

MENTAL CAPACITY ASSESSMENT (AN UPDATE): LASTING POWER OF ATTORNEY CERTIFICATION AND COURT APPOINTED DEPUTY APPLICATION FOR PATIENTS

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ABSTRACT

The Mental Capacity Act (MCA) addresses the need to act on behalf of persons who are unable to make decisions for themselves.

One of the consequences of Singapore's rapidly aging population is the rise in the number of patients suffering from stroke and age-related neuro-degenerative diseases. As their cognitive function deteriorates, they also lose their ability to make independent decisions, and this 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 wishes of the individual with mental incapacity. There is a growing concern amongst individuals that, on losing their mental capacity, they also lose their right to determine their preferences to choose. The MCA has mechanisms in place to address such issues.

The Singapore Family Physician first published an article on the Mental Capacity Act in 2009, and its lessons and messages hold for family physicians today. This article further updates on two provisions of the MCA:

1. Lasting Power of Attorney (LPA) Certification
2. Court-appointed Deputy Application for Patients

The former allows for persons who are cognitively intact to appoint one or more persons to act on their behalf should they lose their mental capacity in the future.

Should a person not have made an LPA before losing mental capacity, a deputy is appointed by the court to make certain decisions on their behalf. A deputy can be an individual or a licensed trust company under the Trust Companies Act (Cap.336).

This paper will explore the processes involved in certifying the LPA as well as the court-appointed deputies.

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

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INTRODUCTION

One of the inevitable consequences of Singapore's rapidly aging population is an alarming increase in the number of patients suffering from multiple strokes and age-prevalent neurodegenerative diseases such as dementia. These diseases cause a progressive diminish in a patient's cognitive function, robbing them of their ability to make autonomous decisions, as well as rendering them vulnerable to adverse decisions made by themselves and others. Often when well-intended family or relatives attempt to make decisions on their behalf, conflicts and uncertainties arise due to lack of clarity with regards to the wishes of the mentally incapacitated individual. For persons who are still capable of making decisions, there is also a growing concern as to whether their preferences to avoid certain types of care will be respected when they are no longer able to advocate for their choices.

The Mental Capacity Act (MCA) 2008 is, therefore, timely legislation that attempts to address the need to decide and act on behalf of persons who are unable to make those decisions themselves. Prior to the MCA, provisions already exist in the Mental Disorders and Treatment Act (MDTA) for the appointment of Committee of Persons and Committee of Estate by the High Court to act on behalf of mentally incapacitated persons in their daily affairs and financial matters, respectively. This component of the MDTA will be supplanted in the MCA by provisions for court-appointed deputies to act on behalf of such persons.

The new provision in MCA 2008, which is not found in the previous MDTA, is the making of a Lasting Power of Attorney (LPA), which allows those who are still cognitively intact to appoint one or more persons to decide and to act on their behalf if and when they lack mental capacity in the future [Section 11-12, MCA].

This paper will discuss some of the ethical issues related to MCA 2008 and the new provision of LPA in the MCA.

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 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 fulfill 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.

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 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.

MAKING DECISIONS

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.¹ 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.² 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.

DECISIONS RELATED TO CARE OR TREATMENT (SECTIONS 7 AND 8)

Sections 7 and 8 of MCA 2008 reaffirms the both the United Kingdom(UK)³ and Singapore⁴ 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 has a reasonable belief both 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 treatment decisions by a donor, 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. One possible scenario though may be a change in the framing of conflict between doctors and patient's surrogate from who should decide to one centred around which treatment is "necessary to prevent a serious deterioration in the patient's condition."

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 desired⁵⁻⁷. A systematic analysis by Shalowitz and colleagues showed that overall, surrogates predicted patients' treatment preferences with only 68 percent accuracy⁸. 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 best interests for the patient.

One additional point to note concerning medical treatment is that in contrast to the UK Mental Capacity Act 2005⁹, 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.

