

## MENTAL CAPACITY ASSESSMENT, LPA, COURT APPOINTED DEPUTY APPLICATION, AND ETHICAL ISSUES RELATED TO MENTAL CAPACITY ACT –2021 UPDATE

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### ABSTRACT

The Mental Capacity Act (MCA) addresses the need for authorised individuals (donees) to act on behalf of persons who are unable to make decisions for themselves. One of the consequences of Singapore's rapidly ageing population is the rise in the number of patients suffering from stroke and age-related neurodegenerative diseases. As their cognitive function deteriorates, they also lose their ability to make independent decisions, which makes them at risk of potentially detrimental decisions made by them or others. Conflicts and uncertainty may come about because of a lack of clarity concerning the individual's wishes with mental incapacity. There is a growing concern amongst individuals that, on losing their mental capacity, they also lose their right to make decisions based on. The MCA has two mechanisms to address such issues, namely, (1) Lasting Power of Attorney (LPA) Certification and (2) Court-appointed Deputy Application for Patients. The former allows for cognitively intact persons to appoint one or more persons to act on their behalf should they lose their mental capacity in the future. The Court-appointed Deputy Application for Patients is required for persons who have not made an LPA before losing mental capacity. The court-appointed deputy can make certain decisions on their behalf. A deputy can be an individual or a licensed trust company under the Trust Companies Act (Cap.336). There are also five ethical issues related to the MCA of 2008 to be discussed.

**Keywords:** Ethics, mental, capacity, deputy, lasting power of attorney, court-appointed

### INTRODUCTION

#### WHAT HAPPENED?

Singapore's population is ageing rapidly. As our society ages, we expect a corresponding rise in dementia. At the age of 65, one in 20 may have dementia, and the incidence could be as high as one in ten by the age of 75. We would feel much safer if we knew that the person, we were going to depend on at that point in time was someone we had chosen when we had the capacity to choose - someone we could trust and rely on and someone willing to undertake that burden.

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The forerunner of the Mental Capacity Act of 2008 was the Mental Disorders and Treatment Act (MDTA). This Act has no provisions to allow individuals to plan ahead in appointing someone to tend to their affairs, should they lose capacity. The Mental Capacity Act (MCA), on the other hand, gives individuals that choice. Passed by Parliament in September 2008 and updated in 2010<sup>1</sup>, the MCA empowers individuals while they still have the capacity to plan in advance for a time when they may lack the capacity to make decisions for themselves, with respect to the areas of personal welfare and financial matters.

Even if the individual does not choose to elect a proxy decision-maker in advance, applications can be made to the Court to appoint a deputy to make decisions on an individual's behalf, when he loses his capacity. The MCA also enables parents of a child with intellectual disabilities to appoint a deputy to oversee the child's welfare and financial matters. Under the Act, individuals who wish to make advance plans for themselves can do so through a new statutory document known as the Lasting Power of Attorney (LPA). In the LPA, the individual (donor) can appoint a proxy (donee) to act or make decisions on his behalf for matters relating to his personal welfare and/or property and finances. The MCA applies to a wide range of people, from family members to healthcare providers to formal and informal caregivers to third parties with whom transactions are made.

#### 2-CHOICE TO APPOINT TRUSTED PERSON(S) (DONEE(S)) IN ADVANCE BEFORE LOSS OF MENTAL CAPACITY

One of the key ideas underpinning the MCA is that of choice. The MCA provides an individual (donor) with the choice to appoint a trusted person (donee) in advance, to manage his affairs should he lose his capacity in the future.

#### LASTING POWER OF ATTORNEY

A new statutory document, the Lasting Power of Attorney (LPA), gives legal authority to the donee(s) to carry out matters on behalf of the donor. There are two types of LPA (Chan C, 2009)<sup>2</sup>:

##### Personal Welfare LPA

Some examples of personal welfare decisions include:

- Deciding where the donor is to live;
- Deciding issues pertinent to day-to-day care;
- Deciding the level of contact the donor can have with any particular person(s);
- Prohibiting particular person(s) from coming into contact with the donor;
- Refusing consent to treatment (including the conduct of clinical trials) by a healthcare provider for the donor.

