

**LEGISLATING TO GIVE EFFECT TO PRECEDENT AUTONOMY:
COMPARATIVE REFLECTIONS ON LEGISLATIVE INCOMPETENCE**

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ABSTRACT

This article considers the legislative responses to the perceived need to provide for the binding force of precedent autonomy in Austria, Germany and England. It reflects comparatively upon the impact of these responses in considering to what extent it is possible to make an anticipatory refusal of consent to medical treatment that will bind healthcare professionals, as opposed to being merely a factor to be considered in determining the patient's best interests or presumed will. It concludes that each of the three legislatures has introduced significant hurdles to the creation of a binding anticipatory decision, ensuring that medical discretion and the presumption in favour of life will be preserved in the majority of cases, and in so doing undermines the very concept of precedent autonomy.

INTRODUCTION

During the past fifty years, the nature of the doctor-patient relationship has moved from a medical paternalism paradigm to one that stresses the importance of patient autonomy and adopts a model of shared decision-making. Within this model, doctors play a pivotal role in providing information and expertise to enable patients to make effective choices about the

medical care and treatment they receive. This shift in perspective from ‘doctor knows best’ to patient autonomy is made more important by the fact that, with improvements in medical science and advanced medical knowledge, death is now often the result of a decision to withhold or withdraw treatment; a decision that will ultimately depend upon what may be regarded as an acceptable quality of life in relation to the patient concerned. It is common ground that ‘every person’s body is inviolate’¹ and that an adult patient with the requisite capacity may refuse medical treatment, including life-sustaining treatment.² This ensures that such decisions are made by patients themselves, in accordance with their own values and judgements about what constitutes an acceptable quality of life. However, the logical extension of this principle is that individuals with capacity should also be empowered to exercise precedent autonomy, making choices during times of capacity that take effect in the future where the individual lacks the capacity to make a contemporaneous decision, rather than treatment being provided in accordance with the patient’s best interests or presumed will as assessed by a third party.

The principle of patient autonomy stresses respect for the patient as an individual, rather than as an object of concern, and attempts to promote precedent autonomy aim to extend that respect to those no longer capable of exercising autonomy and so to prioritise the patient’s wishes over her³ welfare. An important mechanism for conveying precedent autonomy is an advance directive, an instrument designed to act as a communication bridge, bridging the occurrence of incapacity and providing a clear statement of how the patient wants to be treated, or more usually what treatment the patient does not wish to be afforded. However, whilst an important tool, an advance directive is a mono-directional form of communication that takes effect only once the patient lacks capacity and is therefore no longer able to discuss alternative treatment and care options, to clarify her wishes, or indeed potentially to rescind her previously expressed wishes.

Anticipatory decision-making offers great promise and could make a substantial contribution to the empowerment of those lacking capacity, but there are important asymmetries between anticipatory and contemporaneous decision-making, asymmetries with the potential to undermine both the legal and moral authority of an advance directive. At one level obvious practical problems exist, including how to ensure that the anticipatory decision was voluntary and that the individual had capacity to make the decision. In addition, Buchanan and Brock identified four significant problems associated with anticipatory decisions that distinguish them from contemporaneous decisions and undermine the moral authority of advance directives.⁴ The first two problems acknowledge the inherent difficulty in drafting an advance directive to take effect at a future time when, depending upon the current health of the patient, the range of treatment scenarios and treatment available are inherently unpredictable and advances in medical science may have significantly altered the treatment options. Thirdly, at the time the directive should come into operation, an individual's interests may be radically and unforeseeably different from those anticipated. Finally, they recognised that the 'informal safeguards that tend to restrain imprudent or unreasonable contemporaneous choices by a competent individual are not likely to be present, or if present to be as effective' in relation to an anticipatory choice.⁵

Each of the abovementioned problems is inextricably linked to the temporal and psychological distance that separates the anticipatory decision from the time at which it should be implemented. However, it is suggested that such problems can be resolved by the introduction of suitably stringent safeguards determining the criteria for validity and (continuing) applicability of advance directives, together with an understanding of the true nature of autonomy. Autonomy's central premise is that individuals should be permitted to make decisions for themselves, but the corollary to this must be that individuals must be able to make decisions contrary to their own best interests that they might later regret and that

choosing to exercise autonomy in anticipation of incapacity involves accepting responsibility for that choice. Nevertheless, the validity and authority of anticipatory decision-making calls into question the interplay of two potentially conflicting interests—that of society in upholding the sanctity of life and the patient’s right to self-determination. In considering this potential for conflict courts have stressed that in cases of doubt the sanctity of life must prevail.⁶ Therefore any attempt to give legal force to precedent autonomy must institute suitable safeguards, but at the same time do so in such a manner as to achieve a balance between respect for the sanctity of life and self-determination, ensuring that the safeguards do not render the right to make an anticipatory choice and to expect that choice to be implemented merely illusory.

Against this background, this article considers recent legislation⁷ enacted in Austria, Germany and England and Wales which sought to clarify the standing of advance decision-making and to promote legal certainty by providing statutory recognition of the importance and binding nature of at least some advance decisions. Prior to the introduction of these Acts judicial, legislative and professional support for the binding nature of advance directives could be discerned in each of the jurisdictions. However, concern existed as to whether such anticipatory refusals of treatment would bind healthcare professionals, or were merely a factor to be considered in determining the patient’s best interests (in England and Wales) or her presumed will (in Germany and Austria) and thus that treatment could be afforded to the patient lacking capacity despite the existence of an applicable directive. This lack of clarity impinged upon patients and healthcare professionals alike, therefore, in each of the jurisdictions it was decided that legislation should be introduced to give statutory recognition to binding anticipatory refusals, rather than leaving the issue to the vagaries of the common law. In England and Wales and Germany this was achieved within the broader legislative

context relating to those lacking capacity; in Austria legislation relating specifically to advance directives was introduced.

Whilst sharing the same aim of empowering patients, the maxim, *in dubio pro vita* can be seen to have greatly influenced the three legislatures to the extent that it must be questioned whether, through the imposition of weighty (and in some cases expensive) safeguards, the legislation adopted pays more than lip service to precedent autonomy, rendering the ability to create a binding advance decision little more than an unattainable ideal. This article will consider the legislative responses to the perceived need to provide for the binding force of precedent autonomy in the individual jurisdictions, then reflect comparatively upon the impact of these responses, considering to what extent it is possible, in each of these jurisdictions to make an anticipatory refusal of medical treatment that will bind healthcare professionals. It is concluded that each of the three legislatures has introduced significant hurdles to the creation of a binding anticipatory decision, ensuring that medical discretion and the presumption in favour of life will be preserved in the majority of cases.

I THE THREE LEGISLATIVE RESPONSES TO THE PERCEIVED NEED FOR LEGISLATION TO GIVE EFFECT TO PRECEDENT AUTONOMY

1) England and Wales (hereafter England)⁸

a) Background to the Act

It has long been recognised that an adult patient with capacity may refuse medical treatment, including that which furthers her own best interests and life-sustaining medical treatment⁹ for ‘any reason, rational or irrational, or for no reason at all.’¹⁰ Treatment provided

contrary to such a refusal will expose the healthcare professional to both criminal and tortious liability for battery.¹¹ By contrast, in the case of a patient lacking capacity, absent a valid advance decision or the existence of a proxy decision-maker¹² empowered by the patient to take such decisions, the patient must be treated in accordance with her best interests.¹³ Although the assessment of best interests does incorporate consideration of the patient's previously expressed wishes and the values and beliefs she held while she had capacity,¹⁴ these are merely factors to be considered, rather than determinative of treatment decisions.

Prior to the introduction of the Mental Capacity Act 2005 (MCA) the courts had recognised that an advance refusal could bind healthcare professionals in a similar manner to that given contemporaneously, but stressed that in the case of anticipatory refusals an added degree of care is required to ensure that the patient's anticipatory refusal is valid, indicating that more stringent requirements may be applied to the exercise of precedent autonomy.¹⁵ Largely in keeping with the Law Commission's proposals,¹⁶ the MCA effectively codified the existing common law, recognising that an individual can make a valid and binding advance refusal of treatment, including life-sustaining treatment, that will take effect if she later lacks the capacity to make a contemporaneous decision. Nevertheless, it is argued that the Act limits the opportunity to exercise precedent autonomy by imposing a number of limitations upon the scope of anticipatory decision-making and by leaving a substantial degree of discretion to a healthcare professional to determine whether or not an advance decision is binding.

b) An examination of the new law regulating advance directives

i) Initial validity and applicability

The ability to exercise precedent autonomy is restricted to advance refusals of treatment made by an adult aged eighteen or over with capacity: s.24(1) MCA. In relation to contemporaneous decision-making, although a minor's age¹⁷ and/or understanding¹⁸ is crucial in determining whether a minor can consent to medical treatment in her own right, the courts have consistently held that a refusal of consent to treatment adjudged to accord with her best interests is subject to recidivism by a parental responsibility holder or the court.¹⁹ When it is considered that a mature minor may be capable of fulfilling the capacity criteria set out in the Act, it seems rather arbitrary to exclude the possibility of her making an advance decision on the sole criterion of age. Thus the failure to provide for a mature minor's ability to make an advance decision should be seen as a missed opportunity for the legislature to correct the overly paternalistic approach adopted by the courts to minors and the treatment thereof, particularly given that the Act generally applies to those aged sixteen and over, rather than merely adults.²⁰

In relation to adults, the validity of a refusal of treatment is dependent upon the individual being deemed to have the capacity to make the relevant treatment decision at the time it was made. The Act defines incapacity as the inability to make a decision²¹ as the result of the individual being unable to 'understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate his decision.'²² Thus a functional test of capacity is adopted; capacity is decision specific, but as was recognised in *Re T* the patient must have the requisite capacity for the decision in hand, whereby the graver the circumstances, the higher the degree of capacity required will be.²³ It is worth noting that a much higher degree of capacity will be required to refuse medically-indicated life-sustaining treatment, than would be required to consent to it due to the attendant consequences.

Whilst the Act maintains its link with the common law in perpetuating the presumption of capacity,²⁴ when the impact of s.26(2) MCA is considered it would appear that in fact the general presumption of capacity may not apply to advance refusals. When the time comes for implementation of an advance decision, attending doctors are required to satisfy themselves of its validity,²⁵ an assessment that will include a retrospective consideration of whether the patient had the capacity to make the decision at the time of drafting, rather than simply presuming that to be the case. The Code of Practice and the GMC guidance require doctors to specifically consider whether patients had the requisite capacity, but stress that a doctor should presume that to be the case unless there are grounds for doubt.²⁶ Nevertheless, a key deficit in the MCA, is that it does not require an assessment of capacity at the time the advance decision is formulated, a requirement that would form an important safeguard of the patient's ability to exercise precedent autonomy, obviating any need for a retrospective capacity assessment at a time when the patient is unable to demonstrate that she possessed the requisite capacity at the time of drafting.

Regarding the permissible scope of an advance decision, the MCA mirrors the common law relating to contemporaneous decisions, stressing that an advance decision may not be used to request assisted suicide or active euthanasia,²⁷ and merely permitting individuals to refuse specific medical treatments in anticipation of incapacity. By limiting valid advance decisions to refusals of treatment, the Act preserves clinical judgement in terms of what treatment should be available to the patient,²⁸ although treatment preferences expressed in an advance decision will fall to be considered under the assessment of best interests as expressions of the person's past wishes. Thus, it is clear that the right to self-determination in both the contemporaneous and anticipatory contexts is conceived of as a right to decide not to be treated, a right to defend one's bodily integrity, but not a right to demand treatment.²⁹

At common law it was accepted that all anticipatory decisions could be made in any manner, for example orally³⁰ and through blinking.³¹ However, the MCA imposes a form requirement upon anticipatory refusals of life-sustaining treatment, requiring such refusals to be set down in writing; be signed by the individual, or someone acting on her behalf in her presence, and witnessed; and to include a specific statement that the refusal is intended to operate even if life is at risk.³² As the majority of advance decisions are designed to exclude life-sustaining treatment, most advance decisions will be required to be set down in writing. The imposition of a form requirement underscores the difference between anticipatory and contemporaneous refusals as no such requirement is imposed upon the latter. It also illustrates the preference for life that pervades the MCA, applying only to advance decisions to refuse life-sustaining treatments, defined by the Act as ‘treatment which in the view of a person providing health care for the person concerned is necessary to sustain life’.³³ Nevertheless, it must be remembered that the determination of what will constitute life-sustaining treatment will largely depend upon the patient’s condition. Thus the relatively innocuous antibiotic could well constitute life-sustaining treatment in the case of a patient suffering from pneumonia.

