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Hang Wu TANG
Singapore Management University, hwtang@smu.edu.sg

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Singapore's Adult Guardianship Law and the Role of the Family in Medical Decision-Making

Hang Wu Tang

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Abstract

Singapore's adult guardianship law was derived from the Mental Capacity Act in England and Wales. This article explores the process of how Singapore's Mental Capacity Act was adapted and fine-tuned to operate in a jurisdiction with different cultural conditions, religions, familial norms, and social institutions. The first part of the article demonstrates that despite its apparent similarities, the policymakers in Singapore have omitted crucial portions of the Mental Capacity Act which deal with the human rights of persons lacking capacity. This omission is unsurprising considering Singapore's history of advancing an Asian values approach to human rights. In the second part, it will be demonstrated that Singapore's Mental Capacity Act has been interpreted by some healthcare professionals through the lens of relational autonomy in certain circumstances to accommodate a family-centric mode of decision-making. The appeal to relational autonomy may be explained on the centrality of the family in the lived reality of most persons in Singapore. In this regard, this article argues that a formal protocol should be drafted to guide healthcare professionals in navigating the tricky minefield of furthering a person's autonomy while recognizing the centrality of the family in certain contexts.

I. INTRODUCTION

Singapore's Mental Capacity Act[1] passed in 2008 is the centrepiece legislation governing adult guardianship. This Act was adapted from the Mental Capacity Act 2005 applicable in England and Wales[2] with some modifications and omissions. Policymakers in Singapore studied the legislative frameworks of various countries including Germany, Japan, and Hong Kong[3] before deciding that the Mental Capacity Act 2005 was the most suitable.[4] The reported rationale for the enactment of Singapore's Mental Capacity Act was to prepare for an ageing population.[5] Singapore's Mental Capacity Act took almost a decade of gestation and involved extensive consultation with the public including social welfare organizations, legal, banking, and medical sectors.[6] Prior to the enactment of the Mental Capacity Act, the Mental Disorders and Treatment Act[7] governed matters. Under the previous Act, a Committee of Person or Estate may be appointed by the High Court to manage the

personal welfare and financial matters of a person with 'unsound mind' and who are deemed to be incapable of managing their affairs. The drawback to this previous law was that the legislation only allowed for the appointment of the Committee of Person or Estate after the person had lost his or her mental capacity. Thus, a person could plan his or her affairs in advance. Singapore's Mental Capacity Act changed this position and allows pre-planning by introducing the lasting power of attorney which may be executed before one loses mental capacity. Furthermore, the previous Act relied on the archaic concept of a person of 'unsound mind' which is completely out of line with modern medical views of mental capacity.

The adoption and adaptation of foreign law, especially from Commonwealth jurisdictions, is a common occurrence in Singapore where the legislator rarely drafts entirely new statutes from scratch but prefers to borrow from the laws of established jurisdictions and thereby benefit from the experience and case law of these countries. This article explores the process of how the Mental Capacity Act was adapted and fine-tuned to operate in a jurisdiction with very different cultural conditions, religion, familial norms, and social institutions. In examining this process, this article reveals two aspects of adult guardianship law in Singapore. First, the policymakers in Singapore were less concerned with the issue of human rights as compared with their English counterparts. Secondly, the Western model of adult guardianship based on individual autonomy appears to be incompatible with the lived reality of most persons in Singapore where the family plays a central role in their lives. As a result, some healthcare professionals have advanced the idea of relational autonomy in medico-legal journals to accommodate the role of the family in medical decision-making. Instead of a decision-making process which regards the individual as an autonomous unit, there is emerging literature from medico-legal scholars based in Singapore justifying a family-centric mode of decision-making. These medico-legal scholars have constructed a family-centric mode of decision-making from the perspective of relational autonomy or on a negotiated tacit consent model. Although the present author is sympathetic to the project of including familial relations in medical decision-making, there is the danger of fetishizing the role of the family in this context. While some familial relationships are positive and enabling, there are some relationships which are abusive and harmful to the individual. Drawing from the work of some of these medico-legal scholars and the jurisprudence on undue influence in private law, this article proposes a code of conduct for healthcare professionals to follow before involving a patient's family members in the decision-making process. The proposed code of conduct seeks to balance furthering the patient's autonomy while recognizing the centrality of the family in certain contexts.

