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LIVING WILLS AND LASTING POWERS

Living wills and lasting powers of attorney – two controversial provisions of the Mental Capacity Act 2005 – became effective on 1 October 2007.

Although the provisions were predictably welcomed by the pro-euthanasia lobby as 'a great day for patient choice,' they continue to be steeped in controversy, the Lawyers' Christian Fellowship claiming that the lives of many elderly and vulnerable people 'could be put at risk.'

Although they have their similarities, living wills and lasting power of attorney are two quite separate provisions of the Mental Capacity Act 2005.

Living wills, otherwise known as 'advance decisions' or 'advance directives,' are authoritative statements made by individuals indicating in advance their wish to refuse all or some forms of medical treatment if circumstances arise in which such a decision is required, and the individual concerned has lost the mental capacity to make the decision at the time. An advance directive cannot be used to request treatment – only to permit its withdrawal.

A living will must specify the treatment to be refused and the circumstances in which the refusal would apply. If the advance directive includes the refusal of life-sustaining treatment, it must include an express statement that the decision stands 'even if life is at risk.' It cannot be used to ask for life to end, or to force doctors to act against their professional judgement.

However, there are several circumstances in which a doctor is permitted not to act on an advance decision – including a change of religion by the person since the living will was made.

Where none of the exceptions apply, an advance decision will have the same effect as a refusal of treatment by a person with capacity. Treatment refused by the terms of a 'living will' cannot lawfully then be given, without the doctor risking civil liability or criminal prosecution.

The LCF claims that such 'watertight enforcement' provisions should be accompanied by much better safeguards. Their concern is that individuals will be able to make an advance decision, at a

time when they are fit and well, for life-sustaining treatment to be withdrawn at a future time of illness and incapacity, without necessarily understanding the consequences. These consequences are that patients will die, not of their illnesses, but of thirst. Evangelicals, among others, have taken the opportunity to re-state their profound belief that giving nutrition and hydration to a patient should not be viewed as medical treatment, but as basic care which ought never to be withdrawn. However, it remains the case that the artificial provision of food and water is officially regarded as a medical intervention, and therefore as 'treatment.'

Elspeth Chowdharay-Best, secretary of the pressure group *Alert* is quoted as saying: 'People sign living wills thinking they will die a little bit earlier... but what this law does not say, and most people do not know, is that they will be condemning themselves to die terribly of thirst.' (*Daily Mail,* 28 September 2007)

In addition to introducing 'living wills,' the new legislation also enables someone to appoint another person, known as a Lasting Power of Attorney (LPA), to make decisions on his or her behalf, in the event of future incapacity. The LPA replaces the Enduring Power of Attorney (EPA), which has existed for many years, though the powers of the EPA were restricted to property and everyday practical matters, whereas the new LPAs also cover issues of personal welfare, such as decisions on medical treatment. Existing EPAs will remain in force.

The new system will be overseen by the Office of the Public Guardian, an agency of the Ministry of Justice. Ultimate jurisdiction over all powers of attorney rests with the Court of Protection.

To appoint an LPA, two 25-page forms need to be completed, and the cost of registering is £150 for each of the two parts.

But the cost is not the most contentious issue aroused by the new LPA provisions.

Concern has been expressed that a family member appointed an LPA could consent to someone's life ending, while at the same time being a beneficiary under the patient's will. There are no safeguards in the LPA system to prevent such a basic conflict of interests arising. There are safeguards at the time the LPA is appointed, aimed at ensuring that no fraud or undue pressure has been applied against or upon the patient, but nothing to safeguard the integrity and objectivity of LPAs at the time medical decisions are taken. However, the person appointing an LPA can exclude authority over decisions to give or refuse consent to life-sustaining treatments.

The LCF has identified three 'deficiencies' in the procedures relating to the appointment of an LPA:

- The forms used to appoint an LPA have omitted a proposed checklist, which the government had indicated during the passage of the Mental Capacity Bill was a 'key safeguard.'
- The appointed Attorney is not asked in part C of the LPA form to state that he or she understands his or her checklist duties.

- The LPA Personal Welfare form does not clarify that medical treatment includes the withdrawal of tubes for food and water.

In summary, the LCF concludes: 'We believe the safeguards for both living wills and lasting powers of attorney are insufficient.'

In its submission in response to the consultation on the provisions of the Mental Capacity Bill, Affinity had objected to the fact that a 'living will' could not direct that food and water should never be withdrawn in any circumstances. In this Hobson's choice of a situation, evangelical patients wanting to subject the whole of their life journey to the providence of God were entirely disadvantaged.

In the light of all these concerns about the new Act, the most obvious course of action for evangelicals is to appoint a trusted LPA, but to limit the powers to those practical areas of life which are comparable with those covered by the Enduring Power of Attorney under the previous system. This would mean that end-of-life decisions would not be the responsibility of the LPA, and would have to be made on medical grounds by medical practitioners in consultation with family members, as was the case before 1 October 2007.

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