

Annex A

LAW SOCIETY OF SCOTLAND CROSS-COMMITTEE WORKING GROUP ON ADVANCE DIRECTIVES, AND MEDICAL DECISION-MAKING IN INTENSIVE CARE SITUATIONS

“Advance Directives” by Adrian D Ward MBE LL.B

Abbreviations and definitions

“2000 Act”:	Adults with Incapacity (Scotland) Act 2000
“2003 Act”:	Mental Health (Care and Treatment) (Scotland) Act 2003
“2005 Act”:	Mental Capacity Act 2005 (England & Wales)
“Adult Incapacity”:	“Adult Incapacity”, W Green, Ward, 2003
“CoE 2018 Report”:	Council of Europe Report “Enabling citizens to plan for incapacity: a review of follow-up action taken by member states of the Council of Europe to Recommendation CM/Rec.(2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity”, prepared by Adrian D Ward, Consultant (Scotland, UK), on behalf of the European Committee on Legal Cooperation
“CRPD”:	The United Nations Convention on the Rights of Persons with Disabilities (13 December 2006)
“ECHR”:	The European Convention for the Protection of Human Rights and Fundamental Freedoms, Council of Europe, (1950)
“HCCH”:	Hague Conference on Private International Law
“Hague 35”:	Convention on the International Protection of Adults (The Hague, 13 January 2000, 2600 UNTS)
“the Project”:	The Law Society of Scotland project on (a) advance directives, and (b) medical decision-making in intensive care situations
“Rec.(99)4”:	Council of Europe Recommendation CM/Rec.(99)4 of the Committee of Ministers to member states on principles concerning the legal protection of incapable adults (adopted 23 rd February 1999)
“Rec.(2009)11”:	Council of Europe Recommendation CM/Rec.(2009)11 of the Committee of Ministers to member states on principles concerning continuing powers of attorney and advance directives for incapacity (adopted 9 th December 2009)
“Rec.(2014)2”:	Council of Europe Recommendation CM/Rec.(2014)2 of the Committee of Ministers to member states on the promotion of human rights of older persons (adopted 19 th February 2014)
“SLC 1995”:	Scottish Law Commission Report No 151 on Incapable Adults, September 1995
“SLC draft Bill”:	The draft Incapable Adults (Scotland) Bill forming Appendix A to SLC 1995
“SLC 1997”:	Scottish Law Commission Report No 160 on “Interpretation in private law”, 28 th October 1997

[Note that this paper was written before adoption by the Working Group of “advance choices” in place of “advance directives”. See the explanation in the last paragraph of the Introduction in the principal paper to which this paper is now annexed.]

1. Introduction

1.1. The overarching aim of the Project is:

- To consider and address current deficiencies in Scots law in relation to –
(a) advance directives, and

- (b) medical decision-making in intensive care situations, including decisions about refusing or withdrawing life-sustaining treatment.
 - To advocate the need for Scots law adequately to address those deficiencies.
 - To formulate and offer proposals for legislative provisions for that purpose.
- 1.2. The Project thus has two principal objectives, respectively addressing (a) and (b) above, though they overlap, for example when an advance directive addresses a situation which has arisen in an intensive care setting. This paper, however, seeks to “set the scene” in relation to element (a), the topic of advance directives, only.
- 1.3. Section 2 of this paper describes and defines some key concepts and terms as they are used for the purposes of the Project. They are concepts and terms generally used internationally. It is suggested that the descriptions and definitions of them in section 2 are appropriate to their use in relation to Scots law. They may be appropriate to their international use generally. The ensuing sections of this paper seek to address the following questions:
- 3. What are advance directives?
 - 4. What are advance directives for and what is their standing in Scots law?
 - 5. What are the provisions of international instruments relevant to advance directives?

Section 5 seeks to identify relevant provisions of ECHR, the Council of Europe Recommendations, CRPD and Hague 35.

Note that integrated in section 5 of this paper, and shown in bold, are questions that the Project Working Group might care to address in formulating the proposal to be offered in terms of its remit¹. Section 6 describes existing proposals for provision in Scots law. For convenience, Appendix A reproduces selected relevant passages and paragraphs of the CoE 2018 Report; Appendix B replicates the provisions regarding advance statements of the 2003 Act; Appendix C replicates unimplemented provisions of the SLT draft Bill; and Appendix D reproduces selected relevant passages from “Adult Incapacity”.

- 1.4. It is my intention (time permitting) to follow up this paper with a supplementary working paper reproducing the questions that are integrated into the text of section 5 of this paper, possibly with further questions added, and with each cross-referred to this paper including the material in the Appendices.

2. Key concepts and terms

- 2.1. It is helpful to start with the concept of “**juridical acts**”, defined in paragraph 1.10 of SLC 1997 as “**any act of the will or intention (other than a legislative or judicial act) which has, or is intended to have, a legal effect**”, and elaborated in that definition as follows:

“A juridical act will include a contract; a grant, assignation or renunciation of a right; a discharge of an obligation; a conveyance of property; a declaration of trust; a will or other testamentary deed; a grant of consent to what would otherwise be an invasion of a legal right; a notice required by law for any purpose; and an acceptance of office as an arbiter, trustee or guardian. We are concerned only with acts which contain expressions capable of interpretation. We are not concerned with purely factual or physical acts. We exclude legislative acts from the term “juridical act” because special considerations, and to some extent, special rules of interpretation apply to legislative acts. We also

¹ One of those questions arises from section 4 of this paper, and for convenience is repeated as the last question in section 5.

exclude judicial acts because the interpretation of court judgments may also involve special considerations. We are not here concerned with questions of validity or effectiveness. Juridical acts may be invalid for various reasons, formal or substantial. Rules of law governing particular juridical acts may require something additional, such as delivery or registration or possession, before they will be effective. These are separate questions. Here we are concerned only with interpretation.”

- 2.2. Adult incapacity law in Scotland provides for situations where a relevant disability impairs, or might be anticipated to impair, an adult’s capability for one or more valid juridical acts. Such impairment of capabilities equates to the definition in section 1(6) of the 2000 Act of “incapable” as being incapable of acting or deciding². In section 1(6), that definition is qualified: “As mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability ...”. Those qualifications are not relevant to such impairments for the purposes of this paper, and of the Project. Adult incapacity law is potentially engaged where any juridical act is or might be void or voidable, in whole or in part, by reason of any such impairment of capabilities. Put the other way round, the relevant disability is such actual or potential voidness or voidability. Section 1(6) equates “incapacity” with such incapability. Conversely, “capacity” accordingly equates to capability: hence phrases such as “impairments of relevant capabilities”.
- 2.3. Note that “capacity” in Scots law does not equate to “**legal capacity**” in CRPD, where “legal capacity”, though not defined, equates to the status and all the inherent rights in law that amount to an adult’s legal personality. One cannot say that such personality equates to the person. Rather, it is an attribute that clothes every adult person, and includes the right to effect all judicial acts. It clothes every adult throughout lifetime, and indeed may be effective beyond death, when (for example) the “act of the will” referred to in the SLC 1997 definition is expressed in a Will or other document with testamentary effect.
- 2.4. Using “legal capacity” in that sense, Article 12 of CRPD assures equal recognition before the law, with an obligation on States Parties to “recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. Albeit implicitly³, Scots law accepts the universality of such “legal capacity” of all adults, regardless of disabilities. Adult incapacity law addresses situations where a relevant disability may impair, or may be anticipated to impair, the exercise by any adult of that adult’s inherent and inalienable “legal capacity” in one or more ways.
- 2.5. CRPD addresses such impairments, and potential impairments, in two ways. Article 12.3 obliges States Parties to “*take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity*”. Article 12.4 addresses situations where measures relating to the exercise of “legal capacity” are taken, and Article 12.4 prescribes safeguards that States Parties must ensure regarding “*all measures that relate to the exercise of legal capacity*”. It is in this sense that this paper refers to “**measures**”, meaning all or any such measures.
- 2.6. In legal systems generally, such measures may (using modern terminology) be categorised as follows:

- Voluntary measures
 - bilateral

² The definition in section 1(6) is rather more extensive, referring to “incapable of (a) acting; or (b) making decisions; or (c) communicating decisions; or (d) understanding decisions; or (e) retaining the memory of decisions”.

³ One must assert that it would be better if this were explicit in statute, to demonstrate unequivocal compliance in this respect with CRPD.

- unilateral

- Non-voluntary measures
 - automatic
 - established by a court or other authority
- Third party measures

2.7. The terms “voluntary measures” and “non-voluntary measures” have generally superseded the former classifications of “anticipatory measures” and “responsive measures”. The change reflects an important shift in perceptions and values, a change accelerated by CRPD. We formerly had a binary world of capacity or incapacity, sanity or insanity, educability or ineducability, and so on. It became recognised that these extremes were the theoretical ends of a wide and diverse spectrum of characteristics and capabilities, with no-one completely capable or completely incapable.

2.8. Reality for any individual, at any one time, for any one purpose, lies somewhere along that spectrum, and is likely to be subject to significant variation depending upon positive factors such as provision of suitable support, and negative factors such as intrusion of undue influence. The shift in terminology away from “anticipatory measures”, in particular, recognises the extent to which persons with relevant disabilities (including mental, intellectual and sensory disabilities) may nevertheless themselves establish measures sufficient to meet their circumstances and needs, particularly if they are given adequate support to do so.

2.9. Put simply, “**voluntary measures**” are measures established by people themselves, and “**non-voluntary measures**”, sometimes called “involuntary measures”, include those established by a court or other authority. In the 2000 Act, “non-voluntary measures” are provided for in section 3(3) and in Parts 3 (except for section 32), 4, 5 and 6. Automatic non-voluntary measures appear quite extensively in some states, where (typically) the first person on a specified hierarchy of relatives has automatic authority to act and make decisions for an adult in the event of incapacity. In some states these are restricted to certain purposes, such as healthcare decision-making.

2.10. The shift in terminology from “anticipatory measures” to “voluntary measures” is another aspect of the growing emphasis upon rights to autonomy and self-determination, coupled with realisation that black-and-white concepts of “capacity” and “incapacity” do not reflect reality. Thus, under Article 12.3 of CRPD, anyone – however disabled – who might be capable of granting a voluntary measure is entitled to the support needed to achieve that.

2.11. The diagram in paragraph 2.6 above demonstrates an ascending order of emphasis upon autonomy from bottom to top. Third party measures, such as trusts, will generally largely reflect the decisions and wishes of the party establishing the measure. Non-voluntary measures are not generally the result of exercise of autonomy and self-determination by the adult in question⁴, though some but not all non-voluntary measures in Scots law require establishment and exercise of non-voluntary measures to respect and support the autonomy of the adult. Generally, however, only voluntary measures are established by adults themselves, in the adult’s own terms, and in the case of bilateral voluntary measures (such as powers of attorney) empowering a person selected and appointed by the adult.

⁴ Though a small number of adults have availed themselves of the express facility in section 57(1) of the 2000 Act to apply for appointment of guardians to themselves.

- 2.12. Unilateral voluntary measures (which all fall within the definition of “advance choices” in the paper by the Law Society of Scotland on “Advance choices, and medical decision-making in intensive care situations”) are the highest form of exercise of autonomy, in that rather than appointing someone else to act as authorised by the adult, acts and decisions in advance instructions are the acts and decisions of adults themselves, albeit intended to have delayed effect; and advance statements are statements by adults themselves of their own wishes.

3. What are advance directives?

- 3.1. Voluntary measures sub-divide further. Powers of attorney are contracts between a grantor and an appointee. They are **bilateral voluntary measures**. As techniques, they sit beside or are alternatives to unilateral measures. They have a valuable role to play. In Scots law, when used as “measures that relate to the exercise of legal capacity”, they are governed by Part 2 of the 2000 Act. Another form of bilateral voluntary measure is provided for in section 32 (“joint accounts”) of the 2000 Act.
- 3.2. A wide range of measures, with varied terminology, comes within the general category of **unilateral voluntary measures**. They have descriptions such as advance directives, advance statements, advance decisions, advance healthcare decisions or directives, living Wills, patient decrees, and others. They are probably all encapsulated within the definition in Rec.(2009)11, Principle 2.3:

*“**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”.*

This is supplemented by Principle 14:

“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”.