II. THE THEORETICAL FRAMEWORK: LAW'S TRAVEL IN CONTRAST TO LEGAL TRANSPLANT

Comparative law scholars often analyse the process of transposing the laws from one jurisdiction to another as a form of legal transplant.[8] In writing this article, I resist looking at this process from the lens of legal transplant, a term which carries substantial baggage. Instead, I view this example of law as a travelling phenomenon using the perceptive words of Dr Iza Hussin who writes:

[The] analytic project … is not simply *that* law travels, but with whom; not just that it is carried, but alongside what other commodities and baggage; not just that it moves, but that it is transformed by its passage across borders and among localities.[9]

In Singapore, it is an empirical fact that many laws including statutes travelled from various jurisdictions such as England[10] and Australia.[11] The interesting phenomenon is how these laws are transformed by the travel to adapt to a local context. Adult guardianship law is a particularly complex and challenging area of law to transport from a foreign jurisdiction because it operates at the crossroads of familial, social, cultural, and religious context. Therefore, the emphasis of this article is to discover the way adult guardianship law travelled from England to Singapore and how this law was articulated, used, and adapted to a local context. In this article, I seek to demonstrate that in the context of the adult guardianship law in Singapore two forms of 'tuning' is currently taking place. This article adopts Esin Örücü's thesis that for laws to be successfully transposed from one jurisdiction to another a process of refinement to local concerns must occur. Örücü names this process as legal 'tuning' by the appropriate legal actors in order to ensure that the transposition of law is successful.[12] In the present case, the actors who function as the 'tuners' are the policymakers, healthcare professionals, social workers, non-governmental organizations, and scholars. In terms of the 'tuning', this has been very subtle because the Mental Capacity Act appears similar on face value. Yet, a close comparison of both statutes shows that the policymakers in Singapore have excised provisions meant to facilitate human rights of persons lacking in capacity in Singapore's version of the legislation. Another form of 'tuning' which is potentially taking place is the emerging literature, as evidenced by the case studies in medico-legal journals written by Singapore based healthcare professionals, of heavily involving family members in a patient's decision-making process. Prima facie, such an approach is arguably incompatible with the Mental Capacity Act. As a result, medico-legal scholars have sought to justify this practice as a means of furthering the relational autonomy or reflect instances of negotiated consent of the patient. It is suggested that the attempts by medico-legal scholars to justify this phenomenon is also a form of 'tuning' which allows the law in the statute to work effectively in the local context. This process of

'tuning' is far from over. At some point in time, the policymakers need to spell out the limits of family involvement and develop a protocol to counter the effects of abusive relationships.

III. COMPARING SINGAPORE'S MENTAL CAPACITY ACT WITH THE ENGLISH MENTAL CAPACITY ACT

This section of the article will explore the similarities and dissimilarities between Singapore's Mental Capacity Act and its counterpart in England and Wales.

1. The Similarities between Singapore's Mental Capacity Act and its English Counterpart – Lasting Power of Attorney, Deputies, Office of the Public Guardian, and Substituted Decision-Making

In terms of its structure, Singapore's Mental Capacity Act looks almost identical to the Mental Capacity Act 2005.[13] Each legislation starts with a recitation of guiding principles. The other similar features include the following:

- Lasting power of attorney which enables a person to appoint another person called the donee to act on his or her behalf when capacity is lost;
- A court appointed representative called a deputy who can act for a person who lacks capacity;[14]
- A regulating body known as the Office of Public Guardian; and
- Substituted decision-making based on a person's best interest.

