affinity
gospel churches in partnership

SALT AND LIGHT PAPERS

Salt and Light Papers provide important information and analysis to help Christians and Churches to engage with 21st century social issues

JA4

MAKING LIFE AND DEATH DECISIONS FOR SOMEONE ELSE

Under the Mental Capacity Act, which received Royal Assent in April 2005, it will become possible for people to nominate an attorney who can make important decisions on their behalf, if circumstances arise in which people are no longer able to make those decisions for themselves.

The Act creates a Lasting Power of Attorney, which replaces and extends the current role of an enduring power of attorney.

Since the Act was passed, further consideration has been given to the scope of the delegated powers, the extent to which they will be binding, and the procedures under which the system will operate. These matters will need to be resolved by April 2007 when the Act is expected to take effect.

These are sensitive and controversial issues, since the powers introduced within the Act will enable a number of personal welfare matters to be delegated to attorneys, including refusing or consenting to particular kinds of healthcare and life-sustaining treatment, and decisions concerning admission to residential care.

A Consultation by the Department for Constitutional Affairs closed on 14 April and the result is awaited.

The intention of the Act is to provide a statutory framework to empower people to make decisions for themselves as far as possible and to protect vulnerable people who are not able to make their own decisions.

In addition to making personal welfare decisions, attorneys, or the same attorney, can also be appointed to decide on personal property and financial matters, as they can now under enduring power of attorney arrangements.

Under the Act, an LPA only becomes operative once registered with the Office of the Public Guardian and in accordance with any conditions set by the donor (the person who makes a LPA). For instance many LPAs may only become operative when a donor is deemed to be lacking mental capacity.

To provide the opportunity for someone who suffers bouts of mental incapacity to specify that certain treatments are not used seems eminently sensible. The person concerned knows from previous experience (direct or indirect) how to make that decision. In that sense it is an informed decision and an extension of the patient's consent to treatment.

However, Affinity's concern is that if this statement of wishes is applied to life-sustaining treatments, it will not have been possible for the donor to have made a truly 'informed' decision. The statement will have been drawn up some time in advance of the situation to which it is intended to apply, and in ignorance of the precise clinical circumstances.

The provisions for attorneys appointed under an LPA seems to allow for decisions to be first made by doctors and then, in the light of their advice, by the attorney. A clause in the Act does seem to suggest that the attorney will have the right to give or refuse consent to the doctors' decision. If this is the case, it places a heavy burden of responsibility on the attorney to reflect accurately the wishes of the donor, to think as they would think, to understand the medical advice, and to make appropriate decisions in the 'new' circumstances.

Advance directives about life-sustaining treatment would seem to be an unnecessary and ethically problematic provision of the LPA scheme. Where there is no LPA directive, the proposed guidance notes say that 'the doctor in charge of… treatment will make decisions' in the 'best interests' of the patient, and, where possible, in consultation with attorneys and other people interested in the donor's personal welfare. In those circumstances, the selection of appropriate attorneys would be the key issue, rather than burdening them with directions which may prove difficult to fulfil.

Decisions relating to life-sustaining treatment will be a concern to those who hold a high view of the sanctity of life and the prerogative of God's sovereignty in matters of life and death. The proposed guidance notes say that life sustaining treatments include artificial nutrition and hydration (ANH) – food and water given through a tube in the nose or directly into a vein.

The proposed guidance notes claim that an LPA for personal welfare is not the same as an 'advance decision' or 'living will.' Strictly speaking this is true. An attorney appointed under the LPA for personal welfare scheme does not have the right to make an advance decision for the donor. However, if the donor states on the LPA for personal welfare form that he or she wants an attorney to refuse life-sustaining treatment (and the donor can specify ANH) then this aspect of the LPA form will in effect act as an advance decision.

There are clear moral and ethical grounds for objecting to the inclusion of life-sustaining treatment within the scope of an LPA, if this has the same effect as an 'advance decision.' These objections are:

- Advance decisions are inevitably static statements that do not take into account progress in medical practice, technology and medications.
- Advance decisions cannot be considered as an expression of 'informed consent' as they may be written years in advance of the circumstances to which they will apply.

This type of advance directive can only lead to an undermining of good medical practice. Society accepts that personal autonomy has to be limited where the best interests of others are at stake – an example is the recently-approved ban on smoking in public places. The consequences of advance decisions are equally, though perhaps less obviously, dangerous to society.

Once we enshrine in law the right of some individuals to choose death we are setting a precedent which will set one person's 'death wish' against another person's 'life wish'. This then introduces a whole range of contentions about the value of life (when is life not worth living?), what is unreasonable and unjustified treatment or care, and what are the cost implications of life support over death.

If patients are given personal autonomy over life-sustaining treatments, including ANH, then we are heading for a situation in which a culture of death can prevail over a culture of life.

A responsible Government needs to affirm a culture of life rather than one of death. Hard cases will certainly arise in connection with whether a particular life should be sustained. However, encouraging an attitude of life termination rather than life affirmation does not promote the security and worth of citizens, attribute the highest possible value to human life, nor create a positive framework for medical decisions.

Christians want a healthcare system committed to health and well-being and undergirded by a 'right to life' rather than a 'right to die' philosophy.

We want a society which rejects living wills as an arrogant expression of man's sinful desire for personal autonomy, and which is committed to the well being of everyone whatever their condition, circumstances or situation in life. Such a society is threatened when legislation and practice legitimises the 'living will'. Ultimately this approach, whatever the supposed benefits for a few, dishonours the value of life and places undue pressure on those who are vulnerable.

Gerald Tanner

The above was published in The Bulletin [July 2006]