

Neurofibrillary and Ethico-legal Tangles: In Search of Surrogates for Dementia Patients Lacking Decision-making Capacity and Relatives

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Abstract

Singapore's greying population has led to an alarming increase in the prevalence of dementia, and inevitably to a rising number of dementia patients who lack competence and relatives. Although legislative provisions exist in the current Mental Disorders and Treatment Act (MDTA) for the appointment of committees of person and estate for incompetent patients, healthcare professionals continue to face challenging obstacles in their attempts to search for appropriate surrogate decision-makers for such patients. We illustrate, with 2 cases from our clinical experience, the ethical, legal and administrative tangles faced in our search for appropriate surrogate decision-makers. Specific problems, such as administrative ambiguities in applying the MDTA and the impracticalities of a rigorous judicial process in appointing surrogates, are discussed. We propose possible solutions how these obstacles can be effectively tackled, in particular adopting a radical shift from the present judiciary model to a clinical-based model of appointing surrogates for healthcare decisions. This clinical model is based on best interests considerations and emphasises peer review and a multidisciplinary consultative approach in determining the clinical merits of proposed treatment and its impact on quality of life. The ultimate aim of such a change is to facilitate timely medical care while ensuring ethical practices that respect the patient's dignity.

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Introduction

Dementia is an age-prevalent chronic degenerative disease that causes gradual and progressive deterioration of a patient's cognitive abilities. With Singapore's rapidly ageing population, the prevalence of dementia has been rising inevitably and steadily. The prevalence rate of dementia in Singapore was estimated in 1991 to be 1.8% among community dwellers aged >65 years old.¹ In 1995, a prevalence rate of 2.5% among the Chinese elderly and 4.0% among the Malay elderly in Singapore was reported.² The rates are expected to be even higher today, and will likely escalate in alarming proportions within the next decade.

The malignancy of dementia, unfortunately, goes beyond the domain of cognition. With progression to global cognitive decline, dementia results in impairment of abilities such as recognition and sense of reality, expression, and judgement, as well as emotional instability. These also translate functionally into a loss of the capacity to make decisions in daily affairs.³ Patients who have lost their decision-making capacity as a result of dementia or other psychopathology require others to make informed decisions

on their behalf for medical treatment, management of monies and properties, and in all other personal and financial aspects of their lives. Surrogate decision-making is a strategy for respecting the patient's right of autonomy while ensuring beneficence and nonmaleficence, and is provided legally via the concept of guardianship.⁴ The guardian has the responsibility of making decisions that serve the best interests of the patient, while seeking to make decisions that are faithful to the known or documented personal values and prior wishes of the patient.⁵ In Singapore, guardianship for the mentally incompetent is provided for legally under the Mental Disorders and Treatment Act (MDTA) in the form of committees of person and estate. The Act also stipulates the due process of application and responsibilities of guardians.⁶

In the majority of cases, guardianship and decision-making for these patients lacking the capacity for autonomous decisions tend to be delegated in an informal way to a surrogate or proxy, usually a spouse or child. Like the United States,^{7,8} it has been traditional and routine practice in Singapore to recognise the family as a fundamental social unit and, thus, to seek permission for

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healthcare interventions from the incapacitated patient's family. This assumes that the family best knows the patient's preference and will provide the necessary care and support for the patient. Empirical data collected from the West, too, support the assumption that most people want their family members to decide, generally, in consultation with their physician.⁹

However, there remain a significant number of incapacitated older adults who do not have any family or friends that are both able, and willing, to act as their surrogate decision-makers. These include patients who are single, widowed with no children and those estranged from their family. Such patients pose great legal and ethical challenges to their caregivers and clinicians. Many difficult questions arise in the course of providing medical care for these patients: who should assume the role of surrogate decision-maker? How should such surrogates be appointed? Can healthcare workers automatically assume the role of surrogates whenever such patients require medical intervention? How do we protect such vulnerable patients from overbearing paternalism while, at the same time, ensuring that treatment decisions are made without undesirable delays and deterioration of patient's health?

In this paper, we endeavour to illustrate, with 2 typical cases, some of the common medical, legal and ethical conundrums faced by those caring for mentally incapacitated older adults who have no surrogate decision-makers.

Case 1

A 76-year-old pensioner was living alone in a 3-room rental flat when she first presented to the Memory Clinic in 1996. She was never married but had 2 adopted children. They had not been in contact with her for many years and were not supporting her socially or financially.

