THE ELDERLY PATIENT AND THE HEALTHCARE DECISION-MAKING FRAMEWORK IN SINGAPORE

Tracey Evans Chan

Introduction

The legal decision-making framework supporting the needs of incapacitated patients is an important element of any effective response to the challenges posed by healthcare for the elderly, particularly at the end of life. The problems posed by surrogate or proxy decision-making are significant because under the conditions of modern medicine, many elderly patients with chronic illness lack decision-making competence to some degree. Further, advances in medical technology offer the potential to artificially prolong life with questionable compensating benefit, which give rise to greater uncertainty as to the ethical course of action in such situations (Buchanan and Brock, 1985). This has also spurred increasing reflection and debate in society on attitudes and preferences towards the dying process, responses to the aggressive intervention of medical technology and the concept of a “good” death. An effective decision-making framework is therefore a critical piece of legal infrastructure that assists healthcare professionals, administrators, family members and other interested persons in coming with reasonable certainty to the best decision that promotes the welfare and individual interests of each elderly patient.

After a considerable period of legal uncertainty, the recently enacted Mental Capacity Act ("MCA 2008") in Singapore provides important clarifications and institutions to facilitate the healthcare decision-making process, especially in respect of elderly patients who gradually or abruptly lose decision-making capacity as they age and their health deteriorates. This paper will examine the key concepts and institutions that the MCA 2008 contributes to the legal infrastructure in the context of healthcare decision-making. In particular, it examines the statutory concepts of decision-making capacity and best interests, and considers continuing issues of implementation and interpretation of these concepts. It then considers responses to conflict in decision-making that are inevitable in any such system, and what can be done institutionally to respond effectively to such potentialities. Finally, it proceeds to examine the extent to which patient autonomy is valued and incorporated within a proxy decision-making framework, and how this might be improved in order to facilitate better decision-making outcomes.

Important elements in a decision-making framework

The starting point of any discussion of healthcare decision-making must be the legal right of self-determination and the value that the law places on bodily integrity. The pronouncement in Schloendorff v Society of New York Hospital (1914) that every adult of sound mind has the right to determine what should be done with his or her own body – and therefore, what medical treatment to agree to or refuse – has been cited with approval throughout the common law world. However, this principle has not yet received unequivocal endorsement by a Singapore court. In Re LP (Adult Patient: Medical Treatment) (2006: paragraph 4), the court cautiously observed that “[g]enerally, a person who is sufficiently matured is entitled to give or withhold consent to any medical treatment and the doctors are entitled, if not obliged, to respect that person’s decision.” The principle of patient self-determination is nevertheless explicitly endorsed in the National Medical Ethics Committee’s Report on Advance Medical Directives (“NMEC”) (1995), implicit in the provisions of the Advance

* Assistant Professor, Faculty of Law, NUS. The author welcomes any comments on or criticisms of this paper. These can be directed to lawchant@nus.edu.sg.
Medical Directive Act (1994) and the general principles embodied in the MCA 2008 itself (Bartlett, 2008).

However, some of the more critical issues emerge once the underlying assumption in Schloendorff proves false: where an individual lacks decision-making capacity (or competence, as the concept is alternatively termed in the legal literature). Once this threshold for self determination is lacking, two consequential issues arise. Who is to be granted authority to make medical decisions on behalf of the incompetent elderly patient and to what standard is the surrogate or proxy to be held accountable? Prior to the enactment of the MCA 2008, each of these questions received uncertain legal analysis in Singapore. Statutory definitions of incapacity or incompetence were context specific, varied and ambiguous in substance. No default legal rule provided for or assumed that next of kin or family members were ipso facto entitled to make legally authoritative decisions on behalf of the incompetent (Re LP (Adult Patient: Medical Treatment), 2006), even if received medical practice often delegated such responsibility to family members despite the lack of legal basis (NMEC, 1995). Legal institutions that existed for the formal appointment of legal proxies were cumbersome and archaic in procedure and conception, whilst being cost prohibitive for many individuals and families in requiring a court application to invoke (Singapore Academy of Law, 1999). The MCA 2008 now thankfully provides a clearer foundation on which each of these issues may be deliberated and resolved with greater legal certainty.

**Decision-making capacity**

It is patent that decision-making capacity is the important threshold on which self-determination rights rest. It sorts individuals into two classes: those whose voluntary informed decisions will be respected and are binding on others, and those whose decisions will not. For the latter, proxy decision-makers will have to be designated to decide on their behalf. Capacity determination does not merely entail a formal difference. Loss of capacity to decide leaves an individual with more limited options and a distinctly different path at, for example, the end of life than if the individual were competent to direct healthcare at each stage of the progress of illness or ageing (Marson, 2007). Unfortunately, the search for an optimal test for capacity has been an elusive one, as it involves the pursuit of inherently conflicting goals (Jackson, 1994). On the one hand, a test of incapacity should afford a individual a full measure of respect for her own beliefs, values and preferences, even if these produce decisions that appear objectively irrational and imprudent. On the other hand, the state also has a legitimate concern that her critical interests in life and health are preserved to the reasonable extent possible, an interest that has a tendency to doubt decision-making capacity when its exercise produces unwise results.

The emerging consensus on an appropriate balance between these conflicting values focuses on a functional approach to assessing decision-making capacity, and in particular, on the process of making a particular decision. This involves various distinct capacities such as an individual’s cognitive and affective abilities in understanding and processing relevant information (Buchanan and Brock, 1985; Law Commission of England and Wales, 1995; Singapore Academy of Law, 1999). Status based tests, using age, disease or a fixed minimal capacity standard are generally easier to implement, but have the tendency to produce arbitrary results unrelated to a person’s actual ability to decide. Outcome-based tests swing to the other extreme. They tend to promote the values and views of the assessor rather than the individual and fail to respect self-determination (Gunn, 1994). Nonetheless, a functional approach still engenders uncertainties in conception and application. In part, these are due to our evolving understanding of how the brain functions in making decisions and the different neural pathways utilized in producing a decision (Wood and Tanius, 2007). In addition, a functional process-based standard still has a tendency to infuse some objective requirements in application, by requiring an individual to be able to offer some reasons for a decision (Buchanan and Brock, 1985; Gunn, 1994; Veitch, 2007). Given these evolving conceptions of a functional standard dependent on continuing research and assessment application, one suspects that in assessment
outcomes, a sliding scale approach is the *de facto* norm: the more significant the consequences of a decision are to individual welfare, the more stringent the capacity assessments, and the more likely that objective rationality considerations influence or are injected into the assessments in furtherance of the patient’s well-being (Buchanan and Brock, 1985).