See Section 22 (1) of MCA for more examples of personal welfare decisions.

### Property and Affairs LPA<sup>2</sup>

Some examples of property and affairs decisions include:

- Control and management of property;
- Acquire or disposal of property;
- Make business decisions;
- Conduct banking transactions;
- Investment management.

See Section 23 (1) of MCA for more examples of property and affairs.<sup>1</sup>

### Appointment of donees under the LPA<sup>2</sup>

The LPA is a flexible instrument that allows a donor to appoint more than one donee. It also allows for the donor to appoint replacement donee(s) if the original donee(s) can no longer discharge their duty towards the donor. Anyone who is above the age of 21 can qualify as a donee. However, an undischarged bankrupt cannot be appointed as a donee for the donor's property and affairs.

Parents of intellectually disabled children will also be able to make advance arrangements for their care. These parents can apply to the Court to appoint themselves as the child's deputies and a successor deputy to make decisions on behalf of their children when the parents should themselves lose mental capacity or pass on.

### Cancellation of LPA<sup>2</sup>

Revocation of lasting powers of attorney – Section 15 of MCA. An LPA can be revoked under certain circumstances:

- The donor, while he still has mental capacity, decides to revoke the LPA;
- Death of the donor or donee;
- The donee loses mental capacity;
- Bankruptcy of the donor or donee terminates any powers granted by the LPA in respect of property and affairs;
- Dissolution or annulment of the marriage between the donor and donee, unless the donor specified in the LPA that such an event would not cause the LPA to be revoked.

### 3-DEFINITION OF INCAPACITY<sup>2</sup>

This is defined under Section 5(1) Inability to make decisions Under the MCA, a person is defined to lack capacity if he is unable to make a decision or take action for himself at the time the decision or action needs to be made. This can be caused by the impairment of, or a disturbance in the functioning of the mind or brain. The impairment or disturbance could be permanent or temporary.

A person lacks mental capacity if he or she cannot do one or more of the following things:

- Understand the information relevant to that decision
- Remember that information
- Use or weigh that information as part of the decision-making process
- Communicate that decision by any means; e.g., talking, using sign language, drawing, etc.

### 4-ASSESSMENT OF CAPACITY<sup>2</sup>

(1) Section 4(1) of MCA, 2008. The Act in this section provides a two-step test in assessing capacity:

- Step 1 - Is the person suffering from an impairment of, or a disturbance in the functioning of the mind or brain?
- Step 2 - If yes, does that impairment or disturbance impede the person from making the decision when it is required?

(2) Section 4(2) of MCA states that it does not matter whether the impairment or disturbance is permanent or temporary.

Section 4(3) of MCA states that a lack of capacity cannot be established merely by reference to –

- (a) a person's age or appearance; or
- (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(3) Section 4(4) In proceedings under the MCA (other than proceedings for offences under this Act), any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

(4) Key principles in the assessment of persons who lack the capacity to avoid pitfalls are shown in Table 1.

**TABLE 1: 5 Key Principles (Section 3 2010 Edition)**

<p>Persons who lack capacity</p> <p>The principles</p> <p>3. – (1) The following principles apply for the principles of this Act.</p> <p>(2) Principle One: "A person must be assumed to have capacity unless it is established that he lacks capacity."</p> <p>(3) Principle Two: "A person is not to be treated as unable to make a decision unless all practicable steps taken to help him do so have been taken without success."</p> <p>(4) Principle Three: "A person cannot be assumed to lack capacity, merely because he makes an unwise decision."</p> <p>(5) Principle Four: "An act done, or a decision made, under this Act for or on the behalf of an individual who lacks capacity must be done, or made, in his best interests."</p> <p>(6) Principle Five: "Before the act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action".</p> <p>Source: Cynthia Chan, 2009<sup>2</sup>, MCA, 2010 ed<sup>1</sup></p>
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### 5-SAFEGUARDS

With the powers conferred on the donees and deputies, there is a need to balance them with safeguards to protect the person who lacks capacity. The Act sets limits and restrictions as to what the donees and deputies can or cannot do. Some of the key safeguards are highlighted below.<sup>2</sup>

#### (1) III-Treatment and Wilful Neglect<sup>2</sup>

Under the MCA, acts of ill-treatment and/or wilful neglect towards the person who lacks capacity will be treated as criminal offences. Any caregiver, donee or deputy found guilty of such an offence can be imprisoned, fined or both.

