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REVISITING ADVANCE DECISION MAKING UNDER THE MENTAL CAPACITY ACT 2005: A TALE OF MIXED MESSAGES

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ABSTRACT

Whilst most of the existing literature relating to advance decisions has focused on philosophical questions, this article reflects on the significant legal developments that have occurred since the introduction of the Mental Capacity Act 2005. The article provides a critique of the controversial issues which have emerged within contemporary case law. The focus of the discussion centres on capacity, the interpretation of the safeguards, and the bias towards preservation of life.

KEYWORDS: advance decisions, capacity, safeguards, autonomy, preservation of life

I. INTRODUCTION

Despite being recently placed on a statutory footing by section 24 of the Mental Capacity Act 2005, medical advance decision making is not a new concept in English law.[1] It was recognised by Lord Goff in *F v West Berkshire Health Authority*[2] that one of the limits on necessity, the legal justification for providing treatment without consent in emergency situations, was the existence of some evidence of a pre-existing wish of the patient, expressed at a time when she was competent, which indicated that she may wish to refuse medical treatment for a particular illness or injury.[3] Proceeding to treat the patient in the face of this known objection would amount to tortious battery, and could potentially lead to criminal prosecution.[4] However, advance

1 See *Re AK (Adult Patient) (Medical Treatment: Consent)* [2001] 1 FLR 129; *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290.
2 *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.
3 Ibid at 75–6.
4 See *B v NHS Hospital Trust* [2002] EWHC 429 (Fam); [2002] 2 All ER 449; *Collins v Wilcock* [1984] 1 WLR 1172 at 1177.

decisions at common law were subject to two strong caveats; the choice of the patient had to be 'clearly established' and 'applicable in the circumstances'. Fulfilling these requirements, from a patient's perspective, was easier said than done.

It was held by Munby J in *HE v A Hospital NHS Trust* that the burden of proof rested on those who seek to establish the existence and continuing validity and applicability of an advance decision and that, where life is at stake, the evidence must be scrutinised with especial care.[5] Thus, the patient faced an uphill struggle under the common law to create and then prove a legally valid advance decision and these obstacles served to constrain the legal protection that was afforded to a competent patient's decision about her future incompetent self.[6] Indeed, as Michalowski has pointed out, 'the new legislation as well as the common law apply a bias against the validity or applicability of an advance refusal of life-saving treatment'.[7] While this was certainly true of the common law position, and is also true of the inherent framework of the Mental Capacity Act 2005, the crucial question is whether or not this attitude continues to be evident in the judicial application of the legislation.[8] Michalowski herself acknowledges that 'the impact of the Mental Capacity Act 2005 on the validity of advance directives remains to be seen',[9] and so the recent case law that has materialised since the inception of the Act provides fertile ground for exploring this important matter.

Within the framework of the Mental Capacity Act 2005, there remain a number of contentious issues which have caused problems for judges when it comes to assessing the validity and applicability of advance decisions. Questions concerning capacity, the interpretation of the safeguards which were designed to allow an advance decision to be legitimately overridden, and also the preservation of life, have all emerged as recurring themes in the case law and serve to demonstrate the unsettled nature of the law under the Mental Capacity Act 2005. While the majority of the existing literature surrounding advance decisions focuses on philosophical and theoretical questions, this article seeks to reflect on, and critically analyse, recent developments in the substantive law since the introduction of the Mental Capacity Act 2005.[10]

The article begins by framing the debate and then moves the discussion beyond the consideration of principally philosophical concerns and engages with a number of important practical legal issues. The discussion then proceeds to explore the trajectory of the law following the legislative intervention. Particular focus is placed on capacity, the interpretation of the safeguards and the preservation of life, the problematic nature of these themes being illustrated by reference to the evolving case law. The

5 *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam) at [46].

6 There are other examples of cases under the common law in which advance decisions existed and were overruled by the courts. See *W Healthcare NHS Trust v H* [2004] EWCA Civ 1324; [2005] 1 WLR 834.

7 S Michalowski, 'Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of an Absolute Right' (2005) 68 Mod LR 958 at 960.

8 The Mental Capacity Act 2005 came into full force in England on 1 October 2007.

9 Michalowski, above n 7, at 968.

10 For other discussion, see AR Maclean, 'Advance Directives and the Rocky Waters of Anticipatory Decision-Making' (2008) 16 Med LR 1. For comparative perspectives see M Navarro-Michel, 'Advance Directives: The Spanish Perspective' (2005) 13 Med LR 137; TK Leng and SL Huey Sy, 'Advance Medical Directives in Singapore' (1997) 5 Med LR 63. For a historical account see K Stern, 'Advance Directives' (1994) 2 Med LR 57.

article finally concludes by assessing whether or not the continuing bias in favour of preservation of life is as prevalent now as it once was under the common law.

II. BACKGROUND: FRAMING THE DEBATE

Advance decisions are usually justified on the basis of autonomy. Dworkin argues that respecting autonomy is important because it allows us to construct our own identity; it 'encourages and protects people's general capacity to lead their own lives out of a distinctive sense of their own character, a sense of what is important to and for them'.[11] His view of autonomy is thus based on a 'narrative' or 'biographical' view of an individual human life: the person whom an individual develops into will depend on the autonomous choices he or she makes now.[12] If that individual then loses the capacity to make further autonomous decisions, as that period of incapacity is as much a part of their life as any other, then there is no reason why they cannot be responsible for moulding that chapter of their life, provided they had the prescience to do it while having capacity. This is referred to by Dworkin as 'precedent autonomy'.[13] On this interpretation, the future incompetent person is powerless to overturn a previous decision because they no longer have the capacity for any fresh exercise of autonomy.[14] It is useful here to illustrate this by reference to the infamous 'Margo story', which was discussed at length by Dworkin and subsequently analysed by Alasdair Maclean in his piece in the *Medical Law Review*.[15] Margo is a 54-year-old woman who is suffering from dementia. Despite her illness, she seems incredibly happy in her existence, demonstrating signs of pleasure from reading the same books, painting the same pictures, and from eating her favourite meal of banana and jam sandwiches. However, Margo, in her previously competent state, drafted an advance decision to refuse life-saving medical treatment should she ever be diagnosed with dementia. Margo, in her now demented state, develops a chest infection which requires antibiotic treatment to save her life. Do her doctors override the advance decision or do they respect it?

The difficulty in Margo's scenario resides in the fact that whilst she has experiential interests, she has no critical interests.[16] She seems to have a happy life which provides and satisfies her experiential interests and therefore the understandable temptation for most doctors may be to ignore the advance decision and treat her. Dworkin, however, argues that critical interests ought to be given priority over experiential ones and, as the advance decision is the most convincing evidence of Margo's critical interests, it should be respected and the treatment withheld.[17] His view of life as a narrative unity places emphasis on identifying the 'overall shape of the kind of life Margo wants to

11 R Dworkin, *Life's Dominion* (Harper Collins 1993) at 224.

12 AR Maclean, 'Advance Directives, Future Selves and Decision-Making' (2006) 14 Med LR 291 at 294.

13 Dworkin, above n 11 at 226. See M Quante, 'Precedent Autonomy and Personal Identity' (1999) 9 Kennedy Inst Eth J 365 at 372.