Other techniques, such as gifts, are sometimes used for the purpose of making unilateral provision for incapacity. They can obviously be hazardous.

- 3.3. No scheme of categorisation of measures can for all purposes put measures into entirely self-contained boxes, separated from each other. Thus, Principle 14 of Rec.(2009)11, quoted above, envisages a directive relevant to the establishment of a non-voluntary measure (which becomes voluntary only as regards the choice of guardian). In some states a bilateral voluntary measure can be relevant to the establishment of a non-voluntary measure, such as a contract with a potential guardian setting out that potential guardian’s remit and powers, should a guardianship appointment become necessary. Such arrangements are, for example, well developed in China, and despite assertions by practitioners in China that bilateral voluntary measures are unknown there, in a broad sense that is probably what such arrangements are. One could envisage advance directives being used to somewhat similar effect in Scotland.
- 3.4. It is relevant to note that Scots law, as a civil law jurisdiction, requires valid engagement of the will for a purported juridical act to be valid. If there was no capable exercise of the will, the resulting juridical act is void. If vulnerability was exploited to induce the juridical act, it may be voidable. In civil law jurisdictions such as Scotland’s, the nullity of a juridical act of which the adult was not capable is fundamental and applies regardless of the knowledge of other parties. That is ultimately a political judgement on the balance between protection and commercial efficacy⁵.

⁵ Common law jurisdictions tend to tip that balance the other way, so that in England & Wales a purported contract that would be void here would, there, be voidable only, and that only if the other party knew or ought to have known of the incapacity.

3.5. All “measures that relate to the exercise of legal capacity” can be seen as bridging gaps, but in two ways. Non-voluntary measures are designed to bridge the gaps between an adult’s capabilities and the acts of will necessary for one or more juridical acts to be valid. Some voluntary measures may seek to bridge that same gap by an act of the will that puts in place a mechanism that will immediately allow that first gap to be bridged. More commonly, however, they bridge a potential gap in time from creation of the voluntary measure when there is no gap of the first type, with the intention that it will become operable at some future date when there may be gaps of the first type. Instead of the act of will having immediate effect in the form of an immediate valid juridical act, it is an immediately valid juridical act only to the extent of creating the voluntary measure. Beyond that, that act of the will enters a tunnel until it emerges at some unpredictable time later to become effective to address a gap of the first type that then exists. Except when the tunnel may be opened to amend and update the voluntary measure, it travels through the tunnel impervious to changes of circumstances – or even changes in the views, preferences and wishes of the adult – that may happen “above ground”. The challenges resulting from that underground journey of the initial act of will require to be addressed in any proposals for advance directives⁶.

4. What are advance directives for and what is their standing in Scots law?

4.1. In Scots law at present, we have advance statements under the 2003 Act. Beyond that, advance directives depend upon the common law position. The assessment of the common law position by Scottish Law Commission in its 1995 Report⁷ was limited to healthcare circumstances, but would appear to be applicable to advance directives generally, and still to be accurate.

“... the factual situation facing the doctors must be within the scope of the refusal, the assumptions upon which it is based must not be falsified, and the patient must have been capable at the time of making the refusal. ... We consider that legislation setting out the position in Scotland ... would be helpful ...”

In my view the account of the position in Scots law in “Adult Incapacity” remains valid. That account is however limited to use of advance directives in healthcare settings. Selected relevant passages in “Adult Incapacity” are reproduced in Appendix D to this paper⁸. They include paragraph 7-12, which gives rise to the following question: “To what extent, if at all, might an “instructions given” advance directive be superseded, revoked or amended by a subsequent intervention or guardianship order, or by any other non-voluntary measure (existing or future)?”⁹.

4.2. Under Principle 2.3 of Rec.(2009)11 (quoted in full above), advance directives may take two forms. They may be “**instructions given**” or they may be “**wishes made**”. The 2000 Act contains no provisions relevant to “instructions given” in an advance directive. They may however be given effect by incorporation in a power of attorney (verbatim or by cross-reference). As “wishes made”, they are relevant to the principle contained in section 1(4)(a) of the 2000 Act, which requires that in determining if an intervention is to be made and, if so, what intervention, account must be taken of:

⁶ See questions 12 and 13 in section 5 of this paper.

⁷ Paragraph 5.46.

⁸ Relevant to the Project, but not directly relevant to this paper, are selected excerpts from “Adult Incapacity” on *negotiorum gestio*, which for convenience are nevertheless also reproduced in Appendix D.

⁹ That question is, for convenience, reproduced as Question 17 in paragraph 5.13.

“the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult.”

4.3. Advance statements under the 2003 Act are of the “wishes made” type. The relevant provisions of the 2003 Act are reproduced in Appendix B to this paper.

4.4. Principle 16 of Rec.(2009)11 recommends 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 2000 Act, unlike the Mental Capacity Act 2005 (applicable to England & Wales), gives no particular status to wishes and feelings recorded in writing. Under section 4(6) of the 2005 Act, there is an obligation to “*consider, so far as is reasonably ascertainable –*

*“(a) the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
....”*

The passage in brackets does not appear in the equivalent section 1(4)(a) of the 2000 Act. Sections 25 and 26 of the 2005 Act contain further provisions about an advance decision in medical matters – all medical matters.

4.5. If in Scots law there were to be provision for both “instructions given” and “wishes made” advance directives, with clarity in law as to requirements to establish them and their effect, how might advance directives be used?

4.6. To pick some examples beyond medical matters, they could direct that if an adult’s house has to be sold, then it should first be offered at valuation to a named relative; that if specified assets require to be disposed of, they should be gifted in accordance with specific bequests in the adult’s Will. More of an advisory character would be simple practical day-to-day instructions: I prefer coffee to tea in the morning, but don’t give me coffee after lunchtime for the rest of the day, as then I do not sleep well. If visiting has to be limited or rationed, this is my order of priority for visitors, and here’s a separate list of people who should not be admitted to visit me in any way to the exclusion or inconvenience of anyone on the first list. If I have to move to a care home, I would prefer this to be close to my own existing community rather than at a distance from there and close to family, or the converse. I do not in any circumstances consent to CCTV being installed in my bedroom to monitor me, or alternatively I do consent. For more possibilities, go to the checklist on pages 99-100 of “Power of Attorney” by Sandra McDonald, Souvenir Press, 2021.

4.7. An advance directive might be granted instead of, or in parallel with, a power of attorney. Thus, an adult might like to grant a power of attorney but does not adequately trust members of the adult’s own family, does not know whom to appoint, accepts that at some future date a guardian may be appointed, but is quite clear about who should not be appointed guardian. The adult has clear views about how matters should be managed. These are accordingly set out in an advance directive that is designed to be binding, as are the statements as to who should not be given a role in the matter.

4.8. Alternatively, an adult might have an obvious choice for attorney, hopes that the attorney will outlive the adult while still able to act as such, but has no obvious alternative to be appointed substitute. The adult accordingly grants and issues both

a power of attorney and an advance directive in substantially the same terms, again drafted with the intention that the advance directive be binding – which will not cause problems to the attorney if effectively mirroring the power of attorney document, but will cover the situation if the attorney dies or otherwise ceases to act.

- 4.9. The advantages of such advance directives, however, go further, because they are addressed to the world. “The world” could cover carers, medical practitioners, and providers of other services, as well as anyone appointed to any particular role to act on behalf of the granter. They have direct effect, rather than effect dependent upon a proxy such as an attorney acting accordingly; though as pointed out above, they would be applicable to any appointees under powers of attorney, intervention orders or guardianship orders, who might then require to implement them in their own acts and decisions on behalf of the granter (subject to any statutory provisions limiting such application).

5. What are the provisions of international instruments relevant to advance directives?

- 5.1. This section considers potentially relevant provisions of the following international documents (here, as elsewhere, using the abbreviations and definitions listed at the beginning of this paper):

ECHR (European)
Council of Europe Recommendations (European)
CRPD (international)
Hague 35 (international)

ECHR

- 5.2. In Council of Europe instruments, the right to autonomy and self-determination is implicit in ECHR and explicit in a number of Ministerial Recommendations. In ECHR it is implicit in Articles 6 (Right to a fair trial), 8 (Right to respect for private and family life), 13 (Right to an effective remedy), and 14 (Prohibition of discrimination), particularly when these are read in combination.

Relevant Council of Europe Recommendations

- 5.3. Relevant Recommendations indicate that priority should be given to rights to autonomy and self-determination, so that voluntary measures established by an adult should be preferred to non-voluntary measures created otherwise than by adults themselves.
- 5.4. Relevant Council of Europe Recommendations have developed from urging states to consider providing for voluntary measures, to requiring them to promote self-determination by means of both powers of attorney and advance directives. Principle 7 of Recommendation (99)4 reads:

“Consideration should be given to the need to provide for, and regulate, legal arrangements which a person who is still capable can take to provide for any subsequent incapacity.”

Issued a decade later, Principle 1 of Rec.(2009)11 reads:

“1. States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives.

“2. In accordance with the principles of self-determination and subsidiarity, states should consider giving those methods priority over other measures of protection.”

Likewise, Principle 14 of Recommendation (2014)2 declares that:

“Member States should provide for legislation which allows older persons to regulate their affairs in the event that they are unable to express their instructions at a later stage.”

The Council of Council of Europe *“Guide on the decision-making process regarding medical treatment in end-of-life situations”* (May 2014, at page 18) sets out the priority to be accorded to written advance directives, subject to the fulfilment of specific requirements, in the following terms:

“A formal, written document appears to be the safest and most reliable way of making known one’s wishes expressed in advance. Accordingly, written advance directives are the means that most directly reflect patients’ wishes. When they exist, they should take precedence over any other non-medical opinion expressed during the decision-making process (by a person of trust, a family member or a close friend, etc.), subject, of course, to the fulfilment of a certain number of requirements to ensure their validity (authentication of the author, legal capacity of the author, appropriate content, length of validity, arrangements for them to be redrafted so that they can be kept as closely in line as possible with current developments, possibility for them to be revoked, etc.), and their accessibility (arrangements for them to be kept in such a way that the doctor can access them in good time).”

The human rights importance of voluntary measures (powers of attorney and advance directives) was emphasised in 2014 by the Council of Ministers of the Council of Europe when it approved a recommendation by the European Committee on Legal Cooperation, which had invited and considered proposals for review of implementation of all of the Committee of Ministers’ Recommendations with a view to selecting one of them for such review; then selected Rec.(2009)11. The resulting Report was approved for publication by the Committee on Legal Cooperation, which approved the recommendations in it. The full title of the Report is “Enabling citizens to plan for incapacity: a review of follow-up action taken by member states of the Council of Europe to Recommendation CM/Rec.(2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity: Report prepared by Mr Adrian D Ward, Consultant (Scotland, UK) on behalf of the European Committee on Legal Cooperation (CDCJ). The Report is available at: <https://www.coe.int/en/web/cdcj/activities/powers-attorney-advance-directives-incapacity>.

- 5.5. On the basis of the foregoing, it could be said that Scots law at present fails to comply with human rights obligations in respect that it contains no clear and adequate provision for advance directives, and that Scottish Government is accordingly under an obligation to make such provision. Scotland is not alone in this position: see the findings of the CoE 2018 Report referred to below.
- 5.6. There follow the relevant provisions of Rec.(2009)11, with numbered questions that the Project Working Group might care to address following each (Principles 2.3 and 14 having been already quoted above, but being repeated here for ease of reference):

Principle 2 – Definition of terms used in the present Recommendation:

“2.3 “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”.

Principle 2.3 thus divides advance directives into two different types. “Instructions given” are intended to be binding. They are competent decisions by the adult, albeit with the intention that they should become effective at a time when the adult is not competent. “Wishes made” are not intended to be binding. It is intended that they be taken into account in relation to any act or decision on behalf of the adult in a matter in which the adult does not at the time have the competence to act for himself/herself. In any matter under the 2000 Act, they must be taken into account in terms of section 1(4)(a) of that Act. We use the respective terms “*advance instructions*” and, for wishes made, “*advance statement*.”

Question 1: Should Scots law provide for both “instructions given” and “wishes made” advance directives, either separately or in the same document?