III-treatment of an incapacitated person is defined in the MCA to consist of acts that will cause the victim to experience:

- Unnecessary physical pain, suffering or injury;
- Emotional injury;
- Injury to health and/or development.

III-treatment can be carried out in the following ways:

- Physical abuse, for example, hitting or other forms of violence;
- Sexual abuse, for example, rape or molestation;
- Financial abuse, for example, financial fraud;

- Psychological abuse, for example, verbal abuse or threats of harm;
- Wilful and unreasonable neglect, for example, ignoring the basic health and physical care needs.

**(2) Excluded decisions<sup>2</sup>**

There are some decisions that are so sensitive or sacred that NO proxy decision-maker would be able to make on behalf of the person who lacks mental capacity. These are known as “Excluded Decisions”, and are shown in Table 2.

**TABLE 2: List of Excluded Decisions by Proxy decision Maker (Donee) Under the Mental Capacity Act**

Consenting to marriage
Consenting to touching of a sexual nature
Consenting to divorce being granted on the basis of three years separation
Consenting to adoption
Adopting or renouncing a religion
Receiving treatment for change of gender
Decisions relating to sexual sterilisation
Decisions relating to abortion
Registering or withdrawing an objection under Human Organ Transplant Act
Making or revoking an advance medical directive under the Advance Medical Directive Act
Making or revoking a gift of a body or any part thereof under the Medical (Therapy, Education and Research) Act
Making or revoking a nomination under the Central Provident Fund Act
Chan C, 2009 <sup>2</sup>

**6-OFFICE OF THE PUBLIC GUARDIAN<sup>3</sup>**

The Office of the Public Guardian (OPG), headed by the Public Guardian, is set up under the MCA to provide a range of functions that contribute towards the protection of persons who lack capacity. Such functions include:

- Providing information to help potential donors understand the importance of planning in advance and making an LPA;
- Setting up and maintaining of a register of LPAs and court orders appointing deputies;
- Supervising court-appointed deputies;
- Receiving reports from donees and deputies;
- Dealing and investigating complaints relating to how a donee or a deputy is discharging his duty.

The OPG is supported by a Board of Visitors (BOV), who looks into the well-being of the person who lacks capacity as well as provides independent advice on matters relating to donees and deputies, as requested by the Court or the Public Guardian. Included in the BOV are Special Visitors who are approved and registered healthcare professionals with specialised knowledge and experience in cases of impairment or disturbance of the mind or brain.

