Lasting Powers of Attorney are on essential tool to have in place by any individual whether or not they are young or old.

There are of course two types of Lasting Powers of Attorney (LPA).

Firstly a Financial and Property LPA, this does as it says on the tin deals with a person Finances and Property and it is a very important tool.

Secondly a Health and Welfare LPA. This is an absolute essential document in my opinion for any individual.

I am in this article going to concentrate on the Health and Welfare LPA with a few comments and observations.

Once a Health and Welfare LPA has been created it comes into play when that individual is unable to make such decisions on their own behalf.

Not only does it touch upon the daily needs of an individual it also can set guidance to the Attorney on such issues as to the wishes on future care. In addition the LPA addresses important issues as to whether you want to give or not your attorneys authority to give or refuse consent to life-sustaining treatment on your behalf.

I appreciate these are issues which we do not naturally care to voluntarily consider. Indeed for a sizeable number of people due to lack of capacity it will be too late to address such issues.

I recently come across an article written by Clover Stroud in The Sunday times 09.06.13. In many respects the article is uncomfortable reading but it bears reading and indeed re-reading 'So tell me how you want to die' see below.

I am by no means professing that a Health & Welfare LPA provides an answers to the issues facing all of us. Quite simply it does not. However it can go some way to deal with issues and importantly it will vest in a person of your choice to put forward your wishes and desires when you are not able to do so yourself.

THE SAS DREAM OF OXFORD'S PIPE-SMOKING POLYMATH

THE SUNDAY TIMES

So tell me how you want to die

Many patients are kept alive by unwanted care. Clover Stroud, whose mother has brain damage, tells of a new vision helping families plan a better end

Clover Stroud Published: 9 June 2013

Clover Stroud with her daughter Dolly (Rick Pushinsky)

As yet another crisis hits the beleaguered National Health Service, the question of how and where we might choose to die seems especially pertinent to our ageing population.

The figures are stark: a report from an alliance of the Academy of Royal Colleges, the NHS Confederation, representing health service managers, and the patients' group National Voices, says the NHS is facing a potential funding deficit of £54bn by 2022. A report from the Royal College of Nursing suggests that 6,000 beds — the equivalent of 20 hospitals — may have to be lost to prevent financial ruin.

Mike Farrar, chief executive of the NHS Confederation, warns that without drastic action the NHS could "descend into a vicious spiral of poorly planned reactive responses resulting in unsustainable

demand".

This is particularly worrying for the elderly, coming at a time of heightened anxiety about terminal illness and dementia, underlined by concerns around the Liverpool Care Pathway for terminally ill patients and the Francis inquiry into failings at Stafford Hospital.

In the past 22 years I have spent a lot of time in nursing homes for people with advanced dementia and Alzheimer's. In 1991 my mother was left profoundly brain-damaged after a riding accident and needs skilled nursing care which my family and I cannot give her.

My mother is cared for by nurses who do a demanding job with a grace that I do not possess. But over the past two decades I have noticed a change in the number and treatment of patients suffering from dementia and Alzheimer's.

Dementia is a pressing issue: the number of people with the condition — approximately 670,000 — is forecast almost to double in the next decade to more than a million. The patients around Mum have got older, too, as life expectancy has risen for women from 79.3 in 1992 to 82.6 in 2011. Their condition seems, to my untrained eye, increasingly debilitating.

I have heard people with dementia begging to die while being given treatment and drugs to prolong their lives. I have experienced my mother being resuscitated and ventilated in hospital when she attempted suicide and I have wondered why. Medicine should make life better; when I look at Mum — suffering renal failure, doubly incontinent, epileptic, incapable of communication, existing on a cocktail of anticonvulsants, antidepressants and painkillers and yet with occasional flashes of recognition that suggest she is aware of her tragic state — I cannot help but question the medical advances that "saved" her life and continue to prolong it.

Yet we rarely think or plan for what kind of care we would like when we become ill.

While 70% of us feel comfortable discussing dying, most of us have not spoken to our family or GP about our end-of-life wishes, let alone put care plans in place, according to research published last month as part of the British Social Attitudes Survey by the National Centre for Social Research.