Question 2: If so, what provisions are necessary to ensure that the two types are clearly differentiated?

Principle 14 explains the wide potential scope of advance directives. Many legal systems, including Scots law, make the distinction between, on the one hand, acts and decisions in respect of personal matters, including matters of health and of welfare, and on the other hand acts and decisions in relation to property, financial and economic measures. The reference in Principle 14 to choice of a guardian was generally directed towards legal systems which at the time did not have provision for powers of attorney; though in some circumstances that could be a relevant aspect in systems such as Scots law which do have provision for powers of attorney.

Principle 14 – Content (Advance Directives)

“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.”

Question 3: Should it be possible for advance directives to apply to health, welfare and other personal matters, and to economic and financial matters?

Question 4: Should it be possible for them to apply to other matters in addition?

Question 5: Should the particular matter of choice of guardian, or alternatively general directions as regards the terms of any guardianship order, be included?

Principle 15 – Effect

“1. States should decide to what extent advance directives should have binding effect. Advance directives which do not have binding effect should be treated as statements of wishes to be given due respect.

“2. States should address the issue of situations that arise in the event of a substantial change in circumstances.”

Question 6: Should there be particular requirements to enable an advance directive to have “binding effect”, and should statute provide that all advance directives which do not meet those requirements should be treated as statements of wishes to be given due respect? If so, should a qualification to

section 1(4)(a) of the 2000 Act along the lines of the additional provision narrated above in section 4(6) of the 2005 Act be recommended?

Principle 16 – Form

“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.

“2. States should consider what other provisions and mechanisms may be required to ensure the validity and effectiveness of those advance directives.”

Question 7: As regards the document itself, continuing powers of attorney and welfare powers of attorney require to be in writing and subscribed by the granter (sections 15(3) and 16(3) of the 2000 Act). Should advance directives likewise require to be in writing and subscribed? Should that only apply to some types, such as “instructions given”? Should there be some other allocation?

Question 8: 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, reproduced in Appendix A.)?

Question 9: Continuing and welfare powers of attorney require certification and registration. Should similar requirements apply to advance directives made in writing?

Question 10: Would formal requirements for all advance directives, or all advance directives of specified kinds, disadvantage some granters in some circumstances compared with the current position, albeit that the current position is vague? Should the possibility of great informality be accommodated, on a “better than nothing” principle? What lessons can be learned from the law on testamentary writings (bearing in mind, however, that advance directives may require to be actioned much more urgently than testamentary writings)?

Principle 17 – Revocation

“An advance directive shall be revocable at any time and without any formalities.

Question 11: Should that Recommendation be incorporated in Scottish provision? What would be the practical challenges of operating that (for example, as regards evidencing revocation); or of applying the safeguards of Article 12.4 of CRPD to the act of revoking? Should partial revocation be possible? If advance directives, or some categories, require to be formally registered, would it be acceptable for entirely informal revocation to remove such a document from the register?

Question 12: 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? To what extent should any such procedures or controls be required not only to override

apparent dissent, but 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?

Question 13: Should it be possible for 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?

5.7. I have reproduced a substantial amount of relevant content from the CoE 2018 Report in Appendix A to this paper. Although it appears in an Appendix, I recommend that full account be taken of that comparative experience.

CRPD

5.8. Various provisions of CRPD would appear to support the primacy of autonomy. The Preamble to CRPD recognises “(n) ... *the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices*”. The general principles in Article 3 of CRPD commence with: “(a) *Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons*”. The general obligations undertaken by States Parties in terms of Article 4 of CRPD commence with: “(a) *To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention*”.

5.9. For any “delayed action” voluntary measure particular issues arise in relation to the requirement of Article 12.4 of CRPD to respect “the rights, will and preferences” of people with disabilities. For many purposes, a clear expression of will is determinative of a matter, provided that there are at that time no vitiating circumstances rendering an apparent act or transaction void or voidable. The act of creating an advance directive might undoubtedly represent the will of the granter at time when it is created, but the document (if it is a document) then enters a tunnel for a period. It may see the light of day briefly to be reviewed and updated, but will then continue in a tunnel of completely unpredictable length until it emerges in circumstances where it may well require to be operated. However, what happened above ground level while it was in that tunnel? If the granter had reviewed it, which presupposes that at the time in question the granter was able to review it, would it have been altered or revoked? What should happen if, once it does emerge and become operable, there appear to be significant differences between the granter’s will at the far end of the tunnel and the granter’s will (which might be a “best interpretation” of it) at the other? Does the concept pursued by the Office of the Public Guardian (England & Wales) of a lifelong amendable power of attorney also contain possibilities for advance directives? Would the formulation of what is believed to be the existing position in Scotland (quoted in paragraph 3.1 of this paper) suffice, and should it be embodied in statutory provision? To what extent should advance statements in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003 remain as separate specialities with the existing distinct provisions, and if so could they be successfully embedded in advance directives of wider or other scope?

Question 14: 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)¹⁰**

¹⁰ See “Respecting ‘will’: Viscount Stair and Online Shopping”, Ward and Curk, 2018 SLT (News) 123, and the other extensive literature on this topic.

- 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?

HCCH

5.10. The extent to which people move across borders, have family and other relationships across borders, or have property or other interests across borders, continues to increase. In relation to the consequences of impairments, or anticipated impairments, of an adult's capabilities, relevant international private law is governed by (a) domestic private international law of each jurisdiction and (b) in cross-border matters between two jurisdictions in respect of which Hague 35 has been ratified, by Hague 35. Scotland was the first country in the world in respect of which Hague 35 has been ratified. At time of writing, it has been ratified by Austria, Belgium, Cyprus, Czech Republic, Estonia, Finland, France, Germany, Latvia, Monaco, Portugal, Switzerland and the United Kingdom (Scotland only – there are prospects of ratification in respect of England & Wales in 2022). The pace of ratification is generally accelerating: Scotland was alone for four years, yet there have been one or more ratifications every year from 2016 to 2020. So far, all ratifying states are in Europe, but there is known to be significant interest in ratification elsewhere.

5.11. The interpretation of the provisions of Hague 35 in relation to voluntary measures, and in particular to unilateral voluntary measures, is difficult. It is not self-evident that Hague 35 was drafted with full understanding of the contemporary status, which had existed for several years in several states, of various voluntary measures, or of predictable future developments. Hague 35 incorporates the autonomous term "powers of representation", apparently intended to apply to powers of attorney, upon the supposition that powers of attorney granted by adults are "functionally equivalent" to the *ex lege* non-voluntary authority of parents (or other guardians) over children – which of course they are not.

5.12. The difficulties of the above approach are even more obvious in relation to unilateral voluntary measures, which are – as noted above – "addressed to the world". They may nominate a choice of person to become the adult's representative in the event that a non-voluntary measure should be necessary, but they do not normally of themselves appoint a representative (if they did, then in Scots law and other jurisdictions they would come within the definition of bilateral voluntary measures – in Scotland's case, continuing or welfare powers of attorney – and would be subject to the provisions for such bilateral measures¹¹). This is one of the difficulties currently being addressed by a drafting group convened by the Permanent Bureau of HCCH¹² with a view to preparing a practical handbook on the operation of Hague 35. It is unlikely that such a handbook will be published in its final form in the near future. It is envisaged that the draft will go to a Special Commission convened by HCCH in May or June 2022, for consideration. It is asserted by the Permanent Bureau of HCCH that at time of drafting of Hague 35 it was intended that "powers of representation" should include unilateral voluntary measures, but at time of writing that has yet to be

¹¹ They would also fall within the definition of continuing powers of attorney in Principle 2.1 of Rec. (2009)11; and thus in the context of Rec. (2009)11 they would not be advance directives at all.

¹² I disclose an interest as the UK member of that drafting group, though anything eventually published should not necessarily be taken as according entirely with the views that I have expressed and the submissions that I have made in the course of drafting.

demonstrated from the travaux préparatoires. A possible alternative approach, which might have rather better prospects of achieving consensus, would be to suggest that as unilateral voluntary measures are not explicitly excluded from the scope of Hague 35¹³, Hague 35 should be teleologically construed on the basis that unilateral voluntary measures are within its scope, and that such provisions as can be identified as relevant should be interpreted as applicable. That would appear to present difficulties in relation to the plain language of Hague 35, though if such an interpretation were generally to be adopted by states that had ratified, such an interpretation might gain increasing force¹⁴.

Question 15: Should provision for advance directives in Scots law be drafted so as to enhance recognition, workability and enforcement in other states? If so, how might that be done?

Question 16: Should provision in Scots law for advance directives 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?

5.13. For convenience, the question posed in paragraph 4.1 of this paper is re-stated here.

Question 17: To what extent, if at all, might an “instructions given” advance directive be superseded, revoked or amended by a subsequent intervention or guardianship order, or by any other non-voluntary measure (existing or future)?

6. Existing proposals for provision in Scots law

6.1. It would appear that proposals have not previously been formulated for advance directives in accordance with the broad definition in Rec.(2009)11. The nearest to that are the proposals in SLC 1995, but they would have been contained in Part V (“Medical, care and research”) if they had appeared in the 2000 Act. They did not. The Parliament took the view that the courts should be allowed to develop the concept further before it was to be embodied in legislation. The courts would not appear to have done so to any significant extent. There is no longer any good reason not to fulfil the human rights requirement for advance directives in Scots law.

6.2. The relevant provisions proposed by Scottish Law Commission were contained in section 40 of the SLC draft Bill. That draft section 40 is reproduced in Appendix B to this paper. Section 41 of that draft Bill, on “Withholding and withdrawal of medical treatment from incapable adults”, also was not included in the 2000 Act, for similar reasons. Although not directly relevant to the topic of advance directives addressed in this paper, for convenience it is also reproduced in Appendix B.

6.3. The discussion by Scottish Law Commission of the proposal for advance statements is contained in paragraphs 5.41 – 5.59 of SLC 1995. The Commission’s relevant Recommendations are Recommendations 68 – 74. Although addressing a more limited and specific form of advance directive than advance directives as defined by Rec.(2009)11, those passages of SLC 1995 should be referred to.

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2nd November 2021

¹³ For the explicit exclusions, see Article 4 of Hague 35.

¹⁴ On interpretation of international instruments, and in particular consideration of the plain language of an instrument, the travaux préparatoires and the interpretations adopted by parties, see the Vienna Convention on the Law of Treaties.

RELEVANT PROVISIONS OF THE CoE 2018 REPORT

EXECUTIVE SUMMARY

Across Europe, implementation of Recommendation CM/Rec(2009)11 is work-in-progress. Achievements to date by member states are commendable. Much has been done, and continues to be done, by member states towards promoting self-determination for their citizens, by providing and refining voluntary measures, and encouraging their use.

The picture across Europe is however that outcomes envisaged by the Recommendation are only at an early stage of development, leaving most member states still with much to be done. It is also a picture of diversity, ranging from unavailability of continuing powers of attorney (“CPAs”) and/or advance directives, through to relatively wide-ranging provision for CPAs, and at least some provision for advance directives. There is also diversity in that some member states have legislation in force and in full operation, some have passed legislation which is not yet in operation, some have proposals before their legislatures, and some have proposals which are not yet before their legislatures. These categories are reflected in Table A in Appendix IV. Where CPAs and advance directives are available to citizens, there is diversity among member states as to the length of time for which they have been available, and remarkable diversity in the extent to which – so far as statistics have been provided – they are used. Relevant statistics appear in Table C in Appendix IV.

As at 1 September 2017, nine member states currently had in force all of the areas of relevant provision of (1) CPAs to cover economic and financial matters, (2) CPAs to cover health, welfare and other personal matters, and (3) advance directives as defined in Principle 2.3 of the Recommendation. One more state will have all of those areas of provision when legislation already passed comes into force. Only one member state, when legislation already passed comes fully into force, will have implemented all of the Principles identified as fundamental in this report.

Completed questionnaires, in the form in either Appendix I or Appendix II to this report, were received from 26 member states. They contributed a wealth of information, which has been correlated and analysed in this report. These responses to questionnaires (“Responses”) reflect great care and enthusiasm with which member states have analysed and addressed relevant issues in recent years. In addition to Responses, one abbreviated form, and further information from two further member states, were received, contributing further information contained in Table A.