**Table 3. Form 224 and the information required**

Section	Heading	Information required
1	Patient's particulars	<ul style="list-style-type: none"> <li>• Full name</li> <li>• NRIC/FIN/passport number</li> <li>• Age</li> </ul>
2	Doctor's particulars	<ul style="list-style-type: none"> <li>• Full name</li> <li>• NRIC/FIN/passport number</li> <li>• Medical Council registration number</li> <li>• Hospital/clinic name and address</li> <li>• Doctor's qualifications and experience</li> <li>• Doctor—patient relationship: to state whether the doctor has been seeing P regularly, or only for the purpose of the mental capacity assessment; if the former, to state when the doctor first started seeing P, when he last saw P, and the frequency with which he saw P in between these dates (see 'Lapse of time between date of last examination of P and date of report')</li> </ul>
3	Patient's medical information	<ul style="list-style-type: none"> <li>• P's clinical history: to state the source of the information on P's clinical history (i.e., whether the information came from medical records, P himself, P's caregiver, etc.)</li> <li>• Findings from physical examination/mental state examination: to state the doctor's observations of P (i.e., P's demeanor, body language, tone of voice, etc.), if relevant to the doctor's assessment of P's mental capacity, as well as the doctor's interactions with P, the questions posed to P and answers given by P, and the date of examination</li> <li>• Relevant investigation results: to state the results of computed tomography and magnetic resonance imaging of the brain, and other investigations performed, if any</li> <li>• Diagnosis: to state the impairment or disturbance to the functioning of P's mind or brain (e.g., dementia, stroke, etc.)</li> </ul>
4	Opinion on patient's mental capacity	<ul style="list-style-type: none"> <li>• The first part is a series of questions with 'Yes' and 'No' check boxes. Each question must be answered by checking the 'Yes' or 'No' box. No question should be left out. The questions require the doctor to state his opinion on the following issues –</li> <li>(1) In relation to personal welfare issues, if P can: <ul style="list-style-type: none"> <li>(a) understand information relevant to a decision relating to his personal welfare</li> <li>(b) retain information long enough to make such a decision</li> <li>(c) weigh information as part of the process of making such a decision</li> <li>(d) communicate his decision on the matter</li> </ul> </li> <li>(2) Taking 1a–d into consideration, whether P has mental capacity in respect of personal welfare</li> <li>(3) In relation to property and affairs issues, whether P can: <ul style="list-style-type: none"> <li>(a) understand information relevant to a decision relating to his personal welfare</li> <li>(b) retain information long enough to make such a decision</li> <li>(c) weigh information as part of the process of making such a decision</li> <li>(d) communicate his decision in the matter</li> </ul> </li> <li>(4) Taking 3a–d into consideration, whether P has mental capacity in respect of property and affairs</li> <li>(a) Statement on basis of opinion given in respect of P's mental capacity: to state why the doctor has checked the 'Yes' or 'No' boxes in the way that he has</li> <li>(b) Prognosis: to state whether P is likely to regain mental capacity by checking either the 'Yes', 'No' or 'Not Sure' box; if the doctor checks either the 'Yes' or 'Not sure' box, he must state the date another assessment of P's mental capacity should be carried out</li> <li>(c) Would the patient understand if he/she were informed of this application? ; to check either the 'Yes' or 'No' boxes</li> <li>(d) Is the doctor aware of any other doctor who holds a different professional opinion regarding the patient's mental capacity? ; to state either 'Yes' (the doctor is aware of another doctor who takes a different view from him on P's mental capacity) or 'No' (the doctor is not personally aware, to the best of his knowledge and information, of any other doctor who takes a different view from him on P's mental capacity); this item should not be left blank</li> </ul>
5	Declaration	<ul style="list-style-type: none"> <li>• The declaration requires the doctor to sign off on the following statement: 'I have read and understood the provisions in Sections 3, 4, 5 of the Mental Capacity Act. I believe in the correctness of the opinion set out herein. I understand that in giving this report my duty is to the court and I confirm that I have complied with this duty.'</li> <li>• The purpose of this section is to ensure that the doctor: <ul style="list-style-type: none"> <li>(a) understands the framework for deciding whether a person has mental capacity and what a lack of mental capacity means</li> <li>(b) believes in the correctness of what he has written in the medical report</li> <li>(c) is aware that his first duty is to the court, to give his impartial and honest opinion on P's mental capacity, as a medical professional (and not to allow his opinion to be influenced or swayed by P, his caregiver or other persons)</li> </ul> </li> </ul> <p>Sections 3, 4 and 5 of the Mental Capacity Act are set out in the last two pages of Form 224</p>

**7-CAREGIVERS<sup>2</sup>**

The MCA also provides statutory protection for formal and informal caregivers who have discharged their duties without negligence and in the best interests of the mentally incapacitated. This protection covers both civil and criminal liability.

The protection is especially important for informal caregivers, who are most likely family members of the person who lack capacity. This allows them to confidently discharge their duty of care, without fear of being criminalised, as long as they are acting in the best interests of the person.

**Whistleblower Protection.** The MCA grants immunity to healthcare service professionals from civil or criminal liability when they alert the Public Guardian to cases of ill-treatment or wilful neglect of a mentally incapacitated person. This immunity applies as long as such disclosure was made in good faith.

