

Annex C

Advance Directives and Medical Decision-Making in Intensive Care Situations

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Introduction

In 2009, Professor Sheila McLean noted that ‘in Scotland, there is no statute that gives legal effect to advance directives,¹ but there is a general view that they should be followed’.² This ‘general view’ is buttressed by ‘an oblique reference in the Adults with Incapacity (Scotland) Act 2000³ and an assumption in professional guidance that doctors would and should take account of previously expressed wishes’.⁴ Although the British Medical Association (BMA) enjoins medical practitioners to ‘comply with an unambiguous and informed advance refusal when the refusal specifically addresses the situation that has arisen’⁵ and maintains that ‘there is no reason to assume that the courts in Scotland would take a different approach to the English courts’,⁶ it remains the case that ‘the legal standing of [so-called] living wills in Scotland has [to date] never been tested’.⁷ The letter of the applicable legislation in Scotland is quite different to that which operates in England and Wales⁸ and the (substantive and adjectival) common law position differs markedly between the jurisdictions as well.⁹ While it may be the case that so-called advance directives, or ‘living wills’, would be treated as binding *de jure* by the courts in Scotland,¹⁰ ‘it is [still] not possible to state this with certainty in the absence of any authoritative [judicial] statements’.¹¹ In light of this, to assert that conformity can be taken as read seems wrongheaded. Instead, there appears to be, at present, a notable lack of clarity in Scots law.

That there is a lack of clarity is unsurprising. In spite of the legislative intervention that occurred early in the first decade of the Twenty-First century, Dr. Meyers’s observation that medico-legal matters in this jurisdiction are in fact categorised by ‘an absence of judicial or legislative decisions decreeing appropriate conduct’, suggested in a 1991 book chapter, remains true today.¹² In 2021, as in 1991, ‘private decision-making remains the norm in

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¹ The position in respect of ‘advance statements’, in the context of the Mental Health (Care and Treatment) (Scotland) Act 2003, is different, as noted *infra*.

² Sheila McLean, *Are advance directives legally binding or simply the starting point for discussion on patients’ best interests?* [2009] BMJ 1230, at 1232

³ Specifically, s.1 (4) (a): ‘in determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of – (a) 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 Sarah Christie, *Effective End-of-Life Care Planning in Scotland: Culture and Law*, [2017] JMLE 1, at 7

⁵ BMA Ethics, *Medical treatment for adults with incapacity*, [2009] British Medical Association 9.2.1

⁶ *Ibid.*

⁷ *Living Wills: Scope for Reform?* [2018] SPCLR 63, at 63

⁸ That is, the Mental Capacity Act 2005: See the discussion in G. T. Laurie, S. H. E. Harmon and E. S. Dove, *Mason and McCall Smith’s Law and Medical Ethics*, (11th Edn.) (Oxford University Press, 2019), at 4.26

⁹ Due to the Civilian heritage of Scots law, the jurisdiction recognises a number of concepts which are unknown in, or indeed have been excised from, the Anglo-American Common law world and the fundamental structure and framework of the law differs also: See the discussion in Jonathan Brown and Sarah Christie, *Pater Knows Best: Withdrawal of Medical Treatment from Infants in Scotland*, [2020] OJLS 682, *passim*.

¹⁰ As noted *infra*, paragraph 2.30 of the Adults with Incapacity: Code of Practice for Medical Practitioners maintains that ‘advance directives’ are ‘potentially binding’, though other than indicating that the refusal of treatment is envisaged in such circumstances, offers little guidance as to when this potentiality might be realised.

¹¹ Report on Incapable Adults (Scot Law Com no. 151) (1995) paras 5.46

¹² David W. Meyers, *Letting Doctor and Patient Decide: The Wisdom of Scots Law*, (in David L. Carey Miller and David W. Meyers, *Comparative and Historical Essays in Scots Law: A Tribute to Professor Sir Thomas Smith QC*, at 103

Scotland on virtually all matters related to medical treatment'.¹³ This 'largely hands-off attitude' was said by Meyers to 'be backed by a strong social consensus', which recognises that 'few want the intrusion of outsiders into these decisions'.¹⁴ Nonetheless, Meyers recognises that even if there is some wisdom in avoiding an overly-prescriptive approach, 'the legal system must provide readily available recourse to ensure that the welfare and best interests of the disadvantaged, the handicapped and those who cannot speak for themselves are fully protected'.¹⁵ While the Adults with Incapacity (Scotland) Act 2000 was 'was hailed as world-leading 20 years ago',¹⁶ in part for ostensibly providing a means for achieving such recourse,¹⁷ it is not so well-regarded now and there have been notable changes in medical and general jurisprudence, as well as societal attitudes, since the turn of the new Millennium.¹⁸

While the present lack of clarity might be understandable, it is unacceptable. 'It is no good asking the doctor to make extensive enquiries as to what advance planning documents, and advance decisions, exist. It is no good asking the doctor to go off and make a google search about what the relevant law is, only to find phrases such as that the law is "thought to be", or telling him that in some decisions where a doctor in England has statutory protection, a doctor in Scotland could be committing a crime'.¹⁹ Thus, to facilitate the realisation of the first stated aim of this cross-committee working group, the following literature review has been prepared to provide a clear and comprehensive picture of Scots law in this area at present, with reference to the perceived deficiencies in that law and legislative framework. It is hoped that the review will, in and of itself, provide some much-needed clarity by collating relevant sources and commentary in one place, but ultimately it should be apparent that some (perhaps considerable) degree of legislative reform is ultimately necessary.

Beginning with a consideration of some notable societal developments which have occurred in this jurisdictions since the 1990s, the review then moves to discuss the stated aims, and effect, of the present legislative regime (particularly the 2000 Act and Mental Health (Care and Treatment) (Scotland) Act 2003) and examine literature concerning the relation and interrelation of 'advance directives' and 'advance statements', within this framework and with the Scots common law position. Recognising that the statutory framework and background common law position correlates with the law of other European jurisdictions such as Germany (and, prospectively, France and Spain, although the present author lacks the linguistic capability to engage in a review of these legal systems), the review considers the extent of this correlation and asks whether lessons might be learned from these jurisdictions. Noting that the statutory framework differs greatly from the position in England and Wales, and that the Scots position, in some respects, turns on the recognition of concepts which are unknown (or at the very least unarticulated in)²⁰ Anglo-American jurisprudence, the review cautions

¹³ David W. Meyers, *Letting Doctor and Patient Decide: The Wisdom of Scots Law*, (in David L. Carey Miller and David W. Meyers, *Comparative and Historical Essays in Scots Law: A Tribute to Professor Sir Thomas Smith QC*, at 103

¹⁴ David W. Meyers, *Letting Doctor and Patient Decide: The Wisdom of Scots Law*, (in David L. Carey Miller and David W. Meyers, *Comparative and Historical Essays in Scots Law: A Tribute to Professor Sir Thomas Smith QC*, at 103

¹⁵ David W. Meyers, *Letting Doctor and Patient Decide: The Wisdom of Scots Law*, (in David L. Carey Miller and David W. Meyers, *Comparative and Historical Essays in Scots Law: A Tribute to Professor Sir Thomas Smith QC*, at 103

¹⁶ Adrian D. Ward, RFPG Webinar – Tuesday 25th May 2021: 17.30-18.30

¹⁷ It should be noted that the Act itself 'is not exclusive, either in relation to general incapacity law or in relation to medical matters. [Rather] it allows for intervention in a wide range of property, financial or welfare matters where the adult lacks capacity': Adults with Incapacity: Code of Practice for Medical Practitioners (20/10/2010), para.1.5

¹⁸ There has been, as the authors of Mason and McCall Smith's *Law and Medical Ethics* noted in the latest edition of that work, 'some case law which appears to demonstrate the need for reform', notably *G v West Lothian Council* 2014 GWD 40-730: See G. T. Laurie, S. H. E. Harmon and E. S. Dove, *Mason and McCall Smith's Law and Medical Ethics*, (11th Edn.) (Oxford University Press, 2019), at 4.26

¹⁹ Adrian D. Ward, *Every Life Matters: Advance Care and Treatment Decisions and Planning, End of Life, Covid-19*, The Centre for Mental Health and Capacity Law (Edinburgh Napier University) Autumn 2020 series: Advance Care Planning: Law, Rights, Practicalities: 11th November 2020, 3.30pm-5.30pm, p.2

²⁰ See Duncan Sheenan, *Negotiorum Gestio: A Civilian Concept in the Common Law?* [2008] ICLQ 253, *passim*.

against regarding sources from England and Wales as ‘persuasive’ in this context (particularly due to the continued reliance on the now maligned ‘best interests’ test in that jurisdiction) and concludes by asserting that it is imperative that any Scottish framework be spelled out in clear, readily accessible terms, to minimise the possibility of confusion and ‘borrowing’ from inappropriate (yet ostensibly linguistically accessible) materials.

