

## Annex B

### LAW SOCIETY OF SCOTLAND CROSS-COMMITTEE WORKING GROUP ON ADVANCE DIRECTIVES AND MEDICAL DECISION-MAKING

#### ADVANCE CHOICES

by

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**The Working Group's analysis of specific issues to be addressed, an account of relevant deliberations, and the resulting formulation of the Group's proposals**

#### Introduction

The starting-point for this part of the Working Group's deliberations was the list of questions in the paper "Advance Directives" by Adrian D Ward MBE LL.B which forms Annex A to the foregoing report. These questions were formulated in response to particular provisions of Council of Europe Recommendation (2009)11, the UN Convention on the Rights of Persons with Disabilities, and Hague Convention 35 of 2000 on the International Protection of Adults. The questions appear on pages 9-13 of that paper. From that starting-point, Alex Ruck Keene QC ("ARK") formulated a preliminary list of questions to be addressed by the Working Group, which was finalised in discussion with Adrian D Ward ("ADW"). That finalised list was used to structure the discussions. The remainder of this paper sets out those questions in bold, with his original footnotes to them retained, followed by a record of the Group's deliberations in relation to each. The first three questions, characterised as "Foundational", were however considered together, and gave rise to extended discussions.

#### Foundational

- **Should Scots law provide expressly for a person to be able to (1) to give instructions; or (2) express wishes in advance?**
- **Does the answer to that question hold true across all areas of law, or is it limited to specific fields (for instance, continuing the current statutory limitation in relation to the effect of advance statements within the Mental Health (Care and Treatment) Scotland Act 2003)**
- **What should such provisions be called?<sup>1</sup>**

#### Scope and terminology

The Working Group agreed that the potential scope of advance directives in Scots law should be as defined in Rec. (2009)11. Advance directives are defined in Principle 2.3 of Rec. (2009)11 as follows:

*"**Advance directives**' are instructions given or wishes made by a capable adult concerning issues that may arise in the event of his or her incapacity".*

That structure may be represented thus:

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<sup>1</sup> Note: I think it is important to ask this question. For my part, I do not like the term "advance directives" because it is (I think) misleading in two ways: (1) if they cover statements of wishes, they aren't 'directive' and (2) they can give the impression that they are directing someone to do something which may, in fact, not be achievable. In this document, "instructions" and "wishes" are used. (ARK)

Diagram A (per Rec. (2009)11)

Advance Directives

- Instructions Given
- Wishes Made

The Working Group agreed to adopt that structure, but not that terminology. For example, a statement of wishes cannot reasonably be termed a “directive”.

Using modern “technical terminology”, and setting “advance directives” in a broader structure, produces the following:

Diagram B (Modern “Technical Terminology”)

Measures

- Voluntary Measures
  - o Unilateral
  - o Bilateral
- Non-Voluntary Measures
- Third Party Measures

Again, the structure was adopted, but not the language. Proposals must be conducive to producing provision which not only is set out clearly and accurately in law, but will be widely understood, and correctly used and applied. In particular, the language used must be clear and accessible. The scope for misunderstanding and misuse is considerable. One need only point to frequent confusion between “powers of attorney” and “guardianship”, use of “powers of attorney” to mean both the document and the person appointed under it, and failures to distinguish between English and Scottish terminologies, and their respective consequences. Also and separately, if the concept of “advance statements” under the 2003 Act is retained in proposals to be made by SMHLR, then that should be treated as a separate type of “advance directive”, using that name or such other name as may be accorded to it under SMHLR proposals. Subject to that qualification, this paper uses the existing term “advance statement”. A further consideration was that the Group considered that to facilitate maximum use of “advance directives”, and accessibility for the maximum range of people in the maximum range of circumstances, various levels of formality at time of creation would require to be accommodated, and would result in varying levels of certainty or – put another way – lesser or greater scope for possible disapplication in particular situations. The Group adopted “top-level” for a document made with maximum formalities and thus conferring maximum certainty.

In consequence of the above considerations, the Working Group adopted the following terminology:

Diagram C (Accessible Terminology used and recommended in this paper)

**ADVANCE CHOICE**

- **ADVANCE INSTRUCTIONS** (= instructions given)
  - o **TOP LEVEL** (explained below)
  - o Other Advance Instructions
- **ADVANCE STATEMENT** (= wishes made)
  - o **TOP LEVEL**
  - o Mental Health Advance Statement
  - o Other Advance Statements

The terminology in Diagram C is adopted for the remainder of this paper, and is recommended. [Subsequent note: The term “medical advance choices” is also used in the Working Group’s final report.]