**8-WHAT DOES THE MCA MEAN TO THE MEDICAL PRACTITIONER?**

- In order to conduct a formal assessment on mental capacity, medical practitioners would need to attend a training course organised by the Singapore Medical Association, and pass a

- test to qualify to be on the panel list maintained by the OPG.
- Registered medical practitioners would need to apply the two-stage capacity assessment framework (see subsection “Assessment of Capacity” under section “Guiding Principles”) and the principles of the Act (see Table 1) in carrying out mental capacity assessments.
- There are statutory protections for healthcare workers, including medical practitioners as long as they act in the best interests of the person lacking mental capacity.

## 9-MEDICAL REPORT WRITING FOR COURT APPOINTED DEPUTY APPLICATION

Medical reports are required to support court applications to appoint a deputy to make decisions on behalf of a person who has lost mental capacity. A deputy can be an individual or a licensed trust company under the Trust Companies Act (Cap 336). The doctor writing such a medical report needs to be able to systematically assess the mental capacity of the person in question, in order to gather the necessary evidence for the court to make a decision. If the medical report is not adequate, the application will be rejected, and the appointment of the deputy delayed. The best practices for performing the assessment and writing the medical report, common errors, and issues of concern is shown in Table 3. See also Form 224 and information required in the Appendix of this paper.

## ETHICAL ISSUES RELATED TO MCA 2008<sup>6</sup>

There are five ethical issues that need to be discussed:

### 1-Respect for persons – preserving autonomy

One critical ethical tenet expressed through the provisions of the MCA is the principle of respect for persons. This includes respecting the autonomous right of persons with capacity and respecting the vulnerability of those who lack capacity through the protection of their welfare. The MCA 2008 recognises the severe legal and ethical implications of declaring a person to be lacking in capacity, and lists explicit and robust guidance for making a capacity determination before a person’s civil liberty can be curtailed in the name of his best interests.

Firstly, the MCA [2008] affirms the default position in law of presumed capacity in persons of majority age (21 years old) [subsection 3(2), MCA].

Secondly, this principle of respect is further emphasised in clauses that outlaw biased judgment of incapacity based on the persons’ age, appearance, condition, behaviour [subsections 4(3)(a) and (b), MCA] and quality of his decision [subsection 3(4), MCA]. These clauses of the MCA uniformly advocate a non-prejudiced approach, avoiding discriminatory judgment based on irrelevant criteria in the capacity assessment.

Thirdly, the MCA stipulates that “all practicable steps” must be taken to help a person in decision making before declaring him incapable of making a decision [subsection 3(3)]. The Code of Practice elaborated practical steps such as attention to speed and manner of presentation, use of communication aids, attention to

cultural and religious issues, and use of competent interpreters as ways to communicate appropriately. The Code also proposes ways to optimise capacity by relaxing the person through a patient-centred approach, conducting the assessment at a time when the patient is most alert, allowing support from close relatives, familiarisation with the location where the decision will be carried out and offering privacy to the assessed person.

These are essential points for medical practitioners to note when conducting capacity assessments. To avoid inappropriate inter-assessor variance, the MCA stipulates a set of clear criteria for determining capacity [section 5, MCA], and accepts as valid capacity even if the demonstration of comprehension requires the use of “simple language, visual aids, and any other means” appropriate to the circumstances of the person being evaluated. It is notable that even when a person is found to lack capacity, the MCA is oriented towards respecting the person’s autonomy to the extent permitted by his residual abilities. Firstly, the MCA recognises that capacity can be task-specific and is therefore assessed according to the ability of a person to make a decision about a matter at a particular time, rather than an ability to make decisions in general [subsection 4(1), MCA]. This means that a person who has inadequate capacity to decide on his complex financial matters should still be allowed to decide to say, how he wants to spend his 10 dollars pocket money or choose the colour of his clothes, if making these choices are clearly within his abilities. This is further reflected in two other clauses in the MCA: Subsection 3(6) highlights the need to act on behalf of a person who lacks capacity in “a way that is least restrictive of the person’s right and freedom of action”, and in subsection 6(4), where the MCA states that a person lacking capacity should be permitted and encouraged to participate as fully as possible in any act done for him or any decision affecting him.