The Principles in the Recommendation remain highly relevant. In a time of dynamic development across our continent, guided by the common Principles in the Recommendation, this report seeks to provide a starting-point for further collaborative progress. Member states are encouraged to continue to share information, initiatives and experience. Member states are encouraged to contact the Secretariat to the Directorate General of Human Rights and Rule of Law (“DGI Secretariat”) with proposals for joint projects, conferences and the like.

As well as the general need to continue collaboratively the work of full implementation of the Recommendation, particularly significant conclusions emerging from this review include:

- Provision for advance directives, compared with CPAs, is under-developed. Nowhere is there clear legislative provision maximising the scope of self-determination by advance directives, so as, in conjunction with CPAs, to maximise the total range of provision for self-determination.

- There are insufficiently strong requirements to ensure that, in accordance with the UN Convention on the Rights of Persons with Disabilities, during operation of CPAs granters are informed and consulted, and their wishes and preferences identified and respected.
- Europe-wide, there is insufficient clarity as to how to balance expressions of self-determination when voluntary measures are created, with inconsistent expressions when they are subsequently in operation.
- Promotion of self-determination requires not only availability in legislation of voluntary measures, but availability of fully inclusive forms of document and procedures to establish them; proactive promotion of use of voluntary measures; and removal of barriers to their effective operation, both within member states and in cross-border situations. All of these aspects require to be developed further in many member states.

This report contains six proposals designed to address the foregoing issues, and 30 suggestions (see paragraphs 217 – 247), four of them directed to both Council of Europe and member states, and the remainder to member states. Some of those suggestions are at least partly supplementary to the proposals. The majority are free-standing.

The proposals set out below, and the suggestions appearing later in this report, have been drawn by the consultant from the information provided in this report, and from matters within his own knowledge. These proposals and suggestions are solely those of the author and do not necessarily reflect the views of CDCJ, the Council of Europe or its member states.

The proposals are:

Proposal 1:

(A) – That all member states should, on an ongoing basis, continue to review and develop provisions and practices to promote self-determination for capable adults in the event of future incapacity by means of CPAs and advance directives.

(B) – That in doing so, member states should have regard to such assistance as may be provided by the solutions to issues, and experience in practice, of other states as described in this report; should continue to share information, initiatives and experience; and should where appropriate, and in conjunction with Council of Europe, promote joint projects, conferences and the like.

Proposal 2:

(A) – That member states consider, in particular, developing provision for advance directives, as a component in the overall promotion of self-determination in conjunction with CPAs, having regard to the full potential scope of application of advance directives to all health, welfare and other personal matters, to economic and financial matters, and to the choice of a guardian should one be appointed; and with appropriate distinction between the categories of instructions given and wishes made.

(B) – That Council of Europe should consider promoting research and consideration at a European level, and issue of guidance or recommendations, with a view to assisting member states in implementing Proposal 2 (A).

Proposal 3:

That member states review laws relating to CPAs to ensure –

(A) That in relation to all acts and decisions in their role as attorneys, attorneys are required to take all practicable steps to ascertain the will and preferences of the granter, or failing that the best interpretation of the will and preferences of the granter.

(B) That in their acts and decisions on behalf of the granter attorneys are required to give effect to the will and preferences of the granter (or best interpretation thereof) except only where stringent criteria for doing otherwise, set forth in law, are satisfied.

(C) That the requirement to inform and consult the granter on an ongoing basis includes a requirement (i) to present to the granter, in the form that the granter is most likely to understand, the information necessary to enable the granter to formulate and communicate his or her will and preferences, (ii) to provide the granter with all reasonable support towards enabling the granter to formulate and communicate the granter's will and preferences, and (iii) to keep the granter informed of acts and decisions taken and implemented.

Proposal 4:

That Council of Europe give consideration to promoting discussion and research with a view to clarifying matters relevant to situations of conflict between the terms of a continuing power of attorney or advance directive, on the one hand, and on the other the apparent will and preferences of the granter at time of exercise of powers conferred by a CPA, or of implementation of instructions in an advance directive, or when wishes expressed in an advance directive are to be followed.

Proposal 5:

(A) – That member states facilitate and encourage the use of continuing powers of attorney and advance directives in forms helpful to people with disabilities, including in easy-read form, and the maximisation of support to enable people with disabilities to exercise their legal capacity by granting CPAs and issuing advance directives.

(B) – That member states facilitate and encourage the incorporation of supported decision-making and co-decision-making provisions in continuing powers of attorney.

(C) – That Council of Europe develops and issues guidance or recommendations to assist member states in implementing Proposals 5 (A) and (B).

Proposal 6:

That member states should:

(A) – Educate citizens about CPAs and advance directives, and proactively promote the granting of CPAs and the issue of advance directives.

(B) – Assess whether financial savings achieved by higher levels of uptake of CPAs and advance directives would make it economically prudent to fund such public education and promotion, and/or to subsidise the costs of granting CPAs and issuing advance directives.

(C) – Review whether all available involuntary measures comply with international human rights requirements, and whether they avoid inhibiting uptake of voluntary measures.

(D) – Review and address any barriers, internally or in cross-border situations, to the full recognition and effectiveness in practice of CPAs and advance directives.

“VOLUNTARY MEASURES”

13. The UN Committee on the Rights of Persons with Disabilities, drawing upon the UN Convention on the Rights of Persons with Disabilities, is increasingly stimulating the use of what in this report are termed “voluntary measures”. As explained in the definitions and abbreviations section of this report, that term covers CPAs and advance directives. It covers the creation by people with intellectual disabilities of CPAs to take effect immediately, and of advance directives, where necessary with support. It also covers other emerging methods, such as those described in the definition of “voluntary measures” on page 12. The alternative to such voluntary measures is the imposition by a court or other authority, or by operation of law, of measures which are likely at least to some extent to be involuntary¹⁵. The use of involuntary measures is strongly discouraged by the UN Committee. The underlying theme of this report is the Europe-wide promotion of self-determination for all citizens of our continent, by encouraging continuous progress in the provision and use of voluntary measures. For further explanation of the evolution of terminology, using the terms “anticipatory measures”, then “autonomous measures”, and now “voluntary measures”, see Appendix V to this report.

PROMOTION OF SELF-DETERMINATION

[referring to Principles 1, 3 and 14]

28. These Principles are taken together. At first sight, and on a narrow reading, only Principle 1.1 might be viewed as “fundamental”. Even more narrowly, it might be thought that implementation would be achieved by a member state even if very limited forms of CPAs, and of advance directives, were statutorily available. However, the two-part structure of Principle 1.1 is significant. The recommendation to member states is that they should promote self-determination for capable adults in the event of their future incapacity. The means by which they should do so is by CPAs and advance directives. The operative verb in this opening Principle is “promote”. That means more than making available by legislative provision. This review of implementation of the Recommendation must consider not only the availability of CPAs and advance directives in member states, but the extent of the effective self-determination which they provide, and the extent to which their use has been successfully promoted. To that end, this section draws together Principles 1, 3 and 14; and it reviews the information drawn from the primary classification of Responses shown in Table A in Appendix IV, the statistics in Table C of Appendix IV, and certain information from Responses not collated elsewhere. Proactive promotion to the general public is addressed in Part B of Chapter IV.

29. The broad picture provided by the above sources is one of diversity. There is diversity ranging from unavailability of CPAs and/or advance directives, through to relatively wide-ranging provision for CPAs and (subject to the reservation noted in paragraph 35 below) reasonably extensive provision for advance directives. There is diversity in the sense that some member states have legislation in force and in full operation, some have passed legislation which is not yet in operation, some have proposals before their legislatures, and some have proposals which are not yet before their legislatures. These categories are reflected in Table A in Appendix IV. In two member states¹⁶ there is no legislation providing expressly for CPAs, but CPAs have nevertheless been made available within the framework of existing law.

30. A small number of member states¹⁷ are in course of introducing statutory regimes for provision of CPAs, but may have existing, largely unregulated, situations where general powers of attorney continue in force after impairment of the granter’s relevant capabilities. Where a Response has ignored the existence of such powers of attorney which are

¹⁵ Characterisation of measures as “involuntary” requires however to be modified increasingly by aspects of voluntariness, such as the provision in Germany that a “*Betreuer*” (guardian) may not be imposed contrary to the “free will” of the adult; provisions for choice of persons to be guardian (see Principle 14 defining the scope of advance directives); and provisions in various jurisdictions (e.g. Germany and UK – Scotland) under which people may initiate proceedings for appointment of guardians to themselves.

¹⁶ The Netherlands and Turkey.

¹⁷ E.g. Denmark prior to its new provisions coming into force on 1 September 2017.

unregulated but which might nevertheless be classified as CPAs, and has described a prospective statutory scheme only, this report does likewise.

31. There is of course diversity in the nature of the provisions which may or may not qualify for entry in the boxes provided in Table A. Even adopting a teleological approach, in some cases categorisation has to be a matter of judgement, and it is acknowledged that judgements in such matters can themselves vary. Thus a judgement has been made, which could be disagreed, that instructions given to the attorney in a CPA should not be classed as an advance directive. Accordingly, states such as the Netherlands, where only such instructions may be given, and advance directives as a separate instrument are not available, have not been classed as having advance directives.

32. The categorisation of the provision available in Romania has in particular been a matter of judgement, greatly assisted by the full and careful explanation in the Response from Romania. On the face of it, all that is available in Romania is the possibility to nominate guardians and administrators, both of whom may be appointed only by a court. As a general rule, Romanian legislation does not recognise contractual representation by means of a CPA. A general power of attorney ceases in the event of the grantor becoming incapacitated, with the limited exception that when the purpose of the document is the conclusion of successive acts in the context of an ongoing activity, that activity may continue to completion. However, the nomination of a guardian or administrator (though not always binding upon the court) may be made either by unilateral document or by bilateral agreement with the nominee(s). Moreover, in the case of administrators, the bilateral document may state the powers to be conferred. For the purposes of this report, accordingly, such a nomination in Romania is treated as marginally within the definition of CPA in Principle 2, the role of the court being within the scope of Principles 4.3 and 7. Romania should however be taken as exemplifying the minimum end of the range of self-determination achievable, in terms of Principle 1.1, by a measure categorisable as a CPA¹⁸. The principle of self-determination is to some extent limited in any situation where entry into force of a CPA may be denied by a court or other authority.

33. Where CPAs and advance directives are available to citizens, there is diversity among member states as to the length of time for which they have been available, and remarkable diversity in the extent to which – so far as statistics have been provided – they are used. Relevant statistics appear in Table C in Appendix IV¹⁹.

34. CPAs in both economic and financial matters, and in health, welfare and other personal matters, are currently available in 16 member states²⁰. Both forms are available in Switzerland, except that in relation to personal matters there is a limitation to healthcare decisions, though a supporter may be appointed for other welfare matters. Conversely, in two member states (Ireland and Sweden) healthcare matters are excluded and only welfare and other personal matters may be covered, but in Ireland provision has been enacted, though is not yet in force, to cover healthcare matters as well. Legislation which would provide for CPAs to cover economic and financial matters, and also health, welfare and other personal matters, is proposed but not yet before the legislature in two member states²¹. CPAs in economic and financial matters only are available in two member states²². CPAs in healthcare matters only are available in one member state²³ and have been legislated for in one member state²⁴. CPAs are neither available nor proposed in five member states²⁵.

¹⁸ This is ultimately a rather arbitrary limit which could be said to be of little more than terminological significance: see for example the position under advance directives in Lithuania described in paragraph 190.

¹⁹ Dates when some regimes came into force are given in Table D.

²⁰ Armenia, Austria, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Latvia, Republic of Moldova, Netherlands, Norway, Sweden, Turkey and UK – both England & Wales and Scotland.

²¹ Andorra and Croatia.

²² Belgium and Romania (though in Romania powers may to a very limited extent be available in health, welfare and other personal matters where such matters require to be assessed in conjunction with economic matters).

²³ Slovenia.

²⁴ Italy (legislation passed on 14 December 2017).

²⁵ Bulgaria, Hungary, Lithuania, Montenegro and Ukraine.