She was apparently in good health until she developed progressively worsening short-term memory deficits. She was referred to the Memory Clinic for a formal evaluation and was subsequently diagnosed to be suffering from mild dementia secondary to Alzheimer's disease. At that juncture, she was still able to cope with her activities of daily living, with help from her church friends. She insisted on living alone in her rented flat.

Her memory continued to worsen and her difficulties with tasks involving recognition and executive functions became more serious and overt. She developed depression and psychomotor agitation and had difficulty complying with her medication regimen. Clinically, her dementia was progressing to a moderate stage. The medical social worker failed repeatedly to get her adopted children to be involved in her care. Soon, she started to have wandering behaviour and could not find her way home without the help of the police. Her neighbours also became alarmed as she left her gas stove on several times. According to a close church

friend who visited her regularly and who was the only reliable informant for her during her visits to the Memory Clinic, the neighbours reported seeing strangers being invited into her flat. She kept most of her savings in the bank, and during this period, her friend had to bring her more frequently to the bank for cash withdrawals. She, however, was unable to give a coherent account of how she spent the money. Her compliance to her antidepressants and anti-agitation drugs was also haphazard and unpredictable, despite her friend's frequent reminders through phone calls. In spite of all these problems, she still insisted on living alone in the flat due to a glaring lack of insight into her own cognitive impairments. She stubbornly refused to consider the option of either moving to live with her adopted daughters or to an institutional care facility.

The occupational therapist and medical social worker at the Memory Clinic conducted a domiciliary assessment, which confirmed that it was not safe for her to continue living on her own in the community with the available support services. The clinical psychologist assessed that she lacked decision-making capacity to handle her own affairs, including decisions regarding appropriate living facility. The multidisciplinary team at the Memory Clinic decided, based on these reports, that there was a pressing need to institutionalise her for optimal care. Financial investigations also revealed that she had sufficient savings to live in a decent private nursing home. However, despite repeated invitations and appeals, her 2 adopted daughters continued to remain disinterested and categorically declined to initiate the legal inquiry into her mental state and the subsequent appointment of the committee of person and estate for her, under the provisions of the MDTA.

Faced with these obstacles and the mounting hazards posed by her dementia to herself, a written request highlighting her plight was made to the relevant public officers in the hope that the inquiry process could be initiated by them, as provided for in Section 4 of the MDTA.⁶ No reply or response was received. Meanwhile, her behavioural problems continued to deteriorate. After a clinic consultation at the Institute of Mental Health, she was admitted for stabilisation by the geriatric psychiatry service based on concerns that she may endanger not just herself, but also her immediate neighbours. She has since remained there as attempts to place her in a nursing home had reached an impasse.

Case 2

A 72-year-old man was wandering in the streets and begging for food when he was arrested by the police. After a routine search, no relatives or close friends were found. The psychiatric evaluation revealed that he was cognitively impaired, had no visible means of subsistence or place of residence, and was unable to give a satisfactory account of

himself. He was, therefore, admitted to a welfare home administered by the Ministry of Community Development and Sports (MCDS) under the Destitute Persons Act (DPA).¹⁰ Although he was able to converse in simple Malay and Tamil, it could not be established if he was mentally challenged since birth or had normal intelligence before developing dementia.

His stay in the welfare home was uneventful until years later, when he developed a small mass associated with a foul-smelling ulcer in his peri-anal region. He was subsequently admitted to the surgical unit and a provisional diagnosis of suppurative hidradenitis was made, though squamous cell carcinoma could not be excluded. Hence, the attending surgeon scheduled him for an incisional biopsy. Meanwhile, he was resistant towards daily inspection and dressing of the ulcer and consistently denied the presence of the lesion, and refused surgical intervention each time the subject was raised. Subsequently, a decision-making capacity assessment was requested by his primary doctors and this confirmed his lack of mental capacity to give informed consent to his treatment. The surgeon then requested the superintendent of the welfare home to sign the consent form for the incisional biopsy on behalf of the patient. The superintendent, however, declined to sign, saying that he was never the legal guardian of the patient; neither did his duties and responsibilities as superintendent of the welfare home include acting as the surrogate decision-maker of residents under his charge. As the clinical problem was not an immediately life-threatening condition, the doctors did not feel empowered to unilaterally proceed with the treatment without any consent or authorised permission. Thus, he was discharged back to the home with a course of antibiotics and an order for daily dressing for the lesion.