Autonomy and Medical Decision-Making in Scotland

The most notable change in Scots medical jurisprudence since the 1990s has been the recognition of the primacy of patient autonomy and the importance of ‘informed’ consent to proposed medical intervention. While in 1990 the paternalistic notion that a doctor ought to primarily act according to their assessment of the ‘best interests’ of the patient (subject to the competent patient’s general right to refuse treatment)²¹ was juridically favoured,²² and indeed as late as 2014 it could be said with some degree of confidence that ‘the doctrine of informed consent has not made its way into Scots law’,²³ the 2015 case of *Montgomery v Lanarkshire Health Board*²⁴ marked a sea-change in the judicial approach to ‘consent’ and individual patient autonomy in this jurisdiction.²⁵ While it has been suggested that the decision itself did little more than allow judicial precedent to catch up with the reality of accepted medico-legal principles and guidance,²⁶ the case ultimately clarified that patients must be seen first and foremost as ‘persons holding rights [and] exercising choices’, and not merely the ‘passive recipients of the care of the medical profession’.²⁷

‘Autonomy’ can thus be categorised as a core (if taxonomically controverted) ‘personality right’²⁸ in Scots law and has ‘often been viewed as sitting at the apex of four principles in Beauchamp and Childress’s concept of principlism’ within bioethics²⁹ (although those authors themselves stressed in their work that no one principle should be held to have primacy over the others).³⁰ ‘The notion of personal autonomy is an important principle underlying the interpretation of [the] guarantees’ made by Article 8 of the European Convention on Human Rights (ECHR)³¹ and the Council of Europe has developed numerous recommendations to further facilitate the development of a common European standard in respect of the protection of individual adult autonomy.³² The weight that the law now places

²¹ Notably, while the Mental Capacity Act 2005 ‘is committed to the patient’s “best interests” as the benchmark justifying non-consensual medical treatment, the Scottish Ministers shied away from the paternalistic overtones of that test’ in constructing the 2000 Act: G. T. Laurie, S. H. E. Harmon and E. S. Dove, *Mason and McCall Smith’s Law and Medical Ethics*, (11th Edn.) (Oxford University Press, 2019), at 4.26

²² *Moyes v Lothian Health Board* 1990 SLT 444, at 449 (per Lord Caplan)

²³ Brian Pillans *Delict: Law and Policy*, (5th Edn.) (W. Green, 2014), para 6-05

²⁴ [2015] UKSC 11

²⁵ Jonathan Brown, *Obligations, consent and contracts in Scots law: re-analysing the basis of medical malpractice liability in light of Montgomery v Lanarkshire Health Board*, [2020] *Legal Studies* 156, at 158

²⁶ Elspeth C. Reid *Montgomery v Lanarkshire Health Board and the rights of the reasonable patient*, [2015] *Edinburgh Law Review* 360

²⁷ [2015] UKSC 11, para.75

²⁸ Though the Scots law of ‘personality rights’ is as yet said to be a ‘thing of shreds and patches’ (Elspeth C. Reid, *Personality, Confidentiality and Privacy in Scots Law*, (W. Green, 2010), para.1.02), Lord Stewart’s observation that autonomy ‘seems to be a personality [as opposed to proprietary] right’ (*Holdich v Lothian Health Board* [2013] CSOH 197, para 102) must, on any definition of ‘personality rights’, be correct. For such a definition, see Niall R. Whitty and Reinhard Zimmermann, *Rights of Personality in Scots Law: A Comparative Perspective*, (Dundee University Press, 2009), para.1.21

²⁹ Jonathan Brown and Sarah Christie, *Pater Knows Best: Withdrawal of Medical Treatment from Infants in Scotland*, [2020] *OJLS* 682, at 691.

³⁰ Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, (8th edn, OUP 2019), at 99.

³¹ *Pretty v UK* App no 2346/02 [2002] 35 EHRR 1, para 61

³² *Shtukaturov v Russia* (Application No 4409/05) 27th March 2008

on consideration of autonomy and self-determination is such that one leading textbook describes the level of regard as ‘near sacrosanct’, at least where the adult is ‘capacitous’.³³

That the ‘autonomy’ of a capable patient has come to be regarded as the overarching concern in biomedical ethics is unsurprising, given the close links between the concept and that of ‘consent’.³⁴ ‘At both national and international level, consent is emphasised as the event (or process) which legitimises medical intervention’.³⁵ The basic idea expressed in the famed *ratio* of Chief Justice Cardozo, from the 1914 case of *Schloendorff v. Society of New York Hospital*,³⁶ appears consistent with the overarching ethos of modern medical ethics and jurisprudence: ‘Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages’.³⁷ Of course, Cardozo’s general rule, which ostensibly foreshadowed the post-World War II international instruments that emphasise a general ‘moral commitment’ to autonomy and self-determination,³⁸ was itself immediately qualified by the recognition that a physician may legitimately intervene, without consent, where the patient is incapable. Thus, the proposition that medical intervention in the absence of consent amounts to an ‘assault’ was said by Cardozo to be ‘true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained’.³⁹ ‘Thus, from an ethical and common law perspective...⁴⁰ it has been long recognised that patients themselves, not their doctors, should decide about medical treatment... Patients know their own values, which will ultimately determine the treatment they are prepared to undergo’.⁴¹

‘Consent’ is not, in spite of appearances however, conterminous with ‘autonomy’, since ‘consent’ is merely a ‘means to an end’,⁴² that ‘end being respect for the person and respect for their autonomy’.⁴³ The separation of ‘respect for the person’ from ‘respect for their autonomy’, here, is interesting as it is indicative of a potential divide between the ostensibly sovereign concept of ‘autonomy’ and that of a related, yet potentially antecedent, notion: That of ‘human dignity’.⁴⁴ Unlike autonomy, which has been said to be ‘contingent both on one’s

³³ G. T. Laurie, S. H. E. Harmon and E. S. Dove, *Mason and McCall Smith’s Law and Medical Ethics*, (11th Edn.) (Oxford University Press, 2019), at 4.28

³⁴ The concept of ‘consent’ is said to be ‘founded upon the right to autonomy and the principle of respect for autonomy’: Alasdair MacLean, *Now You See It, Now You Don’t: Consent And The Legal Protection Of Autonomy*, [2000] J Appl. Philos. 277, at 277.

³⁵ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.57

³⁶ 105 N.E. 92 (N.Y. 1914)

³⁷ 105 N.E. 92 (N.Y. 1914)

³⁸ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.57

³⁹ 105 N.E. 92 (N.Y. 1914)

⁴⁰ The extent to which this is true of Scotland, which is not a Common law jurisdiction, is debateable, however it is nonetheless apparent that in the 21st century ‘in Common law and Civilian jurisdictions alike, competent adults are recognised as holding the right to be the sole arbiter of treatment decisions’: Jonathan Brown and Sarah Christie, *Pater Knows Best: Withdrawal of Medical Treatment from Infants in Scotland*, [2020] OJLS 682, at 691.

⁴¹ Loane Skene, *Advance Directives and Surrogate Decision-Making: When Are Patient’s Prior Wishes Not Determinative?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 96

⁴² Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁴³ Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁴⁴ Some eminent medico-legal scholars, such as Professors Laurie and Mason, have opined that the phrase ‘human dignity’ is one which is ‘best avoided’, due in no small part to the multiple variations in meaning with which it is possessed. Nonetheless, in a jurisdiction such as Scotland – which has historically, as well as contemporaneously, recognised the value of ‘dignity’ as a legal concept (see Elaine Webster, *The Underpinning Concept of ‘Human Dignity’* (June 2020, Academic Advisory Panel to the National Taskforce for Human Rights Leadership Briefing Paper), para.4.1) – the terminology can be utilised with some precision as

ability to recognise and to exercise it',⁴⁵ 'human dignity' – though criticised by some for being a 'nebulous concept', 'easier to recognise than to define'⁴⁶ – is recognised as 'an inherent quality, possessed of all persons and which exists irrespective of their ability to express it'.⁴⁷ 'Respecting persons', in all cases, thus axiomatically means respecting the dignity of the person,⁴⁸ but 'respecting persons' does not in all cases mean respecting the decisions autonomously made by that person.⁴⁹ The law itself proscribes some forms of conduct, even where 'consent' has been given, or decisions autonomously made;⁵⁰ decisions made in the medico-legal sphere may well be influenced by considerations of the other three core principles – beneficence, non-maleficence and justice – identified by Beauchamp and Childress,⁵¹ among other things.

Although the primacy of 'autonomy' as the sole 'fundamental' right or interest at play in modern medico-legal ethics may be doubted, there is no doubt that respect for autonomy is itself an integral part of the broader concept of respect for human dignity. Indeed, such is presupposed by the recognition of 'autonomy' as a 'personality right', which was the categorisation of the concept preferred by the Court of Session in *Holdich v Lothian Health Board*.⁵² 'Autonomy' itself – properly separated from the concept of 'consent' which has tended to dominate medico-legal discourse,⁵³ and the prime concept of 'human dignity' under which 'autonomy' as a meaningful 'personality interest' might be located⁵⁴ – has been described as 'a status whereby the human being is recognised as having the fundamental right, qua human, of control over his or her own body and the direction of his or her own life in both physical and intellectual senses'.⁵⁵ It has been said that 'the importance [now] attributed to autonomy means that the historical dominance of medical paternalism has given way to recognition that patients both can and should play a more active role in their healthcare',⁵⁶ with the patient rather than the physician holding the esteemed role of prime decision-maker.⁵⁷ While a 'capable' patient – that is, a patient (whether having attained the age of legal capacity or not)⁵⁸

denoting a quintessentially legal concept which operates as the highest-level (or governing) 'personality interest' under which all others can be taxonomically located.

⁴⁵ Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁴⁶ Charles Foster, Dignity and the Ownership and Use of Body Parts, [2014] Cambridge Quarterly of Healthcare Ethics Vol.23, Issue 4, 417, at 421

⁴⁷ Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁴⁸ In this context, 'dignity' might be read in a wide sense analogous to its use in South African law; essentially operating as 'an umbrella concept which embraces [other] personality rights' such as the right to autonomy, privacy, identity and esteem: Niall R. Whitty and Reinhard Zimmermann, *Rights of Personality in Scots Law: A Comparative Perspective*, (Dundee University Press, 2009), para.3.2.8

⁴⁹ See Jonathan Brown, *O Tempora! O Mores! The Place of Boni Mores in Dignity Discourse*, [2020] Cambridge Quarterly of Healthcare Ethics 144, at 146

⁵⁰ See the discussion in Jonathan Brown, *When the Exception is the Rule: Rationalising the "Medical Exception" in Scots Law*, [2020] Fundamina: A Journal of Legal History 1, *passim*.

⁵¹ Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, (8th edn, OUP 2019), at 99.