PUNITIVE ACTION AGAINST ABUSE OR NEGLIGENCE

A final comment about the MCA 2008 refers to its punitive measures against failure to act in the best interests of the incapacitated person [subsection 42(3)]. Although provisions against negligent care already existed, the explicit provision in MCA can lead to two opposing response. On one hand, older persons may feel that the punitive actions are inadequate and need increasing to be able 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 declined 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

In conclusion, the Mental Capacity Act is a timely legislation that will go a long way to help resolve some of the conflicts related to care and decision making. It is well-anchored by principles of medical ethics and serves to promote respect for and protection of those who suffer from loss of mental capacity. But 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

- **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.**
 - **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.**
 - **UK and Singapore have common law positions that where an adult lacks the capacity to make decisions on his or her own 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.**
 - **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.**
 - **The MCA is well-anchored by principles of medical ethics and serves to promote respect for and protection of those who suffer from loss of mental capacity.**
 - **The LPA allows a person who is at least 21 years of age ('donor'), to voluntarily appoint one or more persons ('donee(s)') to make decisions and act on his behalf should he lose mental capacity one day. A donee can be appointed to act in the two broad areas of personal welfare and property & affairs matters.**
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CASE SCENARIOS

The following are some case scenarios that serve to illustrate the LPA certification and Court Appointed Deputy Application for Patients.

A 73-year-old Chinese man presents to the hospital for pneumonia/ chest infection. During the check-up, there is an incidental finding of moderate Dementia. Because of cognitive impairment, he unable to make decisions.

During the initial encounter, a few questions come to mind:

1. Who decides for the patient with regards to his personal welfare and financial affairs?
 - i. Medical Matters (non-life threatening)
 - ii. Personal Welfare: Where will he be staying?
 - iii. Financial Matters: Who will be paying for his present and future care? Will he be able to handle his finances?

In 1989, Singapore was still a developing country. The majority of the population were less educated and less aware of personal autonomy. Life expectancy was about 75 years old, and a 3-room HDB flat costs S\$75,000. The couple does not have significant shares, savings, and CPF.

Beneficence/Paternalism

This was the relationship then between clinician and patient. The Clinician had the role of a Guardian-Parent:

He would decide and act in the best interest of the person. This was especially useful when the person's decisional capacity is impaired.

It was also very useful when the burden of the decision is overwhelming; therefore, transfer the decision making.

The approach has an Emphasis on Beneficence (Trust), and we need to take into consideration the risk of exploitation, manipulation, and coercion.

Fast forward to 2019, and Singapore is now a developed country. The elderly now have at a minimum secondary to tertiary level of education and are more aware of personal autonomy as a result of globalisation and the western influence. Life expectancy has increased to 85.7 years old, and a 5-room HDB flat now costs S\$500,000. The couple has significant shares, savings, and retirement funds in the CPF.

Factors affecting the role of the Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD)

- Longer life expectancy in the aging population, and therefore there is a higher risk of physical, cognitive impairment
- Increased complexity of decisions
- Autonomy is the "dominant" ethical principle
- Individual rights and self determination
- Personal responsibility

*Ideally, LPA is made when there is no doubt with regards to mental capacity assessment.

Autonomy

The role of the clinician is no longer that of a Guardian Parent. Roles have changed, such that the:

Clinician: is now a competent technical expert.

Clinician: provides relevant factual information and executes persons selected choices or interventions.

Patient: is now a Person who defines values, exercise choice, and control over illness care.

The Approach now emphasises the principle of autonomy.

We need to take into consideration that the person may make a bad decision, or that defects in autonomy are not detected.

Revisiting basic principles in the Mental Capacity Act

Mental Capacity is the ability of a person to make a specific decision at a particular time that the decision needs to be made.

The (Statutory) Principles of Mental Capacity

- A person must be assumed to have capacity (unless it is established that he lacks capacity).
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- A decision made on behalf of a person who lacks capacity must be made in his best interests.
- A decision made on behalf of a person who lacks capacity must be the least restrictive on the person's rights and freedom

The Two Stage Test of Capacity

STAGE 1:

Is the person suffering from an impairment of, or disturbance in the functioning of the mind or brain?

STAGE 2:

If yes, does the impairment or disturbance cause the person to be unable to make a decision where needs to?

STAGE 1

Table 1: Common causes of impairment/ disturbance:

Medical Causes:	Psychiatric Causes:
Delirium	Schizophrenia
Dementia	Bipolar Disorder
Head Injury	Major Depressive Disorder
Stroke	Intellectual Disability
(And other causes of Cognitive Impairment)	

STAGE 2

- Understanding the relevant information*
- Retain the information
- Use or weigh information (appreciate and applying) **
- Communicating the decision

Common areas of contention (informed consent)

* Important for the appropriate persons to be provided with the relevant information, especially for important decisions

** To be able to assess whether the patient can weigh the information, the assessor needs to have an understanding of the patient’s values, motivations and identify important concerns, if any.

Lasting Power of Attorney (LPA)

Beyond completing a form, it is the opportunity to start a difficult conversation about late life/ end of life issues.