There is also a mismatch between where people want to die and current trends in place of death. Dying Matters, a coalition of health groups, says two-thirds of us would prefer to die at home, yet NHS figures suggest half of us will die in hospital, plugged into machines and separated from our families.

It was in reaction to this sort of suffering endured by sick and elderly patients that Angelo Volandes, a physician at Harvard Medical School and Massachusetts General Hospital, founded Advance Care Planning Decisions, a non-profit foundation supplying videos to hospitals to help patients get the care they choose, rather than "unwanted care" due to a failure in communications.

"Unwanted care is the crisis we are facing in medicine today, resulting in people getting medical intervention they wouldn't choose if they had a true understanding of what that intervention involved and its possible outcomes," Volandes says from Hawaii, where he is making the videos available to 14 hospitals, involving 600 physicians and potentially 1.3m residents.

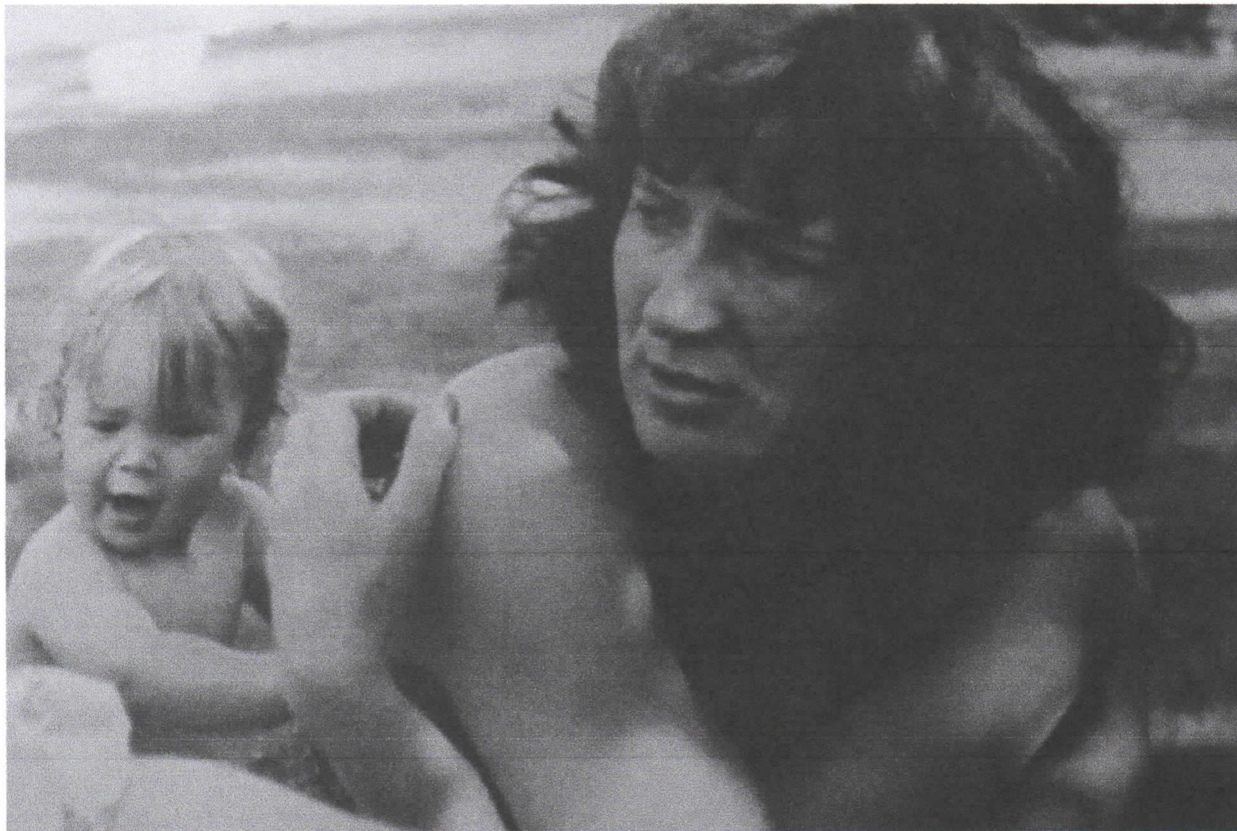
The videos demonstrate in the simplest terms, without medical jargon, the levels of care available to terminally ill patients. They make visually explicit the difference between life-prolonging care, involving aggressive intervention such as CPR (cardiopulmonary resuscitation), ventilation or the insertion of a feeding tube, to the most unobtrusive palliative care, where a patient forgoes life-prolonging procedures knowing they may die sooner but in a more peaceful environment, such as their home.