⁵² *Holdich v Lothian Health Board* [2013] CSOH 197, para 102

⁵³ See the discussion in Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁵⁴ See Jonathan Brown, *O Tempora! O Mores! The Place of Boni Mores in Dignity Discourse*, [2020] Cambridge Quarterly of Healthcare Ethics 144, at 146

⁵⁵ Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 75

⁵⁶ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.56

⁵⁷ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.56

⁵⁸ See s.2 (4) of the Age of Legal Capacity (Scotland) Act 1991

who is recognised as possessing the presence of mind to competently make decisions⁵⁹ – is held by Scots law to be in this position,⁶⁰ and non-consensual interference with a person's body may well amount to both a crime and a civil wrong,⁶¹ the position in respect of incapacitated persons is somewhat different. If a person is incapacitated, for whatever reason, then they may be treated non-consensually,⁶² provided of course that the intervention conforms to the norms of law, public policy and human rights.⁶³

Having regard to an individual's personhood or 'personality', however, 'necessarily entails having a respect for that person's personality interests, whether the person is *capax* or *incapax* at the relevant time'.⁶⁴ While, unless 'other measures have been taken',⁶⁵ incapable patients cannot exercise their immediate autonomy due to their inability to communicate or convey their wishes at the relevant time, so-called 'advance directives' clearly can constitute such an 'other measure';⁶⁶ indeed they are said to be 'integral' to 'advance treatment planning'.⁶⁷ While it is recognised, however, that 'the major consequence of being respected as autonomous is that it implies the capacity or liberty to make decisions, free from external control and in the expectation that they will be accepted as valid and binding on others',⁶⁸ in Scots law at present – as noted in the introduction to this review – no legislation presently enjoins that the directions set out in 'advance directives' should be treated as binding,⁶⁹ in spite of the recognised importance of 'autonomy' as a concept.

This state of affairs is not, in and of itself, problematic. The fact that patient 'autonomy' has come to be perceived as the most important value in medico-legal ethics does not in and of itself mean that it is in fact the most important consideration in this field.⁷⁰ If autonomy is properly categorised as a facet of human dignity, rather than a (or rather the) fundamental governing principle in its own right, then it is apparent that it can (and at times should) be sidelined where other important concerns are at play. These other concerns may be bioethical principles, such as those identified by Beauchamp and Childress, or they may be more prosaic concerns such as those of 'public policy' (in its legal guise). In any case, it is apparent that

⁵⁹ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.17

⁶⁰ The GMC guidance which emphasises that a physician 'must respect the patient's decision to refuse an investigational treatment, even if the doctor thinks that that decision is wrong or irrational... [and] must not put pressure on the patient to accept his advice' has been judicially approved of in the post-Montgomery legal landscape: See, e.g., *Johnstone v NHS Grampian* [2019] CSOH 90

⁶¹ *Gemmell v KSL Hair Ltd.* 2021 SAC (Civ) 6

⁶² Graeme T. Laurie and J. Kenyon Mason, *Trust or Contract: How Far Does the Contemporary Doctor-Patient Relationship Protect and Promote Autonomy?* in Pamela R. Ferguson and Graeme T. Laurie, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean*, (Routledge, 2015), at 77

⁶³ Jonathan Brown, *When the Exception is the Rule: Rationalising the "Medical Exception" in Scots Law*, [2020] *Fundamina: A Journal of Legal History* 1; in this context, it is to be thought that the overarching 'high-order preference' (or 'will') of the patient is to be respected, even if lower-order 'preferences' must be interfered with to realise the ultimate end: See Adrian D. Ward and Polona Curk, *Respecting "Will": Viscount Stair and Online Shopping*, [2018] *SLT (News)* 123, at 124

⁶⁴ Jonathan Brown, *Obligations, consent and contracts in Scots law: re-analysing the basis of medical malpractice liability in light of Montgomery v Lanarkshire Health Board*, [2020] *Legal Studies* 156, at 162-163. As Ward noted in a 1998 seminar, 'what the law is – or should be – trying to do is give to people with mental disabilities the same rights, status or protections as other citizens': Adrian D. Ward, *Adult Incapacity*, (W. Green, 2003), chapter 4pr.

⁶⁵ Sarah Christie and Maggie Anderson, *Making Treatment Decisions for the Future: Advance Directives and the Question of Legislative Clarity?* [2013] *JMLE* 85, at 85

⁶⁶ Sarah Christie and Maggie Anderson, *Making Treatment Decisions for the Future: Advance Directives and the Question of Legislative Clarity?* [2013] *JMLE* 85

⁶⁷ Jill Stavert, *Added Value: Using Human Rights to Support Psychiatric Advance Statements*, [2013] *Edin. L. R.* 210, at 210

⁶⁸ Sheila A. M. McLean, *Autonomy, Consent, and the Law*, (Routledge, 2009), p.40

⁶⁹ Paragraph 2.30 of the Adults with Incapacity: Code of Practice for Medical Practitioners suggests that 'An advance statement which specifically refuses particular treatments or categories of treatment is called an 'advance directive'... [and is] potentially binding', but neither the conditions required to make such a document binding, nor the difference between a 'binding' and 'non-binding' advance directive, are spelled out in the guidance. The Code itself is 'not compulsory', but 'may be referred to by the courts'.

⁷⁰ That is not to say that the concept of 'autonomy' is unimportant; merely that the concept must be viewed holistically as inter-related with other fundamental concepts in bioethics.

rather than seeking to protect and preserve the exercise of 'autonomy' as a singular desiderata, the law should instead seek to safeguard the parent concept of 'human dignity', which is an intrinsic part of 'personhood', recognising of course that affording sufficient respect for 'autonomy' is a necessary prerequisite of respecting the dignity of the human person.

This, of course, gives rise to the question of whether or not the present statutory regime in respect of incapacitated adult persons does indeed afford sufficient respect for their dignity and, by association at a 'doctrinal working level',⁷¹ their individual autonomy. 'Advance directives' may not be recognised as binding legal instruments in this jurisdiction, but that is not to say that the law is incapable of appropriately acting to safeguard the integrity of autonomous decisions made by one who is subsequently incapacitated. The extent to which physicians are currently bound, by law, to consider, if not necessarily act on, prior instructions given by the patient thus merits consideration and thus the next section of the present review will consider the interrelation between the common law of Scotland and the post-2000 statutory framework as these concern the matter of medical decision-making in respect of incapacitated adults.

'Advance Directives' and 'Advance Statements'

'Advance statements (also called variously 'advance directives', 'living wills' or 'anticipatory decisions') are a means by which treatment decisions are communicated before there is a medical need for any decision and in anticipation of that need'.⁷² Since 2003, however, the term 'advance statement' has been given a peculiar meaning by s.275 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and now denotes a subscribed and witnessed written statement, made by one with requisite capacity, specifying the ways that the person making the statement wishes to be treated (or not treated) for a 'mental disorder'.⁷³ 'Advance statements', unlike 'advance directives', are effective due to enabling legislation (in terms of the 2003 Act itself), with the Mental Health Tribunal for Scotland bound to 'have regard to the wishes specified in the statement' provided that certain conditions specified by s.276 (2) of the Act are met.⁷⁴ In terms of the legislation, a 'designated medical professional' is also obliged to have such regard to the specified wishes where certain decisions as to treatment require certification.⁷⁵ The statement itself is not 'binding', in that neither the Tribunal nor the patient's physicians are absolutely required to give effect to the directions contained therein, but the requirement to give consideration to the statement in formulating a view of the appropriate course of action to be taken when a decision must be made ostensibly goes beyond what is required in respect of so-called 'advance directives' under the purview of the 2000 Act.

Within the terms of the 2000 Act itself, no direct mention is made of 'advance directives', 'living wills' or 'anticipatory decisions', hence these terms have come to be thought interchangeable by learned authors and practitioners. This is unfortunate, as a recent study of 'advance directives' across jurisdictions in Western Europe found that there are in fact, broadly speaking, two 'models' of advance directives utilised in European jurisdictions at present: the 'living will' model, which is presently invoked in Scotland by the language of 'advance

⁷¹ For the use of this terminology in connection with personality rights in Scots law, see Niall R. Whitty, *Overview of Rights of Personality in Scots Law* in Niall R. Whitty and Reinhard Zimmermann, *Rights of Personality in Scots Law: A Comparative Perspective*, (Dundee University Press, 2009), para.3.2.8

⁷² SME, *Medical Law (Reissue)* (Butterworth, 2006), para.379.

⁷³ Mental Health (Care and Treatment) (Scotland) Act 2003, s.275 (1) – (2)

⁷⁴ *Ibid.*, s.276 (1)

⁷⁵ *Ibid.*, s.276 (4)

directives',⁷⁶ and the nomination of a proxy decision-maker.⁷⁷ The two models, the authors of that study suggest, ought to be complementary, with 'living wills' understood as 'the document in which the writer expresses his or her preferences regarding specific medical treatments that he or she wants to consent to or to reject in the case of personal future incapacity'⁷⁸ and the terminology of 'surrogate wills' used to denote 'the document that nominates a legal proxy who has the power to make healthcare decisions on the patient's behalf once he or she is declared incapable'.⁷⁹ In Scotland at present, the appointment of a welfare guardian or welfare power of attorney⁸⁰ is not generally conceptualised as falling within the province of 'advance directives', although it should be noted that in the course of appointing a welfare guardian the courts have taken the view that a 'sheriff should arrive at a decision [between two appointable individuals] taking into account factors such as the adult's known views which he had been able to express in the past'.⁸¹ This correlates with the method used to determine the execution of an incapable adults previously expressed wishes within the context of 'advance directive' decision-making.⁸² Thus, as will be explored below, the appointment of proxy decision-makers must be viewed as an integral part of this area of law.⁸³

In Scotland, then, 'advance directive', in preference to 'living wills', 'advance statements' or 'anticipatory decisions', has come to be the favoured generic descriptive term,⁸⁴ though it encompasses only what Veshi and Neitzke term the 'living will' model since it 'is used to denote the specific drawing up of a document to identify, in advance, which types of treatment the individual wishes to refuse and in what circumstances, and is designed to operate only when the individual is in those circumstances, and has lost capacity to communicate a refusal of treatment for themselves'.⁸⁵ Instead of prescribing any set form for the creation of a document which might guide medical decision-makers in the event of an adult's 'incapacity' (defined by s.1 (6) of the Act),⁸⁶ the legislation instead simply provides (*inter alia*) that 'account shall be taken of... the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication'.⁸⁷ It has been noted (by Christie) that 'taking account of something is not the same – particularly from the point of view

⁷⁶ Recall, e.g., (n.7), although note that Scotland was one of the jurisdictions noted by the authors to possess no 'distinct legal concepts corresponding to "advance directives" and "living wills"': Denard Veshi and Gerald Neitzke, *Advance Directives in Some Western European Countries: A Legal and Ethical Comparison between Spain, France, England, and Germany*, [2015] *European Journal of Health Law* 321, at 324

⁷⁷ Denard Veshi and Gerald Neitzke, *Advance Directives in Some Western European Countries: A Legal and Ethical Comparison between Spain, France, England, and Germany*, [2015] *European Journal of Health Law* 321, at 324. In spite of the headline title of the piece, the study in fact concerns more jurisdictions than are there stated, including Scotland, Ireland, Austria, Portugal and Switzerland (*inter alia*).

