Annex F

Commentary on draft sections 40 and 41

Alex Ruck Keene QC (Hon) and Adrian D Ward MBE LL.B

Advance statements (Alex Ruck Keene)

Law Commission draft text[1]	Commentary
40. – (1) This section applies to any statement ("advance statement") which an adult may make as to the circumstances in which medical treatment of a description specified in the statement is not to be afforded to him at any time when the statement is operative.	'Advance statement' is now a term with a different meaning under the Mental Health (Care and Treatment) (Scotland) Act 2003, that meaning, in particular, incorporating 'positive' as well as 'negative' wishes. If section 40 were to be taken forward to legislation now, it would be necessary either: (1) To track across the concept of advance statements from the 2003 Act or (2) Find a new term - ? advance decision to refuse treatment
(2) An advance statement may be – (a) made or revoked orally or in writing by the adult; (b) revoked orally or in writing by a welfare attorney to whom the adult has given authority to do so.	In my view, oral advance statements are, in practice, unworkable. In relation to (b), to my mind this seems to conflates two things: (1) the situation where the person wants, themselves, to make clear what they want; (2) the situation where the person wants to give authority to someone else. It may be worth considering the English approach, which is (as per s.25(2(b)) that granting authority under a power of attorney to make the decision(s) automatically revokes the advance decision relating to that decision. Note also in relation to (b) there's no ability for the attorney to revive the advance statement – what happens at that point?
(3) Where an advance statement or the revocation of an advance statement is in writing it shall not be valid unless it is signed by the adult or, as the case may be, by the welfare attorney.	Bearing in mind the discussion in the paper I drafted as to certainty/accessibility, my own view is that advance decisions which are intended to have binding effect (as opposed to setting out guiding principles) should be accompanied by a confirmation that the person has capacity to make it. I make this observation on the basis that:

[1] From the draft Incapable Adults (Scotland) Bill attached as Appendix A to the Report on Incapable Adults (Scottish Law Commission 151, Cm 2962, 1995).

Law Commission draft text[1]	Commentary
	(1) I consider that there should be one regime for advance statements/decisions applicable across mental health and physical health fields. (2) Section 275(2)(e) MH(CT)A 2003 requires confirmation of capacity (3) In any situation of difficulty, it causes unnecessary problems to then have to work out whether the person might have had capacity to make the decision, and the presumption of capacity may not work in favour of securing the person's interests if there are grounds to doubt this after the event. I appreciate that this may be seen as discriminatory, but if this applies to advance decisions across the piece, it is not singling out those in the mental health zone.
(4) An advance statement is operative during any period when – (a) the circumstances specified in the statement exist; and (b) the adult is incapable of making or is incapable of communicating a decision about such medical treatment.	This would not survive an approach based purely upon 'self-direction' in relation to applicability. However, for my part, I consider that entirely self-directed advance statements/decisions are (1) not required by the CRPD; and (2) cause as many, if not more, problems than they solve.
(5) Subject to subsections (6) and (7) below, where an advance statement is validly made and is operative any authority to carry out medical treatment of a description specified in the statement in the circumstances mentioned in the statement shall have no effect.	This would appear functionally still to do what is required, subject to the relevant legal mechanisms in future remaining authority-based (in E&W, the relevant legal mechanism in s.5 MCA 2005 is not formal authority but a defence to liability).
(6) An advance statement may be disregarded by the person responsible for the medical treatment where he reasonably believes that – (a) the circumstances, other than the medical condition of the adult, have changed to a material degree since the statement was given; and (b) in consequence of such changed circumstances the adult, if he were capable of making and communicating a decision, would authorise the medical treatment.	For my part, I think that this could usefully be stress-tested against the more extensive range of matters considered in s.25 MCA 2005, including in relation to inconsistent acts. I would not favour an approach as per the Assisted Decision-Making (Ireland) Act 2015 which only allows for inconsistent acts to be taken into account where they have occurred before the loss of capacity, because it seems to me that this unduly thins out a morally thick area. Separately, I also think that it would be sensible if it is made clear that an advance