Back in the home, his cognitive impairment continued to prevent him from complying with hygiene measures and nursing care for the ulcer. His erratic level of cooperation with the nursing staff in dressing his ulcer and the anatomical location of the ulcer made it almost impossible for it to heal. Meanwhile the medical social worker in the hospital was experiencing great difficulties finding an office or agency that would take up his case before the court. There was no consensus as to whether the task of initiating the appointment of a surrogate belongs to the welfare home, the hospital or MCDS officials. Definitive surgical treatment, deemed an elective treatment at that juncture, continued to be postponed while his ulcer and general health continued to deteriorate. Fellow residents in the home began to avoid him due to the putrid odour from the lesion, which also appeared to cause some degree of pain.

Over the next few months, he developed progressive anorexia associated with decline in general health. He was

readmitted to the acute hospital for secondary infection of his perineal ulcer. During the hospitalisation, he developed epistaxis after several attempts at inserting a nasogastric feeding tube. Otorhinolaryngological evaluation revealed the presence of an inoperable carcinoma in his paranasal sinuses, infiltrating into his nasal septum and base of skull. He was transferred to a hospice care facility, where he received palliative care till his demise several months later.

Discussion

Beginning with a brief appraisal of the MDTA, we discuss some of the major problems in searching for appropriate surrogates for these legally incompetent patients who have no relatives. This is followed by a detailed discussion of some possible solutions to these problems.

Existing Medico-legal Framework – The MDTA

The legislative framework for the management and placement of patients suffering from dementia in Singapore is found in the MDTA, which was enacted in 1952 and last revised in 1985.⁶ It was originally, and still is, intended to regulate proceedings in inquiries into cases of mental disorder and to provide for the admission and detention of persons of unsound mind into approved hospitals. Section 3 of the Act provides for the application to the court to initiate an inquiry to determine if an allegedly mentally disordered person is or is not of unsound mind, and is incapable of managing himself and his affairs. Under section 9 of the Act, if the court is satisfied that the allegedly mentally disordered person is indeed of unsound mind and incapable of managing himself and his affairs, it may appoint a committee or committees of the person and estate of such person to manage the person and his financial affairs, respectively.⁶ The intention is to protect the patient and society from harm by the patient, and to ensure proper management of the patient's property and financial interests. In section 25, the MDTA empowers the court to compulsorily admit any person found by the court to be of unsound mind and incapable of managing himself and his affairs into a mental hospital.⁶ However, it does allow any friends or relatives, who are able to convince the court that the patient shall be properly taken care of and prevented from harming himself or others, to apply to the court for custody, thereby preventing admission into the mental hospital. The MDTA does not, however, explicitly state that this charge extends to decision-making for the patient in all affairs, particularly in medical and healthcare matters.

“New” Disease, “Old” Act: Impracticalities of Judicial Proceedings for Treatment-Related Decisions for Dementia Patients

The MDTA is primarily directed at patients suffering from psychiatric illness and mental deficiency. It was

drawn up at a time when dementia was less commonly recognised. Dementia is a strongly age-prevalent disease; owing to their advanced age, many patients are physically and functionally frail and have concomitant medical illnesses of varying severity. This combination of dementia and physical illnesses gives rise to several related problems. First, a significant number of medical decisions have to be made almost daily for numerous incompetent dementia patients. Second, while legal and administrative provisions exist for emergency treatment, which empower the medical profession to unilaterally act in the decisionally incompetent patient's best interests (that is, without the need to obtain the patient's consent for the treatment), none exists for semi-urgent treatment. The consequent delay in implementing the treatment plans, while not immediately life-threatening, can further compromise the patient's health and quality of life. These challenges were very likely not anticipated when the MDTA was drawn up years ago.

The appointment of a committee of persons under section 4 of the MDTA effectively transfers decision-making from the incapacitated patient to a committee of guardians.⁶ In the interest of the patient, the due process can hardly be criticised as being too careful and rigorous. The existing MDTA does not distinguish between managing a patient and making treatment decision for the patient. As no other provision is made in the Act or the Statutes, the duties of the committee of person described in section 9 of the MDTA are generally assumed to include making treatment-related decisions.⁶ Unfortunately, this model of a thorough and meticulous judiciary process leading to the appointment of the committee of person is administratively cumbersome and time-consuming. Hence, it is not suited to efficiently handle the increasing load of semi-urgent treatment decisions arising from concomitant illnesses in the management of dementia patients. To aggravate matters, the need to appoint a committee of persons is very rarely anticipated when the demented patient is in stable health. Such a predicament is not peculiar to Singapore.^{11,12} Such impracticalities have compelled many physicians to proceed unilaterally with semi-urgent treatment decisions, an ethically precarious situation in the absence of a system of checks and balances.