In Singapore, the MCA 2008 adopts an interesting two-fold test for capacity. Section 4(1) of the Act defines decision-making capacity as follows:

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter *because of* an impairment of, or a disturbance in the functioning of, the mind or brain. (emphasis added)

Section 5(1) of the Act defines a person as being unable to make a decision for himself or herself if he or she is *unable*:

(a) to understand the information relevant to the decision;
(b) to retain that information;
(c) to use or weigh that information as part of the process of making the decision;\(^1\) or
(d) to communicate his decision (whether by talking, using sign language or any other means).

The Act further implicitly emphasizes the value of autonomy by requiring that a person should not be treated as being unable to make a decision unless all practicable steps have been taken to help him or her to do so without success. In particular, explanations appropriate to a person’s circumstances, whether by sign language, visual aids or other means, must be given before concluding that requirement (a) above is not satisfied. Further, the person need only be required to remember relevant information long enough for him or her to make a decision (MCA 2008: section 5(3)).

These requirements can essentially be reduced into two main components: (i) a status-like requirement of an impairment of brain or mind function that results in (ii) a functional inability to make a decision for lack of any one of the constituent elements in section 5(1) of the Act. These requirements are wholly taken from the UK *Mental Capacity Act 2005* (“UK MCA 2005”). The more familiar latter requirement focuses on the *process* of decision-making, rather than the outcome of a decision, in assessing incapacity. This is reinforced by the principle in MCA 2008’s section 3(4) that a person is not to be considered incapacitated merely because he or she makes an unwise decision. This process-oriented standard represents a fair balance between the inherently conflicting goals of protecting the well-being of a patient while respecting that person’s right to self-determination (Buchanan and Brock, 1985). In the Law Commission of England and Wales’ deliberations, the former status based component (described as a “diagnostic threshold”) was introduced to serve as an additional gate-keeping function to prevent individuals from being caught by the Act’s provisions simply for making unwise or eccentric decisions. This probably reflects the acknowledgement that a purely functional process-based test, as mentioned above, has the potential to overreach. Our understanding of the decision-making processes is evolving. Some subjectivity in assessment is also unavoidable as it is impossible to apply a single set of assessment criteria for every type of decision context (Buchanan and Brock, 1985). Hence, the MCA 2008 follows suit by providing for an additional status requirement of mental disability having some psychiatric, neurological or toxicological in origin.

This raises the question of whether determinations of statutory incapacity must be made by an expert or a suitably qualified professional. The MCA 2008 makes no specific provision for the formalities of capacity assessment. Any person relying on the fact of a person’s incapacity for the purposes of care and treatment has to take “reasonable steps to establish whether [the person] lacks capacity in relation to the matter in question” (section 7(1)(a)). Similarly, a donee of a power of attorney may only act on
What amounts to a practical assessment of capacity in the context of the decision made and the seriousness of its consequences. The Code of Practice in the UK (UK Department for Constitutional Affairs, 2007) takes the view that expert or professional assessment of capacity is not necessary, and indeed it would not be practicable to do so for basic acts of care in the course of daily living. While this may be true for the functional aspect of the test, it is difficult to see how the Act can reasonably be satisfied that such incapacity is caused by some underlying disorder or impairment of the mind or brain without professional medical or expert assessment. Perhaps it is envisaged that lay assessments on a contextual basis may only be made after a person has been medically diagnosed as suffering from a relevant condition under section 4(1) that has the potential to impair decision-making capacity.

Practically speaking, in the medical setting, questions of incapacity are likely only to arise where a patient refuses life-sustaining medical treatment or any other treatment with serious consequences, or where family members, carers or healthcare professionals disagree about a patient’s capacity. It would therefore be prudent for healthcare institutions to establish adequate protocols for capacity assessment involving independent appropriately-qualified professionals. For example, the presence of psychological factors provides good reason for the involvement of psychiatrists (Buchanan and Brock, 1985). Expert involvement would also be important in such situations to mitigate against the possible prejudice that arises from the mere fact that a person has been diagnosed with a relevant impairment of mind or brain.

Secondly, while the diagnostic threshold is understandable given the potentially coercive powers such as detention that can be invoked under the MCA 2008 in respect of incapacitated individuals, the reverse problem of under-inclusiveness should not be ignored. A diagnostic threshold assumes adequate and available expertise to evaluate its existence and causal connection with an inability to decide. Lack of ready and relevant geriatric medical expertise, especially in the case of conditions such as dementia and other chronic illnesses that have the potential to affect decision-making ability, may deprive this cohort of patients of needed protection under the MCA 2008 for want of adequate diagnosis (Wood and Tanius, 2007). In this respect, it is to be hoped that the promised training of general medical practitioners in the relevant skills (Balakrishnan, 2008) will encompass not just the more obvious functional component, but also the diagnostic one, for the law requires certification of a causal connection between the two, and not merely the satisfaction of either in the alternative.

Thirdly, in respect of the functional component, it is important that the statutory test be supported by more detailed and up-to-date guidelines (whether general or institutional) for assessment and standardized training for assessors. Studies have shown that without adequate training, highly variable capacity assessment results were shown in a cohort of human patients with mild to moderate dementia. These results were much improved once the assessors in the study where adequately trained in the relevant capacity concepts, although some variation was still observed (Marson, 2007). Just as important is a need for guidelines to take into account the developing neuropsychological understanding of decision-making capacity. For example, research has shown that as individuals age, their ability to utilize the “rational” thought pathways in the mind diminishes, but elderly persons are able to compensate by utilizing other “intuitive” pathways in the brain (Wood and Tanius, 2007). This may manifest itself by a diminished ability to offer rational reasons for a particular medical decision (or the appearance of weighing competing benefits and dis-benefits) in an informal assessment of capacity. Therefore, insistence on evidence of a reasoning process in neuropsychological assessments may deprive such elderly patients of decision-making opportunities. Rather, an assessment of the nature of the decision, based on experience, related emotions (“intuitive” pathways) and the reliance on opinions of a trusted expert may indicate abiding functional decision-making ability (Wood and Tanius, 2007). It appears that section 5(1)(c) of the MCA 2008, in providing for the “use or
weigh[ing] of relevant information, does not insist on a rational evaluation of the information relevant to a decision, and is wide enough to endorse both types of mental decision-making processes.