⁷⁸ Denard Veshi and Gerald Neitzke, *Advance Directives in Some Western European Countries: A Legal and Ethical Comparison between Spain, France, England, and Germany*, [2015] *European Journal of Health Law* 321, at 325

⁷⁹ Denard Veshi and Gerald Neitzke, *Advance Directives in Some Western European Countries: A Legal and Ethical Comparison between Spain, France, England, and Germany*, [2015] *European Journal of Health Law* 321, at 325

⁸⁰ An office holder who (is limited in their ability to make decisions as to medical treatment on behalf of their principal): See, particularly, s.16 (6) (a) and (b) of the Adults with Incapacity (Scotland) Act 2000

⁸¹ *North Ayrshire Council v JM* 2004 S.C.L.R. 956; Adrian D. Ward, *Abolition of Guardianship? "Best Interests" versus "Best Interpretation"*, [2015] *SLT (News)* 150, at 151

⁸² In all instances, as Ward demonstrates, 'clearly the adult's own input [in any decision-making process] should be maximised': Adrian Ward, *Adult Incapacity*, (W. Green, 2003), para.15.8

⁸³ See, generally, Shih-Ning Then, Hilary Patrick and Nicola Smith, *Reinforcing Guardianship Regimes through Assisted Decision Making - a Scottish Perspective*, [2014] *Jur. Rev.* 263, *passim*.

⁸⁴ Sarah Christie, *Effective End-of-Life Care Planning in Scotland: Culture and Law*, [2017] *JMLE* 1, at 1, although use of the alternative terms is not unknown as the breadth of literature cited in this review makes self-evidently clear.

⁸⁵ Sarah Christie, *Effective End-of-Life Care Planning in Scotland: Culture and Law*, [2017] *JMLE* 1, at 1

⁸⁶ "Incapable" means incapable of— (a) acting; or (b) making decisions; or (c) communicating decisions; or (d) understanding decisions; or (e) retaining the memory of decisions, as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise); and "incapacity" shall be construed accordingly.

⁸⁷ Adults with Incapacity (Scotland) Act 2000 s.1 (4) (a)

of the individual – as requiring that a valid directive is followed⁸⁸ (so too should it be added that an obligation to ‘take account of’, as operates in respect of ‘advance statements’, does not equate to an obligation to follow or enact), however as Meyers notes the position espoused in the Act ‘suggests a movement toward [a] *negotiorum gestio* model⁸⁹ which is consistent with the framework of Scots common law.⁹⁰

Negotiorum Gestio

The institutional concept of *negotiorum gestio* was received from Roman law and it has been said by various authors that the concept was borrowed from that system ‘practically without change’.⁹¹ Though left to languish in the ‘decent obscurity of a learned language’,⁹² since ‘the Latin term ‘*negotiorum gestio*’ rather than ‘unauthorised administration’ [or any such alternative] is invariably used even in modern statutes’,⁹³ *negotiorum gestio* is a foundational element of Scots private law.⁹⁴ At its simplest, the Latin term translates as ‘management of affairs’ and the concept itself can be defined as ‘the voluntary management by one person (the *negotiorum gestor*) of the affairs of another (the *dominus negotii*) without the consent or even the knowledge of the other’.⁹⁵ As *negotiorum gestio* is species of obligation, it allows a *negotiorum gestor* who incurs expenses in the course of a useful intervention in the affairs of another a claim for the recovery of their expenses. Additionally, the institution ensures that any *negotiorum gestor* (provided that they are in fact such and not merely an officious intermeddler) cannot be held liable for their unauthorised interference with the affairs of the *dominus negotii*, unless the *dominus negotii* can demonstrate that the *negotiorum gestor* is responsible for causing loss through their culpable conduct.⁹⁶

To be a true *negotiorum gestor* and not merely an officious intermeddler who may, *prima facie*, be delictually liable for (*inter alia*) wrongful interference with another’s property, the *gestor* must demonstrate that they acted in the reasonable belief that the *dominus negotii* would have consented to the intervention had they been present or capable at the time of said intervention.⁹⁷ If there is evidence to suggest that the *dominus negotii* would not have consented to the intervention (for whatever reason), then the ostensible *negotiorum gestor* is in fact no such thing; they are instead a wrongdoer who may be liable to repair any loss, or to remedy any affront, caused to the *dominus negotii* by dint of their unauthorised intervention.⁹⁸ While the law of *negotiorum gestio* arms the true *negotiorum gestor* with a sword, in the form

⁸⁸ Sarah Christie, *Effective End-of-Life Care Planning in Scotland: Culture and Law*, [2017] JMLE 1, at 7

⁸⁹ David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), pp.207-208

⁹⁰ Jonathan Brown, *Obligations, consent and contracts in Scots law: re-analysing the basis of medical malpractice liability in light of Montgomery v Lanarkshire Health Board*, [2020] Legal Studies 156, at 163

⁹¹ SME, *Obligations*, (Vol.15) para.88, fn.2

⁹² Recall Gibbon, who in the *Memoirs of [his] Life* famously stressed that the most ‘licentious’ passages of his renowned *History of the Decline and Fall of the Roman Empire* were accessible only to the educated and could not serve to titillate the common rabble: Henry Morely (Ed.), *Memoirs of Edward Gibbon*, (Routledge, 1891), at 194.

⁹³ SME, *Obligations*, (Vol.15) para.87.

⁹⁴ See s.126 (4) (c) of the Scotland Act 1998

⁹⁵ SME, *Obligations*, (Vol.15) para.87

⁹⁶ SME, *Obligations*, (Vol.15) para.90

⁹⁷ *A S Kolbin & Sons v William Kinnear & Co* 1930 SC 724 at 752 (*per* Lord Ormidale).

⁹⁸ There is, it should be noted, a distinction between loss-based delictual wrongdoing (historically linked to the *lex Aquilia* and reparation for *damnum iniuria datum*) and affront-based wrongdoing (historically linked to the Roman *actio iniuriarum*) which is latent, and generally unarticulated in, the modern Scots law of delict: see David M. Walker, *The Law of Delict in Scotland*, (W. Green, 1981), at 31; see also John Blackie and Jonathan Brown, ‘The Province and Function of the Law of Delict’, in Joe Thomson (Ed.), *Delict*, (W. Green, 2007-2022) (forthcoming).

of the *actio negotiorum gestorum* (which allows the *gestor* to reclaim their expenses outlaid),⁹⁹ it is more significant for present purposes to note that the law also provides the true *gestor* with a shield which protects them from any delictual claim which a disgruntled *dominus* may wish to bring¹⁰⁰ (provided, of course, that the *gestor* did not culpably cause the *dominus* loss). The law may presume that a *dominus* would consent to certain forms of intervention were they absent or capable at the time of the intervention,¹⁰¹ but in any instance in which it can be shown that the ostensible *gestor* knew, or ought to have known, that the circumstances were such that the particular *dominus* in the particular case would not have consented to their intervention, the protection afforded by *negotiorum gestio* will not be engaged.¹⁰²

While '*negotiorum gestio* is not directly addressed in the Incapacity Act', presently it 'may co-exist with other measures'.¹⁰³ Indeed, the Scottish Law Commission noted in their 1995 report that the law on *negotiorum gestio* was an element of Scots common law which might be usefully invoked to enable action to be taken where an adult is incapable of taking decisions or acting for themselves.¹⁰⁴ The Stair Memorial Encyclopaedia's volume on *Obligations*, written (like the Commission's report) in 1995 notes, however, that 'Scots law has not, or not yet, extended the doctrine of *negotiorum gestio* beyond the preservation of the patrimonial interests of the *dominus* so as to cover the preservation of his health, or the rescue of his person in situations where his life or personal safety is endangered'.¹⁰⁵ Indeed, while it was expected that the courts might develop the common law so as to clarify the position in respect of 'advance directives' in the absence of legislative intervention (this was indeed the rationale for omitting ss.40-41 of the Scottish Law Commission's draft Bill, or equivalents thereto, from the legislation which became the 2000 Act), and clarifying (or extending) the law pertaining to *negotiorum gestio* would have necessarily been a part of that, the courts, in this time, have not in fact done so.

Since 1995, however, it has been suggested that 'adopting [a] *negotiorum gestio* analysis... would not materially change the requirements for a successful suit against a negligent physician'.¹⁰⁶ Indeed, following the decision of the UK Supreme Court in *Montgomery v Lanarkshire Health Board*, it has been suggested that 'a *negotiorum gestio* analysis of medical treatment [of incapacitated, but formerly capable, persons] would also allow the Scottish courts to give effect to the spirit, as well as the letter, of the decision' in that case.¹⁰⁷ As Meyers pointed out as early as 2005, the Scottish courts 'may now be more attuned to accept and to rely upon evidence of patient preference, if such evidence exists'.¹⁰⁸ If this view is sustained, as is seemingly enjoined by the present legislation and the associated codes of practice, then 'they [i.e., medical practitioners] will [be] adopting [a *negotiorum gestio*-based] decision-making fabric' with the net effect of ensuring that 'the fundamental inquiry [in

⁹⁹ Stair was of the view that a *gestor* would be entitled not only to expenses, but to recompense for services rendered (Stair, *Institutions*, 1, 8, 3), but in this he was 'corrected' (to use the words of SME Vol.18, *Obligations*, para.115) by Erskine, who took the view – endorsed by later authorities – that recovery for *negotiorum gestio* is limited to expenses: Erskine, *Institute*, 3, 3, 52.