Like its English counterpart, Singapore's Mental Capacity Act sets out the following guiding principles in assessing mental capacity and assisting individuals who are adjudged to have lost it.[15] First, a person must be assumed to have capacity unless it is established that he or she lacks capacity. Secondly, a person is not treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. Thirdly, a person is not to be treated as unable to make a decision merely because he or she makes an unwise decision. Fourthly, any act or decision for and on behalf of a person who lacks capacity must be done in his or her best interest.[16] Finally, before an act is done or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. Overall, these principles reinforce the commitment to individual autonomy and autonomous decision-making.

Singapore's Mental Capacity Act envisages that a person ('P') would make a lasting power of attorney before he or she loses capacity conferring certain powers on another called the donee(s). The donee may be appointed to act on behalf of P with respect to P's personal welfare and/or P's property and

affairs. Under orthodox agency law, a power of attorney usually comes to an end when the principal loses capacity. However, a lasting power of attorney under Singapore's Mental Capacity Act is unique because the power of attorney will only operate when the principal loses capacity.[17] The creation of a valid lasting power of attorney under Singapore's Mental Capacity Act is a two-stage process. First, the instrument must be completed in a form complying with certain prescribed formalities. Crucially, a valid lasting power of attorney must be accompanied with a certificate provided by an accredited medical practitioner or a psychiatrist or a practicing lawyer that the donor understands the scope and purpose of the authority conferred and that no fraud or undue pressure was used to induce the creation of the lasting power of attorney. Secondly, once the lasting power of attorney is completed, it must be registered with the Office of the Public Guardian. For individuals who have not made a lasting power of attorney, the process becomes more complicated when such individuals lose capacity. An application must be made to court whereby the court may make a decision on P's behalf in relation to matters or appoint another person called a deputy to make decisions on P's behalf.[18]

In order to oversee donees and deputies, Singapore's Mental Capacity Act created a position in the form of an officer known as the Public Guardian. The Public Guardian has *inter alia* the following functions: (i) establishing and maintaining a register of lasting powers of attorney; (ii) establishing and maintaining a register of orders appointing deputies; (iii) supervising deputies appointed by the court; (iv) dealing with representations including complaints about the way a donee or a deputy is exercising his or her powers; and (v) investigating any contravention of the Mental Capacity Act. In addition to this, the Office of the Public Guardian publishes a Code of Practice which is now in its third edition to provide guidelines and illustrations on the implementation of Singapore's Mental Capacity Act.

2. The Differences between Singapore's Mental Capacity Act and its English Counterpart

There are several major differences between Singapore's Mental Capacity Act and its English counterpart. Most of the differences may be explained by the fact that Singapore's policymakers are not as concerned with the issue of facilitation of human rights as compared to their English counterpart.[19] Hence, Singapore does not have any deprivation of liberty safeguards. Instead, the Singapore system allows a person who lacks capacity to be detained for long periods of time if this is certified to be necessary by a relevant medical practitioner or magistrate. The provisions on advanced refusal of medical treatment and medical research found in the English legislation were omitted in Singapore's version of the Mental Capacity Act. Singapore has also chosen not to set up the Independent Mental Capacity Advocate scheme due to a perceived lack of demand and fear of spiralling costs to maintain such a scheme.[20]

A. Advanced Refusal of Medical Treatment

The English Mental Capacity Act provides for a person to make advance decisions regarding treatment. Under the English Mental Capacity Act, a person who is over 18 years of age and who has capacity to do so, may make an advanced decision as to whether a specific treatment is to be carried out or continued in future.[21] In other words, an adult who has the capacity to make a decision of such a nature may stipulate that certain treatments should not be performed on him or her when the person becomes incapable if the person understood the nature and consequences of his or her decision. Such an advanced decision to refuse medical treatment would be respected if there was no undue influence or coercion by a third party. Although no formalities are prescribed in relation to refusal of treatment, there are statutory conditions in relation to the refusal of life-sustaining treatment. The advanced refusal of life-sustaining treatments must include a statement by the maker that it is to apply to that treatment even if life is at risk, be in writing and signed by the maker in the presence of a witness.[22]