Finally, the MCA cautions against any medical decision related to restraining, mandating any medical decision related to restraining must fulfil the test of necessity to prevent harm and to be executed in proportion to the likelihood and seriousness of harm [Subsections 8(2) and (3)]. Although the Act appears to be referring to physical restraint, this should probably be interpreted as including any form of restraint, in particular, pharmacological restraint. These clauses provide some safeguards against unjustifiable use of restraints, again an affirmation of the importance of respecting the freedom and dignity of a person despite his incapacity.

### 2-Respect for persons – protecting against vulnerabilities

For those who have lost their mental capacity, especially on a permanent basis, the principle of respect for persons is expressed through acknowledging the disability, and offering protection to the person against harmful decisions or actions by self, or by others. A major objective of the MCA is, therefore, to provide this protection via: (1) legal empowerment of agent or agents assigned by a person to make decisions on the personal welfare, property, and affairs of the person [Section 11, MCA] via a Lasting Power of Attorney (LPA) created when:

(1) the person still has the capacity, (2) for a person who has not made any LPA by the point of incapacity, the court either makes decisions on behalf of the person or appoint a surrogate decision

maker (deputy) on behalf of the incapacitated person [subsection 20(2), MCA].

The LPA is a legal mechanism which allows those who are capable of deciding to name one or more persons to act as their surrogate decision-maker if and when they lose their capacity in the future. The LPA expresses the ethical principle of respect for persons in two ways.

Firstly, as mentioned above, the LPA is intended to protect a person who lacks capacity (and is hence no longer autonomous) from decisions that are not consistent with his best interests and those that he is unlikely to make had his capacity been intact. The LPA achieves this by transferring the decision-making authority to an agent or agents who have the intact capacity so as to protect the one without capacity.

Secondly, the LPA allows a person ('donor') with the intact mental capacity to exercise his right of self-determination by stating in advance who he wants his surrogate decision maker ('donee') to be if he loses his capacity. In general, this should be a person or persons whom the donor trusts will make decisions that advance his interests or his wishes.

Conceptually therefore, the LPA is a form of advance directive which attempts to extend to a person's autonomy through the legal empowerment of his preferred person or persons who will take over decision making for his personal welfare, property and affairs, or any other specified matters, when he no longer has the capacity to decide on such matters.

### **3-How does the MCA expect decisions to be made for the person lacking capacity: best interests or substituted judgment?**

In general, there are two standards or approach that a donee or deputy can adopt when deciding on behalf of the incapacitated person. Substituted judgment is applied when decisions are made based on a judgment of what decision the person lacking capacity would have made had he been mentally competent.<sup>7</sup> The use of substituted judgment standard is typically defended on the basis that it extends patient autonomy, allowing the preferences and values of the patients to guide their care even after they have lost the ability to make their own decisions.<sup>8</sup> The alternative model is the best interests standard, where decisions are guided instead by what is objectively considered to be beneficial to the person lacking capacity.

A superficial reading of the MCA may persuade one that the legislation advocates an approach of surrogate decision making based solely on an objective best interest of the person, as it devotes an entire section [section 6, MCA] to defining and describing what best interests entail. But upon closer study, one might be persuaded that this apparent skew towards paternalistic protection of the mentally incapable person is quite well-balanced by elements of substituted judgment. In particular, Section 6 of the MCA defines best interests to include reasonably ascertainable past and present wishes and feelings, beliefs and values of the person, and other factors of significance [subsections 6(7)(a)-(c)]. Furthermore, the MCA insists that before an act is done, or a decision is made, due consideration must be made to achieve the intended purpose in a way that is

less restrictive on the person's rights and freedom of action.

This has, to some extent, given rise to the view that the MCA is ambiguous and confusing as to whether it wants primarily to advocate autonomy or beneficence for the person lacking mental capacity. Although conceptually best interest considerations can and should take into account patient's values and known preference, such a "best interests-substituted judgment model" can be potentially challenging for the surrogate decision-maker at the practical level.