¹⁰⁰ Consider, e.g., Bankton, who notes that officious intermeddling amounts to *culpa*, and so gives rise to a right of reparation on the part of the *dominus* whose interests are interfered with, 'yet, when the management is undertaken to serve an absent friend, whose business calls for it, the agent ought not to suffer by his good office' (Bankton, *Institute*, 1, 9, 24).

¹⁰¹ *A S Kolbin & Sons v William Kinnear & Co* 1930 SC 724 at 752 (*per* Lord Ormisdale).

¹⁰² SME, *Obligations*, (Vol.15) para.100

¹⁰³ Adrian D. Ward, *Adult Incapacity*, (W. Green, 2003), para.12.18

¹⁰⁴ Scottish Law Commission, *Report on Vulnerable Adults* (Scot. Law Com. No. 151), para.1.7

¹⁰⁵ SME, *Obligations*, (Vol.15) para.102

¹⁰⁶ Jonathan Brown, *Obligations, consent and contracts in Scots law: re-analysing the basis of medical malpractice liability in light of Montgomery v Lanarkshire Health Board*, [2020] Legal Studies 156, at 163

¹⁰⁷ Jonathan Brown, *Obligations, consent and contracts in Scots law: re-analysing the basis of medical malpractice liability in light of Montgomery v Lanarkshire Health Board*, [2020] Legal Studies 156, at 176

¹⁰⁸ David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), at 209

medical decision-making] will become, “Do we know or can we find out what the patient would want done under the circumstances at hand?” Not, “What do we think is ‘best’ for the patient?”¹⁰⁹

There has not yet been any case law to vindicate, nor for that matter disparage, Meyer’s view of the utility of *negotiorum gestio* (or, rather the *negotiorum gestio* model of approaching decision-making) in this context, but it is notable that the 2014 Scottish Law Commission report on *Adults with Incapacity* noted that ‘*negotiorum gestio* could supply the basis in legal principle for authorisation of what has occurred’ in cases in which there is no established welfare power of attorney.¹¹⁰ Further to this, it is notable that in Denmark – which has a law of *negotiorum gestio* which has been described as ‘similar’ to that of Scotland – ‘it seems to be regarded as self-evident that acts of benevolent intervention may be directed towards saving the life and preserving the health of another’.¹¹¹ This observation was ‘deduced indirectly’ with reference to ‘the fact that the concept of *negotiorum gestio* is accepted as a general ground of justification in Danish tort law’.¹¹² Were Scots lawyers to better appreciate the utility of *negotiorum gestio* as a defence to what are – at first sight – delictual wrongs, it is thought that this jurisdiction too could readily extend the concept to dignitary, and not merely patrimonial, interests of human persons.

In the near 30 years since the publication of the Scottish Law Commission’s 1995 report, however, it has become apparent that the Scottish courts have had little opportunity to develop the law relating to *negotiorum gestio*, let alone to expressly extend it to cover matters which it has not hitherto been taken to cover. Against this background, then, it might be thought that there is justification for a statutory statement of the principle of *negotiorum gestio* which explicitly extends the concept to cover patrimonial and non-patrimonial issues alike. Such would not be a significant innovation – indeed, as the Danish experience indicates, the Scots conception of *negotiorum gestio* should perhaps be taken to apply to non-patrimonial interests at common law in any case – since the Adults with Incapacity (Scotland) Act 2000, as noted above, already suggests that there is a desire to move towards a *negotiorum gestio* model, even if such has not (outwith academic texts)¹¹³ been articulated as such.

It is, consequently, thought that if the general framework of *negotiorum gestio* (i.e., asking ‘would the *dominus* have consented to this intervention had he been present/capable’) were to be taken as a starting point for explaining or justifying the legitimacy of medical intervention in circumstances in which the patient is wholly incapacitated,¹¹⁴ then the idea of supported decision-making might be better embedded in the practice of medicine as it relates to incapacitated adults.¹¹⁵ Indeed, it is submitted here that the process of ascertaining whether or not the *dominus* would have consented to the *gestor*’s intervention may correlate, or readily be analysed as correlating, with the desiderata of the UN Convention on the Rights of Persons with Disabilities (CRPD) than is any ‘best interests’ model.¹¹⁶ In the view of the CRPD

¹⁰⁹ David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), at 209

¹¹⁰ Scottish Law Commission, *Report on Adults with Incapacity*, (Scot. Law Com. No. 240), para.4.20

¹¹¹ Christian von Bar, *Benevolent Intervention in Another’s Affairs*, (Bruylant, 2009), at 74.

¹¹² Christian von Bar, *Benevolent Intervention in Another’s Affairs*, (Bruylant, 2009), at 74, fn.53.

¹¹³ See David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), at 208-209.

¹¹⁴ As it is in other Civilian, and Civilian-influenced jurisdictions: See Søren Birkeland, *Negotiorum Gestio in Family Medicine, Informed Consent Obtainment and Disciplinary Responsibility*, [2016] *International Journal of Family Medicine* 1.

¹¹⁵ See David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), at 210.

¹¹⁶ General Comment No.1 (on Article 12: Equal recognition before the law (Adopted 11 April 2014))

Committee (which has been described as taking a ‘hardline’ position):¹¹⁷ ‘The “best interests” principle is not a safeguard which complies with article 12 in relation to adults’. Instead, ‘full legal capacity [must be] restored to persons with disabilities on an equal basis with others’, insofar as this is possible, and if ‘after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the “best interpretation of will and preferences” must replace the “best interests” determinations’.¹¹⁸

The law of *negotiorum gestio*, as outlined above, consequently provides – or has the potential to provide – a pre-existing formulation of a historically robust approach to allowing for the realisation of ‘best interpretation of a patient’s will and preferences’ approach. *Per Bell*, an officious intermeddler (that is, here, one who acts despite the fact that the ‘best interpretation of the will and preferences’ of the *dominus* would suggest that the intervention is unwelcome) will be liable in delict for the slightest wrongdoing (i.e., for the interference alone),¹¹⁹ but a *negotiorum gestor* will not be liable for anything other than intentional (or grossly negligent) wrongdoing if the intervention occurs in circumstances of necessity or ‘sudden emergency’.¹²⁰ Where the circumstances are not pressing, then a *gestor* may be liable for slight fault (i.e., negligence)¹²¹ if they do not take reasonable care in the circumstances through the course of their intervention.¹²² Insofar as medical intervention is concerned, then, it can be inferred that a physician who acts in accordance with the best interpretation of the will and preferences of their patient is a *negotiorum gestor*, and so potentially liable only for manifestly wrongful acts or in line with the ordinary rules in connection with negligence, while one who acts without regard to the ‘best interpretation of will and preferences’ is an officious intermeddler and consequently open to lawsuit. In respect of this, allowances are made for circumstances of necessity and emergency, and in determining the existence of a *negotiorum gestio* relationship the courts are bound to consider, as relevant, the full facts of any case.

The utility of *negotiorum gestio* in this sphere, it is submitted, correlates with the intention of the Scottish Parliament in passing the 2000 Act. The ‘best interests’ model of substituted decision-making was expressly rejected by the Scottish Law Commission in its 1995 report and resultantly in composing what was to become the Adults with Incapacity Act, ‘the Scottish Ministers shied away from the paternalistic overtones of that test’.¹²³ As the Commission noted, ‘the concept of best interests was developed in the context of child law where a child’s level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured, or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children, and for that reason would avoid extending child law concepts to them’.¹²⁴ In light of this, ‘the 2000 Act requires respect for the competent decisions of every adult, regardless of disability. That can include capable decisions where they are elements of a wider decision making process. It includes past competent decisions where still relevant and applicable, as well as present competent decisions. Where there are some elements, or there

¹¹⁷ Adrian D. Ward and Polona Curk, *Respecting “Will”: Viscount Stair and Online Shopping*, [2018] SLT (News) 123, at 123.

¹¹⁸ General Comment No.1 (on Article 12: Equal recognition before the law (Adopted 11 April 2014)): it should here be noted that ‘the General Comment proposes neither suggestions nor examples as to how a “best interpretation” might properly be arrived at’: Adrian D. Ward, *Abolition of Guardianship? “Best Interests” versus “Best Interpretation”*, [2015] SLT (News) 150, at 151.

¹¹⁹ Bell, *Principles*, (8th Edn.), s.540.

¹²⁰ Bell, *Principles*, (8th Edn.), s.540.

¹²¹ *I.e., culpa levis*: Bell, *Principles*, (8th Edn.), s.540.

¹²² Bell, *Principles*, (8th Edn.), s.540.