Following the stipulations set out in *Re T* by Lord Donaldson MR,³⁴ in order to be effective the advance decision must specify the particular treatment to be refused, and the circumstances in which that refusal is to operate.³⁵ However, s.24(1) MCA 2005 merely refers to ‘such circumstances as he *may* specify,’ suggesting that although there is an expectation that the scope of the refusal should be specified, that may not be a requirement for validity. The majority of advance directives will be necessarily abstract, being drafted with a view to determining treatment to be given or refused across a wide spectrum of clinical scenarios that may, or may not, eventuate. However, if the scope of the refusal is not defined in the advance decision it will be vulnerable to a finding that the individual did not intend it

to apply in the situation that arises. Despite the fact that the decision and scope thereof may be expressed in non-technical language this dual specificity requirement is likely to prove the most difficult criterion to satisfy, particularly in the case of patients who are not suffering from a degenerative disease with a known prognosis that enables likely treatment options and scenarios to be anticipated with a relatively high degree of certainty.

ii) Continued validity and applicability

Provided that the patient's advance decision is valid and applicable to the treatment in question, the decision will have 'effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.'³⁶ However, even if an advance refusal satisfies the eligibility criteria, the continued validity and applicability of the advance refusal must be considered. The Act stresses that an individual can revoke her advance refusal at any time whilst she has the capacity to do so.³⁷ Revocation does not need to take any particular form so could, for example, consist of tearing up a written refusal. Additionally, intervening events may invalidate the advance decision. Three such circumstances are outlined in the Act. Firstly where the individual has subsequently created a lasting power of attorney and devolved power to the donee to consent or refuse consent to the treatment covered by the advance decision,³⁸ positing the LPA as an alternative to an advance decision, rather than as playing a complementary role thereto as in Germany and Austria, discussed below. Secondly, an advance refusal may be invalidated if the patient has acted inconsistently with that decision since making it,³⁹ for example by renouncing her religious faith which formed the basis of the advance decision.⁴⁰ Finally, the advance decision may be found to be inapplicable due to the existence of reasonable grounds for believing that circumstances exist that the individual had

not anticipated, but which would have affected her decision.⁴¹ An example of such a circumstance would be where new, or improved therapeutic options have become available in the intervening period between the making of the advance decision and the time at which it falls to be implemented. As the Code of Practice makes clear, the longer the time between the making of the decision and the time for its implementation, the less likely it is that it will be found to be valid and applicable due to advances in medical science, or changes in the person's life.⁴² Nevertheless, the Act does not impose any requirement that the advance decision be regularly reviewed and renewed, leaving this to the discretion of the patient.

A further aspect of the perceived need for clarity was demonstrated by the British Medical Association's call for legislation to 'clarify the non-liability of doctors who act in accordance with an advance directive,'⁴³ although arguably clarification of the liability of a doctor failing to act in accordance with an advance directive was equally important. The Law Commission's proposals applied the same standard of reasonable belief to both situations,⁴⁴ but it is suggested that the Act provides much greater security for healthcare professionals by adopting a differential standard designed to preserve medical discretion. S.26(3) MCA, confirms that whereas a doctor must only hold a reasonable belief that a valid and applicable advance decision exists in order to avoid liability for non-treatment, she will only incur liability for continuing the refused treatment if she is *satisfied* that the advance refusal is valid and applicable to the treatment. On this basis it would seem that a large degree of discretion is afforded to the healthcare professional to determine whether or not the advance decision is valid and applicable, should she have any doubt (in the sense that she is not entirely satisfied) she will be able to regard the refusal as merely indicative of the patient's wishes.

Therefore the MCA does recognise that an individual can create a valid advance decision that will bind healthcare professionals. However, other than the incorporation of a form requirement for advance refusals of life-sustaining treatment and the clarification of

implications of an advance decision for healthcare professionals, the Act merely codifies the existing common law. This leaves significant discretion to doctors to determine whether or not an advance decision is valid and applicable, but fails to provide clear guidance for, and control of, the exercise of this discretion. The Act does little to resolve the uncertainties regarding how specific the treatment refused and the scope of that refusal must be. Similarly, there is significant doubt about when an advance decision may be regarded as no longer representing the will of the patient and consequently be invalidated, reducing the status of the advance decision to that of an expression of the individual's past wishes, just one of a number of factors to be considered in assessing whether treatment should be afforded as required by the patient's best interests.

2) Germany⁴⁵

a) Background to the Act

In relation to contemporaneous decision-making the law has long been settled in Germany—medical treatment will constitute a battery unless it is justified by law, necessity, or by the patient's sufficiently informed consent.⁴⁶ The requirement of consent reflects the recognition of three basic rights protected by the *Grundgesetz* (GG, German constitution): the right to self-determination (Art.2 I GG), to bodily integrity (Art.2 II GG) and the protection of human dignity (Art.1 I GG). The German courts have long recognised that these constitutional rights entitle an adult patient with capacity to refuse medical treatment, including life-sustaining treatment, for any reason and that the fact that a refusal of consent might be regarded as irrational or unwise will not invalidate the refusal.⁴⁷

In the case of a patient lacking capacity, treatment may only be afforded to the extent that it complies with the patient's presumed will; the determination of which is primarily a subjective assessment that includes consideration of the patient's earlier oral and written statements, her religious faith, other personal values and her life expectancy.⁴⁸ Like its North American counterpart the substituted judgement standard, the presumed will approach centres upon the patient's presumed wishes, rather than her needs, arguably prioritising her dignity and autonomy to a greater extent than the English best interests approach. Whenever an adult is unable to manage her affairs due to mental illness, mental or physical incapacity, the Guardianship Court can appoint a *Betreuer* (guardian) to take responsibility for those areas that the individual is unable to manage herself, provided that the individual doesn't already have a *Bevollmächtigte* (the equivalent of a someone with Lasting Power of Attorney in England)⁴⁹ or other means of assistance rendering a *Betreuer* unnecessary.⁵⁰ Thus, in almost every case where a patient lacks capacity and has not appointed a *Bevollmächtigte*, a *Betreuer* will have to be appointed for her by the court. In the absence of a valid and applicable advance directive, the *Betreuer*'s role is to both assess and implement the patient's presumed will. By contrast, a *Bevollmächtigte* is appointed by the patient herself, at a time when she has the capacity to do so, and she will take the place of the patient, with the ability to consent or refuse consent to treatment on behalf of the patient. As will be considered below, both forms of legal representation play a central role in the new law in determining whether an advance directive is valid and applicable, rather than being regarded as an alternative method of making provision for future incapacity as in England.

Prior to the introduction of the 3rd Law to Amend Guardianship Law 2009, the validity and applicability of advance directives was subject only to the common law. Whilst the English jurisprudence was quite settled prior to the enactment of the MCA, the position in Germany was rather confused as the Criminal and Civil Divisions of the *Bundesgerichtshof*

(the Supreme Court) had issued conflicting decisions in this area.⁵¹ In 1994, the 1st Criminal Division of the *Bundesgerichtshof* acknowledged the importance of previously expressed wishes, holding that they constitute important evidence of the patient's presumed will. It held that if the patient is incurably ill and such statements clearly establish her will, they can justify the withdrawal or withholding of life-sustaining treatment.⁵² By contrast, in 2003 the 12th Civil Division of the *Bundesgerichtshof*⁵³ recognised that advance directives are an independent expression of the patient's will, rather than merely an indication of her presumed will. The court held that such expressions survive incapacity, provided they have not been revoked,⁵⁴ obliging the *Betreuer* to give effect to anticipatory decisions that are applicable to the treatment and medical circumstances.⁵⁵

While significant due to the recognition of the independent and continuing force of an advance decision,⁵⁶ the 12th Civil Division's decision caused considerable confusion and was the subject of extensive criticism.⁵⁷ Although the court accepted that treatment could be withdrawn from a patient lacking capacity if this corresponded to her anticipatory or presumed will, it expressed this as being the case when the patient's underlying condition would irreversibly lead to death,⁵⁸ rather than simply when the patient was incurably ill as held by the 1st Criminal Division. This confirmed that the patient did not have to actually be dying (in which case, as the *Bundesgerichtshof* had previously recognised, life-sustaining treatment would not be medically indicated),⁵⁹ but it raised significant questions about what would constitute an underlying condition that would irreversibly lead to death? There is no requirement that a patient with capacity continue to consent to treatment until such a time as her condition could be said to be such as to inevitably lead to her death. However, this decision appeared to limit the permissible scope of an advance refusal of treatment, arguably rendering those in, for example, a persistent vegetative state passive 'prisoners of medical technology'⁶⁰ and those with a directive refusing blood transfusions on the basis of religious

beliefs liable to treatment. Additionally confusion arose concerning whether or not a *Betreuer* would need to obtain Guardianship Court approval of her decision to refuse consent to treatment on the basis of a valid and applicable advance directive. The 1st Criminal Division had suggested that such a duty would exist in all cases where medically indicated treatment was to be withdrawn.⁶¹ By contrast, the 12th Civil Division stated that approval would only be necessary in the case of conflict between doctors and the *Betreuer* as to whether indicated treatment should be withdrawn, but recommended that legislation recognising the role of the Guardianship Court at the end of life was necessary.⁶²

Due to the confusion created by the conflicting jurisprudence the Federal Minister for Justice established a working party 'Patient Autonomy at the End of Life' to consider whether legislation relating to advance directives was necessary; it answered in the affirmative citing a lack of legal clarity.⁶³ This finding was echoed by the Parliamentary Commission on Ethics in Modern Medicine which recommended that legislation was necessary to resolve the uncertainty faced by doctors, *Betreuers*, *Bevollmächtigten* and Guardianship Courts about the application of advance directives.⁶⁴ The path to legislation was long, but finally the German Parliament passed the 3rd Law to Amend Guardianship Law in 2009, amending the provisions relating to guardianship in the BGB (German Civil Code) by providing for the binding force of advance directives therein, rather than as a separate area of law.

b) An examination of the new law regulating advance directives

i) Initial validity and applicability

§1901a I BGB, as amended, makes provision for the binding effect of valid and applicable advance directives, making it clear that only adults with capacity to consent may execute an advance directive. As the regulation of advance directives is anchored in guardianship law, it follows that only an adult can make a valid advance directive, because only an adult is capable of being placed under guardianship or appointing a *Bevollmächtigte*. However, the fact that the ability to exercise precedent autonomy is restricted to adults does mean that the wishes of even a mature minor can only be considered as part of an assessment of her presumed will and hence that her ability to exercise her constitutional right to self-determination is severely restricted. Capacity is, as in England, decision-specific and requires that the patient be able to understand the type, meaning and consequences, including risks, of the proposed intervention and be able to make a decision upon the basis of that understanding.⁶⁵

The advance directive must consent or refuse consent to specific medical treatments, clinical investigations or medical interventions and set out the circumstances in which the decision is to take effect. Therefore, unlike the MCA, §1901a I BGB also provides for anticipatory consent. However, like the MCA the German law does not require a person drafting an advance directive to take medical advice. This is a significant omission in the German context because, under German law, a consent to medical treatment is only valid if it is sufficiently informed, or if medical advice has been rejected.⁶⁶ Thus, the Bill's explanatory notes recommend that medical advice should be sought, or that explicit reference should be made in the directive that the individual waived such advice.⁶⁷

A permissible anticipatory decision finds its limits in the same boundaries applied to contemporaneous decisions, hence a request for active euthanasia would be invalid as killing on request is prohibited by §216 StGB (*Strafgesetzbuch*, Penal Code). Similarly, as the *Bundesgerichtshof* stressed, the limits of a patient's ability to consent are dictated by the

doctor's assessment of what treatments and investigations are clinically indicated; if the doctor forms the view that the treatment consented to in the advance directive is not clinically indicated, the patient's consent will be irrelevant.⁶⁸ Therefore, as in England, an advance directive cannot be used to mandate treatment. A significant advantage of the new regulation is that it sets an end to the confusion created by the 12th Civil Division of the *Bundesgerichtshof* in establishing that the validity of advance directives is not dependent upon the type or stage of the patient's illness, §1901a III BGB. This provision was introduced in conformity with the recommendation of the National Ethics Council's majority opinion⁶⁹ that such a limitation would impose an unacceptable restriction upon the individual's right to self-determination.

