

Consent in Medical Practice 3

– *Dealing with Persons Lacking Capacity*

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This is the third instalment of a series on informed consent. The first instalment, titled "Consent in Medical Practice 1 – Understanding the Concepts behind the Practice", can be found in the June 2013 issue of SMA News (<http://goo.gl/gmbx2>). The second instalment, titled "Consent in Medical Practice 2 – Disclosure of Medical Information and Communicating Risks", can be found in the July 2013 issue of SMA News (<http://goo.gl/9963UM>).

The legal basis of informed consent is based on the premise that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages" (Justice Benjamin Cordozo in *Schloendorff v Society of New York Hospital* [1914] 211 NY 125, 105 NE 92). In addition, common law supports the legal justification for competent adult patients to refuse beneficial medical intervention as "a mentally competent patient has absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death" (Lord Donaldson MR in *Re T [adult: refusal of medical Treatment]* [1992] 4 All ER 649). Consent to and refusal of beneficial medical intervention requires the patient to be mentally competent or have capacity for medical decision making before they are valid. Persons lacking capacity are not considered autonomous persons.

Presumption of capacity

The presumption in law and medical practice is that all adults have capacity to consent or refuse treatment, unless proven otherwise. The clinician must not consider the person to be lacking capacity until all relevant medical information regarding the patient's illness and treatment has been given to the latter. One of the common impediments to autonomous medical decision making is the deficiency of information given in a manner that the patient can understand and identify with.

The clinician cannot assume that a patient lacks capacity solely based on external appearance, behaviour, belief system, age, disability, socioeconomic status, nationality, employment status, educational level, literacy, medical condition (like a psychiatric diagnosis or history of mental illness) and apparent inability to communicate (like hard of

hearing or speech difficulties). The lack of capacity cannot be presumed when the patient makes a decision that appears unwise and on a belief considered unacceptable or unconventional by the clinician.

Enhancing autonomy and capacity

It is the duty of the clinician to enhance the patient's capacity by removing impediments like language barriers, poor hearing and eyesight, and lack of time and space for reflection to make the decision. Information should always be provided in simple and clear language that allows the patient to understand easily. The removal of jargon, usage of a translator and even consideration of the patient's personal needs should be factored in. It is always helpful for the doctor to create opportunities for the patient to raise concerns and ask questions, and check the patient's understanding of the information provided. Barriers such as unjustified fear, anxiety, economic cost and coercion from third parties must also be considered before any lack of capacity is concluded.

When a patient has a temporary loss of capacity, such as a delirious condition due to alcohol, sepsis, metabolic disorder or drugs, nonurgent decisions can be delayed until the patient regains capacity. If the medical decision is of a nature that delay may lead to death or permanent injury, the principle of necessity dictates that the doctor is to proceed with essential therapy based on the best interests of the patient.

Capacity in medical decision making is related to the transaction

Capacity in receiving medical therapy or relief of illness is "functional" or related to the transaction (a specific decision needed) to be made for the medical situation. Patients may have capacity to make healthcare decisions, even if they are not competent to make other decisions, like financial ones. The patient only needs to show capacity

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to make that particular choice, and not global decision making ability. The threshold to capacity for healthcare decisions is kept low, so as to minimise barriers for persons to receive beneficial medical treatment.

A patient's ability to make decisions may depend on the nature and severity of the medical condition, or complexity of the decision. Some patients may be able to make simple medical decisions (like incision and drainage for a skin abscess), but may have difficulty if the decision is a complex one (like cardiac surgery for ischaemic heart disease). Thus, patients may have capacity to consent to one type of treatment but not another.

Some patients, like those with dementia, psychiatric or neurological disorders, may show fluctuating capacity. The fact that a person is able to retain the information relevant to a decision, albeit for a short period only, does not prevent him from being regarded as lacking capacity. Decision making capacity should be assessed at the particular time when consent is to be taken. If capacity is assessed to be present at the time of consent, such consent is valid. Factors such as the most appropriate location, time of day, and utilisation of decisional aids like drawings and illustrations could be particularly relevant to such patients.