35. Turning to advance directives, it is necessary to make a preliminary point. A reasonable interpretation of Principle 1.1 is that member states should maximise the overall provision for self-determination by a combination of two methods, namely by bilateral arrangements under which an attorney is appointed, and by unilateral arrangements under which an advance directive is issued. The instructions and wishes in a CPA are directed to the attorney, who is responsible for implementing them. The instructions and wishes in an advance directive apply directly as “the voice of the granter”, without being directed through another party such as an attorney. In the case of advance directives, the extent of true self-determination is limited in the Recommendation in that the definition of “advance directives” in Principle 2.3 encompasses both instructions given and wishes made. To express wishes is clearly a significantly less effective form of self-determination than giving instructions. However, even setting aside that distinction, Responses do not reveal a picture of availability in any member states of clear legislative provision maximising the scope of self-determination by advance directives, so as, in conjunction with CPAs, to maximise the total range of provision for self-determination. Subject to that qualification, advance directives within the definition in Principle 2.3 are available in 14 member states²⁶. They are available for the limited purpose of choosing a guardian in advance in two member states²⁷, and for making a prior statement regarding arrangements if conservatorship should be established in one member state²⁸. Legislation providing for advance directives has been passed but is not yet in force in one member state²⁹, and has been proposed but is not yet before the legislature in one member state³⁰. Advance directives are not available in 10 member states³¹.

36. As to whether CPAs and advance directives are given priority over other methods of protection (Principle 1.2), they are not given priority in four member states³². Priority for CPAs and advance directives is given by implication rather than expressly, or is “usually given”, in five member states: in the Czech Republic, under the principle requiring the least restrictive measure; in Norway, in consequence of the principle of self-determination, and the requirement that guardianship should only be established where it is deemed necessary to protect the granter (and where CPAs are given express priority over *ex lege* representation); in Romania, by application of the principle of self-determination; and UK – Scotland, where again this is a consequence of general principles in the legislation and an exclusion of guardianship where other measures suffice (though in the case of advance directives in mental health legislation, these are truly advance statements, being subject to the professional giving care or treatment at the time considering that the terms of the document would not at that time be in the individual’s best interests). In the Netherlands, where there is no express statutory scheme, CPAs are in practice “usually given” priority. In 14 member states³³, CPAs and advance directives are given priority.

37. As well as recommending that member states should consider the scope of CPAs, Principle 3 also recommends that they consider whether some particular matters should be excluded. That aspect of Principle 3 is not fundamental, as defined in paragraph 19, and is accordingly dealt with in Chapter III.

²⁶ Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Lithuania, Republic of Moldova, Slovenia, Spain, Switzerland, Turkey and UK – both England & Wales and Scotland.

²⁷ Croatia and Romania.

²⁸ Hungary.

²⁹ Ireland.

³⁰ Andorra.

³¹ Armenia, Bulgaria, Cyprus, Hungary, Latvia, Montenegro, Netherlands, Norway, Sweden and Ukraine. The Response from the Netherlands suggested that advance directives are available there, but in fact this referred to instructions to an attorney within a CPA document, not to any unilateral arrangement within the definition of advance directives.

³² Bulgaria, Cyprus (where CPAs do not apply where there is specific provision in another form), Sweden (where a guardian or administrator, if appointed, will supersede an attorney) and Turkey (where guardians or trustees are normally appointed upon loss of capacity, and may cancel a CPA).

³³ Armenia, Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Ireland (prospectively as regards advance directives), Latvia, Lithuania (which has advance directives only, not CPAs), Slovenia, Switzerland and UK – England & Wales.

38. Statistical information provided in Responses appears in Table C in Appendix IV. The information in Table C regarding advance directives covers only two member states³⁴. This, coupled with the previous observation about the diverse and often limited coverage of advance directives, means that further comment would be speculative only.

39. The statistics regarding CPAs are subject to the obvious qualification that they do not compare like with like. Procedural requirements and systems vary, therefore the information captured to produce the statistics also varies. The length of time for which CPAs have been available is a further variant. Nevertheless, two conclusions may reasonably be drawn from these statistics. The first is that where CPAs are available, their uptake, year-on-year, will generally increase, sometimes dramatically. The second is that there are major variations among member states in the amount of uptake. At extremes, one would contrast the substantial total uptake in Germany, coupled with significantly high uptake (in relation to population) in Austria and UK – both England & Wales and Scotland, with relatively very much smaller figures in Czech Republic, Finland, France and Latvia. In France, the figures quoted are likely to have been affected by the availability of the *fiducie* (or trust), not included in the statistics, but there would nevertheless appear to be *prima facie* cause for investigation into the reasons for these variations. Advertising campaigns to promote the granting of CPAs, such as the project (in UK - Scotland) described in paragraphs 157 – 161, can be demonstrated to increase uptake, but that particular project only began after Scotland had established a history of substantial year-on-year uptake and, in comparative terms, a high level of uptake.

ADVANCE DIRECTIVES

[Principle 15 quoted here]

62. This section should be read in conjunction with the comments regarding advance directives in paragraph 35. There is much diversity of provision, ranging from none³⁵ through those which should (in the words of Principle 15.1) be treated as statements of wishes only³⁶, to many where there is binding quality subject to provision for exceptions, all with varying areas of operation and frequently limited to healthcare matters only, and two member states where advance directives in relation to healthcare matters are either binding but with narrow effect, or straightforwardly binding. In Germany, advance directives in relation to health matters have binding effect in respect that a *Betreuer* (guardian) or attorney is legally obliged to give effect to them; whereas in Ireland advance directives in the form of advance refusals of treatment are stated to be unqualifiedly legally binding³⁷.

63. The extent to which advance directives have binding effect would appear to be widest in Germany but, except in relation to healthcare matters as noted above, there is a general exception which is understood to mean that the wishes of the granter must be taken into account “as long as their fulfilment does not endanger higher-ranking rights of the person concerned or worsen his or her entire situation in life”. The range of exceptions in other member states from the binding quality of advance directives in relation to healthcare includes:

Czech Republic: “The quality of healthcare has already progressed in the meantime, or respecting it would actively cause death or endanger another person, or if the person providing treatment was unaware of the advance directive when commencing treatment, and that to cease the treatment after having commenced it would cause death”.

France: A life-threatening emergency where acting contrary to the advance directive is permitted “for the time required to make a full assessment of the situation”, or where

³⁴ Croatia and Lithuania.

³⁵ Armenia, Bulgaria, Cyprus, Hungary, Montenegro, Norway, Sweden, Ukraine.

³⁶ Denmark and Finland.

³⁷ As would appear to be the general rule everywhere, a request for any specific treatment is not legally binding, and that is the position in Ireland, though such request must be taken into consideration.

compliance would be “patently inappropriate or incompatible with the medical situation and following a collective procedure”.

Lithuania: Where following the advance directive would be “manifestly incompatible with the best interests of the person” if that is established by a court.

Slovenia: The advance directive is only binding if not deemed to prevent serious risk to the granter’s health.

Switzerland (where advance directives can also apply to choice of guardian or equivalent): Advance directives are binding “unless they violate legal provisions or there are serious doubts that they are based on the patient’s free will or that they correspond to his/her presumed will in a given situation”.

UK – Scotland: Are binding at common law if issued in contemplation of a situation that has arisen and are not vitiated by change of circumstances. Under statutory provisions related to mental health treatment, the advance directive should be followed unless the professional giving care or treatment does not consider the document to be in the individual’s best interests.

64. In Austria and Croatia, advance directives may only be granted in relation to healthcare treatment, and in Croatia only in relation to specified healthcare matters, where they would appear to be binding if certain relatively complex procedures and formalities are followed. In Austria, the binding effect ceases after five years. In Croatia, advance directives may also be issued in relation to choice of guardian, where they are effective “where there are no obstacles prescribed by legislation to making the appointment accordingly”. In Romania, advance directives may only be issued in relation to appointment of guardians. The court “usually” appoints the nominee, but is not bound to do so.

REVOCAATION

[Principle 17 quoted here]

65. In all member states which have advance directives and which responded, advance directives are revocable at any time. In some³⁸, there is an explicit requirement that the granter be capable when revoking. Where the advance directive relates to appointment of a guardian (see paragraph 35), revocation is not possible after appointment of the guardian, or incapacitation leading to such appointment.

66. In many member states, however, advance directives cannot be revoked without any formalities. Formalities range through requirements for the revocation to be in writing (Ireland and Slovenia); in writing and witnessed (UK – Scotland); notarised (Montenegro proposal); and notarised by the same notary (or the same consular officer) who approved the advance directive (Lithuania). Only in France is it explicitly stated that no formalities are required for revocation.

ADVANCE DIRECTIVES

[Principle 16 quoted here]

102. Regarding Principle 16.1, the most advanced provisions reported are in Ireland, where advance statements must be in writing, or by voice and video recording or speech recognition technologies; and they must be signed by the designated healthcare representative (if there is one) and two witnesses. They must be in writing and notarised in Austria and Lithuania. In some member states they must be in writing for some purposes only: in Croatia, for nomination

³⁸ Belgium, Czech Republic (except where the procedure to enter the advance directive in the health notes has been followed, when the same procedure applies to revocation), Ireland, Switzerland, UK – England & Wales and (by virtue of certification requirements) Scotland. In Germany, the standard of capability is described as not full capability, but rather “ability to consent” (“einwilligungsfähig”).

of a guardian, they must be in writing and notarised; in the Czech Republic, they must be in writing for healthcare purposes, but at or immediately before admission this may be done by an entry in the medical documentation signed by the patient; in Germany, they must be in writing for health matters; and in UK – Scotland, mental health advance statements must be in writing and witnessed by a medical or care professional or a solicitor, while as other advance directives are not regulated by statute there are no express provisions regarding form. There is no requirement for writing in the proposals for Montenegro, or in Turkey. Advance directives require to be in writing in the remaining member states which responded³⁹.

103. Regarding Principle 16.2, several member states reported further provisions and mechanisms. In Austria, advance directives may be registered in the Central Register managed by the Austrian Chamber of Notaries, in co-operation with Austrian Red Cross (such registration being voluntary, and not a requirement for validity). In Belgium, they are recorded in the Central Register kept by the Royal Federation of Belgian Notaries. In Croatia, for nomination of a guardian, they must be notified to the Social Welfare Centre; and advance directives are registered in a register managed by the Croatian Chamber of Notaries. In the Czech Republic, to be valid and effective there must be a written explanation of the consequences of the patient's decision by a doctor with an officially verified (legalised) signature of the patient. In France, if the granter is contemplating a decision to restrict or discontinue treatment, the doctor must enquire about the possible existence of an advance directive (which in France can relate only to end-of-life situations). In Germany and in UK – Scotland, advance directives can be combined with a CPA. In addition, in Germany advance directives in health matters, and nominating the choice of *Betreuer* should one be required, may also be registered in the Central Register of Lasting Powers of Attorney (see footnote 85). In Ireland, if the advance directive relates to life-sustaining treatment, it must state explicitly that it is to apply even if life is put at risk. Necessary formalities in Ireland include the name, date of birth and contact details of the granter and of the designated healthcare representative (if any). In Switzerland, it is the doctor's responsibility to check for the existence and validity of advance directives: in the event of serious doubts as to whether the document was issued freely and in an informed manner, the doctor may disregard it. In UK – England & Wales, in order to be valid, an advance directive must have been made at a time when the individual had mental capacity; in order for the advance directive to be applicable, the wording has to be specific and relevant to the medical circumstances which have arisen; the advance directive must have been made when the individual was over 18 and fully informed about the consequences of refusing treatment, including the fact that refusal might hasten death; it must not have been made under undue influence; and if it relates to refusal of life-saving treatment, it must be written, signed and witnessed.

General issues in relation to Principles 14 – 17

104. Armenia responded that advance directives are normally included within CPAs. Austria responded that experience in practice of advance directives "is good". Belgium, Croatia and Turkey all responded that it was too soon to assess experience. Czech Republic reported no negative experience. Ireland reported that there are inconsistencies in practice, which it is hoped will be remedied when new legislation comes into force. Ireland also reported cross-border concerns about non-compliance in other jurisdictions. UK – England & Wales reported problems arising from general lack of knowledge amongst both public and medical professions about advance decisions. UK – Scotland reported problems of lack of use of advance directives, but also that professionals are not always aware of their existence. However, new measures have been introduced there to ensure that advance statements are kept with the person's medical records.