Revocation versus disapplication

The Group had considerable concerns about treating as a revocation of an advance choice anything other than a revocation explicitly made to the same level of formality as was the advance choice, by an adult acting competently and in the absence of undue influence, fundamental error, or other vitiating factor. An adult might, verbally or by conduct, at a time when the adult is immediately confronted with particular circumstances, say or indicate that the adult does not wish the adult’s own advance choice to be applied. However, that would not be what the adult might say or indicate in other circumstances, or in similar circumstances at another time. Revocation is by definition irrevocable. Particularly in circumstances where it might be impractical or impossible for the adult to create a fresh advance choice, or at least one to the same standard of formality as the original advance choice, to deprive the adult permanently of any benefit from having created the original advance choice might not coincide with the adult’s long-term will and preferences. It is better that such a situation be addressed in terms of “Should the provisions of the advance choice be applied in this particular matter at this point in time?”, rather than “Should an advance choice that reflected the will and preferences of the adult at time of creation be irrevocably terminated?”. Put simply, there should be a clear emphasis on considering the possibility of disapplication, as opposed to revocation. That preference is reflected in considerations regarding disapplication and revocation below.

Other “foundational” issues

Note that the following conclusions on questions 1, 2 and 3 are also relevant to some of questions 4 – 19.

On creation of an advance choice, the Group took account of Principle 16 of Rec. (2009)11, recommending that:

*“16.1 States should consider whether advance directives or certain types of advance directives should be made or recorded in writing if intended to have binding effect”.*

The Group concluded that there should be maximum accessibility to the possibility of creating an advance choice, subject to minimum requirements for certainty and effectiveness. Wills can be made with great informality, the classic example being “written on a napkin”, but an informal Will requires to be “set up”, involving a procedure which can take time but which is unlikely to cause undue detriment when the granter of the Will is deceased. Questions as to the validity of an advance choice will often require to be resolved at short notice, where immediate and sometimes urgent decisions must be made, and therefore have to be capable

of determination by the form in which the advance choice is issued, rather than relying on extraneous factors.

Balancing accessibility and effectiveness, the Group concluded that the minimum requirement for validity of an advance choice is that it should be made or recorded in writing or in any other enduring and permanent form (including voice records and video, or other technologies that might become available), provided that the identity and authorship of the granter can readily be ascertained with certainty. For any of the contents of an advance choice to have the status of an advance instruction rather than an advance statement, that intention should be clearly indicated. It should not be competent for any advance choice to authorise withholding or withdrawing life-preserving treatment unless the advance choice specifically and unequivocally states that intention.

Those should be the minimum requirements for validity. The requirements for “top-level” advance choices should accord maximum effectiveness. For documents with some of the requirements for top-level status, but not all of them, the degree of compliance with top-level requirements should be relevant to considerations as to whether the advance choice should be disapplied in particular circumstances (see answer to question 15 below).

The requirements for top-level status should be as follows:

- (a) The minimum requirements for validity stated above should be met.
- (b) The advance choice should be accompanied by a certificate that at time of granting the granter had adequate capacity. The certifier should certify from the certifier’s own knowledge, including relevant professional skills. “Second-hand certification”, as is possible for certification of powers of attorney under the 2000 Act<sup>2</sup>, should not be permitted. There should be a separate certificate, again by a person able to grant it from his or her own knowledge, that the granter was not acting under undue influence and that there were no other vitiating factors. In relation to both certificates, each certifier should state any qualifications relevant to being able to grant the certificate. Where the same person can properly grant both certificates, the same person may do so.
- (c) At least one of the certifiers should certify that the advance choice was issued in the certifier’s presence. There should be no further requirement for witnessing.
- (d) The advance choice should be centrally registered under a system in which basic facts of the advance choice should be accessible immediately in an emergency, and as quickly as they may reasonably be required in any other situation. The basic facts should include whether the individual has issued an advance choice, whether it is a top-level advance choice, whether it is still in force, and whether it includes advance instructions and/or advance wishes in relation to (i) any property and financial matters, and/or (ii) medical or other healthcare matters, and/or (iii) other personal welfare matters. On cause shown, the full advance choice, in the form in which it has been created, should be made accessible to an applicant within such timescale as might reasonably be required, subject to a discretion on the part of the registrar to withhold such disclosure in whole or in part for reasons stated by the registrar, which withholding may be overruled, partly overruled, or confirmed by a court upon application by a person having an interest.

