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Review Article
Published: 16 Mar, 2018

Journal of Forensic Medicine Forecast

Advance Statement *vs* Advance Decision: A Critical Evaluation of the Legal Status and the Moral and Pragmatic Advantages and Disadvantages

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Abstract

An Advance Statement (AS) is a general statement about anything that is important to people (patients) in relation to their future treatment and wellbeing. An Advance Decision (AD) (sometimes known as Advance Decision to Refuse Treatment) is a document that allows a person to make a legally binding refusal of medical treatment in advance of a time before losing capacity. An AD only concerns refusal of medical treatment, whereas an AS can include any information that is felt important in relation to a person's health or care. An advanced statement is not legally binding but advance decision is legally binding, if it meets the necessary criteria for it to be considered valid and applicable. This article will critically evaluate the legal status of AS, from the perspective of its legal bindingness, as well as the moral and pragmatic advantages and disadvantages of AS relating to future life-sustaining treatment made by patients who subsequently lack the capacity to make such decisions contemporaneously.

Introduction

When people can no longer make, or communicate their decisions, medical choices have to be made which reflect their best interests, Advance Statement (AS) is a statement of wishes wherein people stipulate what they consider to be their interests about the medical treatment they do or do not want in future among others [1]. There are both moral advantages and disadvantages of making some treatment statements in advance. Nevertheless, if the statement were made when a person was competent to comply with the legal criteria, health professionals ought to comply with them [1]. Most of these binding decisions concern Life-Sustaining Treatment.

It has been held in case of *Airedale NHS Trust* v *Bland* [2] that in the circumstance where it is in the best interest of the patient, a decision made on behalf of the incapacitated patient to remove a nasogastric tube kept for the nutritional and hydrational requirements of the patient is not unlawful even though it will lead to the inevitable death of the patient [2]. Section 24 of the Mental Capacity Act, 2005 (MCA) is to effect Advance Decision (AD) to be made subject to strict requirements.

In this article, it will be critically evaluated about the legal status of AS, from the perspective of its legal bindingness, as well as the moral and pragmatic advantages and disadvantages of AS relating to future life-sustaining treatment made by patients who subsequently lack the capacity to make such decisions contemporaneously. Author's central arguments in this article are that advance statement can be said to be legally binding in ways often disregarded in approach to this subject matter by previous researchers. It must be understood clearly that AS and AD are not the same and the difference between the two will be highlighted subsequently. However, the argument here is that AS sometimes can be regarded as being legally binding, since section 4(6) of the MCA requires that 'any relevant written statement' must be considered in the best interest of the patient. Hence, it is a proposition of what the position should be? Secondly, when it relates with life-sustaining treatment, considered on the backdrop of the supreme value for life and the best interest of the society, advance statement is highly disadvantageous.

A critical evaluation of the legal status of advance statement relating to future life-sustaining treatment

An advanced statement is not legally binding but advance decision is legally binding, as long

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Received Date: *11 Feb 2018*
Accepted Date: *13 Mar 2018*
Published Date: *16 Mar 2018*

Citation: *Arora P. Advance Statement vs Advance Decision: A Critical Evaluation of the Legal Status and the Moral and Pragmatic Advantages and Disadvantages. J Forensic Med Forecast. 2018; 1(1): 10085.*

as it meets the necessary criteria for it to be considered valid and applicable [1]. On a closer scrutiny, AS can also be said to have a binding effect, because an Advance Decision cannot be applicable without reference to an Advance Statement in the best interest of the patient, this is the necessary implication of section 4(6) of the MCA when one comprehends the meaning of an AS.

An AS is a general statement about anything that is important to people (patients) in relation to their future treatment and wellbeing [3]. It helps to ensure that one's wishes are known and followed if one cannot speak or make decisions for oneself in future [3]. Even though, the MCA makes no express provision for AS, an AS [3] has a legal status because it must be considered when someone is deciding what is in a patient's 'best interests' [3]. In order to better evaluate the legal status of AS, let us further dissect the relationship between AS and AD.

The relationship between Advance Statement and Advance Decision

It is instructive to note that AS and AD are two different mechanisms. An AD (sometimes known as Advance Decision to Refuse Treatment and referred in section 24 of the MCA) is a document that allows a person to make a legally binding refusal of medical treatment in advance of a time before losing capacity [3]. An AD only concerns refusals of medical treatment, whereas an AS can include any information that is felt important in relation to a person's health or care [3]. While some authors [3-5] have taken time to elaborate on the distinction between AS and AD, it is important to note that both are veritably the same in object, whereas AS is general, AD [6] is more specific to the refusal of medical treatment where the patient becomes incapacitated to make such decisions when the need arises [4]. Both AS and AD can contain the same information such as general statements about the patient's views on care, which may help a doctor to make decisions on course of treatment without restricting them to specified course of action. Therefore, it is safe to assert that there is only a thin line of difference between AS and AD. Hence, some authors collectively refer to them as advance directives, especially in the United States of America [7].