Decision-making standards and accountability

Pre-existing standards and uncertainty

Once incapacity in the relevant sense is established, the next important question is: what standards apply in deciding or acting on behalf of the incapacitated patient in Singapore? Prior to the MCA 2008, there was some uncertainty on this question stemming from the decision in Re LP (Adult Patient: Medical Treatment) (2006). In that case, the Singapore High Court was asked for authorization to perform an amputation of an unconscious woman’s legs which had become gangrenous by reason of diabetes. In considering whether to grant her physicians the permission sought, the court considered her prior instructions to “save her legs at all costs”, her minor son’s (the only available relative) personal uncertainty as to what his mother would have wanted, and her doctor’s views on her medical best interests. Medical opinion recommended surgical amputation as being the lesser evil necessary to save her life. In doing so, the court rehearsed three common principles or standards used in guiding proxy decision-making in healthcare, namely the advance decision, substituted judgment and best interests standards. The first finds clear support in the common law generally, while the second has widest support amongst the various US states (Note, 1990), but has been rejected by the highest courts in the UK and Canada in favour of the third (Airedale National Health Service Trust v Bland, 1993; Re Eve 1992). By finding that Madam LP had not made her prior statements against amputation with the benefit of medical advice about impending death, the Singapore court in Re LP (Adult Patient: Medical Treatment) (2006) granted a declaration that the proposed surgery was in the patient’s best interests. Consideration of Madam LP’s best interests was brief and centred on her doctor’s medical opinion recommending amputation. This is another source of potential controversy since there are cases which reject the equation of the best interests standard with a patient’s medical best interests (Re A (Male Sterilisation), 2000). Thus, while the case recognized the court’s jurisdiction to offer guidance, and applied the best interests standard, it accepted the possibility of recognising advance decisions and seemed to leave open the possibility of using substituted judgment. It was therefore unclear which particular standard, alone or in combination, controls in Singapore.

The three decision-making principles are by themselves not without controversy. Briefly, the advance decision principle is but an extension of individual patient autonomy to make non-contemporaneous anticipatory decisions that extend ahead in time into situations where legal decision-making capacity is lost. However, these decisions are subject to the limitations of an individual’s cognitive and psychological ability to accurately foresee the future and anticipate personal interests and preferences in those hypothetical future contexts. In addition, courts have also been generally reluctant to abide by such decisions, especially advance decisions to refuse life-saving treatment, and constrain such decisions by questioning their weight for want of adequate information or limiting their scope of application through interpretation of ambiguities (Bartlett, 2008).

The substituted judgment standard is subject to even more controversy. First, it is of uncertain formulation. Some clearer formulations of it require the proxy decision-maker to “don the mental mantle” of the incapacitated patient and come to a decision that would follow as closely as possible to what that individual would have decided in the particular situation if he or she were momentarily lucid and competent (Superintendent of Belchertown State School v. Saikewicz, 1977) (“Saikewicz”). The lack of realism of such a hypothesis is self-evident, as is its application to never-competent patients, which was disapproved of in In re Claire Conroy (1985) and In re Storar (1980). Nonetheless, other formulations recognize that although such an exercise is wrought with uncertainty, there may be situations where the patient in question has given sufficient thought to the decision posed and expressed sufficiently clear wishes concerning what he or she would want done (In re
Claire Conroy, 1985). The moral weight of respecting individual autonomy here suggests that as far as reasonably possible, such wishes and preferences, rooted presumably in the individual’s personal values and life plan, should be respected and implemented even though that person has since lost the ability to decide for himself or herself. Many US state courts apply this standard in a hybrid fashion together with the best interests standard: only where there is insufficient evidence of personal values and preferences, or if the patient was never competent, does the best interests standard kick in (e.g. In re Claire Conroy 1985). However, out of concern for the evidential reliability and moral weight of such prior statements of belief or preference, some US courts impose a clear and convincing standard of proof before acting on them for the purposes of substituted judgment (Note, 1990).

A different, more recent conception of substituted judgment eschews the search for what the individual would in fact decide and asks what decision is most consistent and coherent with the incapacitated person’s values, attitudes and life plan, if any (Brudney, 2009). Thus, according to this view, the proxy decision-maker collates information on the individual’s character and views, and extrapolates this to the decisional situation under consideration. The proxy then seeks to make a decision that most “authentically” reflects the incapacitated person. The difference being that the first sense of substituted judgment (as well as respect for advance decisions) is based on the exercise of will leading to a sufficiently specific, expressed choice, while the latter seeks to respect the person by acting rationally in accordance with his or her personal values and beliefs (Brudney, 2009). That said, it will be apparent that even this formulation is subject to the evidentiary and interpretational vagaries inherent in the earlier formulation of substituted judgment.

Finally, the best interests standard. The latest English common law articulation of the principle requires the proxy decision-maker to draw up a balance sheet of benefits and dis-benefits (or costs and burdens) of a proposed treatment decision and to weigh them in the balance. If the analysis shows a particular course to offer significant benefit to the patient, then that is said to be in his or her best interests (In Re A (Male Sterilisation), 2000). The principle is therefore largely an objective analysis of a patient’s various interests at stake, and requires the promotion of the individual’s overall welfare by seeking the most beneficial outcome reasonably possible (Beauchamp and Childress, 2009). While superficially more straightforward, the approach hides a number of ethical uncertainties – foremost of which is the valuation or weighing of the factors considered, especially when these involve competing or conflicting interests. How is a proxy decision-maker to weigh potentially incommensurate factors, apart from using his or her own system of values as a point of reference? What baseline of reference is the decision-maker to use in comparing the benefits and burdens of treatment – the prior “normal” life of the patient or no life at all?

