Mental Capacity Assessment for LPAs:

A Practical, Process-Driven and Proficient Approach

Text by Dr Nurul Ibrahim, Dr T Thirumoorthy and Dr Giles Tan Ming Yee

Under the auspices of the Office of the Public Guardian and Ministry of Social and Family Development, in partnership with SMA Centre for Medical Ethics and Professionalism, College of Psychiatrists, Academy of Medicine, Singapore, and Singapore Academy of Law, a webinar titled "Medical, Legal, and Ethical Perspectives on Mental Capacity Assessment for Lasting Powers of Attorney (LPAs)" was organised to equip certificate issuers (CIs) of LPAs with lessons learnt from recent court cases and to increase confidence in conducting mental capacity assessments for LPAs. A total of 4,383 attendees, consisting mainly of doctors and lawyers, participated in the session on 18 April 2026. Through case studies and multidisciplinary discussion, the webinar explored how medical and legal practitioners can navigate complex certification scenarios, ethical dilemmas and medico-legal risks in LPA work.

This article summarises the practical approaches, legal lessons and clinical principles shared during the webinar, translating them into a structured framework for doctors involved in LPA certification.

Growing importance of LPA assessments

The use of LPAs in Singapore has increased significantly over the years alongside greater public awareness of advance care planning and future decision-making. At the same time, disputes involving LPAs have become increasingly visible in the courts. Questions surrounding mental capacity, voluntariness, family influence, poor process and improper witnessing are now appearing more frequently in legal proceedings.

Against this backdrop, the role of the registered medical practitioner (RMP) acting as a CI has become increasingly important. Doctors are not merely witnessing signatures or completing administrative paperwork. In many ways, we function as one of the key safeguards protecting patient autonomy within the Mental Capacity Act (MCA) framework.[1]

Recent Singapore court judgements have also highlighted an important reality: the CI can inadvertently become the weak link in the LPA process if assessments are superficial, rushed, poorly documented or procedurally flawed. Conversely, where assessments are careful, contemporaneous, independent and well documented, the courts have demonstrated willingness to uphold LPAs even in elderly donors or patients with cognitive impairment.

The role of the CI

The responsibilities of the RMP acting as a CI extend far beyond deciding whether a patient "has capacity". Broadly, the doctor must assess three key domains: capacity, voluntariness and proper execution.

First, the doctor must assess whether the donor has the mental capacity to make the specific decision relating to the LPA. Second, the doctor must assess whether the decision is truly voluntary and free from undue influence or pressure. Third, the doctor must ensure proper execution of the LPA, including personally witnessing the signing process.

These domains are separate but interconnected. A donor may have mental capacity but still be acting under coercion. Likewise, capacity and voluntariness may both be present, but the LPA may still fail because of improper witnessing or process failures.

This is why LPA certification should never be approached as a mere form-signing exercise. It is fundamentally a medico-legal assessment requiring due diligence, independent judgement and careful documentation.

Mental capacity is functional

One of the most important concepts under the MCA is that mental capacity is functional, decision-specific and time-specific.[1,2]

Capacity is not determined solely by age, diagnosis, educational level, appearance or socioeconomic status. A diagnosis of dementia, schizophrenia, stroke, intellectual disability or mild cognitive impairment does not automatically mean a person lacks capacity. Likewise, advanced age alone should never lead to presumptions of incapacity.

The real clinical question is: "Can this patient make this specific decision at this specific time?" This distinction is extremely important in LPA work. Many patients with mild cognitive impairment or early dementia may still retain sufficient understanding to appoint a donee. The law does not require perfect cognition. Instead, it requires the ability to make the relevant decision at the material time. Importantly, frailty, advanced age, hearing impairment, slow speech, repetition or the need for more time should trigger better support and fuller documentation – not automatic assumptions of incapacity.

At the same time, doctors should not assess capacity in isolation from the wider clinical picture. Prior records, collateral

history, fluctuating cognition, previous assessments and evidence of progressive decline may all provide important context in interpreting the patient's presentation during the consultation.

The two-step test under the MCA

In practice, mental capacity assessment follows the statutory two-step test under the MCA.[1] The first step asks whether there is an impairment or disturbance of the functioning of the mind or brain. The second step asks whether, because of that impairment, the individual is unable to make the relevant decision.

A person is considered unable to make a decision if he/she cannot:

- Understand the relevant information;
- Retain that information long enough to make the decision;
- Use or weigh the information as part of the decision-making process; or
- Communicate the decision.[1,2]

These four abilities form the practical structure of the clinical interview.

When a patient explains what an LPA is, the doctor is assessing understanding. Revisiting the same concept later in the consultation provides informal assessment of retention. When the patient explains why a particular donee was chosen, the doctor is assessing the patient's ability to weigh information and appreciate consequences. Finally, the patient must be able to communicate a decision consistently. The assessment therefore becomes less about administering a rigid checklist and more about observing how the patient reasons through the decision in real time.