A change of legal status: how advance statement obtains its binding force?

1. Advance Decision has long been recognised under common law [8,9], prior to the coming into effect of the Mental Capacity Act of 2005 [7]. In order to understand how Advance Statement, can arguably be said to have a binding effect, let us consider it in the light of when it relates with future life sustaining treatAS relating to future life-sustaining treatment in the determination of the best interest of the patient, and

2. AS relating to future life-sustaining treatment made in compliance with the formal requirements of Advance Decision (to Refuse Medical Treatment).

Advance statement relating to future life-sustaining treatment in the determination of the best interest of the patient

In principle, section 1 of the MCA provides that any act done or decision made for or on behalf of a person who lacks capacity must be in his best interest [10]. In determining what is in a person's best interests, the person making the determination must not make it merely on the basis of the person's age or appearance, or a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests [11]. Rather, where the determination relates to life-sustaining treatment the person making the determination must consider all the relevant circumstances including the person's past and present wishes and feelings and, *inparticular*, any relevant *written statement (advance statement)* made by him (the patient) when he had capacity in the event that he subsequently lacks the capacity to make such decisions contemporaneously [11]. Best interest therefore is determinable from the point of view of the patient, however some doctors believe that medical factors are the major determinants of what is in the patient's best interest [10].

Advance statement relating to future life-sustaining treatment made in compliance with formal requirements of advance decision to refuse medical treatment under the mental capacity act, 2005

For starters, an AD does have the same legal force as a decision made by a competent patient contemporaneously [8,9,12-14]. Thus, an AD is for all intents and purposes, an anticipatory decision [15,16]. We have noted that AD is not a creation of statute but common law with only a statutory reaffirmation [17]. At Common Law, one of the limits on necessity, the legal justification for providing treatment without consent in emergency situations, was the existence of some evidence of a pre-existing wish of the patient, expressed at a time when patient was competent, which indicated that patient may wish to refuse medical treatment for a particular illness or injury [18].

Heywood [17] expounded that under common law, an AD must satisfy certain requirements before it can be deemed to be applicable especially when it is in relation to refusal of life-sustaining treatment [17]. "The AD must have been supported by 'convincing' and 'inherently reliable' evidence and that evidence would be subject to a higher degree of scrutiny from a judge" [17-19]. Furthermore, the applicability of AD at common law is subject to two conditions, which are that the choice of the patient had to be 'clearly established' and 'applicable in the circumstances' [17]. It had been decided [14] in satisfying these conditions, that the burden of proof rested on those who seek to establish the existence and continuing validity and applicability of an AD and that, where life is at stake, such as where it relates to future life-sustaining treatment, the evidence must be scrutinised with special care [14]. However, the common-law approach has been marked as its 'bias for life' [20].

At this juncture, it is pertinent to emphasise that the object of this section of this work is to establish that an AS can have binding effect to refuse medical treatment where it satisfies certain formal requirements. At the same time, it is hereby posited that if a person merely intended to make an Advance Statement, where he does so in writing, and the statement complies with the formal requirements ordinarily applicable in assessing an Advance Decision, such an Advance Statement should take effect as an Advance Decision and should be considered to have a binding effect. What is the formal requirement an AD is expected to comply with?

An AD can have a binding legal status at common law if it satisfies the following conditions [20]:

At the time the AD is being created:

i. The patient must be an adult of not less than 18 years of age.

ii. He must be competent.

iii. He must be fully aware of the nature and consequences of the statement.

iv. He must be able to envisage the circumstances under which the AS would apply.

v. He must not be acting under duress.

Note that competence entails an understanding, in general terms of the nature of any proposed treatment, its consequences and side-effects. It also means an understanding of the effect of not having the treatment, the ability to reason consistently over time about a particular subject, and reach a decision based on this reasoning and the ability to communicate this decision accurately. Hence, competence can be said to be decision specific in the sense that a patient can be competent to make some decisions and be incompetent in making other decisions, and that the competence can also vary over time [8].

Also at the time that the AD comes into force [8,20]:

i. The present circumstance must have been envisaged by the patient at the time of creating the AD

ii. The AD must not have been revoked

iii. The patient must have become incompetent as at the time that the AD becomes effective.

Furthermore, at common law, it is not required that the AD must be written following any specific format or that it must be in writing at all, hence, at common law an AD can be validly made orally [8,20].

Under the Mental Capacity Act, 2005, the legal status of AS relating to future life-sustaining treatment can said to be virtually a recapitulation of the position of an Advance Decision under common law with only a little variation. From a statutory stand point of view, there is no generic provision that an AD must be made in writing, however, where an AD relates to a future life-sustaining treatment it is mandatorily required to be made in writing for the purpose of clarity.

