WARDS SOLICITORS your local legal specialists

Introduction to Living Wills

Question: What do Richard Nixon and Claire Rayner have in common?

Answer: They are both part of a growing number of people who have made Living Wills.

Just 2% of the public have made Living Wills. 12% have considered making one.

People are living longer and developments in medical treatment are advancing rapidly. As a result of this medical/legal problems which previously had not been contemplated are now raising their head as medical technology enables doctors to 'keep people alive' much longer than ever before.

Much has been reported in the media over the past couple of years about the controversial and often sensitive questions of a patient's rights regarding medical treatment, the 'right to die' and Living Wills. These are issues which are inextricably linked and in order to understand Living Wills properly it is necessary to look at the background surrounding their development.

Consent to medical treatment

Can a doctor give me whatever treatment he thinks appropriate? What are my rights as a patient? Can a spouse, relative or friend consent to medical treat on my behalf?

Thankfully for both patients and medical staff the law is clear on at least one of these questions.

Conscious Patients

1. It has long been settled law that a conscious patient of sound mind can consent to or refuse treatment even if the result of such consent/ refusal is that death is brought about or hastened. This principle was confirmed in the case of Airedale NHS Trust v Bland (1993) 1 All ER 821 and in *Re T* (Adult) Refusal of Treatment (1992) 4 AU ER 649.

There are certain conditions attaching to the principle:

(i) The patient must have the necessary mental capacity at the time he makes his decision, Re C (adult) Refusal of Medical Treatment (1994) 1 All ER 819.

(ii) The patient must not have been unduly influenced by anyone else.

(iii) Doctors must ensure that the patient is sufficiently well informed of the consequences of (refusal of) treatment to make an informed decision and give informed consent, Sidaway v Board of Governors of the Bethlem Royal and the Maudsley Hospital (1985) 2 WLR 480.

If any of these conditions are not satisfied then doctors are justified in treating the patient in whatever way they consider in their clinical judgement to be in the patient's best interests. In Re T the patient was an ex-Jehovah's Witness who still held some of the beliefs of that faith and therefore she did not wish to receive a blood transfusion.

The Court of Appeal found that the doctors had not been wrong in giving T a blood transfusion as they concluded that T had not reached her decision through her own free will but had been influenced by her Jehovah's Witness mother.

2. The patient's consent to certain treatment, for example an operation, will be evidenced by a signed form of consent. However, in respect of other treatment in practice lack of objection on the part of the patient is often taken as consent.

3. Medical treatment given against a patient's consent is a tort (civil wrong) by the doctor and may also amount to the crime of battery.

4. The patient's consent to the treatment is not consent to negligence on the part of the doctor.

Unconscious Patients

1. Emergencies

A doctor is protected by the doctrine of implied consent if he administers medical treatment if the action is to preserve the patient's life. The treatment

given in these circumstances must be limited to that which is both necessary and reasonable, Bolam v Friern Hospital Management Committee (1957) 1 WLR 582. The doctrine applies unless the doctor acts contrary to the patient's known wishes.

2. Non-Emergencies

In this situation the position is more complicated:

(i) A relative/spouse/friend does not have the legal right to give consent to treatment on behalf of the unconscious patient, *Re T.* However, Lord Donaldson said in *Re T* that consultation with relatives would not be ….. "an undesirable practice if the interests of the patient will not be adversely affected by any consequential delay"

(ii) If the patient has not previously expressed any wishes about his treatment – how then do doctors take decisions about his treatment if he is unconscious? Take for example a situation as in the *Bland* case. Anthony Bland was one of the unfortunate victims of the Hillsboroughs football stadium disaster – he was in a persistent vegetative state and his treatment included nasogastric feeding and hydration (which the Court decided constituted medical treatment). As Bland was an adult continued treatment was only possible on the basis of necessity which had to be shown to be in his best interests. The House of Lords found that due to his state Bland effectively had no interests at all and so continued treatment could not be in his best interests – he was therefore allowed to die.

The House of Lords recognised that the Judgment in *Bland* did not provide easy solutions for doctors, patients or relatives in similar situations. They said that, unfortunately, until Parliament stepped in with some statutory guidelines the only solution would be for a declaration to be sought from the Courts in each case where there is controversy.

If I have previously expressed my wishes regarding the treatment I would wish to receive in such a situation what is the legal effect of those wishes? This leads us inevitably into our next question – that of Living Wills and their legal effect.

Living wills

1. Definition of a Living Will

A Living Will (or Advance Directive/Advance Statement as they are also known) is a statement (whether oral or written) in which a person sets out in advance the kind of medical treatment which he wishes or does not wish to receive in the event that he subsequently becomes incapable of communicating his own wishes.

2. Living Will/Will

The term Living Will must be distinguished from that of a 'conventional Will'. A Living Will cannot be used to dispose of a person's property on his death or make funeral arrangements – these matters must be dealt with by a conventional Will. To avoid confusion it is often preferable to refer instead to an Advance Directive.

3. Format

There is no set format for an Advance Directive. As mentioned above an oral statement may be sufficient. However, it is clearly preferable and for the purposes of certainty to use a formal document and to have it witnessed by two independent witnesses.

In my view it is also advisable that the person making the Advance Directive discuss the document and its terms with his GP and the document should contain a statement to the effect that he has done so. The advantage of this is that any medical terms can be clearly defined and the doctor can clarify any ambiguities. An unclearly drawn Advance Directive could prove more of a hindrance than a help in the future and cause unnecessary (and possibly life threatening) delay if there is any doubt about what the patient intended.