14 Dworkin, above n 11 at 227.

15 Dworkin, above n 11 at 221, 226, and 228; Maclean, above n 12 at 295–9. See also AD Firlik, 'Margo's Logo' (1991) 265 JAMA 201.

16 Critical interests reflect a person's autonomously determined goals and life plan; experiential interests reflect the more immediate enjoyment from certain pleasing activities.

17 Dworkin, n 11 at 224–9.

have led', which is determined by the exercise of precedent autonomy through the use of her advance decision.[18]

Dworkin's view has come under attack from various scholars. Rebecca Dresser, for example, argues that his view of life as a coherent narrative is flawed. It does not take into account the fact that unforeseen events can happen and circumstances can change. Some people will simply live life taking each day as it comes and in 'experiencing various life events, including setbacks in their physical and mental functioning, may revise their goals, values, and definitions of personal well-being'.[19] In short, a person's common life theme may simply be to accept and adjust to the changing circumstances that shape her life.[20] Moreover, Dresser points to some more pragmatic concerns about precedent autonomy, noting that future-oriented decision making is an 'incomplete form of self-determination'. Autonomous decision making prospers in the context of on-going discussions between the patient, the healthcare professional, and any other interested parties. New information can be absorbed into the decision-making process and this cannot be achieved in advance decisions as they omit a patient's 'participation at the crucial point when treatment decisions are activated'.[21]

Perhaps the strongest challenge to Dworkin's work is grounded in the personal identity problem. This problem centres on articulating the conditions under which stages of a person's life are stages of the same person or, alternatively, to explain the circumstances which signal the development of a different person.[22] Parfit's view of personal identity can be used to illustrate the frailties of Dworkin's argument in respect of the hypothetical Margo scenario. Parfit endorses a 'Complex View' of personal identity which consists of two relations: psychological connectedness and psychological continuity.[23] Psychological connectedness exists over time and to greater or lesser degrees, depending on the extent to which a person continues to hold various psychological features such as memories, intentions, beliefs, and desires. Psychological continuity can exist even in the absence of direct psychological connection between two points in time, as long as between those two points there are overlapping chains of psychological connectedness.[24] On this basis, personal identify can fluctuate over time, which, potentially, has ramifications for the validity of an advance decision. Given that an advance decision is predicated on the notion that the individual it purports to bind in the future is in fact the same moral entity that created it, its authority is undermined if that future individual is actually viewed as a different person. As Dresser eloquently explains, 'although in the Complex View it is quite conceivable that the present and future selves will be strongly connected, so that the advance

18 Ibid at 226.

19 R Dresser, 'Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law' (1986) 28 Ariz L Rev 373 at 379.

20 R Dresser, 'Dworkin on Dementia: Elegant Theory, Questionable Policy' in H Kuhse and P Singer (eds), *Bioethics: An Anthology* (Blackwell Publishers 1999) at 316.

21 R Dresser, 'Advance Directives, Self Determination, and Personal Identity' in C Hackler et al. (eds), *Advance Directives in Medicine* (Praeger 1989) at 157.

22 Ibid at 158. See also J Perry, 'The Problem of Personal Identity' in J Perry (ed), *Personal Identity Vol 3* (University of California Press 1975) at 15.

23 D Parfit, *Reasons and Persons* (Oxford University Press 1986) at 204–6.

24 Ibid at 205–6.

decision raises little concern, it is also conceivable that no connection will exist between the two selves'.[25]

Relating this back to the example of Margo, where a patient undergoes a significant change triggered by a condition like dementia, the degree of psychological continuity needed to connect the former competent patient to her later incompetent self may be lost. It is here where the advance decision is at is most vulnerable because, in effect, Margo in her current demented state could be viewed as a 'new' person. If this is believed, it is possible to suggest that the 'old' Margo no longer has the authority to bind the 'new' Margo. Within this, there is of course room for disagreement in relation to the degree of continuity and connectivity that is necessary for the preservation of personal identity, and this is a difficult question to answer.[26] Nonetheless, it is clear to see that Parfit's philosophy on personal identity represents a persuasive attack on Dworkin's view of precedent autonomy and the weight of advance decisions.

These theoretical debates are not easily resolved and there is no definitive answer as to which view should prevail. This, in turn, makes it incredibly difficult for the law to deal with advance decisions. Clearly, it is tasked with finding some sort of 'answer' to the philosophical questions which continue to provoke disagreement. In its attempt to achieve this, it seeks to balance out the tensions between the respect for precedent autonomy on the one hand, and, on the other, the need to address a range of other issues, such as the personal identity problem and the need for the law to acknowledge and respect the rights and interests of those patients who lack capacity.[27] Thus, a person has a legal right to draft an advance decision, but this may be overridden by recourse to a number of safeguards which have been developed over time in consideration of the range of problematic and uncertain factors identified above. The question which then falls to be addressed is whether an apposite balance is struck or whether the deck is weighted too heavily in favour of one side of the argument.

III. FROM PHILOSOPHY TO LAW: THE COMMON LAW AND SUBSEQUENT LEGISLATIVE INTERVENTION

Prior to legislative intervention, there was some authority to suggest that the common law was not only prepared to acknowledge that an advance decision was an acceptable legal instrument to give effect to autonomous choice, but also that it was prepared, in certain circumstances, to enforce them. In *Re AK*, the health trust responsible for the care of the patient sought a declaration that it would be lawful to comply with the patient's request to discontinue, two weeks from the date he lost the ability to communicate, the artificial ventilation, and the artificial nutrition and hydration (ANH), that was keeping him alive. The patient suffered from motor neurone disease and had communicated his prior wishes by blinking his eye, but he was aware that the movement in that eye would shortly cease. Hughes J upheld the directive made by a patient to stop artificial ventilation.[28] In doing so, it was clear he had no doubt about the

25 Dresser, above, n 21 at 158.

26 See A Buchanan, 'Advance Directives and the Personal Identity Problem' (1988) 17 Phil & Pub Aff 277.

27 For an interesting discussion, see R Huxtable, *Law, Ethics and Compromise at the Limits of Life: To Treat or Not to Treat?* (Routledge 2013). In particular, chs 1 and 3.

28 *Re AK*, above, n 1.

patient's capacity.[29] A significant factor in reaching this conclusion may have been the irreversible and degenerative nature of the patient's condition. Nonetheless, when an advance decision was being used to refuse life-saving treatment where there was no existing terminal, irreversible, or degenerative condition, preservation of life seemed to be a key factor.

This attitude was epitomised in the aforementioned case of *HE v A Hospital Trust*.[30] Here, the patient was an adult Jehovah's Witness who required a life-saving blood transfusion; she had, however, previously written an advance decision specifically refusing treatment of this kind in any circumstances. Her father sought a declaration that it would be lawful for the hospital to administer the transfusion notwithstanding the advance decision. Munby J granted the declaration.[31]

Munby J's analysis of the law relating to advance decisions in the case serves to illustrate some of the difficulties faced by individuals attempting to assert the legal validity of an advance decision. As noted, he held that the legal burden of proof was on the person seeking to establish the validity and applicability of an advance decision and that, where the decision concerned the refusal of life-saving treatment, the evidence must be subject to especially careful scrutiny.[32] He also stated that, if there was any doubt, it had to be resolved in favour of preservation of life.[33] Thus, the person seeking to enforce the advance decision must prove, on the balance of probabilities, that it is valid and applicable. That in itself will not always be easy to achieve, especially given that in most cases those seeking to overturn the advance decision will be able to adduce evidence of at least some doubt.