In the case of *W Healthcare NHS Trust v H* [21] where a 59 year-old woman (KH) suffering from multiple sclerosis made an AS many years ago. KH had made statements about medical treatment that she did not want, including one statement refusing life support machines and other statements refusing treatment, if she could not continue with a reasonable quality of life. None of KH's statement had specifically addressed the issue of artificial nutrition and hydration. The Court accepted that some of her statement may have been sufficient to refuse other medical treatment, for example her desire not to be kept alive on life support machines. However, the other remaining general statements, refusing treatment based on quality of life considerations, were insufficiently clear to amount to be treated as though it were an AD and on the strength of that reasoning the court held that she had not refused the artificial nutrition and hydration.

Section 25 (5) and (6) of the MCA provide to the effect that an AD or AS is not applicable to a life-sustaining treatment unless it is made in writing, signed by the patient or by another person in the patient's presence and by the patient's direction. The signature must be made or acknowledged by the patient in the presence of a witness, and the witness must sign it, or acknowledge his signature, in the patient's presence.

A decision or *statement* [22] complies with this subsection only if— (a) it is in writing, (b) it is signed by P or by another person in P's presence and by P's direction, (c) the signature is made or acknowledged by P in the presence of a witness, and (d) the witness signs it, or acknowledges his signature, in P's presence [23].

The subsection does not only contemplate the validity and applicability of an advance decision, it clearly also contemplates that the formal requirements should also be applicable to Advance Statement, hence, it commenced with "A Decision or *'Statement'*". Therefore, where an Advance Statement complies with section 25(6) the effect is not in doubt. Hence, where a document which purports to be merely and AS is executed in the above manner, and it covers the scope under the MCA such an AS should take effect at law as though it was an Advance Decision *stricto sensu*.

This can be seen from a pre-Mental Capacity Act case law, *The NHS Trust v T* [24]. The patient suffered from a borderline personality disorder and had a long history of psychiatric treatment. She had, on a number of occasions, self-harmed by cutting herself and blood-letting. The consequence of this was that her haemoglobin would fall dangerously low so that she would require an emergency blood transfusion. However, in 2004, she expressed her wishes to refuse any blood transfusion on the basis that she was caught in a set of circumstances which were impossible to endure. A letter accompanied the statement from her GP in which it was confirmed that the patient understood the nature and consequence of her decision and that it may result in her death. The Court treated it as binding, valid and enforceable, it however declared it inapplicable on the ground of lack of capacity, and therefore held that it could be overridden [24].

Prior to the coming into force of the MCA (2005), Advance decision or statement relating to medical treatment were generally treated under identical criteria even though it was well understood that AS could be applied to wide variety of issues. The MCA introduces a cap by expressly making provision for AD and only makes it applicable to the refusal of treatment, hence, a critical evaluation of AS yet discloses a close affinity, such that a distinction can arguably be said to be without a difference.

Moral advantages of advance statement relating to future life-sustaining medical treatment

It is highly beneficial for medical professional to have information about their care preferences from competent patients [25]. The legal status as we have noted above can be seen in the MCA which gives people a statutory right to state what forms of treatment they would or would not like should they become unable to decide for themselves in the future [25]. Technically, an AD is legally binding in a particular set of circumstances, whereas an AS is more informal [25] and generally not legally binding under the Act. However, the opinion expressed in this article contends that an AS is legally enforceable by being considered in giving effect to a binding AD. Noteworthy is the fact that it is both morally right and of immense practical help to have clear information from patients about what aspects of medical treatment they find valuable and others they do not [25].

When it relates to a life-sustaining medical treatment, an AD can also create considerable dilemmas for staff, who in some situations may firmly believe that a particular approach or treatment would be in the patient's best interests despite it conflicting with what is in their AD [25]. Such conflicts occur most times, but if there's an AD then there's an expression of the individual's preferences written when they are in a better mental state than they might be at the time the decision might need to be made. Such statements, ideally would have

been made in consultation with medical and general practitioners, as well as other witnesses [25]. It must however be noted that for the times when there isn't a complex conflict of views between patients and medical professionals, an AD proves to be a resourceful material in resorting to a medical treatment decision that the patient would cope with [25].

Ideally, an AS sets out a person's treatment preferences in consultation with medical professionals in case they become incompetent and need compulsory medical treatment. AS inform professionals about the patient's wishes, which will be of great help in difficult and fraught situations. AS often improve communication between a patient and health professions in that they encourage thinking and planning for the future. It helps patients to feel in control about what may happen in the future if they become ill and incapable of making decisions. AS empower them as users of medical treatment to have some input into their treatment, care, support and recovery or otherwise their dying [5].