Capacity and voluntariness must be assessed separately

One of the clearest lessons emerging from recent Singapore cases is that mental capacity and voluntariness are separate concepts. A donor may have sufficient mental capacity to execute an LPA and still be acting under undue pressure or influence. This distinction is critical because the presence of capacity alone does not automatically validate the LPA.[4–8] Practically, this means the assessment cannot stop once the patient demonstrates understanding. Doctors must also explore whether the decision truly belongs to the donor.

Simple but revealing questions include:

- "Whose idea was it to make this LPA?"
- "Why did you choose this donee?"
- "Would you feel comfortable choosing someone else?"
- "Is anyone pressuring you to do this?"

These conversations should ideally occur with the patient alone. Even well-intentioned family members may unintentionally influence responses or inhibit honest disclosure.[2,3]

Doctors should also pay attention not only to what the patient says but how the patient says it. Hesitation, guardedness, fearfulness, inconsistent answers, unusual compliance or obvious rehearsed responses may all be subtle indicators of undue influence. Importantly, voluntariness assessment should not feel interrogative or confrontational. Calm reassurance and neutral questioning often facilitate more genuine responses than aggressive probing.

Why LPAs fail

Many challenged or revoked LPAs share recurring themes. Common pitfalls include superficial capacity assessments, ignored red flags, family pressure or coercion, poor documentation and improper witnessing procedures.

From a practical perspective, LPAs often fail at three levels: capacity failure, coercion or voluntariness failure, and process failure. Understanding these three domains helps doctors structure both the assessment and their documentation.

Lessons from recent court cases

Recent Singapore judgments offer valuable practical lessons for CIs.[4–8] One major lesson is that courts place significant weight on contemporaneous assessments. The court is primarily interested in the donor's functional ability at the material time – that is, when the LPA was executed.[5,8]

This means that even patients with dementia or cognitive decline may still validly execute an LPA if they retain sufficient decisional capacity at that specific point in time. Conversely, prior negative assessments or documented cognitive concerns should never be ignored or taken lightly. A recent refusal or doubtful opinion from another doctor is a major red flag.[8] Before proceeding, the CI should understand why the earlier assessment was negative and whether current findings genuinely overcome those earlier concerns.

Another important lesson concerns witnessing. Singapore courts have repeatedly emphasised that witnessing is not a clerical formality but a substantive safeguard.[5] The donor must execute the LPA in the personal presence of the CI. Doctors should never certify retrospectively, rely on pre-signed forms or accept assurances from family members that signing occurred earlier. Physical presence, identity verification, direct interaction and personal witnessing are part of the safeguard itself – not bureaucratic hurdles to bypass.

Recognising red flags in practice

Red flags do not automatically mean the patient lacks capacity or that certification must be refused. Rather, they are signals to slow down and assess more carefully. Examples include:

- Family members speaking on behalf of the donor.
- Relatives controlling the consultation.
- Excessive urgency ("Doctor, we need this done today").
- Pre-signed forms.
- Previous refusals by another doctor.
- Evidence of "doctor shopping".
- Parroting memorised phrases without real understanding.
- Fearful, hesitant or guarded behaviour.

Another important red flag is a mismatch between the donor's presentation and the decisional complexity of the document. For example, a donor may repeatedly state "I trust my son" but be unable to explain what powers are being granted, when the donee's authority begins or what would happen if family disagreements arose. These situations do not necessarily mean the donor lacks capacity, but they warrant deeper exploration.

A practical three-stage approach

One practical way to operationalise due diligence is to structure the assessment into three stages: before, during and after the consultation.

Before the assessment

The patient should be physically present and his/her identity should be verified using identifiers such as NRIC, date of birth and address. Relevant medical history should also be reviewed, particularly any history of dementia, cognitive impairment, psychiatric illness, stroke or prior concerns regarding decision-making ability.

Communication barriers should also be addressed early. Hearing aids, visual aids, interpreters, simplified language or slower pacing may all be necessary to optimise communication. Importantly, interpreters ideally should not be close family members whenever feasible.

Doctors must also ensure there is no conflict of interest. The CI must remain independent and should not have relationships that may compromise or appear to compromise objectivity.[2,3]

During the assessment

During the core assessment, the donor should ideally be seen alone. This is an important safeguard to allow the doctor to assess the donor independently, minimise the risk of undue influence and ensure the donor can speak freely without pressure or prompting from others.[2,3]

Communication style matters greatly during mental capacity assessments. Doctors should adopt a calm pace, use plain language and focus on one concept at a time. Teach-back techniques are particularly useful. Rather than relying on yes/no answers, patients should be encouraged to explain concepts in their own words.