In contrast, Singapore's Mental Capacity Act has omitted the entire section on refusal of advanced medical treatment. In the Singapore Parliamentary Reports, there is no discussion on this omission. A local commentator[23] suggested that the reason for the omission is that Singapore already had an advanced decision-making tool in the form of the Advanced Medical Directive Act.[24] However, it should be noted that the Advanced Medical Directive Act only applies in a very specific context. The main thrust of the Advanced Medical Directive Act is that it allows a person who is of sound mind and 21 years and suffering from 'terminal illness' to make an advance medical directive not to be subjected to 'extraordinary life-sustaining treatment'.[25] Another possible alternative explanation for this omission is that save for the limited circumstances in the Advanced Medical Directive Act, the Singapore policymakers took the view that it was unnecessary to provide the mechanism to facilitate the advanced refusal of medical treatment. There could be two explanations for this. First, to enlarge the right to refuse advanced medical treatment beyond the situation listed in the Advanced Medical Directive Act would be extremely cumbersome and impractical. Secondly, it could be surmised that the philosophy adopted by the drafters of Singapore's Mental Capacity Act does not seek to enhance the autonomy of the person as fully as the English Mental Capacity Act. In any case, a person under Singapore's Mental Capacity Act may seek to refuse certain medical treatments by making a lasting power of attorney and confer on the person chosen as the donee to make health care decisions. If the donee is empowered to take care of health care decisions for the donor, then the donor may convey his or her wishes to the donee in relation to advanced refusal of certain medical treatments. However, there is a recent study which suggests that for a variety reasons advance care planning is not a popular course of action in Singapore.[26]

B. Medical Research

The English Mental Capacity Act contains a section on regulating research involving persons who lack capacity.[27] In a nutshell, the statute heavily regulates intrusive research on persons who lack capacity. The pre-condition to conducting such research is that an appropriate body must be formed to oversee the research. Research may only be conducted on a person who lacks capacity if:

a. the research is connected with an impairing condition affecting the person or its treatment;[28]
b. there are reasonable grounds for believing that the research of comparable effectiveness cannot be carried out if the project has to be confined to the persons who can consent;[29]
c. the research has the potential to benefit the person without imposing on the person a burden that is disproportionate to the potential benefit to the person or be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or similar condition;[30] and
d. in case of research falling into the latter category in (c), there are reasonable grounds for believing that the risk to the person from taking part of in the project is likely to be negligible and anything done in relation to the person will not interfere with the person's freedom of action or privacy in a significant way, or be unduly invasive or restrictive.[31]

Under the English Mental Capacity Act, clinical trials are not considered as research for the purposes of the act. Instead, clinical trials are governed by the Medicines for Human Use (Clinical Trials) Regulations 2004.

Singapore's Mental Capacity Act, however, has omitted this entire section on research. Instead, whether such research can be conducted lies in the hands of the donee: section 22(*d*) of the Mental Capacity Act confers on a donee of a lasting power of attorney for personal affairs the power to give or refuse consent to the conduct of a clinical trial by a person providing health care for the donor. The donee must, in deciding whether it is in the patients' best interest to participate in such research, take into account matters, considerations, and procedures under the Human Biomedical Research Act 2015,[32] or that prescribed in such written law.[33]

C. Deprivation of Liberty Safeguards

The deprivation of liberty safeguards that are found in the English Mental Capacity Act was due to Article 5 of the European Convention of Human Rights. Article 5 provides:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law…

Specifically, Article 5(1)(e) allows for the 'lawful detention of … persons of unsound mind'. However, such deprivation must be in accordance with a procedure prescribed by law. The introduction of the deprivation of liberty safeguards was motivated by the well-known decision of *HL v United Kingdom*[34] (also known as *Bournewood*). In this case, HL, an adult with autism, initially lived and was cared for by paid carers. HL became agitated while at a day care centre and was admitted to a psychiatric facility. Subsequently, the carers requested for HL's return but the hospital refused to release him. Litigation ensued and the matter was taken all the way to the European Court of Human Rights where it was successfully argued that HL had been deprived of his liberty contrary to Article 5(1) of the European Convention on Human Rights. As a result, Schedule A1 and 1A of the Mental Capacity Act 2005 was introduced to provide for deprivation of liberty safeguards to plug the *Bournewood* gap.[35] These safeguards apply to persons lacking capacity who are deprived of liberty in a care facility or hospital. Whether someone is deprived of his or her liberty is viewed through the lens of best interest of the individual concerned. In other words, the deprivation must be a proportionate response to the gravity and prospect of harm. The care facility or hospital will inform a supervisory body when a person without capacity is deprived of his or her liberty and the supervisory body will send assessors to ensure the provisions of the Mental Capacity Act are followed. An Independent Mental Capacity Advocate will be appointed if there are no family members or relevant to consult.