105. Three member states responded regarding compliance with UN CRPD. Croatia reported that review and possible reform is contemplated. Germany reported that its provisions are designed to ensure that the will and wishes of the granter are effectively

³⁹ Armenia, Belgium, France, Slovenia, Switzerland and UK – England & Wales.

ascertained and given effect, but that experience is that poor drafting results in doubts about effectiveness, and that professional advice is accordingly recommended. Ireland reported that a detailed code of practice is being developed to ensure compliance with UN CRPD.

106. Experience in France was reported at greater length. A law of 2005 provided that anyone could issue an advance directive to apply to situations where they could no longer express their wishes. Such advance directives were valid for three years. They could be amended at any time. Doctors were obliged to enquire about the existence of such an advance directive and to take them into account if the person was not in a position to express their wishes. However, although referred to as “directives”, they did not have any binding force and there were no specific formalities for recording and keeping them. Furthermore, healthcare professionals largely disregarded the law of 2005 due to the far-reaching changes in medical practice and in relations between doctors and patients which were necessary for its full implementation.

107. In 2012, a Committee chaired by Professor Didier Sicard, former President of the National Consultative Ethics Committee for Health and Life Sciences (“CCNE”), was tasked with evaluating the 2005 law as part of a reflection on end-of-life care. The Committee’s report, which was published in December 2012, recommended more effective enforcement of existing laws, reinforcement of the role of advance directives, and development of education relating to palliative care and the administration of terminal sedation under supervision. In addition, the CCNE also considered, in its opinion of 28 June 2013, that everyone should be afforded access to the right to palliative care and that the implementation of advance directives must become binding on healthcare staff.

108. Subsequently, under a parliamentary initiative, Law No 2016-87 of 2 February 2016 was adopted, which created new rights for patients and persons at the end of life and which clarified the situation regarding advance directives, such as those provided for in Article L.1111.11 of the Public Health Code, which can now be drafted by any adult, are used to express the person’s wishes about their end of life in terms of the conditions for continuing, restricting, discontinuing or refusing treatment or medical interventions, can be reviewed and revoked at any time and by any means and, in particular, are binding on the doctor.

PROACTIVE PROMOTION

[France]

154. The French National Authority for Health (“HAS”) has produced guides to assist the public, and professionals from the healthcare, medico-social and social sectors, in drafting advance directives based on an optional template established by decree, and proposed by order of the Minister of Health. This information will be made available *inter alia* on the HAS website. With the aim of promoting this advance directive template, and of allowing everyone to assert these new rights, an information campaign, targeting healthcare professionals and the general public, was due to be launched at the end of 2016 under the auspices of the National Centre for Palliative and End-of-Life Care. Law No 2015-1776 (of 28 December 2015) on the adjustment of society to ageing has made provision for communication initiatives, such as producing films, which will be utilised by the School of Public Health.

APPLICATION OF ADVANCE DIRECTIVES TO OTHER MATTERS

190. The full questionnaire enquired whether advance directives may apply to matters other than those already disclosed in Responses. Only four relevant replies were received. Austria and UK – Scotland replied negatively. Croatia reported that advance directives may be applied for representation in procedures for pronouncing people legally incompetent. Also, under the Family Act a parent who exercises parental care may use an advance directive to appoint a person to look after his or her children in the event of his or her death, and in some other situations. In Lithuania, the granter of an advance directive may specify the place where

the granter would like to live; a person who would be responsible for dealing with financial and other matters; not only the choice of possible guardian or curator but persons who should not be appointed; and other instructions or directives. In other words, where (as in Lithuania) advance directives and not CPAs are available, the full potential for advance directives seems to have been better explored and provided for⁴⁰. This is among the points considered further in the next chapter.

SUGGESTIONS: COUNCIL OF EUROPE (AND MEMBER STATES)

Suggestion 1

217. Having regard to the great diversity in the extent to which registered information is publicly available (see paragraphs 80 and 81), Council of Europe may wish to consider developing guidance as to what limitations, if any, should be placed upon the availability of registered information, with a view to developing greater consistency.

Suggestion 13

230. In respect that Principle 17 recommends that advance directives shall be revocable at any time and without any formalities, but this is only explicitly stated by law in France (as per paragraph 66), all member states should adopt the provisions of Principle 17.

Suggestion 16

233. As regards the form in which advance directives may be granted, member states should have regard to the methods of granting provided for in Ireland, as described in paragraph 102.

Suggestion 17

234. With reference to the discussion in paragraph 103, member states should consider introducing arrangements for registration of all advance directives.

Suggestion 18

235. Member states should consider statutory time limits upon the period of applicability of advance directives, such as in France as described in paragraph 106.

Suggestion 19

236. Member states should consider instituting regimes to permit maximum self-determination, integrating the use of advance directives, in relation to end-of-life situations, having regard to the recent French provisions described in paragraph 108.

Suggestion 20

237. With reference to paragraphs 130 – 138 all member states should, at the next opportunity, introduce into their legislation express provision that voluntary measures have priority over all other measures (where that does not already appear in their legislation); but that the roles of supporters, persons of trust, advocates and so forth should be incorporated into provisions for voluntary measures, and that where relevant these roles should be exercisable to support granters in their dealings with attorneys.

⁴⁰ On the other hand, to the extent that advance directives can, in Lithuania, be used to determine appointments under what would otherwise be categorised as involuntary arrangements, they could be said to cross the line of rather arbitrary judgement which, in paragraph 32, was taken as setting the provision in Romania there described as lying at the limit of categorisation as a CPA.

Suggestion 21

238. Member states should develop mediation services to address situations of dispute and conflict in relation not only to voluntary measures but also to other measures.

APPENDIX B

RELEVANT PROVISIONS OF THE 2003 ACT

275 Advance statements: making and withdrawal

(1) An “advance statement” is a statement complying with subsection (2) below and specifying—

- (a) the ways the person making it wishes to be treated for mental disorder;
- (b) the ways the person wishes not to be so treated,

in the event of the person’s becoming mentally disordered and the person’s ability to make decisions about the matters referred to in paragraphs (a) and (b) above being, because of that, significantly impaired.

(2) An advance statement complies with this subsection if—

- (a) at the time of making it, the person has the capacity of properly intending the wishes specified in it;
- (b) it is in writing;
- (c) it is subscribed by the person making it;
- (d) that person’s subscription of it is witnessed by a person (the “witness”) who is within the class of persons prescribed by regulations for the purposes of this paragraph and who signs the statement as a witness to that subscription; and
- (e) the witness certifies in writing on the document which comprises the statement that, in the witness’s opinion, the person making the statement has the capacity referred to in paragraph (a) above.

(3) An advance statement may be withdrawn by the person who made it by a withdrawal complying with this subsection; and a withdrawal so complies if—

- (a) at the time of making it the person has the capacity properly to intend to withdraw the statement; and
- (b) it is made by means of a document which, were it an advance statement, would comply with paragraphs (b) to (e) of subsection (2) above.

276 Advance statements: effect

(1) If the Tribunal is satisfied as to the matters set out in subsection (2) below, it shall, in making any decision in respect of a patient who is a person who has made and not withdrawn an advance statement, have regard to the wishes specified in the statement.

(2) Those matters are—

- (a) that, because of mental disorder, the ability of the person who made the advance statement to make decisions about the matters referred to in paragraphs (a) and (b) of subsection (1) of section 275 of this Act is significantly impaired;
- (b) that the statement complies with subsection (2) of that section;
- (c) that any measures or treatment which might or will be authorised by virtue of the decision referred to in subsection (1) above or might or will, by virtue of that decision, no longer be authorised correspond to any wishes specified in the statement; and
- (d) that, since the person made the statement, there has been no change of circumstances which, were the person to have been considering making the statement at the time the Tribunal is making the decision referred to in subsection (1) above, would have been likely to cause the person not to make the statement or to make a substantially different one.

(3) A person giving medical treatment authorised by virtue of this Act or the 1995 Act to a patient who is a person—

- (a) who has made and not withdrawn an advance statement; and
- (b) whose ability to make decisions about the matters referred to in paragraphs (a) and (b) of subsection (1) of section 275 of this Act is, because of mental disorder, significantly impaired,

shall have regard to the wishes specified in the advance statement.

(4) Before making a decision under section 236(2)(c), 239(1)(c) or 241(1)(c) of this Act in relation to a patient who is a person who has made and not withdrawn an advance statement, a designated medical practitioner shall have regard to the wishes specified in the statement.

(5) For the purposes of subsections (1) and (2) above and (in the case where medical treatment is to or might be given to a patient otherwise than by virtue of any such decision as is referred to in subsection (1) above or is to be given to the patient by virtue of such a decision which was made in ignorance of the existence or the withdrawal of an advance statement) of subsections (3) and (4) above—

- (a) an advance statement shall be taken to comply with subsection (2) of section 275 of this Act; and
- (b) a withdrawal of an advance statement shall be taken to comply with subsection (3) of that section,

unless the contrary appears.

(6) For the purposes of subsections (3) and (4) above in the case where the medical treatment is authorised by virtue of a decision such as is referred to in subsection (1) above—

- (a) an advance statement shall be taken to comply with subsection (2) of section 275 of this Act; and
- (b) a withdrawal of an advance statement shall be taken to comply with subsection (3) of that section,

if the Tribunal was satisfied when making the decision that the statement or, as the case may be, the withdrawal so complies.

(7) If, in respect of a patient who is a person who has made and not withdrawn an advance statement—

- (a) the Tribunal makes such a decision as is referred to in subsection (1) above authorising measures which conflict with the wishes specified in the statement;
- (b) a person having functions under this Act gives medical treatment authorised by virtue of this Act or the 1995 Act to the person and that treatment conflicts with those wishes;
- (c) a designated medical practitioner makes such a decision as is referred to in subsection (4) above and it conflicts with those wishes; or
- (d) such measures, treatment or decision which could have been so authorised, given or, as the case may be, made are not so authorised or is not so given or made, with the consequence that there is a conflict with those wishes,

then the Tribunal, person having those functions or, as the case may be, designated medical practitioner shall comply with the requirements set out in subsection (8) below.

(8) Those requirements are—

- (a) recording in writing the circumstances in which those measures were or treatment or decision was authorised, given or made or, as the case may be, not authorised, given or made, and the reasons why;
- (b) supplying—
 - (i) the person who made the statement;
 - (ii) that person's named person;
 - (iii) that person's welfare attorney;
 - (iv) that person's guardian; and
 - (v) the Commission,
 with a copy of that record; and
- (c) placing a copy of that record with that person's medical records.

276A Advance statements to be put with medical records

- (1) Subsection (2) below applies where a Health Board receives a copy of an advance statement, or a copy of a document withdrawing an advance statement, from—
 - (a) the person who made the statement, or
 - (b) any individual acting with the person's authority in relation to the statement.
- (2) The Health Board must—
 - (a) place a copy of the statement or document with the person's medical records, and
 - (b) inform the Commission—
 - (i) that a copy of the statement or document is held with the person's medical records, and
 - (ii) of the premises at which the medical records are kept (and the personal and administrative details essential for identifying the records as the person's).

276B Advance statements to be registered by the Commission

- (1) Where the Commission receives information by virtue of section 276A(2) of this Act, the Commission must enter the information in a register of advance statements maintained by it (and mark the date on which the entry is made).
- (2) The Commission must allow an entry in the register to be inspected at a reasonable time—
 - (a) by the person whose medical records are referred to in the entry,
 - (b) with respect to treatment of the person for mental disorder, by any individual acting on the person's behalf,
 - (c) for the purpose of making decisions or taking steps with respect to the treatment of the person for a mental disorder, by—
 - (i) a mental health officer dealing with the person's case,
 - (ii) the person's responsible medical officer,
 - (iii) the Health Board responsible for the person's treatment.

276C Publicising support for making advance statements

- (1) A Health Board is to publicise any support that it offers for—
 - (a) making or withdrawing an advance statement,

(b) sending a copy of an advance statement, or a copy of a document withdrawing an advance statement, to a Health Board.

(2) A Health Board must give the Commission such information as the Commission may from time to time seek on what the Health Board is doing in order to comply with subsection (1) above.