A new single “best interests” standard

The MCA 2008 now weaves some of these distinct strands into a single tapestry of “best interests”, by which all proxy decisions within the purview of the Act are to be judged. Section 6 provides for a checklist of general factors that a proxy decision-maker must “consider” or “take into account”, without limiting his or her general duty to consider “all the relevant circumstances”. After all, any proxy decision taken under the Act is likely to be highly dependent on the circumstances pertaining to the individual patient. Some basic values are further prescribed:

(a) The individual, albeit lacking in capacity, is to be encouraged and developed to participate as fully as possible in the act done or decision-made; thus reflecting the value of considering the individual’s residual autonomy and, therefore, his or her current interests (section 6(4)). Indeed, section 6(7)(a) directs the proxy decision-maker to consider the incapacitated persons “present wishes and feelings”. In addition, this factor is to be considered in the context of the patient’s likely period of incapacity (section 6(3)). Presumably, if the incapacity is temporary, the range of proxy decision should not unnecessarily preempt the patient’s future right of self-determination.
(b) In decisions concerning life-sustaining treatment, a proxy may not be motivated by a desire to bring about death (section 6(5)). This presumably reflects the basic value of life itself and a decision so motivated is precluded from being in an incapacitated person’s interests. Indeed, the Act makes clear that nothing in its provisions is intended to affect the law relating to murder, culpable homicide or abetment of suicide (section 29), which are important general constraints on individual autonomy (Buchanan and Brock, 1989).

(c) In disposing an incapacitated individual’s property, the proxy must be motivated by a desire to ensure as far as is reasonably practicable that the person’s property is preserved for application towards the costs of the person’s maintenance during his or her life (section 6(6)). Thus, the person’s basic welfare interest in personal maintenance overrides any momentary benefits or altruistic purposes with respect to his or her property. The Act thus prioritises the support of the incapacitated individual’s personal needs over altruistic and third party interests. Interestingly, a similar limiting principle guided the early English Chancery cases expounding the substituted judgment doctrine in the administration of incapacitated persons’ estates (Thompson and Hale, 1895). Lord Eldon in Ex parte Whitbread (1816) noted that provision could be made for a lunatic’s dependents where the estate is considerable, and this was what the lunatic himself was likely to do. The court had nevertheless to take care to preserve the estate should the lunatic recover, and apply the property in the mean time in such manner as it thinks it would have been wise and prudent for the lunatic himself to apply if he were capable.

(d) The most significant factor however is a multi-layered requirement to consider the incapacitated patient’s (i) past and present wishes and feelings, particularly where these have been reduced at some point into writing; (ii) beliefs and values that would be likely to influence his or her decision if he or she had capacity; and (iii) any other factors that he or she would be likely to consider if he or she were able to do so (section 6(7)). In considering these, the proxy decision-maker must consult a host of persons, if practicable and appropriate, as to their views on the foregoing and what would represent the incapacitated patient’s best interests (section 6(8)). These persons include anyone expressly named by the patient, anyone engaged in the care of the patient, a donee of an LPA granted by the patient and a relevant court-appointed deputy.

At this juncture, it is perhaps worth observing that the language of Part II of the MCA 2008 does not appear to intend to override any relevant advance decisions that might have been made by the incapacitated patient in question, whether those recognized at common law or the statutory advance medical directive registered under the Advance Medical Directive Act (“AMDA”). It is submitted that the overall scheme and language of the MCA 2008, notwithstanding the omission of provisions in the UK MCA 2005 concerning advance refusals, relate to the circumstances of making decisions on behalf of persons who lack capacity and have not done so, and does not override relevant advance decisions already made when they still retained decision-making capacity. This would be consistent with the emphasis on helping individuals as far as practically possible to make their own decisions (MCA 2008: section 3(3)). Furthermore, the language in section 6(7) is careful to avoid any reference to a deliberate act or choice committing oneself to a certain course of action, confining itself to more general terms like “wishes”, “feelings”, “beliefs”, “values” and “any factor” the incapacitated person would consider if he or she were able to do so. These are relatively more inchoate factors that would inform a proxy decision-maker about how and what the incapacitated patient might have decided if he or she were capable of doing so himself or herself. Thus where an advance medical decision-made under the AMDA or at common law is valid and applicable, it will override the operation of the MCA 2008’s best interests principle.
Approaches to determining an incapacitated patient’s best interests

On the whole, although the MCA 2008 does not expressly say so, the label of “best interests” strongly suggests that a proxy is to weigh the explicit factors and all the relevant circumstances in the balance in order to arrive at an outcome that maximally promotes the welfare of the incapacitated, in similar fashion to the approach in common law precedents.\(^4\) In expressly requiring consideration of the incapacitated patient’s past wishes, values and beliefs that would influence his decision “if he had capacity”, the statutory best interests standard also appears to hark back to considerations that were embodied in the substituted judgment approach; albeit, these are arguably now expressed as being part of the patient’s interests, which include other interests such as his current experiential interests in, e.g., avoiding pain and receiving comfort. This is deliberate: the Law Commission of England and Wales’ report on Mental Incapacity (1995) states that the formulation of best interests contains a “strong element of “substituted judgment”” and represents a compromise between both approaches that were not considered mutually exclusive in the first place (Law Commission of England and Wales, 1995: paragraph 3.25).

How are these potentially incommensurate or conflicting interests to be weighed against each other in proxy decision-making? One response might be to adopt an a priori hierarchy of interests as was the approach in In re Claire Conroy (1985): a proxy decision should first map to what the patient would have decided if competent, provided there was sufficient satisfactory evidence concerning this. Only where there is a lack of satisfactory evidence does a more objective best interests test kick in. Indeed, in an earlier consultation paper, the Law Commission suggested that it favoured a compromise “whereby a best interests is modified by a requirement that the substitute decision-maker first goes through an exercise in substituted judgment” (Law Commission of England and Wales, 1993: para. 2.14). This would seem to promote the underlying value of individual autonomy and self-determination, implicitly supported by the MCA 2008. Alternatively, some argue that the current wishes and experiential interests of the patient should be given normative priority. They question the undue moral weight accorded to a person’s prior choices or preferences, given the constraints on understanding that anticipatory decisions place on individuals, the uncertainties associated with interpreting past expressions of wishes and the fact that a person’s beliefs and wishes can change over time (Donnelly, 2009; Dresser, 1995, 2009).

It is argued that the statutory language of the MCA 2008 in Singapore does not seem to support such hierarchical ordering of approaches or interests either way. The factors are merely listed without any prioritisation. As mentioned, there is implicit support for autonomy and self-determination, and the MCA 2008 does not reproduce the qualified endorsement of advance refusals as is the case in sections 24 and 25 of the UK MCA 2005 (cf. Donnelly, 2009). However, it is submitted that the factors mentioned in section 6(7) of the MCA 2008 in Singapore more appropriately seek to reflect the value of authenticity (discussed above) rather than self-determination. Given its speculative nature, authenticity does not attract the same moral weight as exercises of self determination in making and committing oneself to an advance decision. They may therefore be counterbalanced by the incapacitated patient’s current interests and preferences that may not have been adequately anticipated by the patient in indicating his or her past beliefs and preferences. On the other hand, the emphasis placed in section 6(6) requiring the protection of the incapacitated patient’s basic interests in the disposition of his or her property should not be read too widely as indicating an overriding priority placed on the person’s objective current interests in a medical context. An incapacitated person’s prior statements concerning values, beliefs and preferences have potential to play an important role in evaluating the worth of treatment to that individual in serving his or her overall best interests.