Unsurprisingly, Singapore, not being a party to European Convention on Human Rights, has chosen not to include the deprivation of liberty safeguards in its version of the Mental Capacity Act. Instead, the relevant provisions regulating detention of persons who lack capacity are found in another statute called the Mental Health (Care and Treatment) Act.[36] Since detention of persons who lack capacity is found in Mental Health (Care and Treatment) Act, there was no discussion on deprivation of liberty in the passage of Singapore's Mental Capacity Act. In Singapore, a person may be detained at a psychiatric institution in three circumstances pursuant to the Mental Health (Care and Treatment) Act. First, a police officer is obligated to apprehend any person who is reported to be mentally disordered and believed to be dangerous to himself or herself or other persons by reason of mental disorder and take the person to a medical practitioner or psychiatric institution to be examined.[37] Secondly, the court is also empowered to send a mentally disordered person to a designated psychiatric institution for treatment if there is evidence that the person is ill-treated or neglected by any relative or carer.[38] Finally, a medical practitioner caring for a person believed to be mentally disordered or require psychiatric treatment, may

send the person to a designated medical practitioner at a psychiatric institution for treatment.[39] A designated medical practitioner at the psychiatric institution may, after examining the person, sign a form which results in the person being detained for 72 hours.[40] Another medical practitioner may examine the person and sign another form which causes the person to be detained for a further period of one month.[41] Further detention is possible after two designated medical practitioners (one of which must be a psychiatrist) examine the person and sign the relevant form.[42] This last period of detention must not exceed 6 months.[43] Such detention at a psychiatric institution is only necessary if it is warranted and it is necessary in the interests of the health or safety of the person or for the protection of other persons that the person should be so detained.[44] A period of further detention requires an application to a magistrate who is empowered to order detention for a period not exceeding 12 months.[45] Further applications to the magistrate to detain the person beyond the 12 months is possible.

The upshot is that long periods of detention are possible under Mental Health (Care and Treatment) Act so long it is certified by a medical practitioner or magistrate. It would seem the rationale for the detention does not rest solely on mental capacity but also for the protection of other persons in the community.

D. Independent Mental Capacity Advocate Service

The English Mental Capacity Act allows for the appropriate authority to appoint independent mental capacity advocates to support persons who have no family members or close friends.[46] Such independent mental capacity advocates are consulted in relation to the following matters:

- deprivation of liberty;
- provision of serious medical treatment by the National Health Service body;[47]
- provision of accommodation by National Health Service body;[48]
- provision of accommodation by the local authority;[49] and
- proposal to take measures to protect a person who lacks capacity to minimize risk of abuse or neglect.[50]

In Singapore, the policymakers deliberately chose not to set up the independent mental capacity advocate service due to cost considerations and the perceived lack of need for such a service. The then Minister for Community Development, Youth and Sports, Mr. Vivian Balakrishnan, explained:

in the UK, they have set up an independent advocate. That is a pilot scheme which they have set up. I think they have appointed 144 people, costing them a grand sum of £6.5 million. I am not in a hurry to

go and start up more bureaucracy and more inspectors. The difference is that families in Singapore are available by and large. This is a small place and I think there will be very few people who truly are destined to have no one else to look after their interests. For those people in Singapore, particularly those who are destitute and in our homes, the Ministry, my staff and the voluntary welfare organisations will have to play such an advocate role. But I am not keen at this stage to set up an elaborate Government bureaucracy at great expense to do this.[51]