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<sup>2</sup> Under sections 15(3)(c) and 16(3)(c) of the 2000 Act, the certifier has the option of certifying that he is satisfied “because he has consulted another person”. [ADW]

## Scope

### **4. What should either/both type of provision apply to? For instance:**

- **Health, welfare and other personal matters?**
- **Medical treatment for mental disorder?**
- **Economic and financial matters?**
- **The choice of guardian, or alternatively general directions as regards the terms of any guardianship order?**

There should be no limitations on possible scope, except in accordance with question 5 below. In particular, but without prejudice to that generality, the full scope of Principle 14 of Rec. (2009)<sup>11</sup> should apply. Principle 14 reads as follows:

*“Advance directives may apply to health, welfare and other personal matters, to economic and financial matters, and to the choice of a guardian, should one be appointed”.*

### **5. Should there be any ‘public policy’ exceptions? Section 40(7) of the Incapable Adults (Scotland) Bill excluded treatment under the (then) 1984 mental health legislation, provision of procedures to maintain adequate standards of hygiene and measures to relieve serious pain; and 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.**

The granter should be able to do and decide by way of an advance choice anything that the granter could do or decide with immediate effect if fully capable. However, the test of legality should apply at the point or points in time at which the advance choice becomes operable, rather than at time of granting.

### **6. From what age should a person be recognised as capable of (1) giving instructions or (2) expressing wishes with advance effect?**

- **The 2003 Act has no lower age limit**
- **The MCA 2005 has a lower age limit of 18 for instructions, but 16 for advance statements**
- **Section 40 of the Incapable Adults (Scotland) Bill had a lower age limit of 16**

The Group agreed that the Age of Legal Capacity (Scotland) Act 1991 should apply. If the law were to change, then this would require to be reconsidered.

## Creation

### **7. What test should apply to determine whether a person (of the relevant age, if applicable) is able to give instructions or express wishes in advance?**

To maximise accessibility, requirements should vary from no test to full certification. The status of the document will depend upon the level of formality.

### **8. What formalities should be required in relation to the giving of instructions?**

- **Should there be a requirement for confirmation that the person has capacity to give the instructions (as for advance statements under the 2003 Act and CPAs/WPAs under the 2003 Act, but not required under the draft s.40 Incapable Adults (Scotland) Bill, or ADRTs under the MCA 2005)? If so, how is this capacity to be determined, and by whom?**

- **Should they be in writing and subscribed by the granter (as per advance statements under the 2003 Act and CPAs/WPAs under the 2003 Act)?**
- **Should other formats such as use of voice and video recording or speech recognition technologies be provided for (see paragraph 102 of the CoE 2018 Report)?**
- **Should there be additional/specific formalities required in relation to life-sustaining treatment (as per the MCA 2005 and s.40 of the draft Bill)**
- **Continuing and welfare powers of attorney (but not advance statements under the 2003 Act) require certification. Should similar requirements apply to instructions?**
- **Continuing and welfare powers of attorney (but not advance statements under the 2003 Act) require registration. Should similar requirements apply to instructions?**

See the discussion of “Foundational issues” above.

### **9. *What should happen if those formalities not be complied with?***

To achieve validity, the minimum requirements for creation under “Other foundational issues” above should apply. Beyond that, compliance with the formalities for “top-level” or alternatively some of those formalities, should be as set out under “Other foundational issues” above. If section 1(4)(a) of the 2000 Act, or the principle of it, is retained, then (subject to the terms of any relevant legislation) any past or present expression of wishes and feelings, or of will and preferences, should be taken into account for the purposes of section 1(4)(a) (or a successor provision) but a valid advance choice should have enhanced status.

### **10. *What formalities should be required in relation to the expression of wishes?***

- **The MCA 2005 refers (in the context of best interests decision-making to consideration of the “person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity: s.4(6)(a)) – with no further formalities required.**
- **The AWI does not make equivalent provision.**

See the discussion of “Foundational issues” above.