Like the approach adopted by the English courts, the *Bundesgerichtshof* had suggested that oral statements given in anticipation of incapacity would suffice,⁷⁰ however §1901a I BGB requires that advance directives be written. This form requirement is to be interpreted in line with the general civil law provision found in §126 I BGB, thus the advance directive need not be handwritten and a pre-prepared form may be utilised. The directive must be signed by the individual, or if that is not physically possible it must be notarised. The introduction of form requirement serves once more to underline the restricted scope of anticipatory decision-making when compared to its contemporaneous counterpart.

ii) Continued validity and applicability

The BGB as amended provides for the binding effect of an advance directive, however, it does require an incapacitated patient to have either a *Betreuer* or a *Bevollmächtigte* to assess the validity and applicability of the advance directive. If the initial requirements are fulfilled the patient's legal representative⁷¹ must examine the advance

directive and satisfy herself that it is applicable to the patient's current life and treatment situation and that it still represents the patient's will. In line with the jurisprudence of the *Bundesgerichtshof*,⁷² no requirement to renew the advance directive is imposed upon the individual—she is entitled to expect her directive to remain in force unless or until she revokes it, revocation being possible at any time and in any manner, §1901a I BGB. However, the legal representative is required to assure herself that not only has the patient not revoked her advance directive, but also that the patient's life circumstances and wishes have not changed during the intervening period. This assessment will include considering concrete indications that the patient no longer wishes her advance directive to apply as well as whether the patient would have decided differently now if she were able to.

In assessing whether or not the advance directive is valid and applicable, the Act requires the legal representative to enter into a dialogue with the doctor, §1901b I BGB. As the *Bundesgerichtshof* stressed, the question of consent will only arise in relation to treatment that is clinically indicated.⁷³ §1901b I BGB recognises that the doctor's role is first to consider what treatment is clinically indicated, then to discuss with the patient's legal representative whether or not that treatment would correspond to the patient's advance directive, emphasising that a dialogue between the doctor and the legal representative is central to the legislative scheme regulating advance directives. Moreover, recognition is afforded to the wider social context of decision-making through the requirement that the legal representative consult with close friends and family of the patient in assessing the applicability and validity of the advance directive, or to clearly establish the patient's presumed will if no such directive is available, §1901b II BGB. However, this form of social control will only be possible where the consultation will not occasion considerable delay and the focus of the consultation must be to determine and give effect to the patient's anticipatory decision, not to undermine it.⁷⁴

If the legal representative can assure herself that the validity and applicability requirements are met, the advance directive will bind the legal representative, who is then obliged to communicate the (refusal of) consent on behalf of the patient and to implement the directive,⁷⁵ there is no scope for her to substitute her own decision for that of the patient.⁷⁶ If the directive is not applicable to the patient's current situation, it will fall to be considered by her legal representative in determining the patient's presumed will. In such cases the legal representative must refer to the (non-exhaustive) checklist contained in §1901a II BGB, considering the patient's earlier 'oral or written statements, ethical or religious convictions and other personal values' in determining whether or not to consent to treatment in accordance with the patient's presumed will. If there is no concrete evidence that the patient's presumed will would require a refusal of treatment, the legal representative should consent to medically indicated treatment—in case of doubt the preference for life will prevail.⁷⁷

The new regulation provides clarity about when an application for approval must be made to the Guardianship Court and applies the same rules to both *Betreuer* and *Bevollmächtigte*.⁷⁸ Unlike a *Betreuer*, a *Bevollmächtigte* is generally not subject to court supervision. Thus, whilst this may provide clarity, it effects a significant deviation from the enhanced status of the *Bevollmächtigte* and raises questions of appropriateness given that a *Bevollmächtigte* is appointed by the patient herself, specifically to take the decision whether or not to consent to life-sustaining treatment on her behalf (in accordance with her advance directive or other wishes). By contrast, a *Betreuer* is appointed by the court and may not have had a relationship with the patient based upon the same level of trust. Given the significant distinction between the two types of legal representative, it is difficult to justify applying the same rules to both,⁷⁹ particularly as the BGB does not envisage the Guardianship Court exercising oversight over all non-treatment decisions. As §1904 IV BGB makes clear, approval from the Guardianship Court need only be sought in cases of conflict between the

doctor and legal representative. If the doctor and legal representative agree that the patient's advance directive is valid and applicable, and thus that the decision therein is binding upon them both, there is no need for court approval; the same rule applies to the presumed will as determined by the legal representative. In the case of disagreement between the doctor and the legal representative, an application must be made to the Guardianship Court for approval of the legal representative's decision. The court's role is limited to considering whether or not the legal representative's decision accurately reflects the patient's will, if so the court must approve the decision, §1904 III BGB.

The limited nature of the control function allocated to the court raises real questions given that the justification provided for court involvement does not relate to enabling a legal representative to compel a doctor to implement the patient's wishes, but rather is based on the need to protect the patient's life and right to self-determination, as outlined by the *Bundesgerichtshof* in 2003.⁸⁰ Nevertheless, the control instance is only required by virtue of the *dissens* between the doctor and representative, reflecting the notion that in such cases the principle of *in dubio pro vita* requires court adjudication. The explanatory notes posit that court oversight is not required where the doctor and legal representative agree on the will of the patient as the doctor and legal representative are expected to act as a check and balance upon one another and that absent a suspicion of abuse there can be no justification for such proceedings with the inevitable delay that would entail for implementing the patient's will.⁸¹ This reasoning seems unconvincing—if there is a need for court involvement to protect the patient's life and right to self-determination where doctors and legal representatives disagree, that same need is not obviated simply because the two parties agree that treatment should be withdrawn or withheld. Arguably the fact that the doctor and legal representative agree about whether treatment should be provided does not mean that the representative's decision truly reflects what the patient wanted, it may reflect their own subjective values of the sufficiency

of the patient's quality of life. However the restriction of mandatory court oversight to cases of disagreement reflects a pragmatic attempt to balance the need for protection of life against the needs to facilitate precedent autonomy without undue delay and to avoid overburdening the Guardianship Courts. Moreover, the required involvement of family and close friends in the dialogue to establish what the patient would have wanted should introduce an additional control measure into the process and it remains possible for third parties who suspect abuse to petition the Guardianship Court to review the legal representative's decision to refuse treatment.⁸² Indeed a secondary function of the Guardianship Court would appear to be to legitimise the legal representative's decision, safeguarding her from potential criminal proceedings in respect of the decision, and to provide clarity and legal certainty for the medical personnel required to withdraw or withhold the life-sustaining treatment.⁸³

The 3rd Law to Amend Guardianship Law has clarified many of the existing concerns relating to the applicability and effect of advance directives. It is now clear that an advance directive can contain a valid refusal of life-sustaining treatment, regardless of whether the patient is suffering from an irreversible condition that will lead to death. However, questions remain about how specific the advance directive must be and about when it will apply. A key feature of the German regulatory response to the problems arising from advance directives is that the patient's legal representative acting together with the doctor, rather than the doctor alone, must determine the applicability of the advance directive, ensuring that the interpretation of the advance directive, or indeed the patient's presumed will, is not simply delegated to the attending doctor as in England.

3) **Austria**⁸⁴

a) **Background to the Act**

In Austria, just as in England and Germany, a sufficiently informed consent is a prerequisite to lawful medical treatment and a patient may refuse consent to treatment, including life-sustaining treatment.⁸⁵ However, unlike the other two jurisdictions under consideration, the Austrian Penal Code contains a specific offence of providing unauthorised treatment that will be committed by a doctor who treats a patient without consent, absent an emergency situation, even if that treatment accords with professional standards.⁸⁶ Therefore, treatment provided without a valid consent will constitute a crime, but it is a crime with a significant difference—§110 III ÖStGB states that the accused is only to be prosecuted at the behest of the patient who was treated without consent. Thus, if the patient dies no prosecution can be brought and, if she survives, she (or her legal representative acting on her behalf) must instigate proceedings within six weeks of becoming aware of the unauthorised treatment. This renders the offence almost meaningless, at least in terms of likely prosecution. Furthermore, unlike the position in England and Germany, no action will lie for battery (§88 ÖStGB) in the case of non-consensual indicated treatment, unless the treatment was not provided in accordance with professional standards.⁸⁷

The *Patientenverfügungs-Gesetz* (PatVG) is a single issue Act, regulating only advance directives. Prior to the Act, advance directives were specifically addressed by two separate pieces of legislation. §10 VII KAKuG⁸⁸ imposed a duty upon medical institutions to document a patient's advance directive refusing specific medical treatment in her medical notes, so that in the case of future incapacity account *could* be taken of those wishes. Similarly, Art.18 Patients' Charter stated that patients have the right to make anticipatory refusals of consent so that future medical decisions *can* take account of such wishes as far as possible.⁸⁹ Therefore, medical institutions were required to document advance directives and to take them into account, but they were not required to follow them. There was also no

substantial judicial authority to support the binding effect of advance directives. The only Austrian Supreme Court decision⁹⁰ to consider advance directives did so in the context of a psychiatric directive and did not consider the possible binding effect of a directive as the individual concerned had clearly not had the requisite capacity to complete the directive, enabling the court to leave the question of the validity and impact of anticipatory decision-making for another day. Thus, prior to the PatVG there was no clarity about whether advance directives might be capable of binding doctors, or whether they were simply an indication of the patient's presumed will. The PatVG established a two-tier system of advance directives, with varying requirements.⁹¹ At one end of the scale, the binding directive comes at a high price (in the literal sense), with mandatory legal and medical counselling, form and renewal requirements; by contrast much less stringent requirements are imposed upon what is termed a directive to be considered.

b) An examination of the new law regulating advance directives

i) Initial validity and applicability

Some general provisions apply to both forms of directive, the most important of which is that the patient must have capacity at the time of making the advance directive. Just as in England and Germany, there is a general presumption of capacity, which may be rebutted, and capacity is decision-specific.⁹² The PatVG does not define capacity, but does refer to the individual requiring both '*Einsichts-*' (understanding) and '*Urteils-*' (judgement) capacity—the capacity standard applicable to medical treatment in both Germany and Austria. Thus, as in England and Germany, in order to have capacity the patient must be able to understand the type, meaning and consequences, including risks, of the proposed

intervention and be able to make a decision upon the basis of that understanding.⁹³ However, in contrast to the German and English provisions, the PatVG does not limit the ability to execute an advance directive to adults, reflecting the general Austrian legal position of children in relation to consent to medical treatment. As the Austrian Civil Code (ABGB) recognises, in the case of a minor with the necessary capacity only she can consent to medical treatment and capacity is to be assumed in the case of mature minors.⁹⁴ In practice, this means that a minor can consent, or indeed refuse consent to medical treatment from the age of fourteen. A holder of parental responsibility may override a minor's consent to treatment, but there is no equivalent provision for overriding a refusal of treatment.⁹⁵ Thus, a minor will be able to execute a binding advance directive, subject to fulfilling the other statutory requirements. Moreover, if the child has been certified as having capacity by a doctor during the mandatory medical advice session discussed below, it will not be possible to rebut the presumption of capacity set out in §146c I ABGB.⁹⁶

In line with the earlier statutory provisions, §2 I PatVG makes it clear that advance directives can consist only of advance refusals of medical care. An individual may include a statement of wishes regarding treatment she would like within her directive, but such positive wishes will only be relevant to any consideration of her presumed will, they will have no binding effect. Therefore, in common with the English legal position, the Austrian Act does not permit patients to give a binding anticipatory consent to treatment, rather patients are limited to refusing clinically indicated medical care. Although an advance directive may include a refusal of life-sustaining treatment, the Austrian Parliament stressed that the PatVG was not the first step to legalising active euthanasia, indeed the Act specifically excludes the validity of advance directives that are contrary to criminal law.⁹⁷

If an individual wishes her advance directive to be binding, significant requirements must be met. Firstly, the medical care refused must be described in concrete terms, or must be

clear from the context of the directive as a whole.⁹⁸ The explanatory notes recognise that it would be unrealistic to expect individuals to draw up a comprehensive list of all possible forms of medical care that they would like to refuse, however the notes do stress that general refusals, for example of artificial means to prolong life, will not suffice.⁹⁹ Moreover, §5 PatVG requires that the refusal of medical care be fully informed. This is achieved via mandatory medical advice, whereby a doctor is required to comprehensively inform the patient about the nature and consequences of her advance directive. As the explanatory notes make clear, this is not limited to discussing the effect of refusing a particular treatment, but should also include a discussion of the alternatives.¹⁰⁰ Therefore, by requiring patients to partake of comprehensive medical advice, the Act aims to ensure that binding directives are clear and based on a sound knowledge of the medical situations which may arise. Nevertheless, it is questionable whether comprehensive medical advice is appropriate, or indeed even possible, where the patient is healthy and not suffering from a particular disease with a known prognosis. Similarly, a Jehovah's Witness who wishes to create a binding advance directive refusing blood and blood products in all circumstances is unlikely to require comprehensive medical information about the consequences of this choice. This requirement represents an important distinction from contemporaneous refusals of treatment which may be given without medical advice—whereas the validity of a contemporary consent to treatment will depend upon it being sufficiently informed, no such a requirement is applied to contemporaneous refusals of consent.¹⁰¹ Thus, as Memmer contends what is generally regarded as a *right* to be informed, has been transformed into a *duty* to be informed in the context of advance directives.¹⁰² It may be argued that the mandatory medical advice will improve the quality of anticipatory decision-making, but it is important to note that the provision of this mandatory medical advice and certification will not constitute normal

medical services and will therefore not be covered by health insurance, hence patients are required to pay for this ‘service’ as a necessary step to creating a binding advance directive.