Nevertheless, it is conceivable that a measured and balanced application of the provisions in MCA can provide a decision-making approach that serves to secure the person's well-being and safety while ensuring that the person's autonomy based on his past values and preference is not completely disregarded, but respected to the extent possible. What would be helpful to those making these surrogate decisions would be greater clarity when interpreting relevant sections in the MCA, especially in the event of a conflict.

### **4-Decisions related to care and treatment (Sections 7 and 8 of MCA, 2008)**

Sections 7 and 8 of MCA 2008 reaffirms the both the United Kingdom(UK)<sup>3</sup> and Singapore<sup>4</sup> common law positions that where an adult lacks the capacity to make decisions on his or her behalf, health interventions will be lawful where there is both a necessity to act and any action is in the best interests of the incapacitated adult. MCA clarifies this aspect of common law by conferring legal protection to a decision-maker in these circumstances if there is a reasonable belief that the individual lacks capacity, and that the action or decision is in his or her best interests [subsection 7(1), MCA].

LPA may include authorisation in relation to a donor's treatment decisions, if, and only if the LPA contains explicit authorisation for such decisions [subsection 13(6), MCA]. The MCA states that decisions related to care and treatment should not be inconsistent with valid decisions made by a court-appointed deputy [subsection 20(22) (1) (d)], or by a donor. However, such surrogate decisions related to treatment are restricted and do not include those related to life-sustaining treatment and those which a person providing health care reasonably believes is necessary to prevent a serious deterioration in the donor's condition. These decisions, likely to include most treatment in hospitals, will continue to be made by health care professionals based on medical necessity and medical best interests, as per subsection 7(1) and common law position.

The position taken in the MCA to adhere to the best interest standard for medical conditions with a potential for serious deterioration is indeed a prudent one. Furthermore, empirical data both from Western and local studies have unanimously shown that the even when the substituted judgment model is used, the agreement between decisions made by patients and their surrogates is generally poor, with patients receiving far more treatment than desired.<sup>11-13</sup> A systematic analysis by Shalowitz and colleagues showed that overall, surrogates predicted patients' treatment preferences with only 68 percent

accuracy.<sup>14</sup> In other words, patient-designated and next-of-kin surrogates incorrectly predict patients' end-of-life treatment preferences in one third of cases. These data undermine the claim that reliance on surrogates is justified by their ability to predict incapacitated patients' treatment preferences.

One explanation for this is that substituted judgment tends to be highly subjective, involving interpretation of surrogate's previous wishes or pronouncements. In the absence of good and sustained communication and discussion about treatment philosophy and preferences between donor and donee before the loss of capacity, which is quite common in Singapore, it is not surprising that discrepancies are common. Other contributory factors include surrogates' feelings of guilt or concerns about how other family members might perceive their actions, a switch to consider contemporaneous best interests, surrogates' own values and beliefs, and finally, depression and anxiety, common among surrogates and have been shown to further alter surrogate decision-making accuracy. All these suggest that important and critical health care decisions are best left to the professionals to decide based on what is in the patient's best interests.

One additional point to note concerning medical treatment is that in contrast to the UK Mental Capacity Act 2005<sup>15</sup>, Singapore's Mental Capacity Act does not carry any provision for advance decisions to refuse treatment. The only application of an advance decision in Singapore remains the refusal of life-sustaining intervention when terminally ill, as prescribed by the Advance Medical Directives Act. Again, this is probably a wise move, as advance decisions or living wills, frequently suffer from failure to predict accurately.

### 5-Punitive action against abuse or negligence of the incapacitated person

A final comment about the MCA 2008 refers to its punitive measures against failure to act in the incapacitated person's best interests [subsection 42(3)]. Although provisions against negligent care already existed, the explicit provision in MCA can lead to two opposing responses. On the one hand, older persons may feel that the punitive actions are inadequate and need increasing to offer effective protection to persons without capacity. At the other end of the spectrum, there may be those who fear the potential punitive measures and readily decline to be appointed LPA or deputies. This can generate an unintended but perhaps foreseeable challenge when few are willing to step forward to act as deputies or donors. Looking ahead, the threshold of prosecution for such offences will in some way dictate the willingness of people to serve as surrogates.