The lack of some sort of service for people lacking capacity who do not have family and friends is obviously unsustainable with the shrinking of the modern nuclear family. Singapore's Mental Capacity Act is a work in progress. In 2016, the Mental Capacity Act was further amended to provide for the creation of professional donees and deputies. These amendments allow those without family or close friends who can act as donees and deputies to engage paid professionals to exercise that duty. Prior to the amendments, there was a small number of lawyers who acted on a pro bono basis as panel deputies for persons without anyone willing to act as deputies.[52] The amendments envisaged creating a new market for professional deputies and donees. In terms of regulations, the professional deputies must be registered with the Public Guardian and must satisfy the Public Guardian's prescribed criteria.

IV. THE CLASH BETWEEN INDIVIDUAL AUTONOMY, RELATIONAL AUTONOMY AND THE CENTRALITY OF THE FAMILY IN SINGAPORE

Like its English counterpart, Singapore's Mental Capacity Act promotes and facilitates the idea of individual autonomy by recognizing the fundamental guiding principle that a person is assumed to have capacity unless it is established that he lacks or she lacks capacity.[53] Thus, before a person loses capacity, he or she must not be treated as being unable to make a decision. In the decision-making process, the person's right to make decisions is regarded as paramount under the law. While this idea of personal autonomy is clear in theory,[54] it struggles to accommodate the role of the family in the decision-making process.[55] Jonathan Herring points out perceptively that people are assessed and not seen as relational people in mutually inter-dependent relationships.[56] Herring describes the current construction of capacity to decide as follows:

It seems to be based on the archetype of the philosopher sitting alone in his study carefully and rationally thinking through his decision. But that is not how most people make decisions. Most think it through with others and rely on their insights. The friends chatting through a topic with a cup of tea might be the archetype of decision making, rather than the philosopher alone in his study.[57]

Another scholar, Roy Gilbar, says that the debate is '[d]ominated by the bioethical principle of individual autonomy … [and] the law concentrates on the patient and takes an exclusionary stand regarding relatives'.[58] In an empirical study involving patients in England, Gilbar demonstrates that relatives had an influence on the decision-making process but ultimately left the decision to the patient. Thus, the idea of promoting individual autonomy without considering the role of close family members is strained even in England. Gilbar concludes that his findings reflect a relational approach to a patient's autonomy where patients needed to know that their relatives supported them no matter what they decided. However, Gilbar points out that in certain exceptional cases of substantial familial influence, the law should secure the patient's interest in making his or her own decision.

This tension between promoting individual autonomy and accommodating the family in the decision-making process plays out even more acutely in the Singapore context. It is suggested that there are two reasons why the family plays a central role in the medical decision-making process in Singapore. First, as Terry Carney perceptively points out, the Asian family shoulders much of the burden of care which in Western countries is performed by the state or state agencies.[59] This is also true in the context of Singapore. The Singapore government has always sought to cultivate a culture of self-reliance.[60] Braema Mathi and Sharifah Mohamed succinctly described the government's philosophy as follows:

Securing a good job is the most effective way of ensuring one's needs are sustainably met. The family is the next layer of support, followed by the community and lastly, the government.[61]

Thus, the ideology of social services in Singapore is one of shared responsibilities between the individual, families, community, with the state acting as the last line of defence.[62] In other words, the family functions as the primary unit of care for persons who lack capacity and vulnerable persons and plays a central role in the person's life as carer, protector, and financier of health care costs. Hence, it is unsurprising that some healthcare professionals in Singapore have gravitated towards a communitarian decision-making model which locates the individual within the context of their close family members. This is because the decision of the individual would inevitably affect the family in terms of financial resources and the provision of care for the individual.[63]