In the course of the medical advice, the doctor must not only ensure that the patient’s anticipatory refusal is informed, she must also both certify that the patient has correctly understood the consequences of her directive and set out the reasons why the patient’s understanding is considered correct. Consequently, whereas a contemporaneous refusal of treatment can be given for any reason, or indeed for no specified reason, an anticipatory refusal will require justification. §5 PatVG refers to such reasons as being ‘perhaps because they draw upon a treatment connected to an earlier or current illness of the patient or one of her close relatives.’ The explanatory notes repeat this formulation, but suggest that other justifications could be based on lengthy professional experience of particular clinical conditions which enable a patient to say that she would not want a particular treatment, or refusals based on religious views.¹⁰³ Therefore it is clear that, in contrast to the rules pertaining to contemporaneous decisions, the patient must explain why she does not want to receive a particular treatment and that the doctor must be satisfied that those reasons are sufficient to ground a valid refusal. This highlights the difference between contemporaneous and anticipatory decision-making and suggests that the doctor may have a role in determining what constitutes an appropriate reason for refusing treatment. In addition, the doctor must certify that the patient has the necessary capacity to execute an advance directive. This represents a key benefit introduced by the Austrian Act obviating the need for the attending doctor to consider whether or not the patient had the requisite capacity to refuse medical care at the time of drafting, an assessment which is likely to prove problematic in both Germany and England.

In addition to the mandatory medical advice, the Act compels a patient to receive legal instruction¹⁰⁴ about the consequences of her directive and the possibility of revocation;

and requires that the directive must be in a written format and signed and dated in the presence of a legal adviser following such instruction. A simple reading of §6 PatVG would suggest that the instruction provided will be purely legal, but the explanatory notes make it clear that the distinction between legal and medical advice is somewhat blurred. Recognising that advance directives will always require interpretation, the explanatory notes state that the purpose of the legal advice is firstly to ensure that the directive is clear and corresponds to the Act's requirements; and secondly to provide information about the legal consequences of the directive for the patient, namely that the directive will usually be binding upon the doctor even if the patient will die as a result of an anticipatory refusal of medically indicated life-sustaining treatment. Moreover, the instruction should include discussion of the possibility of creating a non-binding directive.¹⁰⁵

Whilst information concerning the legal consequences of a directive can legitimately be provided by a legal adviser, it is difficult to see why legal advice is required to ensure clarity of expression in the directive itself—surely that is a matter for the medical advice session, where the doctor could reasonably expect to clarify the meaning of terms used and the implications thereof. As Bernat correctly notes, if a person is in need of clarification regarding the consequences of her advance directive, it is difficult to suggest that she has the requisite understanding to make it in the first place!¹⁰⁶ Given the cost involved in obtaining legal instruction, provision is made in the Act for that instruction to be provided not only by a lawyer or notary, but also by a legally trained employee of the regional patients' ombudsmen, some of which provide such legal advice free of charge. However, if the patient is physically unable to sign the advance directive it will need to be notarised in accordance with §886 ABGB, and if the patient wishes to combine her advance directive with a Lasting Power of Attorney with the power to refuse life-sustaining treatment it can only be created by a notary or a lawyer (§284f III ABGB), inevitably incurring legal fees. The legal adviser must certify

on the directive, or in an appendix thereto, that the legal instruction has taken place, but is not required to confirm the individual's capacity, that is a matter reserved for the doctor providing the medical advice/information.

ii) Continued validity and applicability

As the legal adviser must make clear to the patient during the legal instruction required for a binding directive,¹⁰⁷ a patient may revoke a directive at any time and in any manner, §10 II PatVG. According to the explanatory notes, in an exception to the general law relating to declarations of will, capacity will not be required to revoke an advance directive.¹⁰⁸ The notes provide no explanation of why an exception to the general civil law rules applies to the case of advance directives, and the Act itself makes no reference to such an exception. Given that capacity is required to create an advance directive, it is submitted that the patient will need at least a very limited degree of capacity in order to revoke her advance directive, particularly if it is categorised as a binding directive.¹⁰⁹ Indeed, the Federal Ministry of Health's guidelines for doctors concerning the creation and use of advance directives state that full capacity in the sense of capacity to understand and make judgements based upon that understanding is not required, but that 'a certain—even if only limited—capacity to make decisions' will be necessary for an effective revocation.¹¹⁰

The fact that the advance directive must be signed and dated by the patient in the presence of her legal adviser is important because the validity of advance directives is time-limited. According to §7 PatVG, the binding effect of an advance directive will automatically expire five years after it was executed, the only exception being where the patient has lost the capacity to renew the directive during that timeframe. A directive may be renewed after five years. It may also be amended before the expiration of that time period, in which case the five

year term will restart. Any renewal or amendment will require the patient to complete all the formal steps required to execute a binding directive anew, including obtaining medical advice and legal instruction and paying the corresponding fees once again.

A common theme in the literature recognises that advance directives may fail to continue to represent the patient's wishes on the basis of gains in medical science which occur after the directive was written and that a person's values, and indeed the importance one attaches to those values, may change over time. This clearly influenced the Austrian legislature and as the explanatory notes suggest, the fact that renewal is required within five years enables the doctor to make the individual aware of relevant advances in medical science and new treatment alternatives. Whilst medical advances may justify the need for renewal, and making renewal contingent upon medical advice, they do not appear to justify the need for further legal instruction upon the consequences of an advance directive. Moreover, §10 II PatVG specifically states that an advance directive will be invalid if significant changes in medical science occur after the directive has been created. This is clearly intended to exclude the binding force of directives where the medical advice provided could not consider medical advances that have occurred in the intervening period, thus the requirement to renew every five years cannot be based solely on the need for a directive to reflect the current standing of medical science. Worryingly, the fact that both medical and legal advice must be sought prior to the amendment of an existing directive, may in fact lead to directives not reflecting the patient's wishes, simply because the additional cost may act as a disincentive to making what may be a relatively minor amendment.

Any advance directive that does not fulfil *all* of the above criteria will not be binding, rather it will be classified as a 'consider-able'¹¹¹ directive and will merely fall to be considered in the determination of the patient's presumed will.¹¹² Nevertheless, as §9 PatVG makes clear, a directive that should be considered, but that is not binding, is not worthless,

rather its degree of influence is dependent upon the extent to which it complies with the requirements of a binding directive. Therefore, if a patient's directive has lapsed due to non-renewal within the proscribed five year period, but that time limit has only just passed, a now 'consider-able' directive will have significant influence upon the determination of the patient's will, in fact it would perhaps best be described as being 'almost binding'! However, the fewer of the procedural requirements that are abided by in a 'consider-able' directive, the less influence it will have. Consequently a directive issued without medical or legal advice may have only a limited impact upon the determination of a patient's presumed will where it is simply one of the factors to be considered.

Where a valid and applicable binding directive exists, doctors will be bound by that directive and a guardian cannot be appointed to make the decision in place of the patient,¹¹³ rather the doctor should simply implement the refusal as a binding and effective expression of the patient's will. Without a valid and applicable binding directive a guardian must be appointed by the court¹¹⁴ and must consent or refuse consent to treatment on behalf of the patient. The guardian must determine the patient's presumed will and 'consider-able' directives will constitute important evidence of what the patient is likely to have wanted. However, the guardian is required to promote the patient's welfare¹¹⁵ and a difficult arises where the patient's current interests conflict with her previously expressed wishes. It is conceivable that a non-binding, but 'consider-able' refusal of life-sustaining treatment could be overridden by the guardian on the basis of promoting the patient's current welfare.¹¹⁶ In such a case, as the treatment will have serious implications for the patient's bodily integrity, the guardian will be required to gain court approval of her consent to treatment, §283 II ABGB, although somewhat surprisingly there is no corresponding requirement of court approval for a refusal to consent to life-sustaining treatment.¹¹⁷

In summary, the Austrian Act provides individuals with capacity with the opportunity to execute a binding advance directive, but the vast majority of advance directives will, due to the fact they have to anticipate the unknown, fail to meet the specificity requirement and so inevitably be classified as directives that must merely be considered as part of the patient's presumed will rather than binding directives. The Act adopts a very conservative and essentially paternalistic approach to anticipatory decision-making—advance refusals will only be binding if the individual has had the consequences of her decisions explained to her by both a doctor and a lawyer. The patient is, therefore, infantilised and treated as in need of protection from her own ill-thought out decisions. A further criticism of the Austrian Act is that it prioritises form over content, with binding effect only being awarded to those advance directives that meet the tri-requirements of information, form and time limit. However the binding directive comes at a high price, with figures of up to 800 Euros being quoted for the medical and legal advice,¹¹⁸ raising serious questions about social justice and rendering the ability to make a binding advance directive a privilege rather than a right.

II COMPARATIVE REFLECTIONS¹¹⁹

Each of the three jurisdictions recognise the right of an adult patient with capacity to refuse medical treatment, including life-sustaining medical treatment, but in enacting legislation to extend that right of refusal to anticipatory decisions the three jurisdictions have had to confront the problem of how to balance the sanctity of life and the right to self-determination without undermining the utility of advance directives. In seeking to achieve that balance the three Acts adopt different mechanisms. . The English Act sets out a minimal regulatory framework, leaving the attending doctor to determine whether or not the patient's advance decision is valid and applicable. At the other end of the scale, the Austrian Act

adopts a very detailed approach imposing stringent pre-requisites upon the creation of a binding advance directive. This significantly reduces the scope for the resultant advance directive to be considered invalid or inapplicable, but simultaneously severely restricts an individual's ability to execute a binding directive. The German law adopts the middle way, setting out some minimal requirements for a valid advance directive, but ultimately leaving the patient's legal representative and doctor to determine together whether or not the advance directive constitutes a valid and applicable (refusal of) consent to treatment.

The three legislative responses were introduced amid statements of support for precedent autonomy, respect for self-determination and the need to empower those who lack capacity to decide for themselves. However, upon consideration of the impact of the safeguards adopted by the three Acts it becomes clear that the rhetoric of respect for precedent autonomy is at best superficial and that the key achievement of the legislation is the protection of medical discretion.

a) Initial validity and applicability

i) The requirement of capacity

We have seen that there is significant common ground between the three Acts, reflecting the common values and social contexts in which they operate. Each of the Acts requires that the individual has the necessary capacity to consent or refuse the specified treatment at the time of drafting the advance directive. A functional approach to capacity is taken rather than full legal capacity being required. In each jurisdiction, therefore, the individual must be able to satisfy both the cognitive and voluntary elements of decision-making and be able to communicate her decision. Similarly, each jurisdiction adopts the

position that every adult is presumed to have capacity and that the burden of proof falls upon those seeking to suggest the contrary. However, this presumption appears to operate in reverse when applied to the anticipatory decision-making context as each of the Acts requires that the person implementing the decision (the doctor, or in Germany the legal representative together with the doctor) be satisfied that the patient had capacity at the time of making the advance decision. This raises a clear practical problem that does not arise in relation to contemporaneous decisions, namely that doubts as to the patient's previous capacity arise at a time where she is no longer able to demonstrate that the requisite capacity existed. For this reason, the Austrian approach of requiring a doctor to certify capacity at the time of drafting should be regarded as an important safeguard of the individual's ability to exercise precedent autonomy as it eliminates any doubt about this issue.

Of the three jurisdictions considered, only Austria permits a mature minor to execute an advance directive. This reflects the paternalistic attitude adopted by the courts in England and Germany towards minors where a minor's refusal of consent may be overridden by a parental responsibility holder, or the court, reflecting the view that minors need greater protection from their own wishes and that therefore the balance to be struck between self-determination and the protection of life falls firmly on the side of the latter. This stance is, however, problematic because mature minors are likely to be able to fulfil the capacity criteria set out above. It could even be suggested that the discrepancy between the approach taken towards mature minors and adults may be attributed not to a lack of cognitive capacity, but rather to a perceived lack of experience that would enable the minor to exercise that cognitive capacity and provide well-founded reasons for her decision.

The suggested need for a well-founded refusal of treatment may also be applied to adults in the context of advance refusals of treatment. However, the imposition of a requirement to give reasons for an anticipatory refusal would stand in stark contrast to the

well-recognised right of an adult with capacity to refuse medical treatment, including life-sustaining treatment ‘whether the reasons for making that choice are rational, irrational, unknown or even non-existent,’¹²⁰ a right that is recognised in each of the jurisdictions. Nevertheless, as discussed above, in the context of anticipatory decision-making the Austrian Act takes a much more restrictive view, requiring individuals to explain the reason for their advance refusal of particular treatments. Although the consulting doctor is not entitled to consider those reasons in determining whether or not the individual has the requisite capacity to make such a refusal *per se*, she must certify that the individual is able to correctly comprehend the consequences of her decision. Therefore, where the reasons provided do not, in the eyes of the certifying doctor, appear sufficient, it is unlikely that she will consider the individual to have correctly understood the consequences of her decision, thus excluding the possibility of the patient making a binding advance directive. This is likely to be significant because, with the exception of religious based refusals of treatment, the example reasons provided in the Austrian Act and explanatory notes thereto, suggest a very limited basis upon which individuals will be able to refuse treatment, namely on the basis of personal or professional experience of particular conditions.