This suggests that all the factors have to be considered as having variable moral weight, and the resolution of conflict between them is a matter for the proxy decision-maker’s discretion (Buchanan and Brock, 1989). That does not necessarily imply arbitrariness if the proxy decision-maker has to use objective guidelines in evaluating the weight of various interests. If we see factors such as past values,
beliefs and expressions of preference as representing a patient’s value system, the more comprehensively and specifically these are manifested, whether orally, in writing or by conduct, the greater the moral weight they yield in application to the patient’s current circumstances, which provide the necessary context for the proxy decision. Thus a decision that promotes authenticity in accordance with the person’s individual value system could reflect his or her best interests, at least in a situation where his or her current interests do not point strongly in another direction.

Correspondingly, a proxy decision-maker may qualify the weight of past values and preferences if this is attenuated by various considerations such as the specificity and reliability of the evidence available and their consistency with other statements or conduct of the patient, in favour of promoting the incapacitated patient’s current interests. For example, where a patient is severely demented but lives an apparently contented existence under adequate care and supervision, there would be good warrant to qualify the moral weight of general prior statements by the same person desiring not to live under such circumstances. The identity of the proxy decision-maker and the process of weighing the evidence of past preferences and current interests are therefore critical. Practically speaking, considering the difficulties of ascertaining the values and wishes of elderly patients given their observed reticence in discussing these issues openly, the ambiguity of general statements of hypothetical preference and the availability of reliable evidence, intractable finely poised conflicts between past wishes and current interests in the evaluation of best interests are likely to be rare.

To the extent that the incapacitated patient’s values and preferences are incoherently or ambiguously expressed, they will have to be supplemented by common mores and conceptions of a person’s critical or fundamental interests held in society; that is, a more objective conception of the incapacitated person’s interests. Even at this more “communal” end of the value spectrum, any evidence of individual patient values and wishes still have a role to play in the evaluation of the relevance and weight of the circumstances in determining the patient’s overall best interests (Beauchamp and Childress, 2009 at 139).

Other uncertainties inherent in the best interests standard will also have to be worked out, presumably in the context of institutional and community deliberations on issues concerning quality of life and the legitimacy of third party interests. Many consider that a determination of a patient’s best interests necessarily entails considerations of the quality of life, at least in an intra-personal sense – the value of life prolonged by medical treatment to the individual patient, rather than the value of that life to others and society (Barondness et al, 1988; Beauchamp and Childress, 2009; Buchanan and Brock, 1989). However difficulties persist in determining the relevant base line of comparisons of quality. For example, in determining the benefits and burdens of medical treatments on the patient’s experiential interests, should the incapacitated patient’s quality of life be compared to someone who functions normally, or to no life at all? (Note, 1990). It has been argued that in the context of life-sustaining treatment, the assessment of quality of life should be carefully circumscribed to focus on whether the life-sustaining treatment offers a quality of life worse than no life at all (Buchanan and Brock, 1989). Any best interests standard that lacks specification on these issues will assume the proxy will reflect on the common morals and values of society in coming to an assessment of the welfare of the incapacitated patient, rather than the proxy’s idiosyncratic values and opinions (e.g. Saickewicz (1977); U.S. President’s Commission, 1983; Law Commission of England and Wales, 1995). This is potentially a tall order for any proxy decision-maker in the context of a multi-religious and multi-cultural society like Singapore’s. The more realistic hope (where evidence of patient values and preferences is wanting) is for an open, supportive and reasoned decision-making process involving family and healthcare professionals based on their shared values.

In comparison, it seems clear that it is the patient’s individual best interests, and not the family’s or some third party’s interests, which are to be considered (Law Commission of England and Wales, 1995). One possible exception under the MCA 2008 is where it is claimed that the patient would have taken these third party interests into consideration. However, evidence of such claims ought to be
taken cautiously, but should not be dismissed offhand as specious. The more corroborated and unbiased the evidence, the more they should weigh in on the determination of the patient’s best interests, reflecting the reality that a person’s subjective interests are seldom purely narcissistic.

**The seeds of conflict and developing responses for conflict management**

While proxy decision-making has been placed on a relatively clearer footing as compared to the past, important uncertainties remain that depend in part on the assumptive values of a proxy decision-maker and in part on evolving understanding of and societal debate on the core values that underpin proxy healthcare decision-making. The open-ended best interests standard for decision-making leaves many details unanswered, and provides the potential for conflict over what should be done for an incapacitated patient. There are many reasons for conflict in the medical decision-making situation. First, it is often rooted in a strong, irreconcilable disagreement about appropriate treatment between surrogates or between surrogates and treatment providers, especially where the elderly patient has not made her wishes clear (Kapp, 2000; Dubler, 2007), or possibly disagreements over whether the patient should be involved in decision-making at all (Dubler, 2005). Second, it may also have its origin in the proxy’s or family’s unhappiness over the quality of care provided, facilitating confrontational stances over subsequent treatment decisions. Finally, inadequate communication between healthcare providers and surrogates or family members is a ready source for conflict (Kapp, 2000; Dubler, 2007).

It is important to recognise that while the MCA 2008 is prescriptive, it cannot be determinative of any particular disagreement over the issue of best interests. No doubt, the MCA 2008 makes clear that the High Court has the power to make declarations concerning the incapacity of any person in relation to any particular matter or the lawfulness or otherwise of any act done, or yet to be done, in relation to that person (MCA 2008, section 19). Recourse to litigation is, however, generally undesirable in this context. Apart from cost considerations, this may entail delays that would not be able to accommodate the needs of the incapacitated patient, and judicial determinations made in an expedited fashion may well not produce better decisions, being potentially mired in acrimony and adversarial conflict.