3. Precedents

A number of organisations have produced precedents for Advance Directives, the most well known ones being those produced by the Terence Higgins Trust and The Voluntary Euthanasia Society. It is interesting to consider briefly the Terence Higgins precedent – this will give you an idea of some points you need to think about if you are considering making a Living Will.

The Terence Higgins precedent supposes three possible health conditions:

(i) Permanent Physical Illness - an incurable illness and which is so serious that your life is nearly at an end.

(ii) Permanent Mental Illness - if your mental functions are impaired with no likelihood of improvement, and the impairment is so severe that you do not understand what is happening to

you, and you have a physical illness.

(iii) Permanent Unconsciousness - if you have become permanently unconscious with no likelihood of recovery.

The patient can select one of two possible treatment options in each case:

(i) To be kept alive as long as reasonably possible using whatever forms of medical treatment are available.

(ii) You do not wish to be kept alive by medical treatment. Medical treatment is to be limited to keeping you comfortable and free from pain.

A number of questions come to mind about both the definition of each of the health conditions and the two options for treatment. For example:

How many doctors should decide that your physical illness is so serious that your life is nearing its end or that if you are unconscious there is no likelihood of your regaining consciousness?

Both the treatment options are (necessarily/ unavoidably?) quite general - do they provide either much peace of mind to the patient and a sense of control over the care he receives or much guidance to doctors?

The precedent also enables the patient to specify particular types of medical treatment he would or would not wish to receive. This would need very careful wording (probably in conjunction with your GP) to avoid any doubt over meaning.

Can I appoint someone to take decisions on my behalf?

The Terence Higgins precedent gives you the opportunity to appoint a **'Health Care Proxy'** to take part in decisions about medical care on your behalf. However, it must be said that the status of such an appointee is presently unclear and indeed in the *Bland* case the House of Lords thought that such an appointment might be "meaningless".

5. Legal Status

I thought that a Living Will was not valid in this country. What is the position?

It is true that to date the effect of a Living Will has not been tested in the British Courts. All US States have now legislated in favour of Living Wills and they are also valid in Australia. All indications are that developments in this country will follow suit. Anthony Bland did not have a Living Will so the question was not directly in issue there but the House of Lords indicated that in their view an advance refusal of medical treatment could be binding. The Court of Appeal in *Re T* took the same view and laid down a number of criteria which they thought a pre-requisite for valid advance refusal:

(i) That the patient had the necessary medical capacity to take the decision he did at the time he made the Advance Directive. The patient must be competent to make the decision.

(ii) That the patient had contemplated the actual situation which subsequently arose. The patient would have refused medical treatment applicable to the exact medical emergency which arises.

(iii) That the patient appreciated the consequences of refusing treatment and displayed a broad understanding of the nature and effect of the treatment.

(iv) That the patient had not been unduly influenced by another person in the making of his decision, That there was no coercion.

The criteria are difficult to satisfy. For example the Terence Higgins Trust standard Living Will attempts to define the medical emergency as any terminal condition regardless of the circumstances. This is as at present untested and it is not known whether such an approach will meet judicial approval.

6. Future developments - What of the Future?

Various interested parties have been very busy over the past few years looking at this whole question. The Law Commission has issued two reports – one in 1993 and the second in May 1995. A House of Lords Select Committee Report in January 1994 strongly commended the development of Advance Directives. They thought that the way forward was not by way of Parliamentary legislation but the development by the colleges of the health care professions of Codes of Practice of their members. The British Medical Association has done just that with the publication of their Code of Practice in April 1995. In their Report the Law Commission recommended legislation in favour of Advance Directives and thought that the Codes of Practice would fill in the details which the legislation could not cover.

The Mental Capacity Act 2005 introduced statutory regulation to Living Wills. It is also now possible to appoint a Health and Welfare Attorney under a Lasting Power of Attorney. You could give the Attorney the

WARDS SOLICITORS your local legal specialists

ability to refuse life sustaining treatment upon your behalf if you were unable to do so.

What are the advantages/ disadvantages of a Living Will?

Some advantages:

- Peace of mind and a sense of control over a situation where you would otherwise have no control
- Some relief of the burden of difficult decision making which would otherwise fall on your family.
- Guidance for your doctors in providing the medical treatment you would wish to receive

Some disadvantages:

- The Living Will could be valueless if you did not anticipate the particular circumstances which subsequently arose.
- The development of new treatments subsequent to the making of your Living Will – if you have made specific treatment requests/refusals the doctors may be prevented from giving you treatments which might save your life.
- Living Wills are hard to prepare to cover all eventualities but yet be specific enough to be acted upon.
- Living Wills are not easily portable; in an emergency an Advance Directive is useless if no one knows about it.
- They could be subject to abuse by a proxy where the proxy has inheritance prospects.
- Under present circumstances there are no specified formalities for making or revoking Advance Directives.
- If you make a living Will keep it under review as this will evidence you have not changed your mind.

How do I make a Living Will?

If you would like to make a Living Will or to discuss the subject in more detail we would be happy to provide you with further information. Please contact Jenny Pierce on Tel: 0117 9292811

For more information on Wills please follow the link **wards.uk.com/wills-and-mental-capacity**. To arrange a free initial appointment please contact Jenny Pierce on 01179 292811 or at **jenny.pierce@wards.uk.com**

May 2015