As noted above, the experience referred to in the Austrian Act may be observational, rather than participatory, in the sense that it may relate to the experience of a close relative. A narrower variant of this approach was considered in the English case of *Ms B*,¹²¹ where the relevance of experience was considered in the context of a contemporaneous refusal of treatment. Ms B became a tetraplegic following an intramedullary cervical spine cavernoma, and was dependent upon a ventilator; the court considered whether she had the capacity to refuse consent to continued ventilation. The consultant surgeon in spinal injuries accepted that Ms B had capacity, but argued that her ability to give an effective refusal of consent was undermined by the fact that she had not experienced a spinal rehabilitation unit. He

suggested that such an experience could offer her a much more positive view of the quality of life she might attain. However, Dame Butler-Sloss P. rejected this argument, holding that if it 'were correct, the absence of experience in the spinal rehabilitation clinic would deny Ms B ... the right to choose whether or not to go to one. It is not possible to experience before choosing in many medical situations.'¹²² It is submitted that this approach, rejecting the need for a decision to be based upon experience, is correct and that, despite the slightly broader context of relevant experience envisaged by the Austrian Act, the requirement that the consulting doctor effectively approve the reasoning behind an anticipatory refusal of treatment is overly paternalistic in outlook. Nevertheless, the noting of reasons given may well be of assistance in interpreting the advance directive when the time comes for implementation. Thus, there is a strong argument that each of the Acts takes too limited an approach to advance directives by not recommending that the individual include a values statement within her advance directive setting out the values that guide her own decision-making and that should be applied in interpreting the advance decision.

ii) The permissible scope of anticipatory decision-making

In common with contemporaneous decision-making, the limits of what medical care can be refused in each jurisdiction are dependent, firstly, upon that care being lawfully available to the patient and, secondly, upon the treatment in question being clinically indicated. An advance directive cannot refuse treatment that is required by law (typically treatment for a mental disorder), or request 'treatment' that is unlawful. Thus, each jurisdiction has stressed that an advance directive cannot be used to make a request for assistance in dying which is prohibited in each country.¹²³ It could be suggested that the asymmetries between an anticipatory and a contemporaneous refusal require the state to

express a preference for life by restricting anticipatory decision-making to, for example, those suffering from a terminal illness. Thus, the German Parliamentary Commission of Inquiry echoed the *Bundesgerichtshof* (Civil Division) in recommending that advance directives should only be applicable where the underlying illness would irreversibly lead to death. It argued that such a restriction was necessary as part of the state's duty to protect life and to minimise the potential for abuse, characterising the restriction as a limit on the ability of the individual to bind herself, rather than a limit on self-determination per se.¹²⁴

Such extent clauses are susceptible to well-founded criticism at a number of levels. At the practical level, immense difficulties arise due to the difficulty in defining 'terminal illness'¹²⁵ and what will constitute an 'underlying condition that will irreversibly lead to death.' Such a restriction would also exclude many of the conditions in which people are likely to want an anticipatory refusal of treatment to apply, including religious-based refusals of blood and treatment refusals in conditions such as an apallic state, an irreversible coma and dementia. It is settled law that the withdrawal or withholding of treatment consistent with the patient's best interests/presumed will or her refusal of treatment will not violate the state's duty to protect life and that there is no duty to keep a patient alive by all possible means.¹²⁶ Therefore, there can be no justification for restricting anticipatory decisions to terminal conditions based upon the state's duty to protect life, excluding all consideration of the patient's right to self-determination. It is suggested that the three legislatures were correct to recognise that such a restriction would be disproportionate and unnecessary in order to protect life, permitting anticipatory decisions to be made in relation to any kind of (lawful) treatment, to apply during any phase of life.

The parameters of a valid anticipatory decision are established by each of the Acts by reference to clinical indications, excluding the possibility of a patient using an advance directive to mandate non-indicated treatment and emphasising that the doctor's role is not

limited to that of ‘body mechanic.’¹²⁷ The courts in each jurisdiction have accepted that the ability to provide treatment does not mean that it should necessarily be provided,¹²⁸ but there is a significant amount of discretion left to doctors to determine what treatment is indicated. Whilst subject to professional standards, this assessment is not entirely objective as it will also be determined by the doctor’s own subjective assessment of the benefits and burdens of the treatment in question and of what constitutes an acceptable quality of life. Therefore, this preliminary assessment may pose a substantial limit on the patient’s autonomy as it will set the parameters for the permissible exercise of self-determination, excluding the possibility of what Brock refers to as ‘consumer sovereignty’¹²⁹ whereby doctors are simply required to implement orders given to them by patients.

iii) The need for specificity

As Buchanan and Brock recognised, a specific refusal of treatment may need to be applied to a very different clinical situation to that envisaged by the individual at the time of drafting.¹³⁰ To address this problem, each Act requires that the advance refusal fulfil the applicability criteria, namely, the decision must relate to the specific treatment offered by the doctor as clinically indicated and must be drafted to operate in the situation that occurs. This dual-specificity requirement reflects the common law requirements¹³¹ and is likely to be the greatest obstacle to be overcome in drafting an advance directive given the temporal distance between the drafting and the implementation thereof. In cases where individuals are suffering from a disease with a well-established prognosis, such as motor neurone disease or cerebellar ataxia, the range of treatment options and treatment scenarios (as least in relation to that disease) should be capable of relatively precise definition. However, other directives, where the individual is not suffering from such a disease, are likely to be much more general in

nature. It would be unreasonable to expect an advance directive to contain a comprehensive list of treatments to be refused in all possible treatment scenarios, but it is clear that vague statements such as ‘no heroic measures’ will not suffice. It could be suggested that a refusal of ‘all medical care’ might satisfy the specificity requirement,¹³² provided that the individual specified the circumstances in which such a decision were to operate, but it is far from clear that such a blanket refusal of treatment will be considered valid and applicable. Thus the key question in assessing the impact of this requirement upon the ability to make a binding anticipatory choice will be how specific does the refusal have to be? Each of the legislatures has left this question to be resolved by the attending doctor, or in Germany the doctor and patient’s legal representative, in determining whether or not the directive is applicable. The consequence of this solution is to increase medical discretion at the expense of promoting the effective exercise of precedent autonomy.

The specificity requirement is likely to hamper many people wishing to create a binding advance directive. The recent study of the legal, ethical and practical experiences of the PatVG found that patients have real difficulty in fulfilling this requirement because they do not define what they consider to be a worthwhile quality of life in terms of medical parameters.¹³³ Rather, individuals tend to refer to refusals being operative in situations ‘inconsistent with meaningful life,’ or to utilise other such abstract concepts without providing more precise details of what they would consider a meaningful life. One safeguard available in contemporaneous decision-making is the provision of medical advice, affording doctors the opportunity to seek to persuade patients refusing treatment to at least try it, or to consider alternatives to a blanket refusal of treatment. Clearly that opportunity will not exist at the time when an advance directive is to be implemented, however one way to narrow the communication gap in anticipatory decision-making and to enable patients to provide at least a greater degree of specificity would be to require individuals to seek medical advice as a pre-

condition to the creation of a binding advance directive. The provision of medical advice is important at two levels—firstly it could play a vital role in assisting patients to provide clear and applicable instructions about what treatment they want to refuse, in which circumstances. However, medical advice given in this situation can never completely fill the communication gap between the doctor and her patient as in any discussion relating to anticipatory decision-making such advice will necessarily be directed towards hypothetical situations rather than the specific treatment scenario that would be considered in contemporaneous decision-making. Nevertheless, a secondary benefit is that the advising doctor may be able to elucidate the patient's directive and assist in applying it to her current situation when the time for implementation arises.

There can be little doubt that the provision of medical advice is desirable and that it should improve the quality of anticipatory decision-making. As discussed above, medical advice forms a key requirement for the creation of a binding directive in the PatVG. However, given that a patient with capacity can make a valid refusal of consent without having to be informed of the medical consequences, the requirement imposed by the Austrian Act represents a significant limitation upon an individual's right to exercise her self-determination in advance of incapacity, particularly as the cost of that medical advice is not met by health insurance, a point which is considered further below. For that reason it is submitted that both the Westminster and Berlin legislatures correctly rejected proposals that mandatory medical advice be provided to the patient, whilst recommending that patients should seek such advice.¹³⁴

iv) The form requirement

In addition to the requirements noted above, to be valid and applicable the advance directive must not be based on a defect of consent (for example duress)¹³⁵ and must conform to the form requirements imposed by the Acts. The first requirement applies equally to contemporaneous decisions, but as discussed above, each of the Acts imposes form requirements upon anticipatory refusals of life-sustaining treatment. The German and English courts had stressed that clear evidence would be required of anticipatory decisions, but neither had suggested that their validity would be dependent upon them being set down in writing. Although the imposition of a form requirement does constitute a limit on the individual's ability to exercise her self-determination in anticipation of incapacity, it is submitted that the intrusion is proportionate to the benefits in terms of providing clear evidence of the individual's wishes, without raising issues of hearsay evidence, and in underlining the fact that an advance directive represents a considered decision. However, the imposition of a duty to execute an advance directive before a lawyer, as required by the PatVG, appears entirely disproportionate to this aim. The imposition of such a duty cannot be based upon the need for legal advice as to the consequences of an advance directive—if the individual does not understand those consequences she arguably lacks the capacity to exercise precedent autonomy. In any case the determination of capacity and provision of medical advice concerning the terminology used and the implications of the directive are tasks better suited to a doctor than a lawyer. Therefore, it is submitted that the Austrian requirement that advance directives be drawn up subject to legal advice is misguided, serving only to increase the cost of making a binding advance directive without conferring a commensurate benefit upon the patient.

b) The continuing validity and applicability of advance directives

i) Revocation

Each of the three Acts makes express provision for the individual's ability to revoke an advance directive in any manner. Thus, whereas a valid anticipatory refusal of life-sustaining treatment must be set down in a written instrument, it can be revoked orally, in writing, or simply through behaviour. Whilst s.24(3) MCA 2005 states that revocation requires capacity, the notes to the PatVG (but not the Act itself) state that capacity is not required, and the amended BGB does not address the issue of capacity in relation to the revocation of an advance directive. It cannot be the case that capacity is required to execute a valid directive, but be irrelevant when the same directive is to be revoked, therefore it is submitted that at least a limited degree of capacity will be required to revoke a directive in each jurisdiction.¹³⁶ Given that capacity is decision-specific and that the degree of capacity required depends upon the gravity of the decision, it is to be expected that a much lower level of capacity will suffice to revoke an anticipatory refusal of life-sustaining treatment. Such an understanding of the capacity requirement would support the preference for life, but also supports the principle of self-determination by requiring at least a minimal level of capacity to revoke anticipatory decisions made with capacity.

ii) Invalidity resulting from a change of circumstance

Even if the patient has not revoked her advance directive, the continuing validity of her directive must be assessed as each Act makes provision for the advance directive to be invalidated by a change of circumstance indicating that the directive no longer represents the patient's fixed decision.¹³⁷ The potential invalidity resulting from a change of circumstance has great potential to undermine anticipatory decision-making. Indeed it may be suggested

that any doubt as to whether the directive continues to reflect the patient's wishes will suffice to invalidate it. A good example of a case where it was held that an advance directive could no longer be regarded as clearly representing the patient's wishes is provided by the English case *HE v A Hospital NHS Trust, AE*.¹³⁸ This case was heard prior to the enactment of the MCA, but the advance directive satisfies the more stringent requirements introduced by that Act, namely, it was in writing and specifically stated that the advance refusal of blood was to apply even if life was at risk. However, AE's father argued that the directive no longer represented her will due to a recent faith conversion. Munby J. held that anyone wishing to assert that a directive is no longer operative would have to 'point to something that this is or may be so,'¹³⁹ but that once doubts were raised those seeking to rely upon the directive bore the burden of proof as 'the continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence.'¹⁴⁰ Munby J. found that AE's directive was based on her faith and that as doubts had been raised about whether or not she still subscribed to the same religious views doubts as to the continuing validity and applicability of her directive fell to be resolved in favour of the preservation of life.¹⁴¹

This case demonstrates how difficult it may be to determine whether or not an advance directive still reflects the will of a patient who lacks capacity and so is unable to demonstrate that it does just that. The judge required 'clear and convincing evidence' of the continuing validity and applicability of the directive, a much higher standard of proof than that of the balance of probabilities normally required in civil matters.¹⁴² Conversely the antithesis of this standard appears to have been applied to evidence suggesting that the directive was invalid, whereby it appears to have been sufficient to adduce doubts as to her continued faith. The clear and convincing standard is typically used in the USA in the substituted judgment approach to decision-making, where a patient's friends and family are required to give clear and convincing evidence of what the patient would want, referring for

example to oral statements made in the past.¹⁴³ However, it is submitted that Munby J. failed to recognise that such a situation is inherently different to that which exists where an individual has taken the time and trouble to draft a clearly formulated advance refusal of specific treatments. AE had herself alerted doctors to her refusal of blood as late as November 2002; she continued attending Witness meetings until January 2003, despite agreeing to renounce her faith as a condition of marrying a Muslim man in December 2002. On that basis, it is submitted that there should have been significant doubts about the validity of this alleged change of faith, or at least as to its voluntariness when the doubts were raised in May 2003.

