BRIEFING ON THE MENTAL CAPACITY BILL

On behalf of the Lawyers' Christian Fellowship

and the Maranatha Community

This Briefing has been jointly prepared by the Lawyers' Christian Fellowship (the "**LCF**") and the Maranatha Community. We understand that the Second Reading of the Mental Capacity Bill is to take place in the House of Commons on 11th October. We submit this Briefing to highlight our grave concerns about this Bill.

EXECUTIVE SUMMARY

1. **Legally binding advance decisions to refuse treatment could lead to unnecessary suffering and death.**

   There is also no conscience clause protecting doctors and other health care professionals from being placed under a legal obligation to follow advance directives against their conscience and their better judgment.

2. **Failure to distinguish between "treatment" and "basic-care" would allow passive euthanasia and could lead to active euthanasia.**

3. **The definition in the Bill of "best interests" is unacceptable since it is vague, makes no reference to health or life and could easily lead to the conclusion that death is in the patient's best interests.**

BRIEFING

The Mental Capacity Bill (the "**Bill**") aims to provide a legal framework for assisting those who lack capacity to make decisions for themselves. It would also allow decisions to be taken on behalf of those lacking capacity. While we recognise many good suggestions in the Bill, we are seriously concerned about the following points:

1. Legally Binding Advance Directives

The Bill would make advance decisions to refuse treatment ("ADs") legally binding. Healthcare professionals will be forced to follow advance decisions with the consequence that treatment including nutrition and hydration will have to be stopped. The inherent risks surrounding ADs can lead to unnecessary suffering and death. There are the following major problems with ADs:

- **Duress –** It is impossible for doctors to know for certain that an AD was not written under duress.
- **Revocation –** It is impossible for doctors to know for certain that the AD produced (for example, by relatives of the patient) has not been revoked.
- **Change of mind –** It is impossible for doctors to know that the patient had not changed his or her mind since the making of the AD. Research evidence shows that people do change their minds regarding decisions to do with treatment or refusal of treatment**.** In one study from Oregon USA, where physician-assisted suicide is legal, nearly half the patients who had initially requested physician-assisted suicide changed their minds after initiation of treatment, such as pain control, prescription of antidepressant medication or a referral to a hospice.
- **People making ADs rarely know in advance the full implications of such a decision**. Some ADs state that antibiotics should not be given 'to control infection' in certain medical conditions. However, both a patient with a stroke developing a pneumonia and an elderly patient with dementia developing a urinary tract infection may benefit from antibiotics. The first patient may become less breathless and both may become less confused. This treatment might have to be withheld in some cases if ADs became compulsory, causing the patient unnecessary suffering.
- **Advances in medical science may make an AD obsolete and patients might die of treatable conditions.** If a disease, for example disseminated cancer, is to trigger the AD, it may be that at the time of the drafting of the AD this disease was not curable. However, with the advance of medical science, it may be treatable when the AD becomes relevant. The AD of the Voluntary Euthanasia Society stipulates that 'advanced disseminated malignant disease' would be one of the conditions, under which no treatment should be given aimed at 'prolonging or sustaining' a person's life. However, already today, some cancers or lymphomas fall into this category and respond very well to chemotherapy, so that patients can be cured. However, if ADs became compulsory, a doctor might have to let patients die of treatable conditions.
- **Oral ADs are valid -** This contrasts with the will of a deceased person where a verbal statement would not be considered as a valid will. The statement of a close relative (who may gain financially from the death of the patient) that 'I've heard him say that he wouldn't want this treatment' may be sufficient to place a doctor under a legal duty to withhold lifesaving treatment. Life and death decisions would be made on the basis of hearsay.
- **Suicidally motivated ADs may be valid.** An AD can be written with suicidal intent. Whether a suicidally motivated AD (or even a suicide note) would be considered to be a valid AD would depend on whether the person writing the note was considered to have capacity at the time of writing. It is of grave concern that there appear to be conflicting interpretations of whether a suicidally motivated AD is valid or not. In any event, whether or not an AD is suicidally motivated would be extremely difficult, even impossible, to establish.