The second reason why the family looms large in medical decision-making is cultural in nature. At the risk of generalization, many individuals in Singapore do not see themselves as an atomistic unit but instead as a collective part of a family unit.[64] It is suggested that a literal interpretation of Singapore's Mental Capacity Act struggles to accommodate the reality of many people in Singapore and the

centrality of the family in their lives.[65] A study of the literature in the medical journals demonstrates that healthcare professionals often ignore the emphasis on individual autonomy found in Singapore's Mental Capacity Act in favour of a collective decision-making process. For example, a fascinating study on cancer patients and family involvement in decision-making found that the family played a dominant role in the process.[66] Although most patients were eventually told about their cancer diagnosis, a significant percentage of the patients were excluded from the first disclosure of the diagnosis. This presumably stemmed from family members seeking to protect the patient from the bad news. In fact, in more than half of the cases, the family was present at the first disclosure of the diagnosis even though it was not clear whether the patient explicitly consented to their presence. There were also several cases where the family members requested the doctors not to disclose the diagnosis to the patient. In the decision-making process, there was a significant percentage where the patient was excluded from the initial process. Conversely, in most of the cases, the family was included in the decision-making for the initial treatment.

The authors of the study above explain the family members' behaviour as stemming from a desire to protect and support the patient. Doctors also seek familial involvement regarding the patient's treatment decisions because of the potential repercussions on the family who care for the patient and pay for his or her medical treatment. The authors hypothesize:

This phenomenon could also be explained by *a broader concept of autonomy*, often found in the Asian culture, which entails the need for engaging and interacting in a network of relations with others, as opposed to the western definition whereby decisions are solely the prerogative of the individual. (emphasis added)

The authors struggle to justify the doctors' and healthcare professionals' behaviour within the framework of the Mental Capacity Act. They suggest that a better approach is to ask the patient whether they wish to cede the decision-making power to their relatives. If so, the patient's wish should be respected. Alternatively, the patient may be asked whether they want to involve the family members in weighing up their treatment options but ultimately make their own decisions.

The case study above is not an isolated study in Singapore demonstrating heavy family involvement in the medical decision-making process. In another study on the practice of collusion on end-of-life care in Singapore, Krishna and Menon found that the moderation or even omission of information to the patient in relation to a life-threatening diagnosis is commonplace.[67] Relatives often intervene from the outset and are adamant that the patient is not told of their diagnosis. Krishna and Menon explain that

the influence of the family arises due to four aspects—physical care, financial, religious/cultural, and social expectations. First, in most cases the family provides the physical care for the patient. Secondly, the family also often serves as the financial resource of the patient. Thirdly, the family is the backdrop of the religious and cultural context in which the patient is immersed. Finally, the family unit sets the framework of social expectations in relation to the patient. For example, the societal expectation is that the family should act as the patient's primary caregiver and they must maintain hope and never give up on the patient. In relation to preventing the patient from finding out his or her medical condition, this comes from the family's desire to spare the patient from the anguish of a poor prognosis. However, Krishna and Menon point out that not all family motivations are benevolent. In some cases, the family may place their collective interests above those of the patient. This is especially acute when the healthcare decisions have a direct impact on the financial situation of the family.

A reported case study illustrates this complex dynamic between personal autonomy, religious, cultural and familial expectations when dealing with a patient's decision-making process.[68] These tensions are illustrated by the heartbreaking case study of Mariana. Mariana was a competent Muslim lady of Chinese heritage from Indonesia, whose wish at the end of her life was for adequate pain relief. However, her husband did not wish for Mariana to use morphine because he felt that this would amount to giving up hope on Mariana. The family could not afford other treatment options such as oxycodone and neurolytic interventions instead of morphine. Mariana's husband also struggled with the effects of morphine on Mariana when it was previously applied which resulted in her inability to recite verses of the Quran. The husband's steadfast refusal to allow morphine to be administered was despite pleas from other relatives including their children and the local Muslim cleric. Initially, Mariana suffered in silence and was reluctant to exert her personal autonomy. Ultimately, a multi-disciplinary team overruled Mariana's husband on the ground that it was in Mariana's best interest that morphine be administered. The multi-disciplinary team also did not allow Mariana to be discharged to die at home because of lack of physical support and a high suspicion that the supply of morphine will be stopped. Eventually, Mariana passed away in a hospice with the requisite dose of opiods to control her pain. This case is noteworthy for several reasons. First, Mariana was a mentally competent lady at all material times although it may be argued that she was a vulnerable person.[69] Legally, the healthcare professionals dealing with Mariana ought to have given her wishes paramount consideration in deciding her treatment options. Yet, the case study shows that the healthcare professionals treated Mariana's husband with deference before overruling him eventually. An explanation for this is possibly that Mariana's husband was a source of spiritual and emotional comfort for Mariana as well the financial source for Mariana's medical care. If the healthcare professionals did not handle the matter sensitively and alienated