Instead, a couple of general responses on the part of the medical profession and healthcare institutions could go some way in mitigating these eventualities. First, more explicit guidelines for medical decision-making processes concerning, for example, the withholding or withdrawing end of life treatment should be formulated and made publically available. This would not only produce more consistency in approach, but would assist medical professionals and proxy decision-makers. Outlining appropriate procedures can encourage better communication on the issues and opportunities for interested persons to have their say, guided by the broad requirements of best interests under the MCA 2008. For example, the American Medical Association’s Council on Ethical and Judicial Affairs has issued a set of guidelines on Medical Futility in End-of-Life Care (1999). They recognize that patients or proxies and healthcare providers may have conflicting goals for providing treatment. Defining “medical futility” is also an inherently subjective endeavour. The guidelines therefore seek to provide for a fair process for resolving these issues. In brief, the recommended process entails: (1) attempts at prior discussion between patient, proxy and physician where possible; (2) joint decision-making at the bedside between patient or proxy and physician; (3) recourse to an third party consultant and/or patient representative to facilitate discussion; and (4) involvement of an institutional ethics committee if disagreement persists (American Medical Association, 1999).

Second, and following from the first, an effective hospital ethics committee (“HEC”) should be (if not already) created and adequately supported for this purpose. While HECs or Institutional Review Boards may already exist, in the medical decision-making context, the committee’s role should be expanded to encompass communication facilitation and mediation. Members of the committee or its supporting staff should be trained in mediation skills. The role of such a committee should not be
confined to pronouncing on the ethics of the decision in a detached fashion, but extend to facilitating its resolution (Dubler, 2005).

Facilitating greater patient involvement in decision-making

The new statutory framework is grounded on a healthy respect for patient autonomy by encouraging individual choice as far as is reasonably practicable and, where this is not possible, requiring the weighing of an incapacitated patient’s prior values and preferences under the rubric of best interests. For the latter to work meaningfully, patients have to be encouraged to reflect in advance on healthcare issues that are likely to affect them and find ways of expressing their views and preferences that will be effective in contributing to better proxy decision-making.

Advance decisions concerning healthcare

This brings us to a consideration of the third principle of decision-making that seems to have received little attention in the new statutory framework: the principle of advanced decisions. Interestingly, while following the general contours of its UK model, the new MCA 2008 in Singapore omits any provision on the recognition of advance decisions relating to healthcare. Under the UK MCA 2005, sections 24 to 26 make provision for advance decisions to refuse treatment. An advance decision, made when a patient has capacity, applies at the time and in the circumstances specified in it when the patient subsequently lacks capacity to refuse or withdraw the specified treatment (UK MCA 2005: section 24(1)). Treatment is defined as including a diagnostic or other procedure, but is to be distinguished from the broader concept of “care”. Advance refusals therefore typically cover a narrower range of decisions for which consent is needed in a medical context (Bartlett, 2008).

The effect of such an advance decision is the same as if the patient had made it at the time when the question arises whether the treatment should be carried out or continued (UK MCA 2005: section 26(1)). The scope of an advance refusal includes life sustaining treatment if the patient verifies by a statement, made in writing and witnessed, that the advance decision is to apply to such treatment even if his or her life is at risk (UK MCA 2005: section 25(5) and (6)). Otherwise, no formalities technically apply, although reducing such advance refusals into writing would practically increase their effectiveness (Bartlett, 2008). Significantly, if an advanced decision is valid and applies, there is no room for consideration of the patient’s best interests or the overriding of the advance decision by a court (Bartlett, 2008).

One obvious explanation for this significant omission in Singapore is that separate legislation already exists allowing for such a decision-making tool: the AMDA. Nevertheless, the decision to leave advance decisions or refusals to the status quo is of concern for several reasons. First, the AMDA is extremely restrictive in scope and application. The instrument (for which there is an official registry) is applicable only when a patient is diagnosed with a “terminal illness” and applies to require a medical practitioner withhold or withdraw “extraordinary life-sustaining treatment” (AMDA: sections 3(1), 10(2) and (6)). “Terminal illness” is defined as an incurable condition for which there is no prospect of temporary or permanent recovery where (a) death is imminent regardless of the application of extraordinary life-sustaining treatment and (b) the latter would only serve to postpone the moment of death (AMDA: section 2). The notion of immanency is not specifically defined and leaves some uncertainty as to how chronologically close death must be. The National Medical Ethics Committee and the Select Committee of Parliament that proposed and reviewed the Bill respectively preferred to leave this determination to medical judgment (NMEC, 1995; Select Committee on the Advance Medical Directive Bill, 1996). However, the SUPPORT project in the US conducted over a period of 5 years in the 1990s showed that prognoses remain ambiguous even very close to death (Lynn, 2005), suggesting that consensus over whether death is “imminent” between two or three
medical practitioners as required under s.9(3) of the AMDA is likely to be infrequent. Thus, few AMDs under the current framework are likely to be triggered before the patient dies.

What also seems to be clear is that these definitions restrict AMDs to situations of undeniable medical futility vis-à-vis treatment, for which it is arguable that an expression of an anticipatory decision by the patient does not add further deliberative value to an ethically obvious result (Buchanan and Brock, 1989). In contrast, patients in a persistent vegetative state, where basic respiratory functions can continue indefinitely with medical assistance, cannot constitute terminal illness even though full or partial recovery of consciousness is unprecedented. Furthermore, extraordinary life-sustaining treatment excludes the provision of palliative care, which in turn includes the “reasonable provision of food and water” (AMDA: section 2). The qualification of reasonableness suggests that an objective medical classification is to be adopted, which means that this may include ANH, e.g., through a nasogastric tube or intravenous drip. Such “reasonable” provision is therefore excluded from the scope of advance refusal by an individual patient and subject to proxy decision-making in accordance with the principles outlined above. An individual can therefore only refuse or require withdrawal of certain types of life-sustaining treatment in the limited context when death is considered imminent within the narrow but ambiguous definition under section 2. AMDs cannot apply to any period before that point is reached, no matter how burdensome the individual anticipates such provision to be in comparison with its benefits. Finally, the terms of the statutory advance directive cannot be altered as they must be made in the prescribed standard form (AMDA: section 3(1)).

Although there is some ambiguity in the provisions of the AMDA itself, it seems reasonably clear that the Act was not meant to preclude the creation and validity of advance decisions under the common law. Section 13(1) simply states that that Act shall not affect the right of any person to refuse medical or surgical treatment, without attempting to restrict it to contemporaneous decisions. This standing common law right to make advance decisions concerning medical treatment is well recognized (Re T (1992); Re AK (2001)). Furthermore, the National Medical Ethics Committee’s proposals to legislate on advance medical directives made clear that the intention in doing so was to provide a clear and certain legislative route while allowing for the continued development of ethical principles and common law in relation to advance medical directives and related issues (NMEC, 1995).