The 1994 House of Lords Select Committee on Medical Ethics recognised the inherent dangers and recommended that advance directives should *not* be made legally binding. The same view was taken in Scotland, with the Adults with Incapacity (Scotland) Act 2000 omitting all reference to legally binding advance directives.

In addition, the Bill would apply undue pressure on healthcare professionals who object to euthanasia on grounds of conscience. Making ADs compulsory places healthcare professionals in an invidious position in that they will have to participate in withdrawing treatment (including hydration and nutrition) leading to the death of patients. No provision is made in the Bill to allow healthcare professionals to opt out from participating in euthanasia.

We urge the Government not to make advance decisions compulsory through this Bill. Advance decisions should remain advisory, coupled with an express opt-out provision on the grounds of conscience for health care professionals.

2. The distinction between 'Treatment' and 'Basic care'

The Bill allows for decisions to be made on behalf of an incapacitated person for treatment to be withdrawn. 'Treatment', according to the Bill, includes the provision of hydration and nutrition. Many consider this not to be treatment, but to be basic care. The failure to differentiate between 'treatment' and 'basic care' could lead to euthanasia through the backdoor, since both can be withdrawn under the provisions of the Bill.

- 'Basic care' includes hydration and nutrition. The Bill only mentions 'life-sustaining treatment'. **Withdrawal of treatment therefore could mean withdrawal of nutrition and hydration.** If the Bill became law in its current form patients would die of dehydration and starvation. This amounts to 'passive' euthanasia, i.e. the intentional termination of a patient's life by omission. There is no qualitative difference between this form of passive euthanasia and other types of euthanasia – the intention and the outcome are the same, only the method is different.
- In addition to allowing passive euthanasia, **the Bill could also lead to active euthanasia**. It creates a political and social climate where withdrawal of life-sustaining treatment (including withdrawal of fluids and nutrition) is being seen as beneficial to the patient. Not only will this change society's view of the inviolability and worth of human life, but there will be increasing calls to legalise euthanasia, since it will be considered much more humane to kill patients quickly (for example through a lethal injection), rather than letting them die slowly of thirst or hunger.
- We want to remind policy makers that over time, the application of a law can become quite different to its original intention. **Abortion was legalised with the intention to stop risky back street abortions. However, three decades later we have what is in essence abortion on demand.** The Government appears to be opposed to euthanasia. However, if that is so, it must take steps to ensure that this Bill does not allow or lead to euthanasia in any form.

We urge the Government to clarify in the Bill that euthanasia, both passive and active, is clearly prohibited. While we welcome the inclusion of clause 58 into the Bill, we believe that this clause would be insufficient to prevent 'passive' euthanasia.

3. <u>The definition of 'Best Interests'</u>

The vague definition of 'best interests' could be misapplied thereby causing fatal consequences.

- The Bill suggests a list of criteria to determine the best interest of a person. These include for example the 'past and present wishes and feelings' which are inevitably subjective and open to interpretation. Unfortunately, there is no reference to absolutes such as life or health.
- If the current 'non-absolute' criteria for determining 'best interests' in the Bill are applied to a real case history of a patient with severe depression and multiple suicide attempts who was incapacitated following an overdose, one could easily come to the conclusion that it was in this patient's best interest not to be resuscitated.
- We understand that the definition is to cover financial as well as medical decisions, but when medical decisions are being made the decision makers should be required to take account of the patient's medical or clinical best interests.

We urge the Government to include absolute criteria such as health and life when determining a person's 'best interests'. Otherwise, it could be construed that death is in the patient's best interest.

CONCLUSION

The LCF and the Maranatha Community submit this Briefing out of a concern for the principle of the sanctity of life, which we believe would be eroded by this Bill as it currently stands. The purpose of the Bill is to help those who are among the most vulnerable in society. This purpose reflects the Christian principle of acting as a good Samaritan to those who are in need. It would therefore be tragic and unacceptable if this Bill actually led to increased suffering and death.

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The Lawyers' Christian fellowship has over 1500 members, including barristers, solicitors, members of the judiciary, law lecturers, legal researchers and other professionals involved in the law.

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of doctors, nurses and other health professions and individuals involved in a wide range of voluntary work.