APPENDIX C

UNIMPLEMENTED SECTIONS OF THE SLC DRAFT BILL

Advance statements

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.

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(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

(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.

Withholding and withdrawal of medical treatment from incapable adults

41. – (1) Subject to subsections (2) and (3) below, it shall be lawful for a medical practitioner to withhold or withdraw, or to authorise the withholding or withdrawal of, medical treatment from an adult who is incapable of making or is incapable of communicating a decision about the medical treatment if in his reasonable opinion the medical treatment or its continuation would not be of benefit to the adult, notwithstanding that such withholding or withdrawal would result in the death of the adult.

(2) Before withholding or withdrawing, or authorising the withholding or withdrawal of, medical treatment from the adult the medical practitioner shall carry out such consultation as accords with good medical practice.

(3) The Court of Session, on an application by any person claiming an interest in the personal welfare of the adult, may, if it is satisfied –

(a) that the adult is in Scotland at the date of the application;

(b) that the adult is incapable of making or is incapable of communicating a decision about his medical treatment; and

(c) that in all the circumstances of the case it is appropriate to do so, grant an order declaring that the withholding or withdrawal, or that the continued withholding or withdrawal, of the medical treatment would be lawful or, as the case may be, would not be lawful.

(4) In considering whether or not the medical treatment or its continuation would be of benefit to the incapable adult, it shall not be assumed that the prolongation of the life of an adult, regardless of his circumstances, is necessarily of benefit to him.

(5) For the purposes of the application of section 1(2) to (4) of this Act to this section, the intervention referred to in that section is the giving or continuation of the medical treatment.

(6) An application under subsection (3) above shall be intimated to the Lord Advocate for the public interest.

(7) In this section “medical treatment” has the same meaning as in section 37 of this Act.

APPENDIX D

SELECTED EXCERPTS FROM "ADULT INCAPACITY"

Advance directives

7-5

Advance directives are also known as "living Wills", "advance directions" and "advance statements", the last being adopted by the Scottish Law Commission⁴¹ to cover both documents recording wishes and feelings ("advisory statements") and documents which seek to be binding. Only the latter is a decision-making technique, hence "advance directives" here, meaning a document which seeks in advance to give or refuse consent to future medical or other healthcare treatment.⁴² Of course, all decisions to give or refuse such consent have future application. Unless explicitly time-limited, or unless the circumstances change materially, if the patient makes such a decision today it will hold good tomorrow. The question in law is when such a decision will cease to have effect. A patient cannot demand to be given treatment considered by doctors to be clinically or ethically inappropriate, but the question becomes critical where the patient has refused treatment which doctors consider to be clinically and ethically appropriate and which, but for the refusal, they would be justified in giving.⁴³ The dilemma for doctors is also critical: to give such treatment in the face of a competent and valid refusal of consent would potentially be wrongful and an assault; but if the purported refusal of consent is no longer valid or not applicable to the circumstances which have arisen, failure to give necessary treatment could be deemed negligent and professionally wrongful. As to the position in law, the available authorities are English, but there does not appear to be any basis for anticipating that the Scottish courts would take a different view, particularly on the basic proposition enunciated, albeit *obiter*, in the House of Lords by Lord Goff of Chieveley in *Airedale NHS Trust v Bland*⁴⁴: "It has been held that a patient of sound mind may, if properly informed, require that life support be discontinued. The same principle applies where the patient's refusal to give consent has been expressed at an earlier date before he became unconscious or otherwise incapable of communicating it." If the advance directive is not competently given, then it cannot have binding effect, even though for purposes of the Incapacity Act it may still be evidence of wishes and feelings. If the advance directive is competently given, it will not cease to have effect merely by effluxion of any particular period of time, but the English authorities identify two circumstances in which it will be ineffective. "If the factual situation falls outwith the scope of the [advance] refusal or if the assumption upon which it is based is falsified, the refusal ceases to be effective", *Re T (Adult: Refusal of Treatment)*.⁴⁵ In that case, an advance directive was held ineffective because it was made without proper appreciation of the consequences (that the refusal of a blood transfusion could result in death- though there were also suggestions of undue influence by a parent). The same principles

⁴¹ SLC Report, paras 5.41-5.59 and clause 40 of draft Bill. For other terms, and more importantly a helpful practical discussion of the subject, see A.R. Barr *et al.*, *Drafting Wills in Scotland* (Butterworths, 1994) paras 3.63-3.67. The most comprehensive modern treatment of the subject of which the present author is aware is that by Chris Docker in *Tolley's Finance and Law for the Older Client*, Society of Trust and Estate Practitioners (looseleaf, as updated to April 2002). Also recommended is a paper *Advance Directives- What is the Current Position?* and annexures given by Ann Sommerville of British Medical Association at a joint conference with the Law Society of Scotland and the British Medical Association on *Competency & Consent in Vulnerable Persons* on March 27, 2000 (course papers available from the Law Society of Scotland).

⁴² A. Sommerville *op.cit.* defined advance directives as "a subset of more generalised advance statements".

⁴³ e.g. by the principle of necessity- see paras 14-30 *et seq. infra*. The relationship between advance directives and the statutory authority to treat is discussed in paras 7-9 and 7-10 *infra*.

⁴⁴ [1993] A.C. 789.

⁴⁵ [1992] 4 All E.R. 649.

produced the opposite result in *Re C (Adult: Refusal of Treatment)*,⁴⁶ where a man with a gangrenous leg obtained an injunction against its amputation: the court was satisfied that he sufficiently understood the nature, purpose and effect of the proposed treatment and the probable consequences of refusal. The Scottish Law Commission summarised the position as follows: "The current law in England and Wales that an advance refusal is binding is qualified by the further rules that the factual situation facing the doctors must be within the scope of the refusal, the assumptions upon which it is based must not be falsified, and the patient must have been capable at the time of making the refusal. This may well also be the law in Scotland although it is not possible to state this with certainty in the absence of any authoritative statements by the courts".⁴⁷ Legislative provision for Scotland was suggested by the Commission,⁴⁸ but not included in the Incapacity Act, on the basis that: "Attempts to legislate in this area will not adequately cover all situations which might arise, and could produce unintended and undesirable results in individual cases".⁴⁹ It is thus left to the courts to decide and develop the law in the light of the circumstances of such cases as may be brought before them, and the arguments then presented, though it is possible that powers under the Incapacity Act applicable to non-Act measures (as described in para.5-41 above) might be invoked in relation to issues concerning or arising from an advance directive. Earlier, the House of Lords Select Committee on Medical Ethics commended the use of advance statements but took the view that legislation was unnecessary, in particular on the point that it was already the law that a doctor acting in accordance with an advance directive would not be guilty of negligence or of any criminal offence.⁵⁰

BMA policy

7-6

In accordance with a recommendation of the Select Committee, the British Medical Association published in 1995 a code of practice on "Advance Statements about Medical Treatment", and in May 1995 a short paper "BMA Views on Advance Statements" which concluded with the following summary⁵¹:

"(1) The BMA strongly supports the principle of an advance statement. Through advance statements, patients have a legal right to decline specific treatment, including life-prolonging treatment. (2) Patients cannot use advance statements to insist on the provision of certain treatments but they may authorise or refuse treatments. (3) Drafting an advance statement is the patient's responsibility. It is recommended that this be done with medical advice and counselling as part of a continuing doctor-patient dialogue. (4) It is the responsibility of the patient to ensure that the existence of an advance statement is known to those who may be asked to comply with its provisions. (5) No person has a legal right to accept or decline treatment on behalf of another adult.⁵² Nevertheless, in addition to advance statements, the BMA recognises that the nomination of a health care proxy by the patient may be another helpful development in communicating the patient's views when the individual is no longer capable of expressing these. (6) It is strongly recommended that patients review their advance statements at regular intervals and destroy rather than amend the advance statement if they feel dubious about any previously expressed

⁴⁶ [1994] 1 W.L.R. 290.

⁴⁷ SLC Report, para.5.46.

⁴⁸ SLC Report, draft Bill, clause 40.

⁴⁹ Scottish Executive Policy Statement, *Making the Right Moves: Rights and Protection for Adults with Incapacity*, August 1999, para.6.14.

⁵⁰ Report 1994, approved in government response Cmd. 2552.

⁵¹ The author is grateful to British Medical Association for permission to reproduce the text quoted here.

⁵² This is (and was when published) incorrect in Scotland. See Ch.14.

choices. (7) The BMA urges its members to consider their own views and inform patients at the outset of any absolute objection the doctor has to the principle of an advance statement. Doctors with a conscientious objection to curtailing treatment are not obliged to comply with an advance statement but must be ready to step aside. They should ensure that at the time of drafting, the patient is aware of the situation and can make an informed choice. (8) The Association encourages doctors to raise the subject of an advance statement in a sensitive manner with patients who are anxious about the possible administration of unwanted treatments at a later stage. (9) Late discovery of an advance statement after life-prolonging treatment has been initiated is not sufficient grounds for ignoring it. (10) There is a significant ethical and legal difference between the concept of an advance statement and the issue of euthanasia. In supporting advance statements, the BMA confirms its commitment to the fundamental and legitimate right of patients to accept or reject treatment options. This is in contrast with euthanasia, where the primary purpose is to actively cause or hasten death. Euthanasia is illegal and the Association's conclusions should not be seen as supporting it."

Taking instructions

7-7

As with powers of attorney, great care must be exercised when taking instructions to prepare an advance directive. That is particularly necessary where the grantor has indicated an intention to refuse treatments of certain kinds or in certain circumstances, even at risk of shortening life. The following suggestions are not intended to be prescriptive or comprehensive, but may be found helpful. Firstly, if the solicitor has conscientious or ethical objections to what is proposed, the client should be courteously advised of these at the outset, and advised to seek assistance elsewhere. Some solicitors will already have clear views as to their own stance; those who do not should, before commencing to take instructions, reflect as to whether they will be able properly and with clear conscience to give the professional standard of service to which the grantor will be entitled, if the solicitor proceeds. Secondly, with reference to the discussion in para.7-5 above, it should be explained that there is a degree of uncertainty about the precise status and enforceability of advance directives in Scots law. Thirdly, it should be stressed that there is no doubt about the illegality of euthanasia, and an explanation should be given of the clear distinction between (on the one hand) a patient's legitimate right to accept or reject treatment options and (on the other) the illegality of anything which has the primary purpose of actively causing or hastening death. Fourthly, the grantor should be taken through the points in the summary of BMA views quoted in para.7-6 above. Fifthly, at this point, and also at any subsequent point where it may appear appropriate to do so, the grantor should be offered the alternative of recording non-binding wishes and feelings. It should be explained that anyone exercising any intervention in terms of the Incapacity Act, including the medical authority to treat under s.47, will be under an absolute obligation to ascertain and take account of the grantor's wishes and feelings if the grantor then lacks capacity to make relevant decisions. Such wishes and feelings could be included in a welfare power of attorney (see the *Style* in Appendix 5, Schedule Part 5) or separately recorded. Sixthly, if after these preliminaries the grantor proceeds to instruct an advance directive, the task of the solicitor- as always- is to ascertain and accurately implement the wishes and instructions of the grantor, provided that they are lawful, but to ensure that relevant issues have been identified and properly considered by the grantor. Any styles create a particular danger that the draftsman's words intrude or constrain. Presented with care, a style can sometimes helpfully prompt a grantor to identify what he does not want, or to propose his own words. Styles such as those referred to in para.7-8 below raise issues which many grantors may require to address, not necessarily with the same outcome.

Styles

7-8

Styles of advance directive, one simple and the other more detailed, are offered by Docker.⁵³ A style similar to the more detailed one, though now somewhat outdated, is reproduced in *Drafting Wills in Scotland*.⁵⁴ The *Style* power of attorney in Appendix 5 contains in Schedule Part 5 a statement of wishes and feelings⁵⁵ (an advisory statement, not an advance directive) containing material drawn from Docker's simpler style, with his permission, and may in turn be of some assistance in drafting an advance directive. Styles should only be presented to a grantor in the context of the recommendations in para.7-7 above, and the terms and consequences of each clause should be discussed fully, with a view to amendment or to adopting the alternative of a statement of wishes and feelings.