Law Commission draft text[1]	**Commentary**
	statement/decision which does not serve to remove authority / defence to liability is not therefore to be ignored entirely, but that it is to be given such weight in the decision-making process as is in all the circumstances reasonable.
(7) An advance statement shall not have effect – (a) where compliance with it would endanger the life of the adult, unless the terms of the statement expressly provide for such an effect; (b) to prohibit the provision of procedures to maintain adequate standards of hygiene and measures to relieve serious pain; (c) to prohibit the treatment for mental disorder by virtue of Part X of the 1984 Act of a patient liable to be detained under that Act; (d) in the case of a female adult, where compliance with it would endanger the development of a foetus being carried by her where the pregnancy has exceeded its twenty-fourth week.	As to each of these, which are in effect public policy exclusions: (a) I think these need to be in writing and 'authenticated' as to capacity (b) This wasn't included in the MCA 2005 after a lot of debate, but I can see the force of it. (c) If there is to be parity, there needs to be consistency of approach across both incapacity and MH legislation, or a coherent explanation as to why not. (d) Why? I can see the underlying ethical reason for this, but if the foetus does not have rights in law why is a bar on a woman's right to make decisions which might endanger it unlawful (there is a separate criminal offence, at least in England, here Infant Life (Preservation) Act 1929 (legislation.gov.uk))
(8) Where the advance statement was valid and operative or the person responsible for the medical treatment reasonably believed that it was valid and operative, the person responsible for the medical treatment and any person withholding it, or participating in the withholding of it, in accordance with the advance statement shall not thereby incur liability.	This is functionally fine, but I think that there needs to be express reference to the mechanism that is to be invoked in the cases of doubt as to (1) whether an advance statement was validly created; (2) it is operative; or (3) whether the 'public policy' provisions in subsection (7) are in play. That could be reference to MWC in the first instance or court.
(9) Where – (a) the person responsible for the medical treatment – (i) did not know of the existence of an advance statement relating to the medical treatment in question; or (ii) reasonably believed – (*aa*) that such an advance statement was not valid or was not operative; or	This is still functionally fine

Law Commission draft text[1]	Commentary
(*bb*) that subsection (7) above applied to the case; or (b) such an advance statement was disregarded by virtue of subsection (6) above, and medical treatment was carried out contrary to the terms of the advance statement, the person responsible for the medical treatment and any person carrying it out or participating in it, shall not thereby incur liability.	
(10) In this section – "medical treatment" has the same meaning as in section 37 of this Act; and "welfare attorney" includes a person granted, under a contract, grant or appointment governed by the law of any country, powers (however expressed) relating to the granter's personal welfare and having effect during the granter's incapacity.	Something along these lines will be needed.

Further evaluation of draft section 40 (Adrian Ward)

Draft section 40 relates only to statements in the narrow context of health and medical matters. It is not formulated in accordance of the broad definition in Rec.(2009)11.

The term 'advance statements' is now a term with a different meaning under the 2003 Act. The terminology would require to be updated, or linked to the 2003 Act definition.

Draft section 40(2) provides for advance statements to be made or revoked both orally and in writing. This may create tensions between accessibility and certainty. The proposed role of a welfare attorney in revoking an advance statement also creates some potential for confusion, and risks conflation of two separate legal concepts. Under the English approach, granting authority under a power of attorney to make the decision(s) automatically revokes the advance decision relating to that decision.

Draft section 40(3) provides that an advance statement or the revocation of an advance statement in writing must be signed by the adult (or, as the case may be the welfare attorney), but does not provide any mechanism for confirmation that the person has capacity to make the advance statement or revocation. This can be contrasted with the provisions of the 2003 Act on advance statements, and the requirements for granting a power of attorney under the 2000 Act.

Draft section 40(4) would not be compatible with an approach based on 'self-direction' as articulated by the Committee on the Rights of Persons with Disabilities in in General Comment 1 to Article 12.

Draft section 40(6) should be reconsidered in light of the more extensive range of matters considered in section 25 of the MCA 2005, including in relation to inconsistent acts.

Draft section 40(7) sets out what are in effect public policy exclusions. These draft provisions should be reviewed to ensure consistency with current public policy and relevant incapacity and mental health legislation.

Draft section 40(8) should include a mechanism to be invoked in cases of doubt. This could be by reference to an oversight body, such as the Mental Welfare Commission, or to the court.

Further evaluation of draft section 41 (Adrian Ward)

Draft section 41 may or may not follow on from a situation where there is an “advance statement”. It could equally arise in a situation where the doctor does not know the wishes of the patient or where there is no relative or other person to advise of the patient’s wishes. Except where an application is made to the court by a person who might not necessarily be the doctor, the decision rests with the doctor. The doctor is bound to act in accordance with the section 1 principles of the 2000 Act, and accordingly must decide whether the treatment is of benefit to the patient, even if withdrawing or withholding the treatment results in the patient’s death. The decision must accord with good medical practice and therefore must presumably accord with GMC guidance, or the doctor risks being struck off.

The section refers, as does draft section 40, to “medical treatment” under section 37, which did translate into the 2000 Act in section 47(4) as “includes any procedure or treatment designed to safeguard or promote physical or mental health”. There are specific provisions under the 2000 Act dealing with the situations where guardianship or intervention orders are in progress under sections 49 and 50 of the Act. At the time this draft section was being considered it was not envisaged it would cover a situation involving withdrawal of nutrition and hydration resulting in the death of a patient. Some element of deciding to withhold or withdraw the medical treatment was however envisaged and was seen as something different. “Benefit to the patient” was not defined. Again, the medical practitioner is thrown back on the GMC guidance.