For those wishing to use an advance decision to refuse life-saving treatment, it appeared under the common law that they would be held to a higher standard of proof when seeking to establish validity and applicability. The advance decision must have been supported by 'convincing' and 'inherently reliable' evidence and that evidence would be subject to a higher degree of scrutiny from a judge.[34] As a result, Michalowski accurately identified that 'to scrutinise evidence with special care seem [ed] to amount to scrutinising evidence supporting the continuing validity and applicability of an advance decision with special care, without applying a similar standard of scrutiny to the evidence against its validity'.[35] A modicum of doubt raised against validity could therefore trigger the bias in favour of the preservation of life and the subsequent overriding of an advance decision, while the individual trying to prove validity, someone who was often not the patient, was left having to second-guess what amounted to 'convincing' and 'inherently reliable' evidence. Munby J did very little to expound the meaning of these two terms, so those seeking to assert validity faced a degree of uncertainty as to precisely what would suffice to discharge the evidential burden.

29 Ibid at 133 and 136.
30 See above, n 5.
31 See above, n 5 at [52].
32 See above, n 5 at [46].
33 Ibid.
34 Ibid.
35 Michalowski, above, n 7 at 971.

In *HE*, the patient had executed a detailed advance decision in writing which was signed and witnessed.[36] Her advance decision was, admittedly, based on her previous religious beliefs as a Jehovah's Witness and there was evidence that she had recently renounced her faith by becoming engaged to a Muslim. Thus, on one view, Munby J may have been justified in concluding that, as her prior wishes were based entirely on her beliefs as a Jehovah's Witness, her advance decision may have lost its credibility at the point she rejected the faith.[37] However, there was still strong evidence suggesting that her advance decision remained her fixed decision. It was created only two years prior to the incident, it was extensive, and the patient had made no attempt to withdraw it. What more could the patient have done? Equally, what further evidence could her representatives have introduced to prove that the advance decision represented her true wishes? This underscores the problem, as those seeking to override a decision, in this case the patient's father, simply had to introduce an element of doubt into a judge's mind, this seemingly being enough to negate even the most watertight of written advance decisions.[38]

It could be argued, then, that after Munby J's judgment in *HE*, the common law was operating from the wrong position. Once a patient has executed an advance decision in writing, why should the legal burden rest on the patient to prove its validity and applicability? This is akin to saying that the presumption is that any advance decision is invalid unless proved otherwise. Is it not credible to suggest that the law should work from the opposite starting point in that once the existence of advance decision is, in principle, established, then the legal burden should rest on those seeking to question it by requiring them to disprove, on the balance of probabilities, its continuing validity and applicability? The criticism of this opposite approach may be that the considerable amount of legal and evidential uncertainty surrounding advance decisions under the common law warranted this cautious attitude and that to hold otherwise would cause damage to the presumption in favour of life, which would constitute an undesirable legal position. Nevertheless, it may certainly go some way towards redressing what was an uneven balance between respecting the patient's prior wishes and the preservation of life. Even if this is rejected, certainly there is a more convincing argument that imposing the burden on the patient or their representative, *coupled with* the requirement of a higher standard of proof, placed them at too great a disadvantage. In this context, there should not be a more demanding standard of proof required from one side than the other. This position can be adequately redressed by simply saying that the evidence on both sides has to be scrutinised with special care to ascertain where the balance should tip in a given case. To expect something more from the party who is already at a disadvantage is to place an almost insurmountable obstacle in their way. This did not seem to be recognised by Munby J, indeed the very clear message from him was that the bias in favour of life was a central feature of the common law position.

Sections 24 and 25 of the Mental Capacity Act 2005 introduced statutory advance decisions. Section 24 (1) states that an: '"Advance decision" means a decision made

36 See above, n 5 at [4].
37 See above, n 5 at [49].
38 See above, n 5 at [50].

by a person, after he has reached 18 and when he has capacity to do so, that if (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued'.[39] The advance decision can be expressed in layman's terms,[40] can be withdrawn or altered at any time when the patient has capacity to do so,[41] and any withdrawal or alteration does not need to be in writing (unless the decision is altered to concern refusal of life saving treatment).[42] The counterbalance is found under section 25, which provides a range of safeguards that allow any advance decision to be overridden where it is deemed invalid or inapplicable. Hence, a decision is not valid if it has been withdrawn at a time when the patient has capacity to do so,[43] or if the patient has done anything inconsistent with the advance decision remaining his fixed decision.[44] Similarly, the advance decision is not applicable to treatment where the patient has the capacity to give or refuse consent.[45] Under the legislation, the grounds for declaring a decision inapplicable to the treatment in question are far-reaching and include situations in which the treatment is not the treatment specified in the advance decision,[46] where any circumstances specified in the advance decision are absent or where there are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of making the advance decision.[47] Further to this, there are additional formalities which must be complied with if the advance decision concerns refusal of life-saving treatment: the patient must make this decision in writing and it needs to be witnessed and counter-signed by that witness.[48]

The Mental Capacity Act 2005 therefore aims to clarify the law in respect of advance decisions. It strives to obtain the optimum balance between precedent autonomy and the preservation of life by defining clearly the requirements for executing an advance decision and by specifying explicitly the circumstances in which an advance decision may be deemed inapplicable and invalid. Given that the refusal of life-saving treatment via an advance decision under the Mental Capacity Act 2005 now requires the patient to comply with additional formalities, one may be forgiven for thinking that, once these have been completed, an advance decision may be less prone to legal dispute and therefore more difficult to overturn. If this is the case, does the legislation go some way towards remedying the bias in favour of preservation life that pervaded the previous common law position?[49] There has not been a significant amount of case law to date, but the early signs are mixed.

39 Mental Capacity Act 2005, s 24 (1) (a) and (b).
40 Mental Capacity Act 2005, s 24 (2).
41 Mental Capacity Act 2005, s 24 (3).
42 Mental Capacity Act 2005, s 24 (4) and (5).
43 Mental Capacity Act 2005, s 25 (2) (a).
44 Mental Capacity Act 2005, s 25 (2) (c).
45 Mental Capacity Act 2005, s 25 (3).
46 Mental Capacity Act 2005, s 25 (4) (a).
47 Mental Capacity Act 2005, s 25 (4) (b) and (c).
48 Mental Capacity Act 2005, s 25 (5), (6) (a)–(d).
49 For an interesting critical reflection of the Mental Capacity Act 2005, see C Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Hart Publishing 2009), ch 8.

IV. DEVELOPMENTS SINCE THE INTRODUCTION OF THE MENTAL CAPACITY ACT 2005

A. Capacity

The entire premise of an advance decision is that it is made at a time when a patient is competent, and is intended to apply at a future date when that competency is lost. Thus, the issue of capacity is central to validity.[50] However, the difficulty for judges is that, even though capacity is presumed, they have to assess it retrospectively. Given that there could be a considerable time lapse between the creation of an advance decision and that point at which its validity and applicability comes to be tested, judges under the common law demonstrated a tendency, perhaps understandably, to approach the assessment of capacity cautiously.