¹²³ G. T. Laurie, S. H. E. Harmon and E. S. Dove, *Mason and McCall Smith’s Law and Medical Ethics*, (11th Edn.) (Oxford University Press, 2019), at 4.26

¹²⁴ Scottish Law Commission Report No.151 on Incapable Adults, September 1995, para.2.50

is some degree, of relevant disability (i.e. relevant factual incapacity), the input of the adult is still maximised. Past and present wishes and feelings must be ascertained and taken into account. Even where these do not exist or cannot be ascertained, a picture of what the adult could reasonably be expected to do and decide in the circumstances, if capable and able to communicate in the matter, must be built up and must form the basis of satisfying the "benefit" principle in s.1(2).¹²⁵

Against the background of the 2000 Act, Ward proposed that a methodology for 'constructing decisions' in accordance with that legislation.¹²⁶ While it has been said that there is a 'quantum leap from a process of constructing a decision, to transferring a somewhat similar methodology to a process of identifying and perhaps constructing what is a person's will, and assessing the quality of that will, in relation to a particular purpose and at a particular time',¹²⁷ at least in part because the determination of an adult's incapacity in any given instance is functionally a 'value judgement',¹²⁸ made against the overarching presumption of capacity which permeates this area of law,¹²⁹ in 2016 the *Bundesverfassungsgericht* found that the CRPD mandated that the legislature devise a like methodology to allow for the 'construction' of a person's 'will' where that individual's 'free will' cannot be identified.¹³⁰ As the present Scottish legislation requires account to be taken of 'the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication' where any intervention is proposed, it might be thought similarly that the development of a process for determining, and where appropriate 'constructing', the 'present and past wishes and feelings of the adult' (aggregated here as 'the will of the adult') is necessary, or at the very least would be beneficial, in this jurisdiction also.

On 'Will'

The terms 'free will' and 'natural will', used by the *Bundesverfassungsgericht* in their 2016 judgment, hold technical meanings in German law¹³¹ and exist as a spectrum rather than as a binary.¹³² 'Free will' denotes 'an exercise and expression of will by a person with competence in relation to the matter in question, and thus being legally valid where it is capable of having legal significance',¹³³ while 'natural will' describes 'any wish or will that is consciously and wilfully expressed or made known to others, notwithstanding that it might lack legal validity because it was not capably formulated and communicated'.¹³⁴ The *Bundesverfassungsgericht* in 2016 recognised that while a person's 'natural will' might at times indicate only a particular transient preference and thus that in certain circumstances the 'original free will' – that is a 'competent formation and expression of will in the past of a person who may no longer retain such competence'¹³⁵ – can and should be decisive, though of course

¹²⁵ Adrian D. Ward, *Abolition of Guardianship? "Best Interests" versus "Best Interpretation"*, [2015] SLT (News) 150, at 152

¹²⁶ Adrian D. Ward, *Adult Incapacity*, (W. Green, 2003), ch.15

¹²⁷ Adrian D. Ward and Polona Curk, *Respecting "Will": Viscount Stair and Online Shopping*, [2018] SLT (News) 123, at 126

¹²⁸ Adrian D. Ward, *Adult Incapacity*, (W. Green, 2003), para.15.5

¹²⁹ Adrian D. Ward, *Adult Incapacity*, (W. Green, 2003), para.1.1

¹³⁰ Bundesverfassungsgericht, Beschluss (des ersten Senats) vom 26. Juli 2016 — 1 BvL 8/15

¹³¹ There is some 'marginal ambiguity' as to the meaning of each of these terms, but for the most part the 'core meanings' are thought to be settled: Adrian D. Ward, *A Major Step Forward in CRPD Compliance by the German Federal Constitutional Court?* (November 18 2016, Lexology)

¹³² Adrian D. Ward and Polona Curk, *Respecting "Will": Viscount Stair and Online Shopping*, [2018] SLT (News) 123, at 126

¹³³ Adrian D. Ward, *A Major Step Forward in CRPD Compliance by the German Federal Constitutional Court?* (November 18 2016, Lexology)

¹³⁴ Adrian D. Ward, *A Major Step Forward in CRPD Compliance by the German Federal Constitutional Court?* (November 18 2016, Lexology)

¹³⁵ Adrian D. Ward, *A Major Step Forward in CRPD Compliance by the German Federal Constitutional Court?* (November 18 2016, Lexology)

even in such circumstances the expressed ‘natural will’ of the person will nonetheless be ‘taken into account as far as possible’.¹³⁶

The notion of ‘taking account of’ the ‘natural will’ of the person in question of course echoes the 2000 Act and suggests at least a degree of correlation between Scots and German law. While German law would appear to go further, *prima facie*, in holding that a prior ‘original’ expression of free will ought to be thought ‘decisive’ (or in other words held ‘binding’) in certain circumstances, the conceptualisation of a unitary idea of ‘will’ which comprises expressions which are to be taken account of, those which are to be ‘respected’ and those which are to be ‘decisive’ capable of being read in accordance with the ‘three acts in the will’ (‘desire’, ‘resolution’ and ‘engagement’) identified by Viscount Stair in his 1681 (2nd edition 1693) *Institutions of the Law of Scotland*. Stair noted in his *opus* that ‘it is not every act of the will that raiseth an obligation, or power of extraction’,¹³⁷ with only ‘engagement’ being ‘the only act of the will which is efficacious’ since it ‘conferreth or stateth a power of exaction in another’.¹³⁸

Stair identified the three ‘acts of the will’ in the course of his discussion of ‘conventional’ (i.e., *ex voluntate*) obligations, since in his schema such obligations were thought to arise (or be constituted) as the result of ‘the will of man’.¹³⁹ Though *negotiorum gestio* was regarded by Stair as an ‘obediential’ (i.e., involuntary) obligation,¹⁴⁰ it is readily apparent from his work that he (and, indeed, his contemporaries)¹⁴¹ regarded the concept as at least in part analogous to the *ex voluntate* (contractual) obligation of ‘mandate’ or ‘commission’.¹⁴² The foundation of the obligation(s) arising from *negotiorum gestio* is said by Stair to be ‘because it is frequent for men to go abroad upon their affairs, supposing quickly to return, and leave no mandate for managing of anything’,¹⁴³ yet naturally may suffer ‘great inconvenience’ should no one interpose in their absence.¹⁴⁴ While Stair is primarily concerned with discussing the obligations which arise once an instance of *negotiorum gestio* has been constituted, he nonetheless makes plain that ‘those who interpose themselves [in a case of *negotiorum gestio*], do necessarily and profitably for the good of the absent, and so are under no delinquency’.¹⁴⁵ In other words, legitimately constituted *negotiorum gestio* allows the *gestor* to act in such a way as would incur delictual liability (and, by extension, criminal culpability)¹⁴⁶ were they not evidently working in the interests of the *dominus*.

To determine the existence of a legitimate instance of *negotiorum gestio*, there must be some process of ‘constructing’ the ‘will’ of the *dominus*. Though it has been said that the obligation arising from *negotiorum gestio* ‘has a solid foundation in justice, and in human nature, without necessity of recurring to the strained supposition of a contract’,¹⁴⁷ this does not detract from the fact that to establish the relationship it is necessary to show that the intervenor had reason to believe, and believed, that the *dominus* would have assented to the intervention

¹³⁶ Allowing coercive medical treatment only in respect of persons under custodianship who are confined in an institution is incompatible with the state’s duty of protection, Press Release No. 59/2016 of 25 August 2016, para.2(c)

¹³⁷ Stair, *Institutes*, I, 10, 1

¹³⁸ Stair, *Institutes*, I, 10, 2

¹³⁹ Stair, *Institutes*, I, 10, 1

¹⁴⁰ See, generally, Stair, *Institutes*, I, 3, 2

¹⁴¹ Stair notes that in the traditional Institutional schema, *negotiorum gestio* is treated as a species of obligation *quasi-ex contractu*: Stair, *Institutes*, I, 8, 3

¹⁴² Stair, *Institutes*, I, 8, 3

¹⁴³ Stair, *Institutes*, I, 8, 3

¹⁴⁴ Stair, *Institutes*, I, 8, 3

¹⁴⁵ Stair, *Institutes*, I, 8, 3

¹⁴⁶ See John Blackie, *The Interaction of Crime and Delict in Scotland*, in Matthew Dyson, *Unravelling Tort and Crime*, (Cambridge University Press, 2014), *passim*.

¹⁴⁷ Henry Home, Lord Kames *Principles of Equity*, (1825, 5th edn) p 118, note (a)

had the *dominus* been present and *capax*. While in the absence of direction from the *dominus* it may be (rebuttably) presumed that the *dominus* would have assented to certain forms of intervention, acting against the known or constructed wishes of the *dominus* would result in liability on the part of the intervenor. In determining whether or not the *incapax* would have, in fact, consented to the intervention had they been able to, it is thought that reference might be made to Stair's three 'acts of the will', with prior actions demonstrating 'desire' and 'resolution' being relevant, though never determinative, of the will of an incapacitated person and previous acts of 'engagement' carrying much more significant weight.

As Ward and Curk discuss in a 2018 Scots Law Times article, People First (Scotland) (an organisation formed in 1989 for, and run by, people with learning disabilities which 'works for the human rights of people who have the labels of Learning Disability or Intellectual Impairment')¹⁴⁸ 'broadly agreed with... the significance of Stair's concept of "engagement"' and 'all were of the view that at the point of "engagement", if they reached it, they would want their will to be decisive, not merely "respected"'.¹⁴⁹ With that said, however, it must be borne in mind that, to use Stair's words, 'engagement is a diminution of freedom, continuing that power in another';¹⁵⁰ in other words, to treat an expression of a decision as 'engagement' is to bind not only those obligated to accept and enact the decision, but the decision-maker themselves. Where 'advance directives' are concerned, the creation of a two-way bond of this kind may be problematic, as since the decision-maker's subsequent conduct may stand at odds with the wishes expressed in the act of 'engagement'.¹⁵¹ If this is so, then those charged with giving effect to the decision-maker's will are placed in a difficult bind; they must either give effect to the previously expressed direction of the decision-maker, notwithstanding the fact that said decision-maker would appear to have since recanted, or they must override that previous direction seemingly in contempt of the competently communicated engagement constructed when the decision-maker possessed legal capacity.¹⁵²

The difficulties associated with regarding previous acts of 'engagement' as 'binding' is illustrated further by an example discussed by Ward and Curk. They note that although, as stated above, the representatives of People First (Scotland) took the view that they would wish for their own acts of engagement to be held decisive, they acknowledged that acting against the express will of a person may be (indeed, may only be) 'justified on the basis of having thorough knowledge of the person, a long standing relationship with the person, and having the person's trust and acceptance, however occasionally, of being in that role, and not ever on the grounds of classification of the person as being incapable'.¹⁵³ This would suggest that a regime which combines the *negotiorum gestio* model with an express framework for supported, or assisted, decision-making would be desirable and would result in an approach which most appropriately implements the desiderata of CRPD. This may, ostensibly, be illustrated further with reference to German law; though there is, as noted above, a correlation between the Scots and German legislative frameworks, 'The UN CRPD Committee is

¹⁴⁸ <https://peoplefirstscotland.org/people-first-scotland/about-us/>

¹⁴⁹ Adrian D. Ward and Polona Curk, *Respecting "Will": Viscount Stair and Online Shopping*, [2018] SLT (News) 123, at 127

¹⁵⁰ Stair, *Institutes*, I, 10, 1

¹⁵¹ See, e.g., the discussion in Sarah Christie, *Advance Decisions, Dementia and Subsequent Inconsistent Behaviour: A Call for Greater Clarity in the Law*, [2019] JMLE 1

¹⁵² Sarah Christie, *Advance Decisions, Dementia and Subsequent Inconsistent Behaviour: A Call for Greater Clarity in the Law*, [2019] JMLE 1, at 24. It should here be noted that the system with which Dr. Christie is concerned in this article is in fact England and Wales, although the more general issues which she discusses are relevant in any jurisdiction.