Consideration must also be given to what material circumstances will give rise to sufficient doubt as to override the clear and otherwise valid and applicable advance directive. Munby J. suggested that marrying or having children might create such a changed circumstance;¹⁴⁴ similarly Spickhoff¹⁴⁵ argues that pregnancy might constitute a changed circumstance and Balz¹⁴⁶ contends that founding a family after drafting the directive might suffice, suggesting that any material change in circumstance may cast doubt upon the continuing validity of the directive. In each of these examples the change relates to a new, legal, relationship to somebody else being created, in the case of pregnancy a future relationship to the child yet to be born. However, particularly in the case of a religious-based objection such a change in circumstances is unlikely to affect the patient's refusal of treatment; in other cases the impact of overriding her anticipatory refusal will need to be carefully assessed in the circumstances.

Whilst it is surely correct to say that existing doubts should be raised, such doubts must be subjected to a stringent burden of proof, being required to clearly show that the patient no longer intended the directive to apply, otherwise the individual's right to self-determination will become worthless as soon as she lacks the capacity to demonstrate her

continuing wishes. Spickhoff considers the example of a pregnant woman injured in an accident and in a serious condition with a poor prognosis. He argues that her advance directive refusing all forms of intensive care should be disregarded due to the fact that it was drafted prior to her becoming pregnant.¹⁴⁷ However, it is submitted that in such a scenario the fact she has become pregnant does not in itself raise sufficient doubts about the validity of her directive. Instead it must be considered whether there is evidence that she, as opposed to the 'reasonable woman,' would have wanted her directive not to be followed in these circumstances. It must be accepted that pregnancy raises different problems to the fact of simply getting married or founding a family and that pregnancy may constitute a material change of circumstance, a suggestion also made by both the Law Commission¹⁴⁸ and in the MCA Code of Practice.¹⁴⁹ In such a situation, it would be possible to argue that the patient would have wanted to be kept alive for as long as was necessary to sustain the pregnancy until the child could be delivered. However, as the English courts have made clear in cases concerning court-ordered obstetric intervention, pregnancy is not a justification for overriding a woman's autonomy:

While pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment ... The infringement of the mother's autonomy could not, therefore, be justified by the perceived needs of the foetus.¹⁵⁰

Thus, pregnancy should not automatically invalidate a woman's advance directive and it is submitted that a presumption should operate to that effect. If, however, there is clear and cogent evidence that she would have wished to receive treatment to enable the pregnancy to continue to term, implementation of the advance directive could be postponed until the child

is delivered. Ultimately, whatever the nature of the change in circumstance, in stressing the need for certainty about the continuing validity of an advance directive great care must be taken not to subvert the utility of an advance directive. Furthermore, if the change of circumstance is held to invalidate the patient's advance directive, it must be borne in mind that the interests to be considered in assessing her best interests, or presumed will, are her own, not those of her foetus, her existing children, or indeed her spouse.

As Buchanan and Brock note, the fact that an individual's interests may be radically and unforeseeably different from those anticipated significantly weakens the argument for precedent autonomy.¹⁵¹ This is particularly relevant to a very difficult variation of the changed circumstances issue which has received much attention in the literature¹⁵² although it has not arisen for decision by a court in any of the three jurisdictions under consideration—namely, whether signs of enjoying life in a severely demented patient should be taken to have invalidated her directive refusing treatment once the dementia became severe. Whilst the three Acts arguably require at least a limited degree of capacity in order to revoke an advance directive, none of the Acts refer to a need for the patient to have capacity when a change in circumstance occurs potentially invalidating an advance directive. Therefore it may be suggested that in the case of dementia, the fact that the patient lacks the requisite capacity to revoke her advance directive does not exclude the possibility that she may be taken to have invalidated her advance directive through showing signs of contentment. In such circumstances it is argued that the interests of the now severely demented patient (P2) are not the same as those she held as an individual with capacity (P1), and indeed it may be argued that the demented patient is a very different person to the person she was before due to the loss of psychological continuity.¹⁵³

Dresser argues that because the interests of the demented patient differ dramatically from those she held before, advance directives should not be the overriding factor in

determining whether treatment should be provided and that the patient should be treated in accordance with her best interests rather than being subjected to the paternalistic views held by her former self.¹⁵⁴ If an advance directive is invalidated in such circumstances the consideration of the patient's best interests/welfare will focus primarily upon her current situation, concentrating upon the perceived quality of her life and the benefits and burdens of the proposed medical treatment. Such an assessment prioritises the patient's current physical interests rather than recognising her as a person with interests and values that transcend dementia. It is undeniable that individuals may well underestimate the quality of life that they may enjoy at a future time of incapacity, but engaging in bifurcation of the individual does not resolve this issue. P2 shares the same body as P1, P2 is regarded as the same person by her family, albeit a demented version of P1, and so it is submitted that a unitary approach must be taken, that it must be accepted that all lives go through differing phases and that each phase, including a demented phase, is simply part of the same life. Therefore, as Dworkin argues, critical interests, those interests that make each person an individual, their innermost beliefs and values about the circumstances in which they would wish to be treated, must be the determinative interests that survive incapacity, trumping current experiential interests.¹⁵⁵

The particular challenge presented by dementia cases brings the conflict between the right to self-determination, the sanctity of life and respect for human dignity into sharp focus and while there are no simple answers, it is suggested that the recommendation of the German National Ethics Council should be adopted in each jurisdiction. The Ethics Council recommended that signs of a will to live in dementia cases should override an advance refusal unless four cumulative requirements are fulfilled: the treatment scenario is described in sufficiently concrete terms; the directive is in writing or comparably reliably documented; the directive was drafted following appropriate medical advice; and the directive explicitly states that signs of a will to live should be disregarded.¹⁵⁶ In each of the jurisdictions the first two

conditions will be met by a valid advance decision, but the requirement of appropriate advice preceding the drafting of the directive is only required by the Austrian legislation and an explicit statement rejecting signs of willingness to live would be required. It is submitted that adopting the Ethics Council's recommendation provides the best way forward in this situation and that if an advance directive is drafted following medical advice and explicitly states that signs of a willingness to live should be disregarded, the advance directive should remain valid and be implemented. This approach would reflect respect for the sanctity of life, but would prioritise self-determination and respect for human dignity in cases where the individual has made a clear decision about the way in which she wishes to live, or rather not live. Such decisions depend both upon the individual's perception of herself as a person and upon the way in which she wishes others to perceive her. Adoption of the Ethics Council's recommendation would recognise that the individual with capacity is the most appropriate person to determine what treatment she would want in the case of severe dementia, rather than leaving the decision to third parties to determine under an assessment of her best interests or presumed will. As the European Court of Human Rights recognised in *Pretty v UK* 'the way she chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected.'¹⁵⁷

A final change in circumstance must be considered, namely the potential for advances in medical science to undermine an advance directive, rendering it invalid in each of the three jurisdictions.¹⁵⁸ It is submitted that advances in medical science can only intervene to invalidate an advance directive where the advances are significant and undermine the entire basis of the decision to refuse treatment, for example where a cure has become available, or a new or improved treatment could substantially improve the patient's quality of life; a change in medical knowledge *per se* would not suffice.

iii) Renewal

In order to anticipate relevant changes in circumstance of whichever variety individuals should be encouraged to review their advance directive regularly. Of the three Acts only the PatVG makes the validity of an advance directive contingent upon renewal, and does so at five-yearly intervals, intervals which are too long given the pace of change in medical science and indeed the scope for invalidity based upon other changed circumstances. Moreover, the fact that the Austrian Act makes the validity of a renewed directive contingent upon compliance with the requirements of medical and legal advice, both of which may lead to the incurrance of substantial financial cost, is particularly problematic. Given the need for an advance directive to reflect the individual's will, it is suggested that the financial disincentive to amend the directive during the five year period threatens to undermine the validity of the regulatory scheme adopted, a scheme based upon ensuring that an advance refusal of treatment reflects the patient's wishes, is well-considered and based upon comprehensive medical information.

When considering the need for renewal a balance needs to be struck between the need to protect life and the need to recognise the individual's right to self-determination. On the one hand requiring individuals to renew their advance directives does impose a burden upon them and restricting the validity of advance directives to those renewed regularly would constitute a significant restriction upon their ability to exercise precedent autonomy. On the other hand, recommending that advance directives be regularly updated takes account of the importance of renewal, whilst respecting the individual's autonomy, thus the approach adopted by the German and English legislation is to be preferred. Although a recommendation to renew is proportionate to the aim of ensuring that an advance directive continues to reflect the fixed will of the individual, the same cannot be said of the time-

limited approach adopted by the Austrian legislation, whereby an advance directive will automatically lapse after 5 years, unless the individual lacks the capacity to renew it. Just as a contemporary decision remains valid until such time as the patient withdraws it, an anticipatory decision should not automatically lapse simply because of the passage of time, without regard being had to whether the individual's circumstances, medical or otherwise, have changed.

3) The failure to provide mechanisms to support the effective exercise of precedent autonomy

In seeking to demonstrate deference to the principle of *in dubio pro vita*, each Act has created significant procedural requirements that must be met in order to construct a valid and applicable directive, yet none have provided the necessary mechanisms to support anticipatory decision-making. There is little point in drafting an advance directive, if the attending doctor is unable to check quickly and reliably whether or not an advance directive exists and then act accordingly. In each jurisdiction patients are advised to lodge a copy of their advance directive with their GP, who should record it in the patient's notes.¹⁵⁹ Whether this allows an advance directive to be located will depend on the attending doctor knowing that such a document exists and may occasion some delay in gaining access. Similarly, the suggestion that patients should give copies to their solicitor, family and others who might be approached regarding the existence of an advance directive, fails to overcome the problem whereby the patient who lacks capacity bears the responsibility for ensuring that her advance directive is effectively communicated to the attending doctor. Furthermore, as advance directives may be amended or revoked, there is a need for a single authoritative version and the existence of copies makes the possibility of conflicting directives being brought to the

attention of the attending doctor all too real, leading to a position where it will be difficult, if not impossible, to determine which version represents the settled will of the patient.

If patients are to be able to effectively exercise their precedent autonomy, a central electronic register of advance directives, containing the authoritative text of that directive, must be created and be accessible to all healthcare professionals and a corresponding duty to consult the register must be created. In Austria, an example of just such a register exists, but in a different context, namely the opt-out register for organ donors and a corresponding duty is imposed upon doctors to check the register before harvesting organs.¹⁶⁰ Four years after the PatVG came into force there is still no similar central register for advance directives in Austria; and neither Germany nor England have made the necessary provision for such a register. The failure to establish a central register to allow advance directives to be conclusively located, coupled with a corresponding duty imposed upon the doctor to check the register, renders the ability to make an advance directive of limited utility.

Similarly, each of the legislatures recognised that medical advice prior to the drafting of an advance directive would be desirable, in the case of England and Germany it is recommended, in Austria it is a pre-requisite to the creation of a binding directive. However, none of the jurisdictions have made provision to make this medical service available to patients without charge. A doctor can legitimately be expected to provide advice to a patient known to be suffering from a particular disease about her prognosis and likely treatment options. However, the broader nature of the information required for advance directives not associated with a particular disease, together with a capacity assessment will not be covered by health insurance in Germany and Austria, nor, as the BMA has confirmed, will they constitute 'a primary medical service' in England¹⁶¹ and thus a fee will be payable in each jurisdiction. Nevertheless, if we accept that medical advice should precede the drafting of an advance directive, social justice demands that the ability (or in the case of Austria the right)

to make a valid and applicable directive cannot be dependent upon the ability to pay for such advice.