Relatives: Are They Always Available?

Section 4 of the MDTA appears to assume the availability of suitable and willing "persons related by blood or marriage" to the patient to initiate a court inquiry into the patient's soundness of mind and capability for self-care, with the possibility of subsequently being appointed to the committee of person and estate for that patient. However, in dementia, where many of these patients have either outlived or physically and emotionally exhausted all their relatives, as illustrated by the 2 cases detailed above, such

surrogates are not uncommonly absent or untraceable (Case 2), or even unwilling to undertake the application to court for initiating the inquiry (Case 1). Physicians and medical social workers managing these patients often then struggle to find suitable alternative candidates to initiate the legal process of inquiry that can result in the appointment of surrogate decision-makers.

MDTA: Procedural Ambiguity and Inadequacies

One may be quick to point out that the MDTA does provide for those without any suitable "persons related by blood or marriage"; section 4 of the Act states that the inquiry can be initiated by "any public officer nominated by the Minister". However, the Act stops short of defining explicitly the exact mechanics and agency responsible for the provision of this "public officer".⁶ Although it seems reasonable to expect the MDTA, being an Act that deals with mental disorders, to be administered by the Ministry of Health, it can also be argued that many of these patients are residents from welfare homes and hence, should be under the purview of MCDS. As illustrated by our 2 cases, this administrative ambiguity at the point of commencing the legal inquiry can lead to delays in effecting the appropriate interventions in a patient. This procedural ambiguity is, however, not confined to the commencement phase of the inquiry. Even assuming that an inquiry was finally carried out and finds a kin-less patient to be of unsound mind and incapable of handling his or her own affairs and finances, the MDTA again provides no guidance as to who will be appointed by the court as committees of persons and estate.

Another procedural problem under the present MDTA is the lack of provision for the legal appointment of durable power of attorney (DPOA) for healthcare. Increasingly, many dementia patients are diagnosed early at a mild stage when they still retain the capacity to appoint a surrogate. These patients can therefore benefit from a legal provision that allows them to designate a surrogate or surrogates, who will take over decision-making in matters related to healthcare when they are rendered decisionally incompetent by dementia. Unfortunately, the MDTA does not provide for such authorisation, made by the patient while he or she is still mentally competent.⁶ The Advance Medical Directive (AMD) Act, the only legislation that deals with precedent autonomy in Singapore, is also silent on this area, being limited to advance refusal of extraordinary life-sustaining treatment when terminally ill.¹³

Moving Ahead: Some Proposals for Disentanglement

From our 2 cases and the challenges highlighted above, it is evident that some constructive remodelling needs to take place in our legal and administrative framework, so as to benefit and protect these vulnerable patients more

effectively and expeditiously. We suggest looking into the following areas.

Explicit statement on whom should initiate an inquiry in the absence of relatives

In Case 1, where the adopted children of the patient abdicated their rights of application, the case reached an impasse when it was not clear which administrative agency or officer was responsible for applying to the High Court to initiate the inquiry provided for under section 4 of the MDTA.⁶ Those managing Case 2 faced similar challenges. He was admitted to a welfare home under the provisions of the DPA and was placed under the guardianship of the state. However, the DPA does not deal with decision-making matters when the destitute is, or becomes, mentally incapacitated. Section 4 of the MDTA is also not specific on this matter.

What is needed, therefore, is an administrative framework that unambiguously and expeditiously assigns a public officer to initiate the inquiry for each and every “kin-less” resident in the community and welfare homes. First, the identification and designation of this officer should be clear and systematic. We propose the following system: The healthcare professional, having ascertained that the decision-making capacity of the patient is impaired, will notify the Legal Aid Bureau. It will then expedite the application for an official inquiry into the patient’s competency under section 4 of the MDTA. As this step is needed to kickstart the process, the legal cost to community-dwelling patients with existing financial resources, such as Case 1, can be recouped subsequently after the appointment of a committee of estate for her. Adequate resources and manpower should, thus, be allocated to the Legal Aid Bureau for it to expedite its tasks.