Therefore, there is left open the possibility that patients dissatisfied with the ambit of the statutory instrument can have recourse to a common law advance directive. There are no prescribed formalities for this, although the common law places the burden on anyone seeking to rely on the terms of an advance decision to satisfactorily prove its existence and validity. However, where life is at stake, “clear and convincing” proof is required of its existence and continuing validity (HE v A Hospital NHS Trust, 2003). Apart from the evidentiary and interpretational uncertainties concerning the invocation of a common law advance decision, there is also lacking a statutory duty to respect the terms of a valid advance decision (cf AMDA: section 19). Furthermore, there is no registration mechanism that provides assurance that the terms of a written common law directive will even be brought to the attention of attending physicians in the appropriate circumstances. Much therefore depends on the attentiveness and supportiveness of a patient’s family and other concerned persons to bring such advance decisions to their attention, assuming they are even aware of its existence.

A comprehensive evaluation of the role and significance of advance decisions in the context of healthcare decision-making for the elderly is beyond the scope of this paper. However, it bears noting that advance decisions or “living wills” are the subject of much trenchant criticism concerning their efficacy as a primary mode of facilitating decision-making for incapacitated patients (e.g. Fagerlin and Schneider, 2004). Many elderly patients do not want to discuss end-of-life issues, much less take definitive decisions on which treatments they would refuse or want withdrawn. This is particularly a problem in Asian cultures where talk of issues related to death is often a taboo (e.g. Yeo and Hikoyea, 2000). Even if so minded, elderly patients are often constrained in their ability to foresee the specific
medical situations that call for their advance deliberations. They may not have adequate access to medical expertise to explain the treatment modalities and decisions that need to be made. Moreover, they may not adequately understand these matters in advance as well as they could with a contemporaneous informed consent process (Buchanan and Brock, 1989). One should also not discount the real possibility that an individual’s views on end-of-life treatment may change over time (Fagerlin and Schneider, 2004).

That said, it cannot be completely discounted that documented expressions of preference, value and belief in relation to end-of-life care, can provide useful and important information to assist a proxy decision-maker in exercising better judgment to determine what the elderly patient’s statutory best interests are (Olick, 2001). There may also be certain predictable medical scenarios where individuals hold sufficiently firm opinions on and can express a sufficiently certain determination to refuse or restrict such treatment, whatever the actual circumstances. Furthermore, in an evolving scenario where a significant proportion of the elderly population may be single or widowed and without significant family support (Lee and Yeo, 2003), the facility of an advance decision or statements would offer some institutional support to allow the patient’s voice to be better heard in the context of medical decision-making over the din of medical paternalism, familial emotions and imperfect recollections concerning the incapacitated patient’s wishes (if any) at the end of life. With appropriate execution and registration formalities, there would be less concern over the authenticity of the statements, if not their clarity. This is in contrast to the difficult task of evaluating various familial and friendly accounts of past wishes and beliefs, and the questionable moral weight to be accorded to these. It would therefore be prudent to review and enhance the current limited statutory mechanism available to allow the recognition and registration of a broader range of advance decisions as a part of a more comprehensive healthcare decision-making framework.

**Lasting Powers of Attorney**

Notwithstanding the absence of advance decision provisions, the MCA 2008 does introduce the instrument of the lasting power of attorney (“LPA”), which on its face offers elderly patients an alternative anticipatory means of influencing their own healthcare decision-making. At common law, powers of attorney lapse once the donor loses capacity, thus preventing an individual patient from privately appointing their own healthcare proxy for situations of incapacity. The MCA 2008 now fills this gap by allowing an individual (“P”), to confer authority on a donee to make decisions about general or specified matters concerning P’s personal welfare and/or property and affairs when P no longer has capacity to do so (MCA 2008: section 11). Various formalities and qualifications are provided for the instrument creating the LPA and the appointment of a donee respectively (MCA 2008: sections 11 and 12). On the face of it, a LPA offers a simpler type of choice for an individual anticipating his or her future personal incapacity. The focus of deliberation is on one or more persons whom the individual trusts to make decisions on his or her behalf, rather than anticipating the actual decisions that might need to be made. This appointment would be presumably based on the donee’s trust reposed in and intimate knowledge of P as an individual (in particular his or her values, beliefs and preferences). Although surrogates may not always accurately predict what their appointees would decide, they have the advantage of having more relevant information concerning a healthcare decision than the patient himself or herself could reliably predict in advance (Fagerlin and Schneider 2004), and generally more information about the patient’s personal value system and preferences than any other category of surrogate (Olick, 2001).

Unfortunately, the ability of the LPA to facilitate individual patient influence in proxy healthcare decision-making has been deliberately narrowed under the MCA 2008. Section 13(6) and (7) require authority to give or refuse consent concerning treatment (or participation in a clinical trial) by a person providing healthcare to be conferred expressly by the LPA instrument. However, section 13(8) excludes the carrying out or continuation of the following from the donee’s sphere of decision-making authority:
(a) life-sustaining treatment on P, whether or not amounting to extraordinary life-sustaining treatment within the meaning of section 2 of the Advance Medical Directive (Cap. 4A); or
(b) any other treatment on P which a person providing health care reasonably believes is necessary to prevent a serious deterioration in P’s condition.\(^8\)

“Life sustaining treatment” is defined in section 2(1) to mean “treatment which, in the view of another person providing health care for that person, is necessary to sustain life.” The scope of this exclusion is potentially very wide seeing how it extends beyond the limited definition of extraordinary life-sustaining treatment in the AMDA discussed above. A wide range of treatments might be caught as the section does not specify the probability and period of mortality risk associated with the necessary life-sustaining treatment in question. Thus any treatment restriction or withdrawal that poses a significant or serious risk of accelerated mortality at some indefinite point in the future might well qualify for exclusion. As the two clauses are disjunctive, a “serious deterioration” must relate to other adverse effects on the quality of the patient’s life apart from mortality. This phrase is the subject of the same interpretive ambiguity and could very much depend on the subjective interpretations of morbidity or loss of amenity by the relevant attending physician who controls the administration or withdrawal of such treatment.