Legal framework of medical decision making in persons lacking capacity

The Mental Capacity Act 2008 (Chapter 177A) (MCA) outlines provisions for making decisions about the treatment and care for patients who lack capacity. This legislation aims to address the need to decide and act on behalf of persons who are unable to make decisions themselves. The MCA allows a cognitively intact person to appoint one or more persons as the donees of their Lasting Power of Attorney. A donee is legally empowered to act on the behalf of a person if and when he lacks mental capacity in the future, and to make decisions

related to his personal welfare or financial decisions, or both (Section 11-12, MCA).

In the event that a person is already mentally incapacitated, the court can appoint a Deputy, whose powers of decision making under the MCA are the same as those of a donee under the LPA. While an LPA-appointed donee or court-appointed Deputy is empowered to make personal welfare decisions which include medical ones for an individual, there are limitations. For example, a patient's enrolment or continuation in a clinical trial is an area that an LPA donee may or may not be empowered to decide on. Other limitations include: treatments for change of gender, sexual sterilisation, termination of pregnancy, mental disorder, decisions which could result in serious deterioration of the person's health and life-sustaining therapy (Section 13 [8], MCA), as well as revoking decisions made under the Human Organ Transplant Act (Chapter 131A), Advanced Medical Directive (Chapter 4A) (AMD) and Medical (Therapy, Education and Research) Act (Chapter 175).

The website <http://www.agc.gov.sg> can be accessed to review the complete set of criteria and procedures to be followed in making decisions when patients lack capacity and the application of the best interest principle. In assessing if a patient lacks capacity, the following framework is used:

1. Is the person suffering from an impairment of, or disturbance in the functioning of the mind or brain?
2. If yes, does the impairment or disturbance cause the person to be incapable of making a decision when he needs to?

The following key components should be assessed, and failure in any one of them renders a person incompetent to make the specific decision at hand:

1. To understand the information relevant to the decision;

2. To retain that information;
3. To use or weigh that information as part of the decision making process; and
4. To communicate his decision (whether by talking, using sign language or any other means).

When the healthcare professional is uncertain whether the patient has the capacity to make the decision, she may request a formal assessment of capacity. An accredited medical practitioner or specialist can conduct the assessment and in complex cases, a multidisciplinary team may be employed to make the assessment. To avoid any conflict of interest, the objective assessor should not be involved in the care of the patient, have an interest in or be related to the person being assessed, or be the individual seeking the formal assessment of the person. The assessment usually includes the medical history, physical examination, a mental state examination and necessary investigations. Once a person has been declared lacking capacity, it is presumed to continue until proven otherwise. However, do keep in mind that lack of capacity in medical care can be transactional, ie, specific to the decision at hand.

Best interest principle

In the case where a mentally incompetent adult is without an LPA-appointed donee or court-appointed Deputy, the treating medical team must apply the best interest principle. This is done through consultations with suitable guardians, family members, significant others and other suitably qualified healthcare professionals. The making of a decision on the best interest principle is described in the MCA (Section 6). The best interest principle is accepted both in ethics and common law.

When it comes to a situation where the patient is incapable of giving her consent, or where such consent (or lack of it) was not made reasonably clear, the doctors would have to treat the patient according to what they think is in the best interests of the patient.

... doctors have to concentrate on the medical aspects of treatment. So although the opinions and sentiments of the patient's family ought to be sought, they are not binding (for indeed, as I have mentioned, they can sometimes be at odds) on either the doctors or the court. Where doctors do not have a clear and express consent of their patient, their only course is to act in the best interests of the patient.

– Justice Choo Han Teck in Re LP [2006] SGHC 13

In such adults who lack capacity, while it is good practice to consult their family members or next of kin in medical decision making matters, their consent is neither legally required nor valid. Discussion with the family members is useful to help determine the best interest of the patient, to respect their concerns and is essential to build a good relationship with the family. This is important, whether in the context of the present or aftercare of the patient, so as to avoid any misunderstanding with the family. If asked to account for his medical decisions, the doctor must show that he acted in the best interests of the patient and not necessarily in the interests of a family member.