Explicit statement on who should be appointed committee of person or persons

Upon concluding that a patient is of unsound mind and incapable of managing himself, who then is the most suitable person or persons that can be appointed committee of person?

Within the framework of surrogate decision-making, the standard of substituted judgement appears to be based on autonomy. It is frequently deemed to be ethically “superior” to the best interests standard, which derived from the duty to benefit the patient. To employ the standard of substituted judgement, knowledge of the patient’s wishes is important.⁸ Ideally, the person who serves as a committee of person should know the patient well enough to advocate the latter’s goals and values as a surrogate decision-maker.¹⁴ However, for patients who were never competent, or whose prior preferences cannot be reliably traced (such as Case 2), the committee of person or persons is not able to apply the

standard of substituted judgement in exercising surrogate decision-making. In such cases, it is more appropriate to rely on the best interests standard,¹⁵ with those most able to make decisions based on best interests appointed as surrogate decision-makers.¹⁶ Furthermore, patients with dementia frequently face problems and enjoy a quality of life that they could not foresee prior to their illness. It has, therefore, been argued that the autonomy of the “new” self should be expressed in a guided manner in deciding on treatment options. Dresser¹⁷ cautions against the monopoly of the “substituted judgement” standard (“what the incompetent would want if they were competent”) for incompetent patients, which can lead to a neglect of their current welfare and judgement on their quality of life. Beauchamp and Childress¹⁵ believe that substituted judgement is a poor basis on which to make medical decisions for incompetent patients: “if a surrogate views such a patient in terms of what the patient might wish if competent, rather than in terms of his medical need, a danger arises of overlooking the person’s stake in continued existence.” Therefore, for incompetent patients like our 2 cases, healthcare professionals who are involved in their day-to-day care may be better able to provide valuable insights on their current preferences in the decision-making process; their input helps to make the deliberations complete.

Based on the above arguments, the standard of substituted judgement standard in decision-making may not be applicable to patients without an intact memory or documented past, and with no friends or relatives. Even if their earlier preferences are known, they often lack contemporaneous relevance and may not be the best yardstick for the patient’s current self and clinical problems. Therefore, the best interests method, applied with a system of checks and balances, is the more ideal standard for such patients. The next part of the discussion examines the relative merits and limitations of each potential candidate as an appropriate surrogate for demented patients.

Officers-in-charge of Welfare or Nursing Homes

A common suggestion that surfaces in discussion is the automatic appointment of the officer-in-charge of a welfare or nursing home to the committee of person or persons for his wards who are incompetent. This has the advantage of being convenient and administratively unambiguous. However, tasked primarily with the day-to-day running of their institutions, these officers lack the time, energy and expertise to be efficient and effective in matters like the patient’s medical problems. Concern over conflicts of interest is also valid. For example, the offering of financial incentives to contain cost of medical treatment in some nursing homes renders the officers-in-charge inappropriate candidates as surrogate decision-makers for the residents.

Centralised and Specialised Government Agency

One alternative is the establishment of a centralised government agency to handle all surrogate decision-making activities for those without relatives. This has the advantage of being operationally clear. Being on full-time employment, the officers can be focussed and efficient in processing the applications. The potential for conflict of interest is minimal as the officers are not involved directly in the administration and care of the patients. An example of such a model is the New South Wales (NSW) Office of the Public Guardian, created by the NSW Guardianship Act (1987) to make decisions related to medical and dental treatment on behalf of a disabled person who is under the guardianship of the office.¹⁸ The Public Guardian delegates his authority for decision-making on behalf of people under his guardianship to guardianship staff of the Office of the Public Guardian with the aim of protecting and promoting the welfare and interests of the person under guardianship. However, this solution is far from being ideal, both quantitatively and qualitatively. First, given the rising tide of surrogate decisions that need to be made daily, the office, unless very well-staffed, may not be able to cope with an increasing workload. Second, the expertise and experience of surrogates from an office that is detached from the clinical setting is questionable.¹¹

Multidisciplinary Team in the Long-term Care Facility

A multidisciplinary team from the long-term care facility where the incapacitated patient is residing – comprising attending physicians and local healthcare providers, such as primary care physicians, nurses, medical social workers, therapists and other healthcare professionals – can be appointed to be committee of persons. Such a diverse team helps to avoid blind spots and biased opinions,¹⁹ and ensures that the committee incorporates the overall quality of life issues into medical decisions. This was echoed in a recent position statement by the Ethics Committee of the American Geriatrics Society.²⁰ Such a system can facilitate a good balance between adequate review and practicality. The major drawbacks for such a team approach are costs and manpower. We therefore propose that the appointments be made according to designations and responsibilities, for example “the resident physician of the home”, “nursing officer-in-charge” and “medical social worker-in-charge”. Surrogacy therefore becomes part of the duties and responsibilities of caring for the patient in the local long-term care facility.