In highlighting this exclusion in Parliament on the second reading of the Bill, the Minister explained that excessive powers devolved on donees of a LPA, who may make decisions under a conflict of interests, would open the back door to euthanasia. Accordingly, it was right that medical professionals would exercise judgment in these areas (Balakrishnan, 2008). Several points may be made in response to this rationale. First, this approach has the potential to severely undercut the substantive application of the best interests standard articulated by the MCA 2008. As discussed above, an important interest to be considered is the incapacitated patient’s past wishes, beliefs and values. Although medical professionals also have to exercise judgment in accordance with this test, they are hardly the best persons to evaluate the reliability and weight of (potentially conflicting) evidence concerning the patient’s value system and preferences from a host of family members and other interested individuals whom the medical professional is not familiar with. In the face of evidential uncertainty and ambiguity of recollections, it would not be surprising if a physician tasked with determining best interests falls back on his or her professional medical assessment of the situation.

Secondly, this restriction ironically deprives individuals of the power to appoint a LPA proxy in respect of the foregoing medical decisions in which personal values and preferences are most likely to play an important role. In doing so, the MCA 2008 prevents individuals from exercising autonomy on a matter that they are arguably best placed to decide (whom to trust to decide in one’s own best interests) and more likely to feel most strongly about in proxy decision-making (as compared to making specific anticipatory decisions for which they necessarily lack complete information). On a related note, where an incapacitated patient has no immediate or close family support, appointment of a trusted but unrelated person as healthcare proxy would avoid the substantial difficulties placed on medical professionals assessing best interests in ascertaining whether the views of such a person should even be considered seriously at all.

Thirdly, these criticisms do not seek to discount the real possibility of abuse in the context of a donee’s conflict of interests. But one should also not ignore the reality that a LPA donee generally cannot act alone in critical end-of-life situations. Decisions concerning life-sustaining treatment and the like are practically taken in consultation with the advice of medical professionals. Life-sustaining medical treatment can only be administered or withdrawn by the professionals themselves. Thus the attending medical professionals remain as an important check on the exercise of decision-making authority by a LPA donee, who in any case must exercise his or her authority in accordance with the best interests standard (MCA 2008: section 11(4)). Where there is a real suspicion that this authority is being abused or the standard departed from, medical professionals (with the potential investigative
assistance of the Office of the Public Guardian) can and should seek to review the donee’s discharge of his or her fiduciary duties. In this respect, it should be noted that section 6(7) in the UK MCA 2005 provides that nothing stops a person from providing life sustaining treatment or doing any act to prevent serious deterioration in an incapacitated person’s condition while, for example, a determination concerning a disagreement with a LPA donee over what is in the patient’s best interests is made.

Fourthly, clear recognition of who, amongst a list of various related and interested persons, has authority to decide simplifies the decision-making process and offers assurance to healthcare professionals that the decision properly takes into account the incapacitated patient’s values and preferences (Olick, 2001). Thus, allowing the designation of a healthcare proxy via a LPA may also facilitate the resolution of intra-familial conflicts concerning treatment and care of an incapacitated individual. Finally, section 29 of MCA 2008 makes clear that nothing within its provisions affects the law relating to murder, culpable homicide or the abetment of suicide, while section 6(5) states that in deciding if it is in the best interests of the person to receive life-sustaining treatment, the decision must not be motivated by a desire to bring about the death of the incapacitated person. Consequently, it is hoped that these restrictions will be reviewed and removed at some point, placing greater emphasis on patient autonomy while providing further safeguards against the abuse of powers by a LPA donee.

Conclusion

On the whole, the MCA 2008 is an important step forward, but the process of improving proxy decision-making for the elderly is a continuing one. The statutory test for decision-making capacity is a functional process-oriented one, and reflects a reasonable and increasing internationally accepted conception of capacity. However, its efficacy in balancing competing considerations of respect for autonomy and protection of patient welfare very much depend on conscientious institutional and professional support in keeping track of neuropsychology research developments, providing rigorous training for assessors and clear protocols for assessment.

The recasting of the best interests standard represents a valiant attempt to blend the insights of a considerable period of reflection on various alternative decision-making approaches. In requires greater consideration and weight to be given to an incapacitated individual’s prior values and preferences, while (it has been argued) eschewing any hierarchical ordering of factors in favour of a reasoned weighing of factors approach. Nevertheless, the standard remains open-ended in its implementation, requiring appropriate institutions and processes for further deliberation and articulation of fundamental concepts such as the assessment of quality of life, and the handling of inevitable conflicts over their interpretation.

Finally, there appears to be some disjunction between the newly enacted principles of decision-making and the facilitation of an individual’s expression of relevant values and preferences in an effective way in order to anticipate and influence the proxy decision-making process (if an individual is so-minded to do so). A further review and liberalization of existing advance medical directive and LPA mechanisms is in order.

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1 The Law Commission of England and Wales in its recommendations makes clear that this “using information” requirement is meant to capture affective conditions which prevent the decision-makers from using the information understood in coming to their decision (Law Commission of England and Wales, 1993: paragraph 3.17).

2 An exception under the MCA 2008 in Singapore exists in relation to dealings with respect to property by a donee of a Lasting Power of Attorney. Any person dealing with such a donee may require a certificate from a registered medical practitioner certifying that the principal is likely to be permanently incapacitated (section 13(10)).

3 The validity of common law advance decisions in the context of the present statutory scheme is discussed below.

4 This is also indicated in the Law Commission’s discussion of the checklist of factors: Law Commission of England and Wales, 1995: paragraph 3.29.

5 This appears to be supported by the Law Commission of England and Wales, 1995: paragraph 3.30, citing by analogy Re C (A Patient) (1991).

6 See Buchanan and Brock (1989) which discusses the California Natural Death Act (1976); Cal. Health and Safety Code, §7187(f) (1976), on which the definition of ‘terminal illness’ in the AMDA is adapted: see National Medical Ethics Committee (1995) at 14, para 3.

7 Patients in a persistent vegetative state were deliberately left out of the ambit of the AMDA: see Select Committee on the Advance Medical Directive Bill (1996) at paragraph 17.

8 A similar restriction is placed on the powers that may be given to a court-appointed deputy: MCA 2008: section 25(3)(c).

9 MCA 2008, s.31(1)(h) and (j) provide that the Public Guardian serves the following functions: (inter alia) dealing with representations (including complaints) about the way in which the donee of a lasting power of attorney is exercising his powers, and investigating any contravention or alleged contravention of any provision of the Act.