Consensus needs to be reached between the clinician and patient:

- Clinician:** Interpretative, deliberative (person centric), counsellor, advisor, and teacher
- Clinician:** Clarifies and challenges a person’s values by persuasion and discussion
- Patient:** who undervalue or overvalue choices and interventions would be helpful to think through issues
- Approach:** Supports both beneficence and autonomy. Helps patient to reach a maximally autonomous decision
- Consideration:** Needs skill and time

Balancing Medico-legal Risk and “advocacy for the patient”

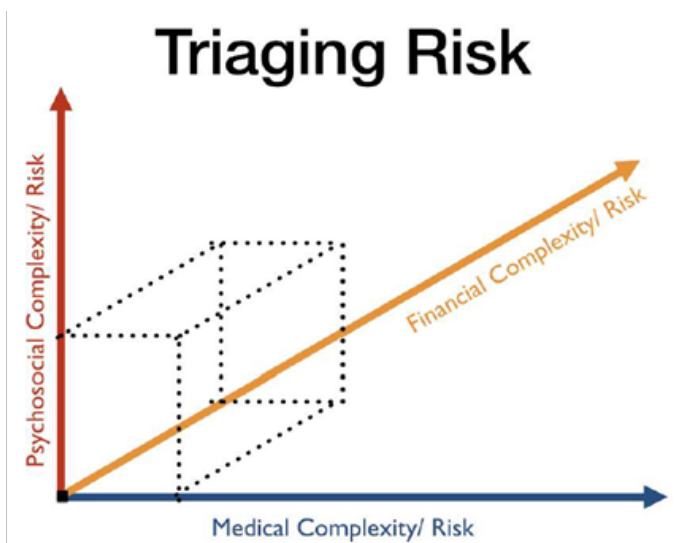


Figure 1: Triaging Risk

Medical complexity/Risk

- Actively look for suspicion/ evidence of cognitive impairment

Psychosocial Complexity/Risk

- Actively look for suspicion/evidence of family conflict and possible legal challenge

POINTERS AND TIPS:

Table 2: Differences between LPA and CAD

Lasting Power of Attorney (LPA)	Court Appointed Deputy (CAD)
Less Expensive • Doctors/Lawyers’ fees OPG cost: waived until 2020	More expensive • Lawyers’ Fees • Doctor’s Assessment Fees + Medical Report
Faster • 6 weeks	Slower • Up to 6 months
Fewer safeguards • Dependent on whistle blowers	More safeguards • Courts will monitor (especially finances)

Example 1:

When a patient has already lost the capacity to manage personal welfare and finances, but during the interview says, “I want my son to make decisions for me if I cannot make decisions.”

- Purpose of LPA: for the family to take control over decision making when mental capacity is lost
- More open to legal challenge, given the significant cognitive impairment

Example 2:

When a patient does not have dementia or evidence of cognitive impairment. However, because of education level and cultural beliefs, the patient is not able or willing to engage in the discussion of LPA. Yet, the family is keen for her to “get the LPA done.”

- Although patient based on principles of MCA is assumed to have mental capacity, however, there is a lack of informed consent as the information is not presented to the patient, allowing the patient to deliberate and make a decision.

Appendix

LPA Form 1:

OFFICE OF THE PUBLIC GUARDIAN **LASTING POWER OF ATTORNEY FORM 1 (2014)** Hotline: 1800-226-6222 Website: www.publicguardian.gov.sg

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

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 _____

 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

PART 4 LPA CERTIFICATE

PART 4A Particulars of Certificate Issuer

Full name as in ID _____
 MCR/NRIC number _____
 Name of clinic/legal practice _____ Contact number _____

PART 4B Statement by Certificate Issuer

1. I am (please tick one box only)
 a medical practitioner who is accredited by the Public Guardian to issue LPA Certificates
 a medical practitioner who is registered as a specialist in psychiatry under the Medical Registration Act
 an advocate and solicitor of the Supreme Court who has in force a valid practising certificate under the Legal Profession Act.

2. I have read the Prescribed Information and understand my role as a certificate issuer.

3. I am acting independently of the donor, donee(s) and replacement donee.

4. I am not disqualified under regulation 7(2) of the Mental Capacity Regulations 2010 to give this LPA certificate.

5. I certify that, in my opinion, at the time of signing this instrument,
 a) the donor understands the purpose of this instrument and the scope of the authority conferred under it;
 b) no fraud or undue pressure is being used to induce the donor to create a lasting power of attorney; and
 c) there is nothing else that will prevent a lasting power of attorney from being created by this instrument.

Signature and stamp of certificate issuer _____ Date signed _____