Fifty hospitals and clinics in America have adopted the videos and extensive medical trials are

overwhelmingly positive, indicating that, given an option, terminally ill patients would not choose the intervention they often receive in hospital against their wishes.

"As physicians we recognise that even when doctors do have what we call 'the conversation' about end-of-life care, they use medical terms patients don't understand, which is a medical error in my book," Volandes says.

Many of us have unrealistic expectations about the success of certain procedures, thanks to television dramas: "Patients don't understand what they might be in for. They've seen CPR on ER and think it always works. In real life it usually doesn't result in miraculous recovery but guarantees a violent death."



Clover Stroud as a baby with her mother, who now needs constant skilled nursing care after a riding accident (Rick Stroud)

The videos are short, suitable for watching on a laptop or iPad in a hospital. Volandes made the films for everyone, including the young and healthy, hoping to initiate open dialogue between families and doctors about illness and death: "It is never too early to start a conversation about how we want to be cared for or die. I want discussions about this to become standard practice."

He says he is being subversive within the medical world: "We're flipping the patient-doctor relationship, giving patients power rather than having decisions they didn't choose forced upon them.

"Medics are high-grade students in chemistry and maths, but at no point during my training was I [taught] about communicating with patients. [We are] focused on technology — we've forgotten about the human relationship, which is where I believe the most cutting-edge medical advances of the future lie."

Volandes's work is attracting interest from medical professionals around the world, especially Canada and Britain. My mother's life constantly reminds me that as a society we would benefit from facing death, the single human experience we all share yet rarely discuss with the people who love us, except in the most shuddering, dismissive terms.

I wish these were conversations I had had with Mum because her suffering would now be over.

While Volandes is motivated entirely by what he sees as the abuse of elderly, critically ill people such as Mum, it is impossible to ignore the fact that his videos might avoid the need for the cost-cutting measures Farrar alluded to last week.

My mother, chronically brain-damaged for two decades and suffering kidney failure, requires full-time skilled nursing care which is paid for by the NHS. Her eligibility for NHS funding for her nursing home fees — known as continuing healthcare — is assessed annually by Wiltshire Primary Care Trust.

Part of her eligibility lies in the fact that she resists care, making otherwise standard procedures such as taking blood challenging. In a cost-cutting effort to remove her eligibility, an NHS nurse assessor and a mental health nurse suggested Mum would miraculously no longer need skilled nursing if she were sedated when blood tests were taken. I am reminded of an abusive scene from One Flew Over the Cuckoo's Nest.

Mum's GP told me that sedating patients with severe head injuries was potentially lethal. Had my mother seen Volandes's videos before the accident, there is no way she would have chosen this fate.

"We want to help patients like your mother avoid this kind of treatment," says Volandes.

"Initiating conversations around death before a critical point is reached means the routes people might choose are very different."

Dying Matters has produced some short films — quieter and less revolutionary than Volandes's videos — to promote conversations about dying and bereavement, including films on terminal illness, the role of carers and making a will.

"In the recent past medicine focused on cure but, in future, communication between doctors and patients should be given more attention," says Simon Chapman, director of policy and parliamentary affairs at the National Council for Palliative Care which consistently calls for end-of-life care strategies to become a core part of the medical training curriculum.

"Medical technology is terrific but we have to remember we've postponed death, not cancelled it."

If saving money on care that patients have not chosen and do not want could help the NHS, then perhaps Farrar should study Volandes's work.

"Of course people are right to be worried about a doctor pulling the plug on grandma," says Volandes.

"But it's a very different issue when it's grandma saying 'don't put the plug in'."