those > 16. Health and welfare deputy may consent/refuse treatment (but cannot refuse life-sustaining treatment) NB an attorney under Enduring Power of Attorney can never have authority to make decisions in relation to medical treatment	Only relevant to ≥ 16. Welfare attorney or welfare guardian may consent/refuse to treatment if authorised in power of attorney/court order, but refusal may be overruled by independent medical opinion, subject to appeal to Court of Session (s50, AWI)	Only relevant to those ≥ 16. MCA 2016 provides for the creation of a Lasting Power of Attorney. Attorney under health and welfare Lasting Power of Attorney may consent/refuse to treatment (including life-sustaining treatment if expressly authorised). NB an attorney under Enduring Power of Attorney can never have authority to make decisions in relation to medical treatment	Proxy decision-maker appointed by patient themselves under Enduring Power of Attorney. Applies only to those ≥ 18 years. Statutory formalities must have been complied with. Only effective when donor of power of attorney lacks capacity (s. 59 ADM(C)A 2015). Must confer authority to do specific things on the donor's behalf in relation to personal welfare, including healthcare. A donor may not, in an Enduring Power of Attorney, include a relevant decision (a) relating to refusal of life-sustaining treatment, or (b) which is the subject of an advanced healthcare directive made by him or her. (s.62 ADM(C)A). Decision-maker appointed under advance healthcare directive. Applies only to those ≥ 18 years. Statutory formalities must have been complied with. Can give decision-maker power to consent/refuse to treatment (including life-sustaining treatment if expressly authorised) (s.88 ADM(C)A) ADMC(A) also provides for appointment by court of decision-making representative. A decision-making representative is not authorised to refuse consent to the carrying out or continuation of life-sustaining treatment or consent to the withdrawal of life-sustaining treatment for the relevant person, subject to the terms of any advanced healthcare directive and the powers exercisable by any designated healthcare representative appointed thereunder (s.44 ADM(C)A)

n.b. all websites accessed on 20/10/2016. See main article document for acknowledgements.