This attitude was illuminated in *The NHS Trust v T*.[51] The case itself was heard under the common law. Nonetheless, it is necessary to discuss it here in order to provide the context and to set the scene for the problems which continue to exist in respect of capacity under the Mental Capacity Act 2005. The patient suffered from a borderline personality disorder and had a long history of psychiatric treatment. She had, on a number of occasions, self-harmed by cutting herself and blood-letting. The consequence of this was that her haemoglobin would fall dangerously low so that she would require an emergency blood transfusion. However, in 2004, she created a written and signed advance decision in which she set out her wishes to refuse any blood transfusion on the basis that she was caught in a set of circumstances which were impossible to endure and that her blood was evil and carried evil around her body.[52] A letter accompanied the advance decision from her GP in which it was confirmed that the patient understood the nature and consequence of her advance decision and that it may result in her death.[53]

Charles J held that the patient lacked capacity at the time she made the advance decision and therefore it could be overridden.[54] This decision was reached despite evidence from two consultants in 2001 (in which a similar incident occurred), and from her GP in 2004, which indicated that the patient retained capacity.[55] Charles J, nevertheless, preferred the evidence of one consultant who reached the opposite conclusion.[56] Admittedly, in terms of the specialist consultants, this evidence was the most recent.[57] However, by Charles J's own admission, the situation in 2004 was virtually identical to that in 2001, and the patient's condition had not significantly changed in the interim.[58]

50 Mental Capacity Act 2005, s 24 (1) (a)–(b).
51 [2004] EWHC 1279.
52 Ibid at [8].
53 Ibid at [9].
54 Ibid at [62].
55 Ibid at [55], [56], and [59].
56 One other consultant seemed to be in agreement, albeit less forcefully, that Ms T 'temporarily lacked capacity', ibid at [57].
57 Ibid at [10] and [16].
58 This was stated by Charles J, ibid at [58], and also confirmed by the consultant who held that Ms T lacked capacity in 2004, ibid at [10].

This strikes at the very heart of the problem created by Munby J's approach in *HE*.[59] Taking the presumption of capacity as the starting point, and adding to that the GP's supporting letter, there was more evidence in favour of the patient in *T* having capacity at the time she made her advance decision than not. Thus, given that the presumption of capacity favours the patient, it seems plausible to suggest that those seeking to disprove capacity must be able to present sufficient evidence in order to rebut that presumption on the balance of probabilities.[60] This was not apparent from the reasoning in *T*. There was some evidence that contradicted the patient having capacity, but it was minimal and arguably not as convincing. Certainly, there were grounds to suggest a varying standard of evidential scrutiny, but possibly in the wrong direction. Charles J examined carefully the evidence of one consultant who assessed and confirmed Ms T's competency in reference to the legal test for capacity.[61] He disagreed with this consultant's application of the legal test, but he had a questionable basis for doing so which seemed to be heavily influenced by the evidence he preferred in respect of Ms T's mental illness and misconception of reality.[62] If he had applied the same standard of evidential scrutiny to the consultant who concluded Ms T lacked capacity as he did to those who confirmed she retained it, he would have had to concede that nowhere in that evidence was there any reference to the assessment being made in reference to the legal test for capacity. It is quite right that a mental disorder may impinge on a patient's ability to make a decision, but this is not automatically the case. The legal test for ascertaining capacity is based on a functional approach and so emphasis is placed on the ability to make a decision having regard to the patient's aptitude to understand information, retain it, use, or weigh it in the decision-making process and appreciate the consequences of their choice.[63] There was evidence that the patient's personality disorder had not affected her to the extent that she could not satisfy these requirements at the time she made her advance decision and on one view this evidence was 'convincing' and 'inherently reliable'.[64] The patient's perception of her blood being evil was unusual, bordering on irrational, but that a decision itself seems strange does not necessarily mean the ability to make that decision is impaired. This unduly cautious approach to the question of capacity may well be underpinned by a misunderstanding of mental illness. Judges, and indeed some expert witnesses, may confuse the (perceived) rationality of a decision with the capacity to understand the nature and consequences of a decision. The reality of the situation may well be that there is a view among judges that the very nature of the underlying mental illness from which a patient is suffering makes it impossible to meet the functional requirement of using and weighing the relevant information to make a decision. If this is the prevailing attitude, it could potentially cause a much

59 See above, n 5.

60 Mental Capacity Act 2005, s 2 (4).

61 See above n 51 at [56]. The consultant in question referred to the common law test for capacity in *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290. The test is now found in the Mental Capacity Act 2005, see below, n 63.

62 See above, n 51 at [63].

63 See Mental Capacity Act 2005, s 3 (1) (a)–(d). For discussion see M Gunn and others, 'Decision Making Capacity' (1999) 7 Med LR 269; M Gunn, 'The Meaning of Incapacity' (1994) 2 Med LR 8.

64 See above, n 51 at [56].

bigger challenge to the validity of advance decisions made by patients who are deemed incompetent simply by virtue of the particular illness from which they are suffering. With this in mind, judges ought not to allow this mind-set to dominate. Negating the functional aspect of the capacity test may be the effect of *some* mental illness, but not all. Notwithstanding the particular illness that the patient is suffering from, or the irrationality or otherwise of the decision, if there is clear evidence to support the fact that the patient still satisfies the functionality aspect of the capacity test, and indeed the other components, then there ought to be no reason why judges should remain unwilling to accept certain decisions made by certain patients. If all cases are approached in a similar way to *T*, a credible challenge could always be mounted in relation to the question of capacity, thereby providing the basis for overriding the majority of advance decisions which are designed to refuse life-saving treatment.

One further weakness of the Mental Capacity Act 2005 in respect of advance decision making is epitomised in the recent case of *A Local Health Authority v E*.[65] This case arose after the introduction of the legislation and so fell squarely within its remit. The patient was a 32-year-old woman who suffered extremely severe anorexia nervosa. E's death was imminent, yet she was refusing to eat and taking only a small amount of water.[66] This situation was compounded by the fact that E had twice attempted to make an advance decision to refuse treatment. After initially being deemed competent and drafting her first advance decision, the patient was formally detained under the terms of section 3 of the Mental Health Acts of 1983 and 2007. There was some confusion about whether in fact she lacked capacity at this time, although it was later confirmed by Jackson J that E did lack capacity to make the first advance decision.[67] She later demonstrated behaviour that indicated that she may have regained capacity, if indeed she had ever lost it in the first place.[68] E then drafted a second formal advance decision, signed and witnessed by her mother and a healthcare professional. This was to the effect that if she was close to death she did not want tube feeding or life support, but would accept pain relief and palliative care.[69] Despite the formalities being complied with, and the finding that E had not withdrawn her advance decision, Jackson J held that she did not have the requisite capacity at the time she made the advance decision. His view ran contrary to the general consensus of medical opinion surrounding E's condition and he reached this conclusion despite E having taken advice from her solicitor and independent mental health advocate.[70] Jackson J's primary reason for reaching this view was that there was no formal assessment of E's capacity at the time she created the advance decision.[71] There was evidence of doubt as to whether, had it taken place, the findings of any such investigation would have yielded a conclusion in favour of capacity. This was enough to tip the balance in favour of preservation of life.[72]

65 [2012] EWHC 1639.
66 Ibid at [1].
67 Ibid at [59].
68 Ibid at [60]. She was either pulling at her peg line or reluctantly agreeing to it being left in.
69 Ibid at [61].
70 Ibid at [64].
71 Ibid at [65].
72 Ibid at [65].