CONCLUSION

The three considered Acts clearly demonstrate the asymmetries between anticipatory and contemporaneous decision-making. The requirements imposed for an advance directive to be considered binding illustrate an extremely conservative, paternalistic conception of the doctor-patient relationship. This means that in all but the clearest of advance directives, an advance refusal will simply be a factor to be considered in determining the patient's best interests/presumed will, prioritising the patient's current welfare, rather than her anticipatory decisions.

In each jurisdiction the legislative measure has not removed uncertainties, particularly in relation to determining whether the advance directive is sufficiently specific to be applicable to the treatment and treatment scenario in question, and what will constitute a sufficient change of circumstance to invalidate a directive. By contrast, considerable clarity has been created for doctors—in all but the clearest of circumstances doctors will be justified in treating patients notwithstanding an advance directive refusing treatment due to the scope of their discretion to determine the validity and applicability of an advance directive. Thus, each Act fails to truly locate decision-making authority in the individual concerned, instead, in each case significant discretion is left to the doctor, or in the case of Germany to the doctor and the patient's legal representative, to determine the validity and applicability of the advance directive. It is unquestionably correct that the exercise of this discretion is subject to review by the courts in each jurisdiction, but such control has to be instigated and will only come into play when somebody disagrees with the decision-maker. For that reason it is

suggested that the German approach requiring dialogue between the doctor and the patient's *Betreuer* or *Bevollmächtigte* (together with the patient's family and friends where time allows) has much to recommend it, particularly as it avoids the situation that arises in Austria and England whereby the doctor(s) must determine what medical treatment is indicated, then determine whether or not the advance directive allows her to administer the treatment she thinks should be provided!

Due to the limitations imposed upon the effective exercise of precedent autonomy by the need for specificity and the doubts that may be created by a change of circumstance, it is suggested that each of the Acts would benefit from the inclusion of a requirement that in conjunction with drafting an advance directive the patient must donate a lasting power of attorney and draft a values statement setting out her critical interests and what she considers to be an adequate quality of life. The proxy should be required to implement a valid and applicable directive, but in cases where the directive is not applicable, due either to a change of circumstance, or to inapplicability to the treatment or the treatment scenario, the proxy should consent or refuse consent to treatment on the basis of what the patient would have wanted as outlined in her values statement. Clearly the second alternative is less satisfactory than simply executing the patient's directive, but it does at least attempt to ensure that the patient's wishes and values determine the treatment given. Due to the fact that the determination of what the patient would have wanted is a subjective decision, it is argued that this is best suited to a LPA, rather than a court appointed guardian because the patient herself must entrust the LPA with the authority to make such decisions, indicating the existence of a relationship based upon a high degree of trust. Similarly, given that the patient has chosen to entrust the LPA with such decisions, there seems little need for court approval in the usual course of events. In cases of suspected abuse healthcare professionals or family members could seek review of the LPA's decision by the Court of Protection/Guardianship Court.

Therefore, it is suggested that each of the Acts needs to be reviewed. More clarity is required concerning how specifically both the treatment refused and the scope of that refusal must be defined in an advance directive. Provision needs to be made for patients to be able to access medical advice and capacity assessments regardless of ability to pay for them. A central electronic register of advance directives needs to be created, at least at the national level, with a corresponding duty placed on doctors to check that register before giving treatment, absent an emergency situation. The recommendations of the German National Ethics Council should be implemented in relation to dementia cases. And, finally, individuals should be required to donate a lasting power of attorney with responsibility for interpreting and implementing the advance directive.

Upon consideration of the three Acts it is clear that although each Act could be considered a step in the right direction, in their current formats they have each failed to achieve the stated aims of providing clarity and recognising the right to make effective anticipatory choices. In attempting to balance the protection of life against the right to self-determination the legislatures in Berlin, Vienna and Westminster have imposed stringent requirements upon the making of an advance directive intended to be binding, and granted a wide degree of discretion to the ultimate decision maker, the person charged with determining whether or not the directive is valid and applicable. In so doing, the resultant legislation has undermined the very concept of precedent autonomy, namely that an individual should be able to make advance choices directing future medical care in the case of incapacity and be able to rely on such choices being implemented, rather than being subjected to a heteronomous third party decision.

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- * Thanks are due to Roger Brownsword, Jean McHale, Elizabeth Macdonald and the anonymous MLI reviewer for their helpful comments on an earlier draft of this article. Any errors remain my own.
- ¹ *In re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1, per Lord Goff, at 72; Art 2 II GG; §110 II ÖStGB.
- ² *In re T (Adult: Refusal of Treatment)* [1993] Fam 95; *Airedale NHS Trust v Bland* [1993] AC 789; *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); BGHSt 11,111 at 113; BGHSt 11,111 at 113; BGHZ 154, 205; BGHZ 163, 195; OGH 6 Ob 286/07p; Erl RV zum Strafgesetzbuch 30 BlgNR 13, GP 242; §110 I ÖStGB.
- ³ The use of feminine pronouns in this article is intended to encompass both genders.
- ⁴ A. Buchanan & D. Brock *Deciding for others: the ethics of surrogate decision-making*, CUP, 1990, at 103-7.
- ⁵ *Ibid.* at 106.
- ⁶ See eg *Re T* (n2); BGHSt 40, 257, 263; OGH 6 Ob 286/07p
- ⁷ *Patientenverfügungs-Gesetz* 2006, Austria, BGBl I 2006/55, came into force 01/06/2006; Mental Capacity Act (MCA) 2005, England & Wales, came into force 01/10/2007; *Drittes Gesetz zur Änderung des Betreuungsrechts* 2009, BGBl. I 2286, Germany, came into force 01/09/2009.
- ⁸ See generally S.Michalowski 'Advance refusals of life-sustaining medical treatment: the relativity of an absolute right' (2005) 68(6) *MLR* 958, A.Maclean 'Advance directives and the rocky waters of anticipatory decision-making' (2008) 16 *Med.LR* 1. The MCA does not apply to Scotland and Northern Ireland.
- ⁹ *Ms B, Re T, Bland* above n2.
- ¹⁰ *Re MB* (n2), per Butler-Sloss L.J., at 432; see also *Re T* (n2), per Lord Donaldson MR at 102; cf. s.1(4) MCA 2005.
- ¹¹ *In re F.* above n1; *Bland* per Lord Mustill at 891; *Re T* per Lord Donaldson MR at 102; *Ms B* above n2.
- ¹² A detailed consideration of the lasting power of attorney, through which a patient with capacity may empower a nominated third party to consent or refuse consent to medical treatment, falls outside the scope of this article. For a detailed consideration, see J. Samanta 'Lasting powers of attorney for healthcare under the Mental Capacity Act 2005: Enhanced prospective self-determination for future incapacity or a simulacrum?' (2009) 17 *Med LR* 377.
- ¹³ The English courts and the Law Commission have rejected the alternative model of decision-making referred to as substituted judgment in the United States and as *mutmaßliche Wille* (presumed will) in Germany and Austria; *Bland* (n2), per Lord Goff at 872; Law Commission Report (231) (1995) *Mental Incapacity*, at para. 3.28–3.31. For a detailed consideration of the two approaches see S.Halliday & L.Witteck (2002) 'Die Regelung von Nichtaufnahme und Abbruch einer medizinischen Behandlung am Lebensende in Deutschland und England' (2002) 15 *Juristen Zeitung* 752 and S.Halliday & L.Witteck 'Decision-Making At The End Of Life and The Incompetent Patient' (2003) 22(3) *Medicine & Law* 533.
- ¹⁴ S.4(6) MCA 2005
- ¹⁵ *Re T* (n2), per Lord Donaldson MR at 112; *Bland* (n2), per Lord Keith at 857, per Lord Goff at 864; *Re AK* [2001] 1 F.L.R. 129; *Re C (Adult: Refusal of Treatment)* [1994] 1 FLR 31; *HE v Hospital NHS Trust, AE* [2003] EWHC 1017, per Munby J. at para. 46.
- ¹⁶ Law Commission Report, above n13.
- ¹⁷ A minor over the age of 16 may give an effective consent to medical treatment: s.8(1) Family Law Reform Act 1969.
- ¹⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
- ¹⁹ See eg *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627; *South Glamorgan County Council v W and B* [1993] 1 FLR 574; *Re E (a minor)(wardship: medical treatment)* [1993] 1 FLR 386; *Re M (a child) (refusal of medical treatment)* [1999] 2 FLR 1097.
- ²⁰ S.2(5) MCA 2005.
- ²¹ S.2(1) MCA 2005.
- ²² S.3(1) MCA 2005.
- ²³ *Re T* (n2), per Lord Donaldson MR at 113; *Ms B* (n2), per Dame Elizabeth Butler-Sloss P., at paras 31; *Bland* (n2), per Lord Goff at 864.
- ²⁴ S.1(2) MCA 2005; *Re T* (n2) at 112; *Re MB* (n2) at 432.
- ²⁵ S.26(2) MCA 2005.
- ²⁶ *Mental Capacity Act 2005: Code of Practice*, 2007 [hereinafter Code of Practice], at paras 9.39 and 9.8; GMC *Treatment and care towards the end of life: good practice in decision-making*, 2010 [hereinafter GMC], at paras 70(b) and para.72.
- ²⁷ S.62 MCA 2005; cf. s.4(5) MCA 2005.
- ²⁸ *R (Burke) v General Medical Council* [2006] QB 273, at per Lord Phillips MR at para. 31.
- ²⁹ S.4(6)(a) MCA 2005.

- 30 *W Healthcare NHS Trust v H* [2005] 1 WLR 834, at 837.
- 31 *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129.
- 32 S.25(5)(6) MCA 2005.
- 33 S.4(10) MCA 2005.
- 34 *Re T* (n2), at 113.
- 35 S.24(1) MCA 2005.
- 36 S.26 MCA 2005.
- 37 S.25(1) MCA 2005.
- 38 S.25(2)(b) MCA 2005.
- 39 S.25(2)(c) MCA 2005.
- 40 *HE v A Hospital NHS Trust, AE* (n15).
- 41 S.25(4)(c) MCA 2005.
- 42 Code of Practice above n26, at para. 9.29.
- 43 BMA *Statement on Advance Directives*, January 1994, at para. 1.
- 44 Law Commission Report, Draft Mental Incapacity Bill, cl. 9(4), above n13.
- 45 See generally D. Olzen ‘Die gesetzliche Neuregelung der Patientenverfügung’ (2009) 9 *JR* 354; A. Spickhoff ‘Rechtssicherheit kraft Gesetzes durch sog. Patientenverfügungen?’ (2009) *FamRZ* 1949; P. Balz *Lebenserhaltung als Haftungsgrund*, Springer, 2010.
- 46 See eg RG, JW 25, 375 at 378; BVerfG 52, 131 at 174f; BGHSt 37, 376 at 37.
- 47 See eg RGSt 25, 375 at 378; BGHSt 11, 111, at 114; BGHZ 90, 103, at 105; BGH NJW 1980,1333 at 1334.
- 48 BGHSt 40, 257, at 261f. For a detailed consideration of this approach see Halliday & Witteck 1, above n13.
- 49 §1896 II BGB excludes the appointment of a *Betreuer* if a *Bevollmächtigte* has been appointed by the patient and has the power to make the necessary decision.
- 50 §1896 BGB
- 51 BGHSt 40, 257 and BGHZ 154, 205.
- 52 BGHSt 40, 257 at 260.
- 53 BGH XII ZB 2/03, 17 March 2003, BGHZ 154, 205 = NJW 2003, 1588.
- 54 §130 II BGB, BGH NJW 2003, 1588, at 1589, 1591.
- 55 BGH NJW 2003, 1588, at 1591.
- 56 *Ibid.* at 1589.
- 57 See eg F.Hufen ‘Verfassungsrechtliche Grenzen des Richterrechts’ (2003) 7 *ZRP* 248; V.Lipp, ‘Sterbehilfe und Patientenverfügungen’ (2004) 51 (5) *FamRZ* 317; T.Verrel (2003): ‘Mehr Fragen als Antworten – Besprechung der Entscheidung des XII. Zivilsenats des BGH vom 17. März 2003 über die Einstellung lebenserhaltender Maßnahmen bei einwilligungsunfähigen Patienten’ (2003) *NStZ* 449.
- 58 BGH NJW 2003, 1588, at 1590, 1593.
- 59 BGHSt 40, 257, at 260.
- 60 *Cruzan v Director Missouri Department of Health* 497 U.S. 261, (1990) per Brennan J (dissenting) at 302.
- 61 BGHSt 40, 257, at 261f.
- 62 BGH NJW 2003, 1588, at 1592-3; BGH XII ZR 177/03, 8 June 2005, BGHZ 163, 195.
- 63 Arbeitsgruppe ‘Patientenautonomie am Lebensende’ *Bericht: Patientenautonomie am Lebensende: Ethische, rechtliche und medizinische Aspekte zur Bewertung von Patientenverfügungen*, 10/06/2004, at 44. Available at:
http://www.bmj.de/SharedDocs/Downloads/DE/pdfs/Patientenautonomie_am_Lebensende.pdf?__blob=publicationFile (last accessed 29/03/2011).
- 64 Deutscher Bundestag, *Zwischenbericht der Enquete-Kommission Ethik und Recht der modernen Medizin: Patientenverfügungen*, 13/09/2004, BT-Drucks 15/3700, at 37-38. Available at: <http://dipbt.bundestag.de/dip21/btd/15/037/1503700.pdf> (last accessed 29/03/2011). Similarly the majority recommendations of the 63rd (*Empfehlen sich zivilrechtliche Regelungen zur Absicherung der Patientenautonomie am Ende des Lebens?* 2000) and 66th (*Patientenautonomie und Strafrecht bei der Sterbebegleitung*, 2006) Deutsche Juristentagen (DJT, German Jurist Forums); and the National Ethics Council (Nationaler Ethikrat *Stellungnahme: Patientenverfügung*, 2005) recognised the need for legislation to clarify the law and protect autonomy.
- 65 BGH 05/12/1958, BGHZ 29, 33 at 36.
- 66 BGHZ 154, 205 at 215, BGHZ 163, 195 at 197; BGHZ 29, 46, at 49ff; BGH NJW 1980, 1333; BGH NJW 1993, 2372, at 2373.
- 67 BT-Drs 16/8442, at 14.
- 68 BGH NJW 2003, 1588, at 1592.