A variation of this team approach is to have representation from both public and healthcare team in the committee of persons.^{4,21} This model, though able to inject some non-healthcare perspectives into the decisions, faces the main problem of being unable to respond expeditiously whenever a need arises. Hence, treatment delays are inevitable.

Furthermore, volunteers who can be summoned at short notice may not be easily found in Singapore presently.

Preparing ahead: durable power of attorney (DPOA) in healthcare and advance care planning

The exercise of precedent autonomy through advance directives is a useful but under-utilised avenue of expressing patient autonomy not just in Singapore, but in many other countries.¹⁶ Locally, this may be due partly to deep-seated cultural beliefs and practices. Many older Chinese adults, for example, find the discussion of end-of-life matters a taboo subject. At present, the legislation for advance directive is found in the AMD Act.¹³ It is strictly confined to the advance refusal of “extraordinary life-sustaining treatment” that “will only prolong the process of dying when death is imminent” for a “terminally ill patient” (excluding palliative care). As discussed earlier, the AMD Act does not include the provision for an individual to appoint a DPOA for healthcare whilst mentally competent, which allows the advanced designation of a surrogate to be activated in future when the person becomes mentally unsound and decisionally incompetent. DPOA for health care, if legally available, could have helped avoid the impasse in Case 1 by encouraging her to appoint a surrogate at a time when she was decisionally competent.

Even with the DPOA being legally sanctioned, the duties and responsibility of the person or public officer appointed to the committee of persons and/or estate under the present MDTA⁶ can be overwhelming. Although they are implicitly empowered to make healthcare decisions, they are usually confronted with such decisions when there is an acute change in the patient’s or charge’s clinical condition, and may feel unprepared, confused or overwhelmed. Even with full-time public officers, the task of making welfare, medical and financial decisions for such patients remains daunting.

One way in which the surrogate’s task can be made more manageable is by advance care planning, that is, to promote “prophylactic” discussion and communication between the surrogate decision-maker and the healthcare team. Appropriate application of advance care planning can lead to a better understanding and appreciation of the patient’s current and anticipated health needs. This process facilitates decision-making by best interests, especially end-of-life care decisions and for patients with no previously known preferences.^{22,23} In 2002, the National Ethics Committee of the United States Veteran Health Administration proposed that long-term care facilities should develop policies that promote advance care planning involving appointed surrogates and healthcare providers (“advance proxy planning”). Discussing anticipated medical problems and treatment issues in advance, particularly end-of-life care decisions, will likely enhance the quality of decisions to be made in later, more acute scenarios while making the

overall experience a less awesome one for the surrogates. Ultimately, the process is ethically sound and protects the interests of vulnerable individuals.²⁴ This is an endeavour worth emulating in Singapore, and requires leadership from the government and healthcare professionals.

Treatment in hospitals: bypassing judiciary procedures via a peer-reviewed best interests approach

Some may argue that since both cases were incapable of providing consent and had no surrogate, the doctors managing them could and should have proceeded with placement and surgery, respectively, as long as they are satisfied that the interventions are in the patients' best interests. This argument finds support in the English common law, which allows physicians to treat incompetent adults without judicial intervention, provided that the treatment is in the patient's best interests; whether the treatment is carried out in the patient's best interests is assessed by the standards of "accepted medical practice".²⁵ There are several obstacles to this approach.

First, from a legal viewpoint, the increasingly litigious climate surrounding medical malpractice in Singapore has led to uncertainty and doubt amongst medical practitioners, especially when the treatment in question is not required on an immediately life-threatening basis. This state of affairs is not unexpected in the absence of any explicit legal endorsement or test case. In Singapore, there has been certain ministry advisory which advocates that procedures that benefit a welfare home resident can be performed if the patient is incapable of giving his or her consent, *but only if there are no indication from the resident that he or she objects to the procedure*.²⁶ Unfortunately, owing to cognitive impairment in Case 2, the patient was not only unable to co-operate, but he also refused attempts to treat his ulcer. His lack of co-operativeness and his objections to surgery could not be ignored. Hence, the surgical team decided not to proceed with the planned incisional biopsy. In Case 1, placement decisions are not traditionally considered a treatment decision, and it is not clear if it can be covered by the common law's provision of treatment based on best interests. In truth, however, such decisions are just as important: by allowing such patients to go on living alone in the community can lead to hazards and deterioration in health status. Finally, from an ethical perspective, a practice which grants the doctor the sole discretionary right to decide on the appropriate treatment for an incapacitated patient without surrogates lacks balance and safeguard against any misdirected paternalism. It is incongruous with the ethics of advocating protection for a vulnerable population that lacks autonomy.