Amid the range of formalities that were included in the Mental Capacity Act 2005, what mechanisms are in place within the legislation to ensure that a patient is competent at the time they actually draft their advance decision? The answer is, quite simply, none. A case can be made that the legislation should have included more robust requirements in terms of the assessment of capacity at this crucial point. Where a patient wishes to use an advance decision to end her life, the additional formalities demand that there is a witness who is signatory to it.[73] Nonetheless, there is nothing to say that the witness must perform a formal assessment of a patient's capacity before they act as a signatory and this may have been worthy of inclusion.

The law, quite rightly, has to be hesitant in placing too many obstacles in front of patients when it comes to advance decision making. A central pillar of the recognition and enforcement of statutory advance decision making is that while the law seeks to provide a greater degree of certainty and clarification, it must also aim to ensure advance decision making is as accessible as possible to all patients.[74] The question of balance comes into play here. The legislation as it currently stands attempts to reach a fair compromise by not requiring a formal assessment of capacity at the time an advance decision is made; the law is therefore open to all patients to utilise who have a *prima facie* right to create an advance decision on the basis that their capacity is presumed, with the counterbalance being that this can be overridden by a judge if there is genuine doubt as to that capacity at the time of drafting. The flexibility offered by this approach is useful in certain situations. Absent any formal assessment of capacity by a witness at the time a patient executes an advance decision, in cases where a patient has a history of mental illness, as was the situation in *E*, or where a patient has previously demonstrated suicidal tendencies, the question of capacity will not always be clear cut and so allowing judges room to manoeuvre and to override the presumption of capacity when a patient's inability to make a decision is called into question may not always be inappropriate. However, any doubt raised must be capable of satisfying the balance of probabilities standard and, in view of the evidence, it was not readily apparent that this threshold was met in cases such as *T* and *E*.[75] Problems are thus encountered if the law allows a judge to override the presumption in favour of capacity too easily, based on an ill-defined measure of doubt. If this happens, the law undoes a lot of the work it has done in seeking to ensure accessibility. What it gives on the one hand, it takes away on the other, if, without great effort, a judge can simply rule that the patient lacked capacity at the time of writing the directive.

The law may have also resisted requiring a formal assessment of capacity for a number of other reasons. First, it would be in direct conflict with the golden thread that runs through the Mental Capacity Act 2005, the presumption of capacity.[76] Requiring an assessment of a patient's capacity by a witness as a prerequisite to validating the advance decision reverses this and works from the starting position that patients are incapable of exercising their right of choice before someone else confirms they are capable of doing so. This would severely undermine the notion of autonomy

73 Mental Capacity Act 2005, s 25 (6) (d).
74 For an interesting discussion see Huxtable, above n 27.
75 Mental Capacity Act 2005, s 2 (4).
76 Mental Capacity Act 2005, s 1 (2).

by placing a barrier in the way of patient choice. Nevertheless, capacity is issue-specific, and requiring a formal assessment of capacity only in relation to validating an advance decision would not cause harm to the general proposition that a patient is still presumed to be able to make autonomous choices about other aspects of their life.[77] Second, there is the further consideration that, in many cases, the witness will not be a trained professional with the ability to assess capacity. Often the person witnessing the creation of an advance decision will be a family member or friend, or a professional person such as a solicitor or doctor. Not all doctors are trained in assessing capacity, and the majority of solicitors will not be able to perform this task.[78] Thus, it would certainly add a further and perhaps unwelcome layer of complexity to insist that the witness must be a trained professional with expertise in assessing capacity. It stands to reason that this would inhibit access by making the process of creating an advance decision more costly, time-consuming, and bureaucratic. Yet, as the law stands, we are still left with a situation in which the central feature of the advance decision, the feature which gives it teeth, is left untested and this will always render it vulnerable to attack.

With this in mind, there is perhaps a different approach to consider. A balance does need to be struck between accessibility and retaining an appropriate scope to override an advance decision when it is deemed necessary based on the circumstances of the patient. However, many patients still do not use the law to create advance decisions, regardless of its attempt to make them as accessible as possible. Thus, for those patients who do take the time and make the effort to create an advance decision, they would be unlikely to object to the additional requirement of an assessment of capacity at the time it is made; this is because, having taken the conscious decision to make an advance decision in the first place, the aim of most patients will be to make it as difficult as possible to overturn. Those patients who cannot, for capacity-related reasons, make that decision will be prevented from doing so at this early stage. This would remove some of the doubt that currently exists surrounding the question of capacity and would give further credence to the argument that the validity of an advance decision should be presumed and that the legal burden should fall on those seeking to negate it to prove that it is not valid or applicable.

Two further points are worthy of mention here. First, a formal assessment of capacity at the time of the creation of an advance decision would not be absolute conclusive evidence of capacity. That is to say it would not mean that a formal assessment and finding of capacity at the time an advance decision was made could never be disproved from that point onwards. The underpinning rationale would simply be to ensure that the court was obliged to place great weight on that formal assessment at the time of creation. However, judges would still not be bound by the assessment carried out by experts and so a finding of capacity at that time could still be overridden in certain exceptional situations. Thus, an advance decision would still be prone to attack if, for instance, judges continue to adhere to the view that certain underlying illnesses negate the ability to satisfy the functional requirement of the capacity test

77 See JK Mason and GT Laurie, *Mason and McCall Smith's Law and Medical Ethics* (9th edn OUP 2013) at 85.

78 See K Evans, J Warner, and E Jackson, 'How Much Do Emergency Healthcare Workers Know About Capacity and Consent?' (2007) 24 Emerg Med J 391.

simply by virtue of the presence of the illness itself. If judges remain aligned to this reasoning, and it is submitted that they should not, it would have to be proved that the particular condition in question was absent at the time the advance decision was constructed in order for the formal assessment of capacity to have any significant impact.

