COLUMNS

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Trials and tribulations of S49 orders

The Mental Capacity Act 2005 (MCA 2005) is an Act of Parliament, applying to England and Wales, that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.[1] Under section 49 (pilot order) of the MCA 2005, launched in 2016, the Court of Protection can order reports from National Health Service (NHS) health bodies and local authorities when it is considering any question relating to someone who may lack capacity, and the report must deal with 'such matters as the court may direct'.[2] This change has caused significant ethical challenges for psychiatrists.

With regard to professional implications, Section 49 reports require an opinion; according to British Medical Association (BMA) and General Medical Council (GMC) guidance, this falls under expert witness work. The recent Pool judgment is a reminder that the GMC is likely to consider that fitness to practice is impaired if a doctor acts outside what is considered their scope of work.[3] The order is usually accompanied by an instruction letter containing legal precedents and a bundle sometimes containing conflicting assessments. Responding to such instructions require medico-legal training and experience in giving opinions to complex questions such as capacity to consent to sex, or consent to drink. We would argue that there is a blurring of boundaries between expert and professional witness. There is a need to clarify what legal safeguards are in place for the author of Section 49 reports, if their opinion is challenged, as it was in the Pool case.

In relation to patient care, the introduction of an automatic right to a medico-legal report, which was previously funded from elsewhere, has shifted the cost on to the NHS. Given that mental health services are still block funded; more work without additional funding leads to dilution of quality of care elsewhere in the system, affecting patient care. Lack of parity of esteem between physical and mental health funding makes this work an onerous burden. Increased workload without remuneration has an adverse effect on staff morale, influencing recruitment and retention within an already struggling NHS.

There is an urgent need to quantify the effects of these orders on services. The Royal College of Psychiatrists, working together with NHS England and the BMA, needs to define how medico-legal work can be safely done within existing resources. Moreover, the BMA, GMC, the College and NHS employers need to resolve the discrepancy that results from what is considered expert witness work by regulatory bodies being framed as normal NHS work by the Court of Protection.[4] Legal safeguards need to be in place if NHS professionals become subject to legal challenge, e.g. from an aggrieved solicitor. Consideration needs to be given to a fresh legal challenge if it is evident that this pilot order is affecting patient care.

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1 *Mental Capacity Act 2005 Code of Practice*. TSO, 2007 (https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice).

2 Courts and Tribunals Judiciary. *Court of Protection Transparency Pilot: Case management S.49 pilots extension*. Courts and Tribunal Judiciary, 2017 (https://www.judiciary.uk/publications/transparency-pilot-case-management-s-49-pilots-extension/).

3 Pool *v* General Medical Council [2014] EWHC 3791 (Admin).

4 General Medical Council (2013) Good Medical Practice; Acting as a witness in legal proceedings. GMC (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/actingas-a-witness/acting-as-a-witness-in-legal-proceedings).

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The requirement for a general psychiatric assessment risks psychopathologising the experience of transgender people

This paper and the service from which the statistics are drawn appear concerning on a number of levels. It appears unlikely that the fundamental assertion which underpins the statistics in this paper is accurate, namely that 'our case note review was able to capture all patients referred within a certain time period in this geographical area'.

The authors state that: 'All individuals who request treatment for gender dysphoria in Oxfordshire are referred to a single clinician (C.B.) for psychiatric assessment and subsequent referral to a specialist centre', and later, 'there is a single point of access in Oxfordshire for onward referral to specialist gender clinics'.

This referral pathway is not consistent with mainstream practice in other areas of England and is not supported by current protocols and guidelines representing best practice. The 2013 College Report *Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria* emphasises referral by or via a general practitioner, with no other gatekeeping requirement.

The requirement for a general psychiatric assessment is at best unnecessary and at worst risks psychopathologising the experience of transgender people who are presenting with gender dysphoria, an experience of discomfort or distress which is not psychiatric in nature.

There is local awareness of the unusual nature of the arrangement in Oxfordshire. The Oxford University LGBTQ+ society advises on its website: 'N.B. A lot of GPs will seek to refer trans customers to psychiatrists (in Oxford, this is usually Dr Chris Bass), but this is a completely unnecessary procedure.

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