Adrian Treloar on the strengths and weaknesses of the new bill

The Mental Capacity Bill

- gateway to euthanasia?

WE SHOULD BE VERY CONCERNED ABOUT THE CURRENT BILL. IT IS A LONG WAY FROM BEING BENIGN

The draft Mental Capacity Bill[1] was published this summer following a decade of discussion and negotiation. One of the remarkable things about the bill is how long it has taken to come to parliament. This is largely due to the considerable input from various faith-based and 'pro-life' organisations, including CMF, who have highlighted flaws and sought to improve the legislation. After years of discussion, we have another document to consider. While some sections are good others are, I believe, a step towards legalising euthanasia.

What is partly good?

The validity of **advance decisions** will be limited under the bill. They will have to be specific, relate to conditions that were anticipated, and the patient must not have done anything inconsistent with the decision since it was made. Furthermore, when the specified situation arises, if there are reasonable grounds to doubt that the patient did not anticipate circumstances that would have made him think differently, the decision can be questioned.

However, apart from these limitations, advance decisions will be given statutory power. This could lead to neglect of a patient if they have made decisions without understanding the consequences. Statutory power will make advance decisions therefore dangerous. Whilst welcomed as *advisory* by Christian doctors they are generally opposed if *binding* because of the damage that may occur to vulnerable patients.

A good aspect of the debate on advance decisions is that we have gained a much clearer description of the limits to their authority. Faced with an advance decision, the bill will give doctors considerable power to continue to cherish the life of the patient and provide appropriate care and comfort. There is a range of opportunities to question the validity of directives when they appear to harm the patient. This is a huge improvement on previous loose definitions. However, it is still not clear whether a suicide note would constitute a valid decision, requiring doctors to allow those who harm themselves to die.

Lasting powers of attorney (LPA) are partly good but also dangerous. They give another individual statutory authority to consent to treatment for those without capacity who refuse or cannot consent to care, including those who resist. This should improve care, as currently incapacitated patients who resist care may not be treated. Enduring powers of attorney already work well for money matters, and LPA may help medical care. However there are cases of fraud in money matters, and the likelihood of an appointed attorney not acting for the patient's best medical interests must concern us all. It is not clear how those who oppose good care for patients will be dealt with.

What is bad?

The bill states that **serious medical treatment** may be withdrawn for the **best interests** of the patient. It is very clear that this means the bill will allow the removal of food and fluids from patients in persistent vegetative state (PVS), as well as stroke patients and newborn disabled babies. It will also enable sterilisation of those with learning disabilities. The Government states that these matters will be subject to a code of practice and that recourse to the courts will continue for the time being in cases where this currently happens. However, codes change with time and the bill will therefore give statutory support to ending the lives of stroke patients by dehydration as well as allowing, without further legislation, the ending of life for PVS patients. Donees of an LPA will be able to *require* such ending of life by refusing serious medical treatment (including food and fluid by tube and possibly use of oral syringe feeding). Where the Court of Protection appoints a consultee, a government appointee will acquire the ability to stop

Mental Capacity Bill[2]

Key principles of the bill:

- An assumption of capacity
- Capacity is decision specific
- Participation of the patient as far as is possible in decision making
- Individuals retain the right to make eccentric or unwise decisions
- Decisions on behalf of incapacitated people must be in their best interests
- Decisions should be those which are least restrictive of basic rights and freedoms

The bill enshrines in law:

- Acts in connection with care and treatment of incapacitated patients
- Protection of carers from liability where they acted in the best interests of the patient
- Lasting powers of attorney (LPA) applying to welfare, healthcare and financial matters
- Court appointed deputies – able to take decisions on welfare, healthcare and financial matters
- Advance decisions – confirming the legal basis for people to make a decision to refuse treatment if they should lose capacity in the future
- Criminal offence of neglect or ill treatment of the incapacitated – liable to five years imprisonment
- New court of protection – to consider decisions about the needs of incapacitated patients (there are currently handled by the High Court).
- New public guardian – the registering authority for LPAs and deputies
- Code of Practice

History of the bill:

- 1989 - Law Commission begins initial investigation of the mental health laws
- 1995 - Law Commission issue their report: *Mental Incapacity*
- 1997 - Consultation on the Green Paper *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*
- 1999 - *Making Decisions* policy statement issued
- 2002 - Mental Incapacity Consultative Forum established to develop solutions to problems under the current law and explore proposals for new legislation
- 2002 - Views on a series of guidance booklets[3] sought through the consultation *Making Decisions: Helping People who have Difficulty Deciding for Themselves.*[4]
- 2003 - Draft *Mental Incapacity Bill* presented to a Joint Committee for scrutiny
- 2004 - Committee report published in February. The revised and renamed *Mental Capacity Bill* published in June

The MCB should not be confused with the draft Mental Health Bill issued by the Department of Health in 2002. Considerable opposition was raised against the controversial 2002 bill. A revised bill providing extra safeguards for mentally ill people was presented to a parliamentary scrutiny committee on 8 September 2004.

treatments in this way. So as well as consolidating the Bland judgement,[5] the bill will go a very long way beyond Bland to enable euthanasia by neglect of a wide group of individuals.

'**Best interests**' remains poorly defined. Indeed the bill 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. We all know, as doctors, that there really should be a consideration of good clinical care in 'best interests'. To omit this from the decision-making equation is unacceptable. Yet under proposed legislation it will not matter.

'**Serious medical treatment**' is not defined. It will certainly include simply administered food and fluid by tube, but may also include other oral nutrition (which we know is harder for many than tube feeding). Therefore the range of treatments that can be withheld or withdrawn is likely to be wide. The range of disabilities and illnesses will also be wide. This risks decisions being made on the basis of 'worth', 'personhood' or 'utility' of individual patients. Disabled and elderly patients are at deep risk in all such quality arguments.

We should be absolutely clear that this is not because we are'vitalist' (ie. that we seek to preserve life at all cost). It is absolutely right that we must limit medical care where it will not help or work. In my clinical practice, working with severely incapacitated individuals we do this frequently. However, this bill puts into statute the ability to require that serious medical treatment (including food and fluid administered by tube) be withheld, with the knowledge that life might soon end as a result. The ethics of this must be questioned.[6] If we are legally required to end life by such means we will, in my view, have fractured the vision we have of each one of our patients as uniquely deserving of respect, love and care. That is precisely what happened in Nazi Germany. The first victims were the disabled and elderly.

What is ambivalent?

Clause 58 was added at the request of Parliamentarians, Catholic Bishops and others. It provides that nothing in the bill will change the law on homicide or assisted suicide. This must be good, but it should be remembered that Bland and other judgements have already seriously weakened the law in these areas. The clause will not therefore prevent euthanasia by neglect and probably has very limited meaning as a result.

What does the future hold?

The Abortion Act 1967 resulted in a large proportion of Christian doctors being blocked from Obstetrics and Gynaecology, as those with a conscientious objection found it harder to ascend the career ladder. A few hung on, believing that doing some abortions enabled them to influence and save others. The same sort of thing will doubtless happen in the care of the sick and vulnerable if this bill is passed. Specialties such as Geriatric Medicine, Palliative Care, Old Age Psychiatry and General Practice currently occupy many Christian doctors. These may become 'no-go' areas; there must come a point where we simply say 'No, we cannot take part in euthanasia'. We should be very concerned about the current bill. It is a long way from being benign, and will probably turn out to have been the point at which euthanasia became legally established in this country.

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References

1. *www.dca.gov.uk/menincap/legis.htm*
2. *www.dca.gov.uk/menincap/mcbfactsheet.htm*
3. *www.dca.gov.uk/family/mi/index.htm*
4. *www.dca.gov.uk/consult/family/decision.htm*
5. *Airedale NHS Trust v Bland* [1993] 1All ER 821, (1993) 12 BMLR 64 (HL)
6. Treloar A. Howard P. Tube feeding, medical treatment or basic care? *Catholic Medical Quarterly* 1998; 49:5-6 *www.catholicdoctors.org.uk*