- 69 Ethikrat above n64, at 31; this approach was also adopted by the BMJ's (Federal Ministry of Justice's) draft Bill: Bundesministerium der Justiz: *Entwurf eines Referentenentwurfs für ein 3. Gesetz zur Änderung des Betreuungsrechts*, 01.11.2004, at 19. But cf. Enquete-Kommission above n64, at 38, recommending that advance directives should only be applicable where the underlying illness would irreversibly lead to death.
- 70 BGHZ 154,205; similarly the BMJ's Draft Bill 2004 stated that advance directives *should* be in written form; however the National Ethics Council and the Parliamentary Committee of Inquiry recommended that a written form requirement should be a pre-requisite of validity: Referentenentwurf above n69, at 16 – 17; Ethikrat above n64 at 33; Enquete-Kommission above n64, at 37.
- 71 The law applies equally to *Betreuer*s and *Bevollmächtigten* (§§1901a V, 1901b III, 1904 V BGB) – thus legal representative should be understood to refer to either/both.
- 72 BGH NJW 2003, 1588, at 1590
- 73 *Ibid* at 1592.
- 74 BT-Drs 16/8442, at 16.
- 75 §1901a I BGB.
- 76 BGH NJW 2003, 1588, at 1590-1.
- 77 BGHSt 40, 257; See also explanatory notes: BT-Drs 16/8442, at 16; BT-Drs 16/13314, at 4.
- 78 §1904 V BGB.
- 79 The maintenance of the distinction was proposed by the BMJ's Draft Bill 2004, above n69, §1904 III BGB – RefE; and supported by the Ethikrat above n64, at 32.
- 80 BGH NJW 2003, 1588, at 1591-3.
- 81 BT-Drs 16/8442, at 19.
- 82 FamGG.
- 83 See also BGH NJW 2003, 1588, at 1591, 1593.
- 84 See generally E. Bernat 'Planungssicherheit am Lebensende? Anmerkungen zum BG über Patientenverfügungen sowie zur Stellvertretung in Gesundheitsangelegenheiten' (2006) *EF-Z* 23 & 41 [hereinafter Bernat]; G. Kathrein 'Das Patientenverfügungs-Gesetz' (2006) *ÖJR* 34; M. Memmer, 'Das Patientenverfügungs-Gesetz 2006' (2006) *RdM* 163 [hereinafter Memmer].
- 85 OGH 7 July 2008, OGH 6 Ob 286/07p; 2009(2) JBl 100; explanatory notes to the Penal Code (ÖStGB): 30 BlgNR 13, GP242; §110 I ÖStGB; §8 III KAKuG.
- 86 §110 II ÖStGB.
- 87 See also M. Haag 'Strafrechtliche Verantwortlichkeit für Aufklärungsfehler?' (2005) *RdM* 48.
- 88 Krankenanstalten- und Kuranstaltengesetz (Medical Institutions Act), 1993 version BGBl 1993/801.
- 89 The Patients' Charter does not set out enforceable rights for patients. It is a contract between the federal state and the individual states which recognises the rights and duties of regional authorities, rather than those of doctors and patients.
- 90 OGH 16/7/1998, 6 Ob 144/98i; RdM 1999/21 = ÖJZ 1999/21 (EvBl.)
- 91 §1 II PatVG.
- 92 §§17, 18 ABGB.
- 93 See also RV 1299 BlgNR22, GP5.
- 94 §146c I ABGB.
- 95 §146c II ABGB.
- 96 See also M. Memmer 'Patientenverfügungen—Rechtslage nach dem 1. Juni 2006' (2006) *FamZ* 69, at 70
- 97 §10 PatVG; §77 ÖStGB prohibits killing another at her request, §78 ÖStGB prohibits assisting suicide; RV 1299 BlgNR22, GP9.
- 98 §4 PatVG.
- 99 RV 1299 BlgNR22, GP6.
- 100 *Ibid*.
- 101 OGH 6 Ob 286/07p.
- 102 Memmer above n84, at 168.
- 103 RV 1299 BlgNR22, GP7.
- 104 §6 PatVG refers to a 'Belehrung' (instruction) in the case of the legal 'advice', as opposed to the 'Aufklärung' (explanation/advice) by a doctor referred to in §5 PatVG.
- 105 RV 1299 BlgNR22, GP 7.
- 106 E. Bernat above n84, at 3d.
- 107 §6 I PatVG.
- 108 RV 1299 BlgNR22, GP9.
- 109 See also Memmer above n84, at 166.

- 110 Bundesministerium für Gesundheit *Patientenverfügung und Selbstbestimmung: Leitfaden für Ärztinnen und Ärzte zur Erstellung und Anwendung einer Patientenverfügung*, at 21.
- 111 Reference to a ‘consider-able’ directive denotes that it falls into the Austrian category of advance directives that have no binding force, rather than that it is necessarily significant.
- 112 §7 PatVG.
- 113 §268 II ABGB.
- 114 §268 I ABGB.
- 115 §275 I ABGB.
- 116 C. Kopetzki, ‘Einleitung und Abbruch der medizinischen Behandlung beim einwilligungsunfähigen Patienten Praktische Auswirkungen der gesetzlichen Neuerungen durch PatVG und SWRÄG’ (2007) *iFamZ* 197, at 202.
- 117 But note Kopetzki, *ibid*, at 203, arguing that a historical and teleological interpretation of §283 II ABGB would require court approval of a refusal to consent to life-sustaining treatment.
- 118 *Bericht des Bundesministers für Gesundheit zur Entschliessung Nr. 187/UEA-BR/2006: Studie über die rechtlichen, ethischen und faktischen Erfahrungen nach In-Kraft-Treten des Patientenverfügungs-Gesetzes (PatVG): Endbericht, 2009*, III – 385-BR/2010 presented to Parliament 11 March 2010, at 12. Available at http://www.parlament.gv.at/PG/DE/BR/III-BR/III-BR_00385/imfname_179848.pdf (last accessed 29/03/2011).
- 119 In the following analysis English case law is used to illustrate relevant points due to the low level of law reporting in Germany and Austria which are both civil law jurisdictions.
- 120 *Re T* (n2), at 113. See also BGHZ 90, 103 at 105f; RGSt 25, 375 at 378f; BGHSt 11, 111 at 113f; BGH NJW 1980, 1333 at 1334.
- 121 *Ms B* (n2).
- 122 *Ibid.* at para. 93.
- 123 Anticipatory requests for euthanasia are permissible in both Belgium and the Netherlands, see S. Halliday ‘Regulating active voluntary euthanasia: what can England and Wales learn from Belgium and the Netherlands?’ in A. Garwood-Gowers, J. Tingle and K. Wheat (eds) *Contemporary Issues in Healthcare Law and Ethics*, Elsevier, 2005, 277, at 288-9, 293.
- 124 Enquete-Kommission above n63, at 38.
- 125 Cf the discussion of the meaning of terminal in House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, 2005: Report, HL 86-I, chapter 4.
- 126 *NHS Trust A v M, NHS Trust B v H* [2001] Fam 348, at 358-9 per Butler-Sloss P.; *Pretty v UK* 35 EHRR 1; *Bland* (n2); BGHSt 40, 257; BGH, 25.6.2010—2 StR 454/09; OGH 6 Ob 286/07p.
- 127 M. Bayles ‘Physicians as body mechanics’ in J.W. Davis et al (eds.) *Contemporary Issues in Biomedical Ethics*, Humana Press, 1978, at 167.
- 128 *Bland* (n2); BGHSt 40,257; OGH 6 Ob 286/07p.
- 129 D. Brock *Life and Death*, CUP, 1993 at 58.
- 130 Buchanan & Brock, above n4, at 103-4.
- 131 *Re T*(n2), per Lord Donaldson MR at 113-4; BGH NJW 2003, 1588, at 1591.
- 132 Code of Practice above n26, at para. 9.13.
- 133 Report, above n118, at 18.
- 134 Code of Practice above n26, at para. 9.14; BT-Drs 16/8442, at 14.
- 135 *Re T* (n2); §10 I (1) PatVG; §§118, 119, 123 BGB.
- 136 See also J. Taupitz ‘Die Debatte um ein Patientenverfügungsgesetz’ in Junginger et al (eds) *Grenzsituationen in der Intensivmedizin*, Springer, 2008, at 121; Memmer above n84, at 166.
- 137 S.25(2)(C) MCA 2005; §10 II PatVG; §1901a I BGB.
- 138 [2003] EWHC 1017 (Fam).
- 139 *Ibid.* at para 43.
- 140 *Ibid.* at para. 24.
- 141 *Ibid.* at paras 49 – 50.
- 142 Munby J.’s suggestion that the requirement of clear and convincing evidence does not require more than the usual balance of probabilities standard (at para. 24), is unconvincing.
- 143 See eg *Cruzan* (n65).
- 144 at para. 43.
- 145 Spickhoff above n45, at 1951.
- 146 Balz above n45, at 67.
- 147 Spickhoff above n45, at 1951-1952.

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- ¹⁴⁸ Law Commission Report above n13, at para. 5.25 – 5.26, proposing that a presumption of non-applicability should apply in the absence of an indication to the contrary, Draft Bill, clause 9(3).
- ¹⁴⁹ Code of Practice above n26, at paras 9.16 and 9.43; cf BMA *Advance decisions and proxy decision-making in medical treatment and research: Guidance from the BMA's Medical Ethics Department*, 2007 [hereinafter BMA], at 6.
- ¹⁵⁰ *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* [1999] Fam. 26, per Judge L.J. at 50.
- ¹⁵¹ Buchanan & Brock, above n4, at 105-6.
- ¹⁵² For a detailed consideration of this issue see R.S. Dresser 'Missing persons: legal perceptions of incompetent patients' (1994) 46 *RULR* 609; R.S. Dresser 'Advance Directives, self determination, and personal identity' in C. Hackler et al (eds) *Advance Directives in Medicine*, Greenwood Press, 1989; N. Cantor, 'Discarding Substituted Judgment And Best Interests: Toward A Constructive Preference Standard For Dying, 'Previously Competent Patients Without Advance Instructions' (1996) 48 *RULR* 1193, at 1210; R. Dworkin *Life's Dominion*, Harper Collins, 1993; N. Rhoden 'Litigating life and death' (1988) 102 *Harv LR* 275; A. Maclean 'Advance directives, future selves and decision-making' (2006) 14 *Med LR* 291.
- ¹⁵³ D. Parfit *Reasons and Persons*, OUP, 1986.
- ¹⁵⁴ Dresser, above n152.
- ¹⁵⁵ Dworkin above n152, at 199ff.
- ¹⁵⁶ Ethikrat above n64, at 34.
- ¹⁵⁷ *Pretty v UK* (2002) 35 EHRR 1, at para.64.
- ¹⁵⁸ S.25(4)(b) MCA 2005; §1901a I BGB; §10 I (3) PatVG.
- ¹⁵⁹ German Medical Association guidelines: BÄK *Empfehlungen der Bundesärztekammer und der Zentralen Ethikkommission bei der Bundesärztekammer zum Umgang mit Vorsorgevollmacht und Patientenverfügung in der ärztlichen Praxis* (2010) 18 *Deutsches Ärzteblatt* 877, at 881; Code of Practice above n26, at para.9.38; GMC above n26, at para.61; §10 I(8) KAKuG
- ¹⁶⁰ §62a I KAKuG.
- ¹⁶¹ BMA above n149, at 6.