### **Revocation prior to operation**

### **11. *What (if any) formalities should be required for revocation of any instructions or expression of wishes (either in whole or in part)?<sup>3</sup>***

- **Under the 2003 Act, “withdrawal” of an advance statement requires compliance with the same formalities as making.**
- **The MCA 2005 contains no formality in relation to revocation of an ADRT (which could be oral), save that the person has to have capacity to do so (s.25(2)(a))**
- **Section 40(2)(a) of the draft Bill provided that an advance statement could be revoked orally (with no requirement of capacity) by the person.**

The requirements for revocation of a particular advance choice should be the same formalities as were applied in the creation of that advance choice. If top-level formalities were followed to create the advance choice, they would be required to revoke it. If the advance choice followed only the minimum requirements, then those same minimum requirements would be necessary to revoke it. Note however the comments under “Revocation versus disapplication”

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<sup>3</sup> A recommendation in the CoE 2018 report is that “An advance directive shall be revocable at any time and without any formalities.” [ADW]

above on the preference for considering disapplication at a particular time and in particular circumstances, as opposed to irrevocable revocation. In the event of valid revocation, the same requirements for registration of the revocation would apply as for registration of the advance choice, though for practical reasons the registrar might find it necessary to state requirements.

**12. Should it be possible for an application to be made to a court or other authority for revocation in whole or in part? If so, who should be entitled to make such application?**

The Group agreed that the possibility of an application to the court should not be ruled out at this stage, and that there should also be a mechanism for an application for rectification. There should be provision for an application to the body maintaining the register in the first instance, followed by application to the court.

**13. To what extent, if at all, should an “instructions given” instrument be superseded, revoked or amended by a subsequent intervention or guardianship order, or by any other non-voluntary measure (existing or future)?**

- The MCA 2005 provides that an ADRT is automatically rendered invalid by authority to make the decision in question being granted under a lasting power of attorney.
- Section 40(2)(b) of the draft Bill provided that an advance statement could be revoked (in writing or orally) by a welfare attorney to whom the adult has given authority to do so,<sup>4</sup> but did not provide for.

As a general principle, the Group agreed that a voluntary measure should never be “trumped” by an involuntary one.

Operation

**14. What should trigger the operation of any relevant instructions or wishes? Can or should these circumstances be entirely self-directed, or should they include an external requirement (such as an identification that the person lacks the capacity to decide/carry out the relevant act)?**

- The 2003 Act requires that the person’s ability to make the relevant decisions is significantly impaired because of mental disorder
- The MCA 2005 requires the person to lack capacity to consent to the carrying out or continuation of the treatment (s.24(1)(b))
- Section 40(4)(b) of the draft Bill required the adult to be incapable of making or is incapable of communicating a decision about the medical treatment in question.

The Group agreed that an advance choice should apply after loss of capacity, as opposed to operating on an entirely self-directed basis. The Group recognised the difficulties inherent in this approach as it related to CRPD, but also that such an approach was required until there were changes to Scots law relating to capacity.

“Advance choices”, by definition, are intended to take effect at a point when persons themselves are unable to take the contemporaneous steps required to exercise their legal capacity. The Group recommend that any statutory provision for advance choices within Scots law proceeds on the basis that, whilst persons should be able to indicate (if they wish) the circumstances under which they may be unable to take those steps,<sup>5</sup> determination of that

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<sup>4</sup> It was ambiguous as to whether “authority” means authority to revoke. [ARK]

<sup>5</sup> For an example, see the “PACT” advance planning documentation prepared as part of the Mental Health and Justice Project (England & Wales), which includes a section where the service user can set out signs that they may have lost capacity to make

inability is ultimately a matter for whoever it is who would otherwise be acting upon the person's contemporaneous decision or action.

In saying this, the Group were aware that the United Nations Committee on the Rights of Persons with Disabilities considers that: “[t]he point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity.”<sup>6</sup>

Such an approach is, however, fundamentally incompatible with the governing legal frameworks for health and social care in Scotland. These are based upon a binary distinction between a person whose current actions or decisions in any particular matter are taken as having legal effect, and a person whose current actions or decisions are not taken as having such effect. Even if these frameworks were to be changed to remove this distinction, the Group also had reservations about whether the approach of the UN Committee is, ethically, the correct path. In particular, making “entry” and “exit” solely contingent on the person's own decision raises the prospect of the person being held to a choice which does not, in fact, represent their will at the time that action is required. This could have consequences which – at the limits – are fatal for the person concerned. It would also have consequences which are likely to give rise, at a minimum, to moral distress on the part of those who might be required to act upon the basis of that advance choice.