Where there are doubts or difficulties on the application of the best interest principle for persons of diminished capacity, the doctor should discuss with fellow doctors, especially senior colleagues in the specialty, and utilise the hospital ethics consultation services. If legal issues are a concern, seek legal advice from the medical defence organisation and/or hospital lawyers, and seek a specific order ruling from the courts when necessary.

Consent in minors

As children and minors are at various stages of maturity, they are mostly financially dependent on adults. This does not qualify them to be fully autonomous individuals for medical decision making. The legal right to give consent for children lies with persons of legal parental responsibility.

However, children show a wide range of evolving capacity, depending on their age, maturity level and psychological state. Hence, clinicians should help them understand their medical conditions as much as possible. Even though the legal right to give consent for children lies with those of parental responsibility, the clinicians should involve the minors in all aspects of medical decision making as well.

In Singapore, the age a person is legally considered an adult is 21. However, Singapore has no statute law that defines the legal age to give consent for medical procedures. Wherever feasible and reasonable, parents or guardians of minors should be directly involved in giving consent.



However, it is important that minors and children should not have beneficial medical treatment delayed unnecessarily while waiting for parents to consent. While the consent of any one person with legal parental responsibility is valid and sufficient, this decision must be in the best interests of the child. If consent is refused against the clear best interests of the child, the treating doctor has a duty to go ahead with treatment if it is an emergency. If urgency is not of the essence, the clinician can seek a court order for treatment if attempts to convince the parents fail.

Gillick competence in children

Gillick competence in children is a concept in English common law where the parental right yields to the child's right to make his own decisions (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402). The doctor has to assess and come to a judgement that the minor who is aged 14 or above has sufficient understanding and intelligence to enable him to understand the proposed procedure and its consequences. If so, the minor's consent can be accepted as valid. There is no specific legal guidance or criteria for judging capacity in minors and how Gillick competence is determined. Common law jurisdictions, including Singapore, have largely accepted the concept of Gillick competence to date, although this has not been specifically tested in the Singapore courts yet.

Table 1: Summary of the law in Singapore with regard to age and consent

Under the Penal Code (Chapter 224, 2008)

1. Consent by parents and guardians needed for children below 12 years (Section 89)
2. Valid consent by persons above the age of 18 (Section 87)
3. Acts done in good faith for the benefit of a person without consent (Section 92)

Under the Civil Law (Amendment) Act (Chapter 43, 2009)

1. Confers contractual capacity to persons aged 18 and above

Under the Children and Young Persons Act (Chapter 38)

1. Juvenile: a person who is seven years or above, and below 16 years
2. Child: a person below the age of 14 years
3. Young person: a person 14 years or above, and below 16 years

Summary

1. Ages below 14: needs consent from a person of parental responsibility
2. Ages 14 to 16: Gillick competence may apply (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112)
3. Ages 16 to 18: presumed to be able to consent for medical treatment unless proven otherwise
4. Ages 18 and above: may consent for necessary medical treatment
5. Age 21: the age of the majority

Advanced medical directives

In Singapore, one could make an advanced medical directive under the AMD Act. This enables any person who is mentally sound, at least 21 years of age, and who does not desire to be subjected to extraordinary life-sustaining treatment in the event that he is suffering from a terminal illness, to make such an advance directive against artificial prolongation of the dying process. This is most useful for patients with terminal illnesses.

While the AMD Act is the only recognised legal instrument for advanced directives in Singapore, treating doctors should respect prior expressed wishes or decisions recorded in the medical notes when exercising decisions based on the best interest principle for patients lacking capacity.

Conclusion

Obtaining valid consent from the mentally competent adult prior to treatment is a fundamental tenet of respect for autonomy that is recognised in both ethics and law. In those who are lacking capacity to make their own decisions, the imperative switches from respect for patient's autonomy to medical beneficence, acknowledging patient's vulnerability and protecting that person (nonmaleficence). For the adult lacking capacity, the treating physician is given the responsibility of acting in the patient's best interests. For the minor lacking capacity, the person with legal parental responsibility is expected to always act in the child's best interests. **SMA**