To this end, would anything have changed in cases such as *E* and *T* had a formal assessment taken place? Certainly, in *E* there was evidence that Jackson J was concerned about the lack of a formal assessment of capacity at the time the patient created the advance decision and so had this been present and supportive of competency he may have been more inclined to find in favour of the patient. Likewise, in *T*, had a formal assessment been carried out supporting a finding of capacity at the time the advance decision was composed, and had this assessment been undertaken by a trained expert in the field rather than a GP, it may well have focused Charles J's mind on the precise *amount* and *type* of evidence that was actually needed to disprove the finding of capacity. He still would have been at liberty to override the view of the expert, but perhaps he would have been more cautious in doing so, especially in view of the fact that he would have had to consider whether he could, justifiably, point to enough evidence to support the conclusion that the patient did in fact lack capacity on the balance of probabilities. This, in turn, raises a question about the standard of proof that would be required to override a formal finding of capacity at the time an advance decision was executed. Once a formal assessment of capacity is made in favour of the patient, it could be argued that it would no longer be sufficient to allow it to be disproved merely by reference to the balance of probabilities. In view of the tightening of the capacity assessment at the time of creation, it may be more appropriate for the law to consider requiring a higher degree of proof to disprove that initial finding of capacity at a later date. For example, in the specific context of advance decision making, in order to disprove a formal finding of capacity, one suggestion may be that it would be suitable to impose the requirement of proof beyond reasonable doubt that the patient actually lacked capacity at the time the advance decision was prepared. On the other hand, introducing this higher standard of proof outside the sphere of the criminal law may be thought to be undesirable as it would overly restrict judges in some delicately poised cases. Accordingly a more appropriate requirement may be to demand 'substantial and convincing' evidence in order to support the overriding of a formal finding of capacity. While the idea of having to disprove any formal assessment and finding of capacity beyond the standard of the balance of probabilities may not sit easily with some, any move to implement this would apply only to advance decisions and the remainder of the Mental Capacity Act 2005 would remain unaffected. The clear benefit, however, would be a greater degree of legal protection for the wishes of patients who can demonstrate clear competence at the time of creating an advance decision.

The second issue, which flows neatly from the above, is that care would have to be taken to ensure that the assessment did not become a mere rubber stamping exercise and measures would need to be considered to prevent patients from 'shopping around' to find an expert who will deem them competent. Yet, in principle, this approach may go some way towards a situation in which advance decisions are prevented from being relied upon in cases where they should not be, and respected and

enforced when they should. At the very least, this would remove some of the confusion and uncertainty that continues to plague not only judges, but also healthcare professionals who are tasked with having to determine the validity and applicability of an advance decision in clinical settings, where time is often of the essence.

Not infrequently, Codes of Practice are used to put flesh on the bones of the substantive law. However, the Mental Capacity 2005 Code of Practice does not provide any useful guidance in relation to the question of assessing capacity *at the time the advance decision was created*. It simply says that, if healthcare professionals are not satisfied that the person had capacity at the time they created the advance decision, they are entitled to treat that patient and will incur no liability for doing so.[79] The interpretation of 'not satisfied' is therefore critical. The Code of Practice indicates that, if doctors are aware of reasonable grounds to doubt that the person had capacity at the time they made the advance decision, then this is enough to treat the patient without fear of liability. This sends a somewhat contradictory message to doctors by espousing blurred standards. The standard of 'not satisfied' invokes subjective connotations. Thus, is a doctor entitled to treat purely on the basis of a subjective belief that the patient did not have capacity at the time they created an advance decision? If so, this is a low evidential standard to satisfy which, on one view, makes it too easy to ignore an advance decision. If, however, doctors have to substantiate 'not being satisfied' by pointing to some 'reasonable grounds' for doubt, this raises the evidential bar slightly as it implies a degree of objectivity is required for meeting that threshold. The problem still remains, though, as to what constitutes 'reasonable grounds' for doubt? The inference is that it needs to be something more than just introducing an element of doubt, but, with the issue of capacity being fraught with so much uncertainty, simply being able to point to something may still be enough to influence a doctor or a judge to override an advance decision.

The imposition of a formal assessment of capacity as a precursor to validating an advance decision is, in many respects, a sensible option. It would reduce accessibility, but, given the importance of advance decisions to refuse life-saving treatment, it would also represent a further appropriate safeguard, helping to achieve the necessary overall balance which the law must strike in this context. At present, the law's open-ended approach to the question of capacity could serve to hinder a competent patient's wish to utilise an advance decision.

B. Interpretation of the safeguards

One of the main aims of the Mental Capacity Act 2005 was to introduce appropriate safeguards which would clarify the situations in which advance decisions are binding and, more importantly, where they can be legitimately overridden.[80] Thus, the law has attempted to reach a compromise.[81] It strives to afford appropriate protection to the competent patient's right to self-determination, but at the same time recognises that

79 See the Mental Capacity Act 2005 Code of Practice (Department for Constitutional Affairs, London 2007) at [9.8].

80 See Explanatory Notes to the Mental Capacity Act 2005, paras [84]–[92].

81 For an interesting discussion on compromise, see Huxtable, above, n 27. In particular, see chs 6–8.

the future incompetent patient is still a person whose rights and interests need to be considered and, in some cases, observed.

One drafting criticism is that the safeguards are opaque, imprecise, and open-ended, almost to the point where it could be said that there will be legitimate grounds to overturn an advance decision in the majority of circumstances. As such, the question of interpretation becomes pivotal.

In *X Primary Care Trust v XB and YB*,[82] the patient suffered from motor neurone disease and drafted an advance decision to instruct the doctors to discontinue his life-sustaining ventilation in the event that he should deteriorate and lose the ability to communicate. He drafted the advance decision by blinking his eyes at a communication board and this was prepared in the presence of his wife, his General Practitioner, and a mental capacity co-ordinator.[83] The application concerning the validity and applicability of the advance decision was actually brought by the Trust due to concerns they had about the circumstances in which the advance decision was signed. These concerns were made known to the Trust by one of the patient's carers, but were found by Theis J to lack substance.[84] However, the specificity of the advance decision was also called into question. An advance decision is not applicable to the treatment in question if that treatment is not the treatment specified in the advance decision.[85] Thus, while the legislation recognises that patients cannot be expected to be familiar with technical medical terminology,[86] there is still some debate about the amount of precision needed to draft a valid advance decision.[87]

In *XB*, the patient drafted his advance decision to refuse 'non-invasive' ventilation when in actual fact what he had received since 2003 was 'invasive' ventilation. Equally, there was confusion about a 'valid until' date section on the advance decision pro forma, which had the date of 2nd May 2012, the day after the court hearing, written next to it. This caused Theis J to openly admit that the terms of the advance decision were 'not always clear'. Notwithstanding this, he upheld its validity.[88] This is curious, particularly when viewed against that backdrop of his concluding remarks that there should be 'clarity in relation to what the terms of the advance decision are'.[89]

The approach of Theis J seems to contradict that articulated by Munby J in *HE* under the common law. His starting point appeared to be that there was an advance decision in place, which raised a *prima facie* presumption that it should be respected. For him, then, the advance decision represented reliable evidence of the patient's intention and actual wishes, and, on the evidence, it was more likely than not that any doubt as to applicability and validity did not undermine the patient's true intent.[90] It therefore seems that the evidence questioning the validity and applicability of the

82 [2012] EWHC 1390 (Fam).
83 Ibid at [16].
84 Ibid at [23].
85 Mental Capacity Act 2005, s 25 (4) (a).
86 Mental Capacity Act 2005, s 24 (2) provides that drafting an advance decision in layman's terms does not, in itself, invalidate it.
87 See M Brazier and E Cave, *Medicine, Patients and the Law* (5th edn, Penguin 2011) at 162.
88 See above n 82 at [20].
89 Ibid at [35].
90 Ibid at [20].

advance decision was afforded greater scrutiny and, on the facts, it was not convincing enough to override it. This approach is welcomed and certainly indicates that some judges at least will not be quick to invoke the safeguards unless there is compelling evidence to support their applicability. In *XB*, however, there was clear and sufficient evidence for the Judge to deduce that the patient had the necessary capacity to make the decision.[91]