¹⁵³ Adrian D. Ward and Polona Curk, *Respecting "Will": Viscount Stair and Online Shopping*, [2018] SLT (News) 123, at 127

concerned that the current legal instrument of [German] guardianship is still incompatible with the Convention'.¹⁵⁴

Negotiorum Gestio and 'Rules on Presumed Consent' in Germany

Drawing on the same (Roman) legal tradition as Scotland,¹⁵⁵ Germany has developed 'rules that govern the benevolent intervention of a third person into the affairs of an adult, who is unable to manage them himself'.¹⁵⁶ As Professor Smith pointed out in a 'pioneering' article of 1959,¹⁵⁷ these rules are modelled rationally through 'the doctrine of *negotiorum gestio*...¹⁵⁸ unauthorised action by surgeon or medical staff in the belief that the victim, if capable of giving rational consent, would approve of the action is regarded as lawful'.¹⁵⁹ The necessary corollary of this position is that a surgeon or medical practitioner acts against the presumed wishes (as opposed to 'interests') of the patient, or without a reasonable belief that the patient, if competent, would consent to the intervention, will act injuriously towards the patient and become liable in an action for reparation.¹⁶⁰ This, if the analysis in the above section is accepted, would strongly correlate with the present position in Scots law.

Unlike Scotland, however, Germany has (since 2009, when the jurisdiction ratified the provisions of the UN Convention on the Rights of Persons with Disabilities)¹⁶¹ developed and integrated rules on 'living wills' (*Patientenverfügung*) alongside the basic doctrine of *negotiorum gestio* (here, conceptualised as *Geschäftsführung ohne Auftrag* [agency without specific authorisation])¹⁶² and rules on 'presumed consent' (or 'presumed will') of a patient in the context of medical treatment. The general duty imposed on a *negotiorum gestor* is formulated in the following terms:

'Wer ein Geschäft für einen anderen besorgt, ohne von ihm beauftragt oder ihm gegenüber sonst dazu berechtigt zu sein, hat das Geschäft so zu führen, wie das Interesse des Geschäftsherrn mit Rücksicht auf dessen wirklichen oder mutmaßlichen Willen es erfordert' [A person who conducts a transaction for another person without being instructed by him or otherwise entitled towards him must conduct the business in such a way as the interests of the principal require in view of the real or presumed will of the principal].¹⁶³

This general expression of the *negotiorum gestio* doctrine is expressly extended to the medical sphere by the rules pertinent to the 'treatment contract' (*Behandlungsvertrag*) set out in § 630d BGB. There is in fact some degree of correlation between the position of German

¹⁵⁴ *Implementing supported decision-making: Developments across Europe and the role of National Human Rights Institutions*, (ENNHRI, 08/06/2020)

¹⁵⁵ See Gerhard Dannemann and Reiner Schulze, *German Civil Code (Bürgerliches Gesetzbuch (BGB) Article-by-Article Commentary*, Vol. I (Books 1-3), at 1377

¹⁵⁶ Volker Lipp, *Legal Protection of Adults in Germany – An Overview*, Revised version (11.01.2016) of a lecture held at the Tokyo Bar Association on 22nd February 2013 in Tokyo, Japan

¹⁵⁷ David W. Meyers, *T B Smith: a Pioneer of Modern Medical Jurisprudence*, in Elspeth C. Reid and David L. Carey Miller, *A Mixed Legal System in Transition: T. B. Smith and the Progress of Scots Law*, (Edinburgh University Press, 2005), *passim*.

¹⁵⁸ §677 BGB 'trace their roots to *negotiorum gestio* in Roman law' and 'have remained unchanged throughout the history of the BGB, except for the addition of headings and adapting the spelling to modern rules'. This element of the BGB corresponds to '*Gestion d'affaires* in French law under Art. 1372-1376 Cc', which is 'likewise modelled on Roman law': Gerhard Dannemann and Reiner Schulze, *German Civil Code (Bürgerliches Gesetzbuch (BGB) Article-by-Article Commentary*, Vol. I (Books 1-3), at 1377

¹⁵⁹ T. B. Smith, *Law, Professional Ethics and the Human Body*, [1959] SLT (News) 245, at 246

¹⁶⁰ See Elisabeth Rathemacher, *The State's Obligation to Protect Life and Health of Vulnerable Adults – The Order of 26 July 2016 of the German Federal Constitutional Court in Light of CRPD and ECHR*, [2019] International Journal of Mental Health and Capacity Law 149, at 154

¹⁶¹ See Marion Albers, *Cases and Regulation of Advance Decisions in Germany*, [2018] European Journal of Health Law 441, *passim*.

¹⁶² Bürgerliches Gesetzbuch (BGB) 2.13

¹⁶³ Bürgerliches Gesetzbuch (BGB) § 677 Pflichten des Geschäftsführers

law in circumstances in which there is no 'living will' and the general position of Scots law as prescribed by s.1 (4) of the 2000 Act:

'Liegt keine Patientenverfügung vor oder treffen die Festlegungen einer Patientenverfügung nicht auf die aktuelle Lebens- und Behandlungssituation zu, hat der Betreuer die Behandlungswünsche oder den mutmaßlichen Willen des Betreuten festzustellen und auf dieser Grundlage zu entscheiden, ob er in eine ärztliche Maßnahme nach Absatz 1 einwilligt oder sie untersagt.' [If there is no living will, or if the determinations of a living will do not correspond to the current life and treatment situation, the custodian must determine the wishes with regard to treatment or the presumed will of the person under custodianship, and decide on this basis whether he consents to or prohibits a medical treatment pursuant to subsection (1).]¹⁶⁴

The German framework, however, goes further in holding that:

'Der mutmaßliche Wille ist aufgrund konkreter Anhaltspunkte zu ermitteln. Zu berücksichtigen sind insbesondere frühere mündliche oder schriftliche Äußerungen, ethische oder religiöse Überzeugungen und sonstige persönliche Wertvorstellungen des Betreuten.' [The presumed will must be ascertained on the basis of concrete indications. Consideration must be given, in particular, to previous oral or written statements, ethical or religious convictions and other personal values of the person under custodianship.]¹⁶⁵

The position in Germany is, however, quite different where a valid 'living will' has been competently constituted by the patient:

'Hat ein einwilligungsfähiger Volljähriger für den Fall seiner Einwilligungsunfähigkeit schriftlich festgelegt, ob er in bestimmte, zum Zeitpunkt der Festlegung noch nicht unmittelbar bevorstehende Untersuchungen seines Gesundheitszustands, Heilbehandlungen oder ärztliche Eingriffe einwilligt oder sie untersagt (Patientenverfügung), prüft der Betreuer, ob diese Festlegungen auf die aktuelle Lebens- und Behandlungssituation zutreffen. Ist dies der Fall, hat der Betreuer dem Willen des Betreuten Ausdruck und Geltung zu verschaffen. Eine Patientenverfügung kann jederzeit formlos widerrufen werden.' [If a person of full age who is able to consent has determined in writing, for the event of his becoming unable to consent, whether he consents to or prohibits specific tests of his state of health, treatment or medical interventions not yet directly immanent at the time of determination (living will), the custodian must examine whether these determinations correspond to the current living and treatment situation. If this is the case, the custodian must see to it that the will of the person under custodianship is done. A living will may be revoked at any time without a specific form.]¹⁶⁶

The 'all in all rather complex legal framework of advance decisions in Germany... do[es] not provide convincing solutions to some of the well-known problems arising in the context of advance decisions'.¹⁶⁷ Just as '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',¹⁶⁸ so too is the position in German law similarly qualified, with the net effect that the courts have

¹⁶⁴ Bürgerliches Gesetzbuch (BGB) § 1901a (2)

¹⁶⁵ Bürgerliches Gesetzbuch (BGB) § 1901a (2)

¹⁶⁶ Bürgerliches Gesetzbuch (BGB) § 1901a (1)

¹⁶⁷ Marion Albers, *Cases and Regulation of Advance Decisions in Germany*, [2018] *European Journal of Health Law* 441, at 458

¹⁶⁸ Scottish Law Commission Discussion Paper No 94 "Mentally Disabled Adults" September 1991, paragraph 5.46

been faced with ‘hard’ cases of the kind discussed by Christie.¹⁶⁹ While on the face of it, when a competent *Patientenverfügung* is constituted, the law considers that ‘the patient has already made the decision... [thus, any] guardian or authorised representative must merely see to it that the will of the patient is done’, it remains the case that ‘advance directives involve decisions made under conditions of uncertainty: [any given guardian] has to check the validity in view of the many different civil-law elements, to interpret the contents of the directive while taking account of all possible interpretive factors, to distinguish, if necessary, between binding and indicative elements, and to ascertain, supported by the attending physician and eventually other members of medical staff, relatives, or friends, the patient’s current intent with a view to the available indicators and with the earlier directive in mind’.¹⁷⁰

Albers posits that the reason for the difficulties experienced by the courts in Germany is that ‘the making and the implementation of advance directives are not sufficiently aligned and linked with each other’ and recommends that ‘instead of being seen as an isolated instrument advance directives must be embedded into a broader context of advance care planning’.¹⁷¹ Albers’ comments here correlate with Ward’s general observation, which is of course applicable to the Scottish experience: ‘In terms of practicalities, it would seem that for advance directives in any sphere to be effective, anyone needing to know about them and to refer to their terms would require an easy, quick and straightforward way of ascertaining the position in relation to any individual’.¹⁷² Against this background, it may then be thought that if a system which recognises ‘binding’ advance directives is to be so much as mooted, let alone implemented, any such system must effectively integrate the creation of binding instruments within the more general practice of medicine. It will not be enough for any new or amended legislative regime to simply spell out the letter of the law in one place – although that, it is submitted, would be helpful in light of Wards comments noted on page 2 above – but rather the law itself must facilitate the access of information pertinent to patient preference and ensure that those who are expected to give effect to any previously expressed decision can quickly and readily access all pertinent information before proceeding with, or avoiding, any proposed intervention.

