5 Barry MJ, Edgman-Levitan S. Shared decision making – the pinnacle of patient-centered care. *N Engl J Med* 2012; **366**: 780–1.

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My response to 'Assessment of decision-making capacity in patients requesting assisted suicide'

Although I congratulate the authors for addressing a controversial and neglected subject, I fear that in their efforts to soften their views they also 'muddy the waters'.[1] Specifically, they refer to the enhanced evaluation and a higher standard of competence for those patients seeking assisted suicide who are not terminally ill. However, capacity as assessed through the tests laid down in the Mental Capacity Act 2005 is issue-specific, time-specific and obviously also patient-specific. There is no concept of differential competence proportional to the gravity of the outcome. To evoke such a doctrine would, in my view, render the entire exercise worthless.

For psychiatrists, our role is to advise as to whether or not a patient requesting assisted suicide is exhibiting any recognised mental disorder. If not, our role ceases immediately. If a disorder is identified, we should then apply the tests laid down in the Mental Capacity Act 2005 regardless of diagnosis. To do otherwise would offend the principles of autonomy and justice, if not also non-maleficence.

My second concern relates to people who lack the capacity for consent, whether for congenital or acquired reasons. Do they not have the same rights and entitlements as everyone else? If so, can we justify denying them access to medically assisted suicide just because they might have reached a different decision if mentally competent? To my mind, this sounds like filing the problem in the 'too difficult' basket. I think the appropriate way forward in these circumstances is to proceed to an assessment of their best interests, as is necessarily the case for any other medically intrusive procedure. This would at least then potentially expose the procedure and its outcome to judicial scrutiny.

Finally, I remain concerned about the term 'assisted suicide' as applied to medical practice. In my view, doctors never 'save' anyone but simply delay, or sometimes hasten, the inevitability of death. Assisted suicide therefore might be better thought of as a form of 'brought forward time'. This also allows for the possibility of different entry routes. So, for example, a request for 'medically assisted brought forward time' could be included within a Living Will, a Lasting Power of Attorney or even as an Advanced Purchase, the latter perhaps being included as part of a pre-paid funereal plan.

Overall, I think that 'medically assisted suicide' or preferably 'medically assisted brought forward time' is actually a perfectly straightforward matter that readily sits within existing mental health law. Why complicate matters?

Reference

1 Shaw D, Trachsel M, Elger B. Assessment of decision-making capacity in patients requesting assisted suicide. *Br J Psychiatry* 2018; **213**: 393–5.

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