Linking to power of attorney

7-9

An advance directive can be linked to a power of attorney. This overcomes concerns that it might be competent for the authority to treat under s.47 of the Incapacity Act to be operated so as to nullify an advance directive. That would be contrary to the primacy of a person's "basic human right" to make his or her own decisions, described in para. 14-3 below, and the fundamental principle that the whole régime of responsive measures applies only if and to the extent that the person has not put in place his or her own competent and relevant anticipatory measures. Moreover, those operating s.47 are required to apply the general principles, including taking into account the adult's past and present wishes and feelings. Nevertheless, although s.47 is "without prejudice to any authority conferred by any other enactment or rule of law",⁵⁶ it is silent on the effect of advance directives.⁵⁷ However, the Act does stipulate that the authority to treat under s.47 does not apply where a welfare attorney has relevant powers, the doctor is aware of this, and it would be reasonable and practicable for the doctor to obtain the attorney's consent.⁵⁸ Linkage between an advance directive and a power of attorney could be achieved by the following adaptations to the *Style* power of attorney in Appendix 5.

Firstly, add to Part 2 of the Schedule: *[2.10] To do anything and everything authorised by the Advance Directive referred to in paragraph 3.3(c) of Part 3 of this Schedule and any other documents such as are therein referred to and to do anything and everything reasonably necessary or appropriate in order to ensure compliance therewith and the purpose and intention thereof (as my Attorney, acting reasonably and in accordance with his or her knowledge of me and my wishes and circumstances, may in his or her discretion consider such intention and purpose to be) notwithstanding that my life may be shortened by compliance, or ensuring compliance, with any valid and applicable refusals of treatment by me.*

⁵³ *op.cit.*: see n.15 to para.7-5 *supra*, referring to *Tolley's Finance and Law for the Older Client*. The foreword to this work indicates that it is intended to address the UK position, but in the main it covers only English law. The exception is section G "Living Wills" in which Docker covers both Scotland and England, very fully. As with all styles, his should not be drawn upon without reference to his text.

⁵⁴ Ban *et al.*: see n.15 to para.7-5 *supra*.

⁵⁵ See para.7-13 *infra*.

⁵⁶ s.47(2).

⁵⁷ The equivalent provision in the SLC draft Bill was declared to be subject to the proposed clause on advance directives.

⁵⁸ s.50(1) and (2). In such cases the position is governed by the remainder of s.50.

Secondly, add to the items specified in Schedule Part 3, clause 3.3: *[(c)] an Advance Directive executed by me of even date herewith and any further Advance Directives or documents of similar nature (including documents amending, revoking or replacing the same) by me.*

If an adult whose capacity had become impaired was found to have executed both a Power of Attorney with relevant powers and an advance directive without reference to each other, the effect of each upon the other would be a matter of construction in the particular circumstances. It would obviously be good practice to avoid such a situation.

Use of interdict

7-10

The most effective way of ensuring compliance with a refusal of treatment, including a refusal contained in an advance directive, would be to obtain an interdict prohibiting the treatment. That would appear to be one of the reasons for the specific references to interdicts in ss.47(10), 49(3) and 50(8) of the Incapacity Act, and in regulation 5(3) of the Specified Treatments Regulations.⁵⁹

Mental health legislation

7-11

Subject to certain exceptions, treatment may be given without consent to a patient liable to be detained under MHSA 1984 if the treatment is given for the patient's mental disorder and if the treatment is given by or under the direction of the responsible medical officer.⁶⁰ Because such treatment may be given without consent, an advance directive refusing any particular category of treatment is in such circumstances ineffective. In some countries an advance directive has been held effective to prevent specified treatments under compulsory provisions.⁶¹ Conversely, there may be provision to permit patients to bind themselves in advance to agreed treatments.⁶² In Scotland, the Scottish Executive has accepted the recommendation of the Millan Report that advance statements should be encouraged, that those providing treatment should be required to take a valid advance statement into account, but that advance statements should not be legally binding in relation to treatment authorised by the proposed new MHSA.⁶³

Guardianship and intervention orders

7-12

The Incapacity Act is not explicit on the inter-relationship between an existing advance directive and a subsequent guardianship or intervention order conferring relevant powers. Clearly, provided that the advance directive was known about when the order was made, the sheriff would be obliged to take account of it when making the order, as an expression of the adult's wishes and

⁵⁹ See paras 14-45 to 14-53 *infra*.

⁶⁰ MHSA 1984, s.103. See s.96(1) for the categories of patient excepted and ss.97 and 98 for the categories of treatment excepted.

⁶¹ A "psychiatric will" was upheld by a decision of the Administrative Tribunal of the Canton of Geneva on March 7, 1995 in *K v Département de l'Action Sociale et de la Santé A(702) 1992-ASAN*.

⁶² As in the provision of the Dutch Mental Health Act of 1994 that a patient may consent to compulsory detention for one period of six months.

⁶³ Scottish Executive Policy Statement, *Renewing Mental Health Law* (2001) paras 33 *et seq.* On the proposed new MHSA, see para.3-31 *supra*.

feelings in terms of the third principle.⁶⁴ Even if it only came to light subsequently, the appointee under the order would likewise be obliged to take account of it. But may the sheriff override it in his order, or may the appointee make a decision contrary to its terms (in each case having duly taken account of its terms)? As explained in paras 11-31 and 14-9 below, it would appear that except in relation to "transactions" an adult competent to do so may make effective decisions notwithstanding a guardian's powers. It would be reasonable to argue that the same applies to a competent past decision which remains applicable to the circumstances; and more fundamentally that the whole régime of responsive measures applies only if and to the extent that the adult has not put in place his or her own competent and relevant anticipatory measures.

Statement of wishes and feelings

7-13

A statement of wishes and feelings does not have binding, directive effect upon anyone to whom it is addressed. Nevertheless, as discussed in paras 4-16 to 4-19 above, account must be taken of the past and present wishes and feelings of an adult whose relevant capacity is impaired in relation to any intervention under the Incapacity Act.⁶⁵ The obligation to ascertain and take account of the adult's wishes and feelings is not qualified by the words "in so far as it is reasonable and practicable to do so". The obligation is to that extent absolute. And to that extent, accordingly, for an adult to consider and record wishes and feelings is a useful persuasive anticipatory technique. The use of that technique in relation to medical matters is referred to in para.7-7 above. It is however a technique of general application, relevant to any matter upon which decisions might require to be made for the adult in the event of impairment of capacity. Wishes and feelings may be recorded in a power of attorney (as is provided for in the *Style* in Appendix 5, Schedule Part 5) or in a separate document. It is important that the existence and whereabouts of a written record of wishes and feelings be intimated as may be appropriate, particularly if contained in a separate document.

Patient's decision

14-3

The patient's decision may be overruled only by Part X treatment. All other categories of health-care decision-making are excluded if the patient is competent to make a valid decision upon the matter in question, is conscious, and is able to communicate (by any means, and with any necessary assistance). The patient's right to make his own decision has been described as "a basic human right protected by the common law".⁶⁶ The effect of a patient's decision contained in an advance directive is discussed in Chapter 7, paras 7-5 to 7-12: broadly, an advance directive which is valid, still effective and applicable (as there discussed) will likewise exclude other categories of health-care decision-making, subject to a possible and as yet unresolved argument that it might be possible for s.47(2) authority to have effect notwithstanding the terms of an advance directive (see para.7-9 above and para.14-47 below). However, as pointed out in para.7-

⁶⁴ s.1(4)(a).

⁶⁵ s.1(4)(a).

⁶⁶ Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871.

5 above, all patient's decisions have future effect. Unless explicitly time-limited, or unless the circumstances change materially, a valid healthcare decision made by the patient today will hold good tomorrow, and will not cease to hold good only because of effluxion of time. An advance directive formalises and records the decision, but does not put it into a different legal category. Whatever the form which a patient's decision has taken, the issues- explored in more detail in para.7-5- are whether the decision was competently made, whether the factual situation which has arisen is within the scope of the decision, and whether the assumptions upon which the decision was based remain valid or have been falsified.⁶⁷ While advance directives are often self-improving documents and whilst health-care practitioners frequently, and sensibly, obtain written consent to invasive procedures, there is no requirement in law for a health-care decision to be in writing, and consent may be given verbally, or even impliedly by the patient allowing treatment to be administered.⁶⁸

14-47

The Act is not explicit as to the relationship between s.47(2) authority and advance directives. Legislative provision on advance directives was proposed by the Scottish Law Commission, and was included in the draft Bill annexed to the SLC Report, but on the basis explained in para.7-5 above was excluded from the Incapacity Act. The excision has left some uncertainties, of which this is one. It is suggested in para.7-9 above that it would be reasonable to argue that a valid and applicable advance directive would prevail over s.47(2) authority. On the one hand, in the absence of clarification to the contrary, practitioners would be unwise to do under s.47(2) authority something forbidden by an advance directive. On the other hand, patients seeking to ensure the effectiveness of an advance directive might wish to link it to a power of attorney as suggested in para.7-9 above. More important in practice is that patients discuss matters with medical advisers before framing advance directives, and that they and any relevant appointees should thereafter ensure that practitioners are aware of the advance directive and the patient's reasons for the content, including relevant wishes and feelings. Treatment not desired by the patient is most effectively blocked by an interdict,⁶⁹ which might be sought following upon the granting of an advance directive by the patient or by an appointee with relevant powers.

Negotiorum gestio

12-18

Negotiorum gestio is the principle under which someone, termed the gestor, spontaneously undertakes the management of a person's affairs without the person's knowledge, because the person either is absent or lacks capacity, in circumstances where it is a reasonable presumption that the person would have given authority if aware of the circumstances and able to do so.⁷⁰ In the case of incapacity, the principle applies both to single acts of management or short-term management, and also to long-term management. Reported cases contain examples of management for periods ranging from two years to over five years.⁷¹ Acts by gestors in the years prior to the availability of intervention orders included acts now likely to be authorised by intervention orders, an example being a gestor who, with the consent of a landlord, executed a tenancy agreement expressly as gestor without incurring personal liability. Under former law the

⁶⁷ See the authorities referred to in para.7-5 *supra*.

⁶⁸ *Thomson v Devon* (1899) 15 Sh. Ct Rep 209.

⁶⁹ ss.47(10), also 49(3) and 50(8), and reg.5(3) of the Specified Treatments Regulations.

⁷⁰ See Bell, *Principles*, para.540; also Scottish Law Commission Discussion Paper No.94, paras 4.21-4.23.

⁷¹ *Maule v Graham*, 1757 Mor. 3529, *Fernie v Robertson* (1871) 9 M. 437, and *Dunbar v Wilson and Dunlop's Trs* (1887) 15 R. 210.

gestor was superseded by the appointment of a curator bonis⁷² or tutor, and consequently would now probably be held to be superseded by appointment of a guardian with relevant powers. *Negotiorum gestio* may co-exist with other measures. While *negotiorum gestio* is not directly addressed in the Incapacity Act, it- like all other techniques- is subject to the investigatory and other provisions of the Act described in para.5-41 above, and the range of provision introduced by the Act has reduced the range of circumstances in which it would be reasonable to rely on *negotiorum gestio* and in which it would be reasonable to request third parties to transact with a gestor.

12-19

The gestor must show the same degree of care as a prudent person acting in relation to his own affairs, and provided that he does so he incurs no personal liability for any loss to the person's estate resulting from his actings.⁷³ The person's estate is liable for obligations and liabilities incurred by the gestor for the person's benefit. Third parties may seek payment from the person's funds, or the gestor may pay them and himself be reimbursed from the person's funds. The gestor may also be reimbursed for reasonable expenses, but is not entitled to remuneration.

12-20

The disadvantages of *negotiorum gestio* include the lack of any procedure to determine whether it is appropriate, the extent to which it is appropriate, and the suitability of the gestor; the lack of any controls or supervision to prevent detriment or misuse; and the lack of any evidence of authority the gestor cannot insist that third parties recognise his authority or implement his instructions and directions.

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⁷² *Dunbar v Wilson and Dunlop's Trs*, *supra*.

⁷³ *Smith's Reps v Earl of Winton*, 1714 Mor. 9275; *Bannatine's Trs v Cunningham* (1872) 10 M. 319; *Kolbin and Sons v The United Shipping Company Ltd*, 1931 S.C. (HL) 128.