Conclusions

Since the Scottish Law Commission consulted on reforming the law pertaining to adult incapacity in the mid-1990s, there have been some significant societal changes, yet some aspects of law and practice have remained constant. Notably, it remains the case that medico-legal disputes in Scotland tend to be resolved without recourse to the courts and that there are resultantly few reported decisions relating to the peculiarities of Scots medical jurisprudence and few commentaries thereon. Against this background, though it was hoped that the courts would be able to develop the law relating to adult incapacity using the 2000 Act as a springboard, they have not – or have not been able to – do so. This, in large part, explains the difficulties that a Scottish medical practitioner may face in attempting to find out what the background law is, to say nothing of the complexities of determining the reality of the factual circumstances in any particular case. England and Wales, as a larger and in some respects more litigious jurisdiction, produces a greater mass of case law to which commentators on the law are naturally drawn and this in turn means that Scots practitioners are presently forced to

¹⁶⁹ Recall Sarah Christie, *Advance Decisions, Dementia and Subsequent Inconsistent Behaviour: A Call for Greater Clarity in the Law*, [2019] JMLE 1

¹⁷⁰ Marion Albers, *Cases and Regulation of Advance Decisions in Germany*, [2018] European Journal of Health Law 441, at 451

¹⁷¹ Marion Albers, *Cases and Regulation of Advance Decisions in Germany*, [2018] European Journal of Health Law 441, at 458

¹⁷² Adrian D. Ward, *Every Life Matters: Advance Care and Treatment Decisions and Planning, End of Life, Covid-19*, The Centre for Mental Health and Capacity Law (Edinburgh Napier University) Autumn 2020 series: Advance Care Planning: Law, Rights, Practicalities: 11th November 2020, 3.30pm-5.30pm, p.9

make an assessment of what the law is 'thought to be', rather than having the opportunity to quickly and readily find out what the law is. This is problematic, particularly so long as the applicable law in England and Wales turns on assessments of incapacitated persons' 'best interests', rather than their 'will' (actual or constructed).

The above would suggest that any reform of the present legislative regime in Scotland should seek to be comprehensive and to leave little scope for ambiguity or discretion in determination of the applicable law. A clear policy determination must be made by Parliament as to whether or not there ought to be such a thing as a 'binding' advance directive framework. This is a complex question, as *prima facie* it would appear that developing such a framework is necessary to respect individual interests in autonomy, which is enjoined by international legal instruments as well as the present norms of domestic medico-legal practice, but of course it must at the same time be recognised that to treat a direction as 'binding' is to dilute the freedom of the decision-maker once the decision has been recognised as effective. This state of affairs is implicitly recognised in the Scottish legislation at present, which follows a path which accords with the *negotiorum gestio* of Scots common law. The position here, in turn, correlates with the law of Germany, which has (unlike Scotland) developed a defined concept of 'living will' (*Patientenverfügung*) which, if validly constituted, will be treated as a binding expression of individual autonomy. In the absence of such an instrument, the relevant parties must – as in Scotland – attempt to determine the wishes of the *incapax*, being guided by the question 'what would the person want' rather than any concern of their perceived 'best interests'. In this respect, the Scottish legislation remains admirable and the core of the approach taken in the 2000 Act should be retained, if perhaps clarified within the legislation itself.

Although in many respects the *Bürgerliches Gesetzbuch* is a model of legislative comprehensiveness, and at present the BGB goes further than the applicable Scottish legislation by recognising, as binding, certain 'advance directives', it remains the case that the German courts have consistently been faced with problems similar to those which have arisen, in respect of 'advance directives', in England and Wales. This is because though the model itself relies on construction of the presumed will of the *incapax*. That § 1901a (1) maintains that '*Eine Patientenverfügung kann jederzeit formlos widerrufen werden*' [A living will may be revoked at any time without a specific form] correlates with the construction of s.25 (2) (c) of the English Mental Capacity Act 2005 discussed by Christie. In effect, if a model of this kind is to be adopted, then it must be decided whether the diminution in freedom which is associated with an act of engagement (here, the creation of a 'binding' directive) is to be maintained even if the person – while legally incapacitated – demonstrates that they no longer wish to be bound by the terms of the directive which they issued while competent. The resolution to the problems posed by subsequent inconsistent conduct while there exists a purportedly binding advance directive will, if a 'binding' model akin to *Patientenverfügung* is introduced in Scotland, require a further policy determination; this matter poses complex and philosophically difficult problems which cannot simply be shied away from.

The difficulties with affording recognition to 'binding' directives are compounded in Germany and England – and to an even greater extent Scotland, since the same general approach is presently to be taken ahead of any intervention – in large part because there does not exist, in either jurisdiction, 'an easy, quick and straightforward way of ascertaining the position in relation to any individual'. Whatever policy decisions are taken in respect of the matters outlined above, it is clear that any amendments to the present Scottish legislative position should seek to ensure, insofar as possible, that a record of the patient's views on medical treatment can be effectively communicated to relevant persons at or before the time at which any decision as to treatment or intervention is to be made. This would undoubtedly

be difficult to achieve in practice, however the combination, and integration, of a regime of 'assisted decision making' alongside recognition of 'advance directives' may go some way towards reducing these difficulties. If, rather than expecting a discrete and diverse range of medical practitioners to discover the purported or constructed will of any given patient in any given instance, there were to exist instead a single person as a point of contact for these persons, then it would be less onerous for those expected to enact the will of the *incapax* to discover what, precisely, that will happens to be.

At present, notwithstanding the fact that Germany has ratified the CRPD, there are concerns that its model of guardianship does not accord with the requirements of the Convention. As such, though much may be learned from that jurisdiction's approach to advance directives, particularly since the model used there – and, indeed, the 'background' law applicable where there is no such directive – presently accords with the legislative and common law position in Scotland, there are fewer lessons to be learned from Germany where guardianship and powers of attorney are concerned. Yet as recognised by Veshi and Neitzke, the creation of so-called 'surrogate wills' can be categorised as a core component of any given 'advance directive' regime. As such, in determining how best the law pertaining to 'advance directives' might be reformed, consideration must be given also to matters pertaining to guardianship and powers of attorney. It might be thought, given the approach taken in the CRPD and the views expressed by the Committee thereto, that a model of assisted decision-making is desirable and that the development of a framework to allow for this would be useful. '[Assisted decision-making] models aim to achieve is to maintain decision making capacity in an adult for as long as possible, and to provide legal means to assist in this... they are a mechanism for promoting, for as long as possible, the autonomy of adults who may have reduced, or reducing, capacity'.¹⁷³ The integration of such a model alongside rules pertaining to 'living will' model advance directives would, it might be thought, mitigate some of the issues identified in the course of this review.

At present, 'the Scottish legislation [i.e., the 2000 Act] does not explicitly oblige those intervening in an adult's affairs to ensure that all reasonable efforts have been made to maximise the person's residual capacity before a decision is taken that the adult lacks capacity'.¹⁷⁴ If the law in this area is to be reformed, and capacity is to continue to be presumed unless manifestly shown to be lost, then the institution of such an obligation may be thought useful. A more express articulation of the application of the common law concept of *negotiorum gestio* to the non-patrimonial sphere could be useful here, and the German experience in the drafting of §677 BGB demonstrates a means in which this might be realised. Likewise, if it is accepted that acting against a person's expressed will may be 'justified on the basis of having thorough knowledge of the person, a long standing relationship with the person, and having the person's trust and acceptance, however occasionally, of being in that role, and not ever on the grounds of classification of the person as being incapable', then a system which recognises and affords some decision-making status to a nominated individual in place of the *incapax* would appear to be acceptable. Safeguards must, however, be built into any such system and the decisions of any proxy must be open to challenge (if, perhaps, only by the *incapax*, having regained capacity, themselves) and there must be some mechanism for oversight. It might appear, given the lack of litigation in Scotland concerning medico-legal matters, that the courts are not the best, or most appropriate, forum for providing such oversight. Law reformers in this area must then consider if the institution or creation of a

¹⁷³ Shih-Ning Then, Hilary Patrick and Nicola Smith, *Reinforcing Guardianship Regimes through Assisted Decision Making - a Scottish Perspective*, [2014] Jur. Rev. 263, at 269

¹⁷⁴ Shih-Ning Then, Hilary Patrick and Nicola Smith, *Reinforcing Guardianship Regimes through Assisted Decision Making - a Scottish Perspective*, [2014] Jur. Rev. 263, at 270

new, bespoke oversight body (ultimately under the jurisdiction of the courts) is desirable as a means of effectively dealing with the challenges presented in this area of law.