The *obiter* comments of Jackson J in the previously mentioned case of *A Local Health Authority v E* are also of relevance.[92] The Mental Capacity Act 2005 provides that an advance decision is not valid if the maker has done anything inconsistent with it remaining their fixed decision.[93] First, the judge acknowledged that some patients will try to close off this particular avenue by including in the wording of their advance decision a clause to the effect that 'if behaviour is exhibited seemingly contrary to the advance decision this should not be viewed as a change of decision'.[94] He confirmed that this would not be effective to override section 25 (2) (c) of the MCA. Moreover, he indicated how he would have approached the question of inconsistent behaviour had it been a relevant consideration, which on the facts it was not, as a result of his conclusion that the patient lacked capacity.[95] Jackson J identified that there were factors suggestive of inconsistent behaviour from the patient. For example, in psychotherapy sessions, the patient had said she had made up her mind to live; she spoke eloquently of a desire to have a life and conveyed that she wanted to study midwifery and eventually wanted to have children.[96] Despite this, Jackson J stated that in continuing to refuse food, E's behaviour was 'entirely consistent' with her advance decision and that he would have been 'reluctant to conclude' that the advance decision was undermined by the evidence supporting inconsistency.[97] If, therefore, the issue of capacity had been decided in favour of the patient, there was still evidence to indicate some uncertainty about her advance decision remaining her fixed decision. Yet, the inference is that this would not have been sufficient to outweigh evidence pertaining to the patient's continued refusal of food. While it was never a live issue, in respect of this particular safeguard Jackson J seemed more convinced by the idea that the actions of the patient spoke louder than the words. His approach echoes that of Theis J in *X*,[98] in that, once the question of capacity is decided in favour of the patient, if there is still evidence to contradict an advance decision by reference to one of the safeguards, it ought to be examined carefully in order to ensure that its strength and veracity can be compared against the evidence weighing in favour of enforcement. It is too early to say with any certainty, but this does not imply that a minimal standard of evidence will suffice in future cases to trigger the application of the safeguards, which could be construed as revealing the possibility of a subtle change in direction from the courts in the sense that they may be more willing not to favour preservation of life.

91 Ibid at [16] and [25].
92 See above, n 65.
93 Mental Capacity Act 2005, s 25 (2) (c).
94 See above, n 65 at [63]. The patient, E, included such a clause in the case.
95 Ibid at [68] and [69].
96 Ibid at [68].
97 Ibid at [69].
98 See above, n 82.

C. Preservation of life

In tandem with a reluctance to apply the section 25 safeguards as evidenced above, Jackson J in the Court of Protection has shown a willingness to accept that preservation of life should not always be the guiding principle, even where an advance decision exists but does not comply with the required formalities.

In *Re D*, a declaration was sought by an NHS Trust that it would be lawful to withdraw all life-sustaining treatment, including ANH, from a patient in a permanent vegetative state (PVS).[99] Originally, a course of surgery was proposed to remove a malignant tumour from the patient's thyroid gland. Various complications after that surgery left the patient in a PVS, but, prior to the initial surgery, the patient gave his sister-in-law a signed letter in which he set out his wishes to refuse all medical treatment that would simply extend a reduced quality of life.[100] The only problem was that this purported advance decision was deemed invalid under the terms of the Mental Capacity Act 2005 because it did not meet the additional formalities required to refuse life-saving treatment.[101] Irrespective of this, Jackson J authorised the withdrawal of treatment on the basis that it was in the patient's best interests. For him, the patient's prior wishes 'carried very great weight'.[102]

This case signifies the potential interplay between, on the one hand, sections 24 and 25 of the Mental Capacity Act 2005, and, on the other, section 4 (6). The signed letter from the patient was insufficient in the sense that it could not be classified as a legally valid advance decision, yet where this is the case any decision made for a patient lacking capacity must be made on the basis of best interests. Thus, as section 4 (6) instructs the decision maker to take into account, so far as is reasonably ascertainable, the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),[103] Jackson J could give legal effect to the patient's prior wishes by placing emphasis on this aspect of the best interests assessment. In many respects, this represents a more enlightened approach from a judge and, on one level, Jackson J's approach ought to be well-received as being more patient-orientated. The general tendency towards favouring preservation of life was eclipsed here by evidence pertaining to what the patient would have wanted. However, it is too early to suggest whether or not this case will represent the beginning of a change in attitude from judges. There are particular characteristics present in this case which mark it out as being distinct from others in which no advance decision was present and in which the opposite outcome was reached in terms of the patient's best interests.

In *W v M and Others*, the patient was diagnosed as being in a minimally conscious state.[104] Baker J sitting in the Court of Protection was asked, in the first case of its

99 [2012] EWHC 885 (COP).

100 Ibid at [15].

101 Ibid at [16].

102 Ibid at [17].

103 Mental Capacity Act 2005, s 4 (6) (a). The decision maker must also consider, so far as is reasonably ascertainable, (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.

104 [2011] EWHC 2443; [2012] 1 WLR 110. For a recent critique see R Heywood, 'Moving on From *Bland*: The Evolution of the Law and Minimally Conscious Patients' (2014) Med LR doi: 10.1093/medlaw/fwu003.

kind, to grant a declaration authorising the withdrawal of life-sustaining ANH from the patient. There was no advance decision present.[105] The decision therefore fell to be resolved on the basis of best interests. Given the lack of an advance decision, the case is ostensibly similar to the position in *Re D*. There was unchallenged evidence supporting the fact that the patient would not have wished to be kept alive in her current state.[106] This was considered under section 4 (6) in the same manner as it was in *Re D*.[107] However, Baker J reached the opposite conclusion and, in his judgment, preservation of life was the dominating factor in his best interests assessment.[108] What, if anything, marks *Re D* out as being different and what persuaded Jackson J to find as he did?

In *Re D*, there were three factors that marked out the evidence in favour of respecting the patient's wishes as being of a 'uniformly high quality'.[109] First, there was compelling evidence in writing from the patient himself as to what he wanted to happen. While this was not a valid advance decision, the written evidence from the patient was articulate, reasoned, and intelligible. Second, at the time he wrote his letter, there was admittedly no formal assessment of his capacity, but there was nothing specifically to doubt it and the content of the letter itself demonstrated a reasoned understanding of his decision and its consequences. Accordingly, it would have been easier for Jackson J to accept that the patient had capacity at the time he expressed his wishes, thereby adding support to the quality of the evidence. Finally, the medical evidence in the case pointed to the fact that because of the patient's condition, continuing the treatment was futile and there was no realistic prospect of recovery.[110] On a rounded assessment of best interests, everything pointed to withdrawal being the most desirable course of action. However, even if the evidence in relation to the patient's wishes was removed from the equation, a narrower assessment of best interests may still have yielded the same result as the futility of the treatment may have been the most significant factor. On this point, while *Re D* could be interpreted as patient-centred and autonomy enhancing, it could equally be viewed as a case in which the patient's wishes and best interests (objectively defined) coincide. In light of the decision of the House of Lords in *Bland*,[111] it is not clear that there were in fact many more options available to the court other than to countenance the withdrawal of the treatment.