### CONCLUSIONS

The Mental Capacity Act is a timely legislation that serves individuals (donors) and their significant others (donees) in helping to effect a system that decisions made for them will be would closer to what they prefer.

Principles of medical ethics promote respect for and protect those who suffer from loss of mental capacity. The effectiveness of instruments such as LPA cannot be guaranteed without the quality and sustained communication between the maker of the LPA and his designated surrogate(s).

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## LEARNING POINTS

### Mental Capacity Assessment, LPA, Medical Report for Court Deputy Application:

- MCA empowers individuals while they still have capacity, to plan in advance for a time when they lose the capacity to make decisions for themselves with respect to the areas of personal welfare and financial matters.
- Under the MCA, individuals who wish to make advance plans for themselves can do so through a new statutory document known as the Lasting Power of Attorney (LPA).
- The LPA gives legal authority to the donee(s) to carry out matters on behalf of the donor when the latter loses mental capacity.
- A Court Appointed Deputy application is required for those who have not created an LPA before losing mental capacity.
- There are legal responsibilities and safeguards to protect an incapacitated person against vulnerabilities of abuse and neglect.

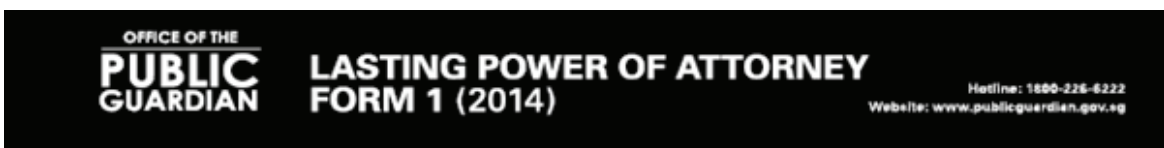
### On ethical issues related to MCA, 2008:

Five ethical issues related to the MCA and provision of protection against abuse, neglect of the incapacitated person need to be borne in mind:

- Preserve autonomy
  - Protect against vulnerabilities
  - Making decisions in the best interests of the incapacitated person
  - Situations of necessity for decisions related to care and treatment
  - Punitive action against abuse or negligence
- 

## Appendix

### LPA Form 1:



## PART 3

### POWERS GRANTED TO THE DONEE

*(The term "donee" includes all donees (if more than one is appointed for that particular power) and a replacement donee.)*

#### PART 3A Personal Welfare

My donee shall have the authority to make decisions in all matters relating to my personal welfare, where I (the donor) no longer have the mental capacity to make such decisions:

Yes  No (please tick one box only)

If 'Yes' then:

a. My donee's authority shall be subject to the terms of this lasting power of attorney and the provisions of the Act.

b. My donee's authority shall extend to giving or refusing consent to the carrying out or continuation of treatment, including the conduct of a clinical trial, by a person providing health care for me:

Yes  No (please tick one box only)

c. Where there is more than 1 donee, they shall act (please tick one box only):

Jointly

Jointly and severally

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**PART 3B**  
*Property and Affairs*

My donee shall have the authority to make decisions in all matters relating to my property and affairs, where I (the donor) no longer have the mental capacity to make such decisions:

Yes  No (please tick one box only)

If 'Yes' then:

a. My donee's authority shall be subject to the terms of this lasting power of attorney and the provisions of the Act.

b. The following restrictions apply (please tick box below if applicable):

My donee shall not sell, transfer, convey, mortgage or charge my residential property at

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without the approval of the court (please indicate one property only).

c. My donee shall have the authority to dispose of my property by making gifts of cash on my behalf subject to section 14(3) and (4) of the Act (please tick one box only):

No

Yes, and the value of cash gifts is unrestricted

Yes, but the total value of cash gifts shall not exceed \$ \_\_\_\_\_ within 1 calendar year

d. Where there is more than 1 donee, they shall act (please tick one box only):

Jointly

Jointly and severally

