

**ABSTRACT**

**The Mental Capacity Act (MCA) 2008 is a timely legislation that attempts to address the need to decide and act on behalf of persons who are unable to make those decisions themselves. The MCA 2008 recognises the serious legal and ethical implications of declaring a person to be lacking in capacity, and lists explicit and robust guidance for making capacity determination before a person's civil liberty can be curtailed in the name of his best interests. This paper will discuss some of the ethical issues related to the MCA 2008 and the new provision of Lasting Power of Attorney (LPA) in the MCA.**

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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 patient's cognitive function, robbing them of their ability to make autonomous decisions, as well as rendering them vulnerable to harmful decisions made by themselves and others. Oftentimes 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 a 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 key 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 protection of their welfare.

The MCA 2008 recognises the serious legal and ethical implications of declaring a person to be lacking in capacity, and lists explicit and robust guidance for making 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) [subsection 3(2), MCA]. Secondly, this principle of respect is further emphasised in clauses that outlaw biased judgement 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 judgement based on irrelevant criteria in 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)]. This is further elaborated in the Code of Practice, which suggests 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 in an appropriate way. The Code also propose ways to optimise capacity by relaxing the person through a patient-centred approach, conducting the assessment at a time when 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.

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These are important 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 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 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 restrain, mandating any medical decision related to restrain 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.

## **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

the person still has 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 has intact capacity so as protect the one without capacity.

Secondly, the LPA allows a person (‘donor’) with intact mental capacity to exercise his right of self-determination by stating in advance who he wants his surrogate decision maker (‘donee’) to be in the event that 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 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 judgement?**

In general, there are 2 standards or approach that a donee or deputy can adopt when deciding on behalf of the incapacitated person. Substituted judgement is applied when decisions are made based on a judgement of what decision the person lacking capacity would have made had he been mentally competent.<sup>1</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>2</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.

Superficial reading of the MCA may persuade one that the legislation advocates an approach of surrogate decision making based solely on an objective best interests 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 actually quite well-balanced by elements of substituted judgement. 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 interests considerations can and should take into account patient's values and known preference, such a "best interests-substituted judgement 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, whilst 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 UK<sup>3</sup> and Singapore<sup>4</sup> common law positions that where an adult lacks 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. 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 interests 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 judgement model is used, agreement between decisions made by patients and their surrogates is generally poor, with patients receiving far more treatment than desired<sup>5-7</sup>. A systematic analysis by Shalowitz and colleagues showed that overall, surrogates predicted patients' treatment preferences with only 68% accuracy<sup>8</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 undermines the claim that reliance on surrogates is justified by their ability to predict incapacitated patients' treatment preferences.

One explanation for this is that substituted judgement 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 with respect to medical treatment is that in contrast to the UK Mental Capacity Act 2005<sup>9</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 accurately predict.

## 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 it can be argued that such 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 piece of 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 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.**