The situation was different in *W v M*. There was no direct evidence from the patient herself as to what her wishes would have been, either in writing or in some other format; the evidence only came from the patient's relatives and partner.[112] Thus, the evidence as to the patient's wishes, from third parties, was not as robust and reliable. Equally, while the patient's capacity was never questioned at the time she was purported to have expressed her views, absent anything in writing from the patient herself, there was less scope for Baker J to assess the level of understanding and

105 Ibid at [223].
106 Ibid at [225].
107 Ibid at [223].
108 Ibid at [249].
109 See above n 99 at [18].
110 Ibid at [18].
111 *Airedale NHS Trust v Bland* [1993] AC 789.
112 See above, n 104 at [242] and [247].

thought process which underpinned her wishes. Finally, the patient was clinically stable in *W v M* and so the question of futility was much more in the balance.[113] A more sophisticated assessment of best interests was therefore required and the question was much more delicately poised, with evidence pulling Baker J in opposite directions. In view of the fact that death was not reasonably imminent for the patient, it would have been a significant break with tradition to base everything on third party evidence as to what the patient's wishes *may* have been. Even so, Baker J's judgment is still open to criticism as being particularly narrow and it does raise some interesting questions about the precise extent to which the bias in favour of life should be allowed to dictate the outcome.[114]

V. A CONTINUING BIAS?

Michalowski is correct in stating that 'the criteria according to which liability can be avoided when upholding the validity of advance decisions (reasonable belief based on objective grounds) are much stricter than those for disregarding such a decision (a physician's satisfaction that the advance decision was not valid or applicable)'.[115] As such, the spirit of the Mental Capacity Act 2005 still embraces a bias towards preservation of life by encouraging doctors to disregard advance decisions instead of abiding by them. However, in light of the uncertainty surrounding the validity of advance decisions in general, whenever healthcare professionals and their legal advisers are faced with a case in which there is an element of doubt, they are now likely to turn to the court for an answer.

Insofar as the question of capacity is concerned, there is still a degree of flexibility in the law in terms of this aspect of advance decision making. If there is any doubt as to the patient's capacity at the time she created an advance decision, judges have been seen to tread cautiously and favour medical intervention. Nevertheless, if a judge is prepared to accept that the patient had capacity at the time of making the advance decision, and that the formalities have been complied with, it seems there will need to be strong evidence pointing the other way in order to trigger the application of the safeguards.

Capacity, therefore, seems to be the control device that judges rely on most frequently to override an advance decision. This component is arguably where the bias in favour of life remains most apparent. It is possible to argue here that the law does not quite reach an optimum balance. Elsewhere, however, a more even balance does seem to be struck because once the issue of capacity is decided in favour of the patient, the early indications are that judges will not be disposed to use the safeguards to override an advance decision unless there is substantial evidence in support of their application. Thus, it may be more appropriate to reduce the flexibly in respect of the capacity question, as suggested earlier in this piece, and then to use the safeguards as

113 Ibid at [248].

114 See Heywood, above, n 104; R Huxtable, '"In a Twilight Word"? Judging the Value of Life for the Minimally Conscious Patient' (2013) 39 J Med Ethics 565; A Mullock, 'Deciding the Fate of a Minimally Conscious Patient: An Unsatisfactory Balancing Act?: *W v M and Others* [2011] EWHC 2443 (Fam)' (2012) 20 MLR 460; R Heywood, 'Withdrawal of Treatment from Minimally Conscious Patients' (2012) 7 Clin Eth 10–6.

115 Michalowski, above, n 7 at 960.

the appropriate counterbalancing mechanism. At present, however, the point is rarely reached in which the safeguards can be used in this manner because the capacity question causes the advance decision to fall at the first hurdle. As a consequence, in view of the law as it stands, judges have to be careful not to lean too far in favour of preserving life by being unduly quick to hold that the patient was incapacitated, as this is where the bias could continue to exert a decisive influence.

Beyond that, even if there is an advance decision which does not comply with the additional safeguards needed to refuse life-saving treatment, where there is some direct written evidence from the patient coupled with medical evidence supporting the futility of the treatment being provided, at least one judge has seen fit to place emphasis on the patient's past wishes in the best interests assessment in order to authorise the withdrawal of treatment.[116] One salient point, which remains to be decided, is whether just one or indeed both of these factors will need to be in existence in order to encourage a judge to adopt an expansive approach to best interests. In *W v M*, on a restrictive interpretation, neither was present.[117]

It would have been intriguing to see, then, what would have been the situation if, in *W v M*, the patient had no valid advance decision but had nonetheless written a letter expressing her wishes with the same level of clarity and understanding that the patient in *Re D* demonstrated.[118] Would this evidence have been enough to tip the best interests assessment in favour of withdrawal under section 4 (6) of the Mental Capacity Act 2005? Or would Baker J have still been persuaded to err on the side of preservation of life because her treatment, on one view, was not medically futile? Alternatively, what if Jackson J had been faced with the same written letter as he was in *Re D*, but the medical evidence was more open to debate, both in terms of the therapeutic benefit the treatment was providing and the clinical stability and life expectancy of the patient? Would this have been enough to influence Jackson J to decide in favour of life? It is only as these factual situations come before a judge, if indeed they ever do, that an accurate contemporaneous assessment can be made of how prominent the bias in favour of life still is. At present, it appears that the bias still exists and relics of the common law decision in *HE* remain,[119] but the actual extent of that bias is perhaps open to question and the early indications appear to suggest that it may not be as strong as it once was.

VI. CONCLUSIONS

This article has reflected upon, and critically analysed, recent developments in the law of advance decision making after the advent of the Mental Capacity Act 2005. The contemporary case law illustrates a far from coherent approach across a range of

116 Jackson J in *Re D*, above, n 99.

117 See above, n 104. On a restrictive view, the fact that the treatment was offering some therapeutic benefit to the patient could be taken to mean that it was not futile. If, however, futility is analysed in terms of the benefits of treatments compared to the burdens, an approach advocated by John Keown, the question becomes a much fiercer subject of debate in *W v M*. See R Cranford and L Gostin, 'Futility: A Concept in Search of a Definition' (1992) 20 Med Law Hlth Care 307; J Keown, *The Law and Ethics of Medicine* (Oxford University Press 2012) at 12.

118 See above, n 99.

119 See above, n 5.

different factual situations. Judicial attitudes oscillate and it is difficult to identify any principled approach. Aspects of advance decision making have continued to cause judges problems in respect of validity. It seems capacity, for instance, is a question which will always be treated, quite rightly in some cases, with caution. Equally, the standard of evidence that is required to invoke the safeguards remains ill-defined. In a wider sense, it is difficult to predict where the bias in favour of life will be upheld and where the evidence will be perceived in a way that gives rise to a more sympathetic approach to accepting the prior wishes of the patient. Some of this continued uncertainty is unavoidable as this area of law is, by nature, case sensitive. However, this is of little help to medical professionals who may find themselves caught between a rock and a hard place when assessing the legitimacy of any advance decision at the coalface of a medical emergency. It is hoped that, as further cases arrive, more useful guidance will emerge from the courts.

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