Medical management in acute hospitals to achieve the best interests for these patients requires a system that appoints and empowers the healthcare team with minimal

delay. A purely legal approach to surrogate decision-making in medical matters is too costly and time-consuming. It will not resolve the issues faced in the management of frail and demented older adults. On the other hand, a purely informal system without external or peer review may allow instances of injustice to go uncorrected. What is more effective and ethical is a system that includes public scrutiny and procedural review, but would still avoid the delays and complexities of a public system.²⁷ Hence, for incapacitated patients with no relatives, the MDTA should be amended so that the powers and responsibilities pertaining to treatment-related decisions for these patients are transferred from the traditional, court-appointed committee of persons to a healthcare surrogate decision-making team or committee comprising healthcare professionals directly involved in the care of the patient. Such an amendment will allow medical decisions to be made based on a clinical model, with the judicial model serving as a last resort in the event of irreconcilable conflicts.

Since decision-making will greatly rely on best interests criteria, it is helpful to clear the air of uncertainty that has caused local physicians to withhold non-critical treatment from incapacitated patients due to a lack of informed consent from the patient or legal guardian. The judicial authorities can affirm the legal position in *re F v West Berkshire Health Authority* (1989), where the House of Lords ruled that a doctor can legally operate on or give other treatment to adult patients who are incapable of consenting to his doing so, provided that the operation or treatment is done in the best interests of the patients. These include saving their lives, ensuring improvement or preventing deterioration in physical or mental health. This is in accordance to what has been accepted as appropriate treatment by a reasonable body of medical opinion skilled in that particular form of treatment.²⁵

Such legal affirmation can support an institutional policy that regulates and facilitates major medical decision-making by physicians in hospitals. This process is envisaged to begin with the attending physician proposing a course of treatment based on what he judges to be in the patient's best interests. The proposal is then peer-reviewed by 1 or 2 other physicians with the same expertise. If available and feasible, the physician can consult or involve the surrogate decision-making team caring for the patient in the long-term care facility in order to incorporate any previously known or documented values of the patient and considerations based on the patient's current quality of life. To safeguard against over-treatment or under-treatment of the patient, the rigorous enforcement of existing professional standards and common law duty of care owed to patients is needed.¹¹ As soon as a treatment is deemed to be appropriate, the physician implements it without delay. A similar process is seen in any proposed withholding or withdrawal of life-sustaining

treatment. Should there be any disagreement or failure to reach a consensus, consultation with the hospital's clinical ethics committee is an option. Such a system will help remove legal barriers to needed care, and yet provides a system of checks and balances against biased value judgements by clinicians. Meier²⁸ warns, however, that such a system can still be unsafe for patients if there are financial conflicts of interest, where those involved in decision-making stand to gain financially from selecting certain options. This is indeed something to be mindful of, and the authorities may perhaps need to establish a surveillance system to avoid such pitfalls.

Conclusion

Physicians are always striving to benefit their patients, a task made more challenging when the latter are incompetent and without any relatives. However, it is equally important that the treatment and care is delivered ethically and legally. Hence, there is a need to explore changes to the present legal and administrative system of finding and appointing surrogates, so that it facilitates, rather than hinders, ethical and effective medical practice. A clinical, rather than a judicial, model of appointing surrogate decision-makers – especially in acute hospital settings – offers the most balanced and practical approach towards achieving the best possible clinical outcomes and overall quality of life for these vulnerable patients.