Core questions commonly include:

- "What is a Lasting Power of Attorney?"
- "Who is your donee?"
- "What can your donee do for you?"
- "When will he/she be able to make decisions?"
- "Why did you choose this person?"

Open-ended questions are especially valuable because they allow doctors to evaluate reasoning quality rather than rote memorisation. Further questions may include:

- "What kinds of decisions might your donee make?"
- "Would this include decisions about your money or property?"
- "Would this include decisions about where you live or your medical care?"
- "Is there anything you do not want your donee to do?"

These questions help assess whether the patient appreciates the practical implications and scope of the LPA.

Witnessing: process matters

Witnessing is also a legally essential process, not merely administrative.[3,5] The CI must personally witness the execution process live, whether physical or digital. Pre-signed forms should never be accepted. Likewise, doctors should not certify execution retrospectively based on family assurances that the donor had already agreed earlier.

After the assessment: documentation matters

Good documentation is one of the strongest safeguards for both patient welfare and medico-legal defensibility.[5,8] Simply documenting "patient has capacity" is inadequate. It records only the conclusion, not the reasoning process behind it.

Strong documentation should include:

- The patient's own explanations of the LPA.
- Evidence demonstrating understanding.
- The patient's reasoning for choosing the donee.
- Assessment of voluntariness.
- Documentation that the patient was seen alone.
- Observations relevant to communication and consistency.

The key principle is simple: document not only the conclusion but also how the conclusion was reached.

Knowing when to decline

Equally important as knowing when to certify is knowing when to decline certification. Declining is not a failure. It is part of responsible clinical judgement.[2,3] Doctors should consider declining or deferring certification when:

- Significant doubt remains after assessment;
- Red flags remain unresolved;
- There are unresolved concerns regarding coercion; and/or
- Previous negative assessments cannot be satisfactorily reconciled.

The law does not expect perfection from doctors. However, it does expect careful and independent clinical reasoning. When in doubt, it is often safer to pause, seek further assessment or decline certification rather than rush through uncertainty.

Conclusion

LPA certification occupies a unique intersection between medicine, law, ethics and patient autonomy.

Singapore courts have consistently shown that superficial assessments, ignored warning signs, rushed processes and poor documentation may undermine the validity of LPAs. At the same time, the courts have also demonstrated clear respect for careful and independent clinical judgement when assessments are structured, contemporaneous and well documented.

Importantly, doctors should not become fearful of participating in LPA work. Not every assessment requires maximal scrutiny or prolonged consultation. Many patients are familiar to their GPs, demonstrate clear understanding, provide consistent reasoning and present with no significant red flags. In such situations, the process may be relatively straightforward.

What matters is proportionality – the degree of scrutiny should match the level of concern.[1,2] Straightforward cases may proceed efficiently, while cases involving cognitive impairment, family conflict, doctor shopping, rehearsed answers or coercive dynamics require a slower and more detailed approach.

Ultimately, the role of the CI is both valuable and meaningful. Doctors are not

merely signing forms. We are helping to preserve patient autonomy while serving as one of the key legal safeguards within the MCA framework. ◆

References

1. Singapore Statutes Online. Mental Capacity Act 2008 (Cap 177A, 2010 Rev Ed) Available at: https://bit.ly/3rYAfSf. Accessed 20 May 2026.

2. Office of the Public Guardian. The Code of Practice. Available at: https://bit.ly/4uXVdks. Accessed 20 May 2026.

3. Office of the Public Guardian. Lasting Power of Attorney Certificate Issuer Guide. Available at: https://bit.ly/4uXVdks. Accessed 20 May 2026.

4. Law Society of Singapore v Sum Chong Mun and another [2017] SGHC 80.

5. Law Society of Singapore v Yeo Poh Tiang (Yang Baozhen) [2025] SGHC 136.

6. XYF v XYG and XYH [2026] SGFC 9.7. XYF v XYG and XYH [2026] SGFC 9.

7. ULP and others v ULS [2021] SGHCF 19.

8. WLR and another v WLT and another and other matters [2023] SGHCF 24.

Dr Nurul, MB BCh BAO (RCSI), MRCPsych (UK), is a GP with MD Family Clinic. She previously worked in a psychiatric department across multiple subspecialties and has a special interest in mental capacity assessment. She serves on the SMA Mental Capacity Assessment and Practice Committee.

Dr Thirumoorthy currently holds the position of Adjunct Professor in the Office of Academic Medicine at Duke-NUS Medical School. He has been with the SMA Centre for Medical Ethics and Professionalism (SMA CMEP) since its founding in 2000.

Dr Tan is a neurodevelopmental psychiatrist at the Institute of Mental Health, Associate Director of SMA Centre for Medical Ethics and Professionalism, and President of the College of Psychiatrists at the Academy of Medicine, Singapore.