**15. Under what, if any, circumstances is it legitimate not to follow instructions or wishes given by the person?**

- **Do those circumstances differ depending upon the nature of any intervention proposed (for instance in relation to medical treatment for mental disorder as opposed to medical treatment for physical disorder)?**

Questions of disapplication should not arise in relation to advance wishes. Advance wishes should only ever have persuasive effect. Any review of their status should be a matter for SMHLR, though if the effect of section 1(4)(a) of the 2000 Act is to be retained, it is recommended that SMHLR consider introducing a qualification to the same effect as in the 2005 Act, giving particular force to wishes stated in writing, with the possibility of further enhancement of an advance statement that qualifies as a top-level advance choice.

Issues about disapplication of mental health advance statements would be a matter for SMHLR.

It should be possible for advance instructions to be disapplied if, but only if, specified criteria were met. The Group recommends that the approach should be to permit disapplication upon a reasonable judgement that disapplication at a particular time and in particular circumstances would accurately coincide with the granter's will and preferences, or a best interpretation of the granter's will and preferences, having regard to (and appropriately balancing if necessary) the following criteria:

- There should be a strong presumption against disapplying top-level advance instructions in any situation to which they apply.
- There should be a presumption against disapplying any advance instructions, the strength of which presumption should be proportional to the extent to which some of the requirements for top-level status have been applied.

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decisions about mental health treatment: see the template in the Appendix to Stephenson, L.A., Gergel, T., Ruck Keene, A, Rifkin, L., & Owen, G (2020). The PACT advance decision-making template: Preparing for Mental Health Act reforms with co-production, focus groups and consultation. *International Journal of Law and Psychiatry*, 71, 101563. [ARK]

<sup>6</sup> General Comment No 1, paragraph 17. [ARK]



- In medical matters, there should be a presumption against disapplication if the granter has taken medical advice in relation to the terms of relevant provisions of the advance instructions.
- In medical matters, there should be a strong, and normally overriding, presumption in favour of disapplying an advance instruction in relation to any care or treatment which, in absence of the advance instruction, would normally be offered and given, and which the granter indicates that the granter wishes to be given.

**16: What legal effect should taking a contrary course have upon any instrument in which instructions and/or wishes are contained?**

The Group agreed that there should be no effect on the actual instrument. There was a distinction between revocation and disapplication. The possibility of a claim for damages was discussed and it was noted that the 2005 Act in England & Wales disappplied damages where certain criteria were met. This gave the 2005 Act provisions particular force.

**17: Under what, if any, circumstances is it legitimate for actions to be taken upon the basis of prior instructions/wishes in the face of apparent dissent by the adult at the time (i.e. to what extent should the person be able to bind themselves in advance?)?**

See the criteria in the response to question 15. A decision-maker acting, or deciding not to act, in good faith and in accordance with those criteria (and, if applicable, with the principles of any other current legislation) could legitimately override current apparent dissent by the adult.

*Cross-border matters*

**18. Should any provisions relating to instructions/wishes in Scots law be drafted so as to enhance recognition, workability and enforcement in other states? If so, how might that be done?**

The Group agreed that effective cross-border application would be necessary.

**19. Should provision in Scots law be drafted so as to provide for the recognition, operability and enforcement in Scotland of non-Scottish unilateral voluntary measures and, if so, how, and subject to what limitations and protections?**

The Group agreed that the standard approach under private international law should apply, including where applicable the provisions of Hague Convention 35 on the International Protection of Adults or any generally accepted interpretation thereof.

Some questions from the paper “Advance directives” were not directly incorporated in the list upon which the deliberations of the Working Group proceeded. Those questions were as follows:

“To what extent should any procedures or controls be required to take action (an example being imposition of controls amounting to a deprivation of liberty in terms of ECHR Article 5) in the absence of indications of assent; and would such assent require to be competently given?

“Should any apparent dissent by the adult at time of operation of the advance directive be treated as revoking the advance directive, or alternatively relevant provisions of it only? If not, to what extent (if any) should the terms of an advance directive make lawful, or assist in justifying as lawful, overriding apparent dissent by the adult at time of operation? If so, to what extent should additional controls or procedures be necessary?

“What safeguards should be provided to ensure compliance with Article 12.4 of CRPD, both at time of granting and at time of operation (insofar as relevant to each), to ensure compliance with the following safeguards, namely that those safeguards:

- respect the rights, will and preferences of the person (requiring assessment and balancing of each of those elements
- are free of conflict of interest
- are free from undue influence
- are proportional and tailored to the adult’s circumstances
- apply for the shortest time possible
- are subject to regular review by a competent, independent and impartial authority or judicial body
- are proportional to the degree to which they affect the adult’s rights and interests?<sup>7</sup>”

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<sup>7</sup> I think this question permeates all of the questions above. [ARK]