It is interesting to note when an AS relates to a life-sustaining treatment, it can operate in two ways, either to direct as to the particular treatment a patient desires to have or to direct as to the particular treatment a patient desires not to be given. We will now approach a critical evaluation of the moral advantages of an AS relating to future life-sustaining treatment from the point of view that it constitutes a form of assisted suicide when the patient directs to the effect that he/she wishes to refuse a life-sustaining treatment, by way of moral disadvantages of AS relating to future life-sustaining treatment.

Moral disadvantages of advance statement relating to future life-sustaining medical treatment

In the exercise undertaken above, we have been able to critically evaluate the legal status of AS, and detail the advantages that it offers when it relates to future life-sustaining treatment. We have also seen that, rather in contrast to popular belief, when an AS satisfies certain formal requirements, it can be applied to the refusal of life-sustaining treatment just like an AD to refuse treatment. Thus, morally speaking, as much as an AS permits the allowance of the death of a patient it is highly disadvantageous. We will approach this line of argument from the perspective of the "best interest of the Society versus the best interest of a patient". It is cornerstone of the principle of autonomy that those with capacity are best placed to determine their own best interests and that exercising one's self-determined choice will enhance that person's overall welfare [10].

These evaluations will be done in contradistinction with the principle of best interest, the concept of dignity of person vis-à-vis autonomy. A life-sustaining treatment is a treatment which is administered to a patient, without which the patient will lose his/her life. The life of an individual underscores continuity in the society, hence, all individual and concerted efforts are directed towards preserving life, and making it better. The supreme value for life is the whole essence of the law and civilised co-ordinations, this is particularly encapsulated in the law against murder, manslaughter, suicide, etc. to the extent that an attempt of these is legally reprehensible. Recently however, suicide has been decriminalised but an assisted suicide remains a crime under our law. The crux therefore, is that *it is in the best interest of the society to preserve life against all odds*. It is legally, morally, and ethically wrong to kill or take life, and dare to say, 'even one's own life', why take what you cannot give? Theorists like Dworkin argue that the integrity of the person and individual autonomy are the bedrock of the predominant reliance on the self-determination of the patient as his best interest [10], but it is fundamentally derailed from social reality as it is in sharp contrast with fundamental tenets of the society.

There is an argument that there is a difference between killing someone medically (euthanasia) and allowing someone to die. The proponents of this thought posit that permitting medical treatment merely allows someone to die and not kill the person [26-28]. In the words of Lord Donaldson of Lymington MR in an appeal before the Court of Appeal Civil Division.

This appeal is not in truth about the 'right to die'. There is no suggestion that Miss T wants to die. I do not doubt that she wants to live and we all hope that she will. This appeal is about the 'right to choose how to live'. This is quite different, even if the choice, when made, may make an early death more likely. It is also about whether Miss T really did choose and, if so, what choice she made [9].

He suggests that a person's decision to refuse a life sustaining treatment knowing that it will lead to the death of the person remains the person's way of choosing to live. It is the opinion of this paper that this does not accord with the logic of cause and effect because withholding or withdrawing a life-sustaining treatment from a patient who wishes it to be withdrawn or withheld would necessarily cause the death of the patient, it is undeniable that it is case of assisted death whether or not it is argued that it is in the patient's best interest.

It is a known fact that it is in the best interest of the society to preserve life, and save life. When a patient's best interest conflicts with the best interest of the society, it is submitted that the best interest of the society must prevail. Hence, AS when it relates to refusal of life-sustaining treatment, especially where it is reasonably ascertainable that giving effect to such decision will lead to the eventual death of the patient, must be jettisoned. Even though an individual is autonomous in making decisions regarding their lives, his autonomy should not extend to causing the society the grief of his loss of life. Asides from this, nature does not envisage that one should take one's own life, either alone or in collaboration with others. It is rather more dignifying and preferable that a patient whose quality of life has deteriorated dies in treatment. A patient who would naturally die with or without treatment, using AD or AS to ascertain the best interest of an individual as allowing the person to conflicts with the desire of the society to preserve life.

Conclusion

In conclusion, the legal status of AS relating to future life-sustaining treatment made by patients who subsequently lack the capacity to make such decisions contemporaneously is that it is not legally binding because ASs generally are not legally binding. When critically evaluated, one will find that AS can actually be said to have a binding by the consequence of its consideration in determining the best interest of the patient in making decisions for an incompetent patient who has made an AD or where a decision is being made for on the strength of a lasting power of attorney. Also, when one considers the formal requirements one realises that it is only a matter of form and context in line with statutory requirements before an AS becomes legally binding in status. An AS has a myriad of advantages, but when we think about it from the perspective of an AS as an apparatus for deliberately causing the death of a patient, it reveals where the moral disadvantage are, there is no benefit in taking what one cannot give in utter disregard of the supreme value for life and against the best

interest of the society.

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