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REFERENCES

1. Kua E H. The prevalence of dementia in elderly Chinese. *Acta Psychiatr Scand* 1991; 83:350-2.
2. Kua E H, Ko S M. Prevalence of dementia among elderly Chinese and Malay residents of Singapore. *Int Psychogeriatr* 1995; 7:439-46.
3. Fellows L K. Competency and consent in dementia. *J Am Geriatr Soc* 1998; 46:922-6.
4. Herr S S, Hopkins B L. Healthcare decision-making for persons with disabilities. An alternative to guardianship. *JAMA* 1994; 271:1017-22.
5. Roberts L W, Geppert C M, Bailey R. Ethics in psychiatric practice: essential ethics skills, informed consent, the therapeutic relationship and confidentiality. *J Psychiatric Prac* 2002; 8:290-305.
6. Government of Singapore. The Statutes of the Republic of Singapore. Mental Disorders and Treatment Act (Chapter 178). Revised ed. Singapore: Singapore National Printers, 1985.
7. Emanuel E J, Emanuel L L. Proxy decision-making for incompetent patients. An ethical and empirical analysis. *JAMA* 1992; 267:2067-71.
8. Arnold R M, Kellum J. Moral justifications for surrogate decision-making in the intensive care unit: implications and limitations. *Crit Care Med* 2003; 31:S347-S353.
9. Puchalski C M, Zhong Z, Jacobs M M, Fox E, Lynn J, Harrold J, et al. Patients who want their family and physician to make resuscitation decisions for them: observations from SUPPORT and HELP. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. Hospitalized Elderly Longitudinal Project. *J Am Geriatr Soc* 2000; 48:S84-S90.
10. Government of Singapore. The Statutes of the Republic of Singapore. Destitute Person's Act (Chapter 78). Revised ed. Singapore: Singapore National Printers, 1990.
11. Miller T E, Coleman C H, Cugliari A M. Treatment decisions for patients without surrogates: rethinking policies for a vulnerable population. *J Am Geriatr Soc* 1997; 45:369-74.
12. Luttrell S. Making decisions about medical treatment for mentally incapable adults in the UK. *Lancet* 1997; 350:950-3.
13. Government of Singapore. The Statutes of the Republic of Singapore. Advance Medical Directive Act (Chapter 4A). Revised ed. Singapore: Singapore National Printers, 1997.
14. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. Deciding to forego life-sustaining treatment. Washington DC: US Government Private Office, 1983:32-3.
15. Beauchamp T L, Childress J F. Principles of Biomedical Ethics. 4th ed. New York: Oxford Univ Press, 1994.
16. Mitchell S L, Lawson F M. Decision-making for long-term tube-feeding in cognitively impaired elderly people. *CMAJ* 1999; 160:1705-9.
17. Dresser R S. Autonomy revisited: the limits of anticipatory choice. In: Binstock P H, Post S G, Whitehouse P J, editors. *Dementia and Aging: Ethics, Values and Policy Choices*. Baltimore: Johns Hopkins University Press, 1992.
18. New South Wales Guardianship Act 1987 No 257. Available at: <http://www.legislation.nsw.gov.au/fullhtml/inforce/act+257+1987+FIRST+0+N#cd>. Accessed 9 October 2003.
19. Pearlman R A. Challenges facing physicians and healthcare institutions caring for patients with mental incapacity. *J Am Geriatr Soc* 1996; 44:994-6.
20. American Geriatrics Society Ethics Committee. Making treatment decisions for incapacitated older adults without advance directives. *J Am Geriatr Soc* 1996; 44:986-7.
21. Sundram C J. Informed consent for major medical treatment of mentally disabled people. A new approach. *N Engl J Med* 1988; 318:1368-73.
22. Teno J M, Lynn J. Putting advance-care planning into action. *J Clin Ethics* 1996; 7:205-13.
23. Forbes S, Bern-Klug M, Gessert C. End-of-life decision-making for nursing home residents with dementia. *J Nurs Scholarsh* 2000; 32:251-8.
24. Volicer L, Cantor M D, Derse A R, Edwards D M, Prudhomme A M, Gregory D C, et al. Advance care planning by proxy for residents of long-term care facilities who lack decision-making capacity. *J Am Geriatr Soc* 2002; 50:761-7.
25. *In re F v West Berkshire Health Authority* (1989) 2 WLR 1025; (1989) All ER 673.
26. Republic of Singapore Ministry of Health Professional circular No 2/90. MH 71:02 Vol 8, Para 2. Singapore: Ministry of Health, 1990.
27. Moody H R. Ethics in an Aging Society. Baltimore: Johns Hopkins University Press, 1992.
28. Meier D E. Voiceless and vulnerable: dementia patients without surrogates in an era of capitation. *J Am Geriatr Soc* 1997; 45:375-7.