

Briefing on the Mental Capacity Bill

1

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We wish to protest those aspects of the Mental Capacity Bill (MCB) which threaten – if unintentionally - the lives and welfare of vulnerable groups in our society.

Particularly under threat are those who, at some stage in their lives, have expressed the view that life is not worth living if one is seriously disabled. In a society where negative views of disabled people's lives are very common, many able-bodied people, and some disabled people themselves, will hold such a view, and make advance refusals of treatment which are suicidally motivated. Instead of protecting such a person, the Bill may give his/her suicidal feelings lasting effect.

On the face of it, **the Bill does not permit doctors and nurses to save the lives of those who were suicidally motivated, but had 'capacity', in making an advance decision.** Those who save the lives of such suicidal patients may be liable to criminal proceedings, if the patient was mentally competent in refusing treatment. In contrast, carers are apparently free to withhold life-saving treatment **even with the aim of causing death.**

Take the following scenario:

P is a person who wants to commit suicide when his disability progresses beyond a certain point. P makes an advance decision, when he is mentally competent, that no treatment is to be given to him should he be (temporarily

or permanently) unconscious. Later, P attempts suicide unsuccessfully and is unconscious as a result.

D, a doctor, intends that P die, as D believes that life is not worth living with P's disability.

The MCB apparently requires D to withhold treatment - thus making P's suicide effective. It apparently allows D to do this even with the aim of causing death.

There is nothing in the Bill which explicitly prevents intentional homicide by omission, which the *Bland* judgement has already legalised in the case of PVS patients. While we note Clause 58 to the effect that nothing in the Bill will change the law on homicide or assisted suicide, it should be remembered that the law in these areas has already been seriously weakened by *Bland* and other judgements. The Bill does not say that homicidally-motivated denials of life-saving treatment by doctors or proxy decision-makers will be invalid. Nor does it exclude suicidally-motivated advance decisions from those which are given legal force.

Even patients who have never wished to end their own lives will be at risk. The Bill does not acknowledge that doctors or proxies may have a homicidal motive in denying treatment to a patient. In the case of proxies, there are other dangers in allowing those with no medical qualifications to veto treatment which a doctor sees as medically required. **Some vetoes will**

be aimed at causing death, while others will be, at very least, harmful to the patient, even if well-intentioned. The onus will be on the doctor to take such cases to court: a burdensome option many doctors (and NHS Trusts) will not wish to pursue. Moreover, the court may simply confirm the proxy's decision – particularly if the proxy claims, sincerely or otherwise, that the patient 'would not have wanted' to be treated or tube-fed.

Some proxies – attorneys - will be nominated by the patient; however, such proxies will have no medical expertise, will not be controlled by a professional body such as the GMC, and may easily have a conflict of interest – for example, a wish to be relieved of the patient's care. Other proxies – deputies - will be appointed by a court: the question then arises why a non-medical decision-maker the patient has not chosen should be able to override a doctor's judgement on what treatment he or she needs.

Competent patients have rights in existing law to refuse treatment in advance. We have no problem with respecting advance refusals of treatment which are well-informed (i.e., where the relevant medical facts have been explained by health professionals) and which are not suicidally motivated. However, this will not apply to many advance decisions, and **busy doctors may not be willing or able to establish if an advance decision is suicidal, ill-informed, written under duress, has been formally revoked, or if the patient's views have changed.** Such doctors may nonetheless comply with the advance decision, as this will be the easier option. (Note that there is nothing in the Bill itself to prevent an advance decision from being both

presented, and supposedly witnessed, by someone who will benefit financially from the patient's death.)

In any case, we believe that **no advance refusal should be binding in regard to basic care - including the provision of pain relief, hygienic care and feeding, whether orally or by tube.** Patients should be given a minimal level of appropriate care, both for their own sake and for the sake of protecting an ethic of care among doctors and nurses. Since 'treatment' in the Bill includes tube-feeding, the Bill will create a legal and social climate where withholding food and fluids, even where these are not burdensome, is seen as beneficial to patients precisely in ending their lives. The support of the Voluntary Euthanasia Society for the Bill is therefore understandable.

The MCB is deeply flawed in its approach to best interests, which are described solely in terms of the patient's actual or hypothetical desires. The Bill nowhere refers to life and health in listing the best interests of the patient. **By focusing solely on subjective criteria for determining best interests, the MCB encourages the view that it is in some patients' interests to die, because this is 'what they wanted.'** Such a view goes against the whole practice of suicide prevention, and support for those who see their lives as worthless at some particular time.

Finally, the MCB permits invasive, non-therapeutic experiments on mentally incapacitated people, if the risks are 'likely to be negligible.' This is dangerous, in view of the attitudes of some in the medical profession to such patients. It is one thing to do research which is intended to benefit the patient, as well as

increasing human knowledge; it is something quite different to carry out invasive procedures which are solely for the benefit of others. We should not create structures which will, or may, allow mentally disabled people to be abused.

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