Mariana's husband, this would produce conflict between the couple and indirectly cause anguish to Mariana. Secondly, the case study as reported shows Mariana's own ambivalence in relation to the morphine treatment in the face of her husband's objections. On one hand, she was reported as being content to suffer in silence[70] and on the other hand, she is said to have pleaded with her husband to allow her to use morphine.[71] This case study illustrates the complexity faced by healthcare professionals in determining the proper course of action where facilitating a patient's personal autonomy as opposed to meeting familial and religious expectations might lead to a different decision.

Singapore's Mental Capacity Act, which is couched in the language of facilitating personal autonomy, is difficult for healthcare professionals to apply because it does not consider the importance of the family in the decision-making process. In order to accommodate the importance of the family in this context, the notion of individual autonomy premised solely on the fiction of a person as an alienated and atomistic individual must be rejected. The concept of a purely atomistic individual wholly separate from everyone else is unrealistic. Feminist legal scholars have always known that the very idea of the free legal actor as an asocial person to be a fiction.[72] A better theory of autonomy and personhood is required. Professor Margaret Jane Radin develops a more plausible hypothesis in arguing that there are three 'overlapping aspects of personhood: freedom, identity, and contextuality'.[73] The first aspect focuses on free will; the second on the integrity and continuity of the self-required for individuation. The contextuality aspect of personhood focuses on the necessity of self-constitution in relation to the environment of things and other people. In order to be differentiated human persons, unique individuals, we must have relationships with the social and natural world.[74]This is an important insight. As Camillia Kong observed perceptively 'A nurturing *interpersonal* environment can do a great deal to ameliorate vulnerabilities and empower the *intrapersonal* conditions of autonomy'.[75] However, this is not to romanticize or fetishize every type of relationships; certain relationships are disabling and may rob an individual of his or her autonomy.[76] Therefore, the challenge is to identify relationships which are enabling as compared to those that are disabling.

Drawing on work by feminist legal scholars, Professor Jonathan Herring argues as follows:

The traditional notion of autonomy promotes the concept of an isolated patient deciding for himself what is in his best interest (the image of 'the male in the prime of his life'), whereas in fact we live lives based on interdependent relationships. It assumes that we can say straightforwardly 'this is my life' and I can do what I want with it, ignoring the deep interconnections … We need therefore to recognize that for most patients the question is not simply 'what is best for me?', but rather, 'given the responsibilities

I owe to those in relationships with me and the responsibilities owed to me by others, what is the most appropriate course of action?[77]

Thus, the crucial issue is that '[w]e need to examine to examine people's choices in light of the relationships within they live and the feelings of worry, concern for others and obligation that they may have'.[78] However the concept of relational autonomy applicable in the context of mental capacity remains contentious due to the spectre of abusive relationships, forces of patriarchy and undue religious pressure which might overwhelm the individual.[79] In reviewing the medico-legal literature, two forms of 'tuning' of Singapore's Mental Capacity Act to apply in the Singapore context may be detected i.e. viewing matters through the lens of relational autonomy or negotiated consent. The first approach is the development of a theory of personhood coupled with a call for the use of a multi-disciplinary team to determine the best interest of the patient. Some Singapore based scholars led by Dr Lalit Krishna have argued for a theory of personhood based on the concept of relational autonomy to guide healthcare professionals' conduct. The proposed concept of personhood explicitly incorporates the idea of relational autonomy which considers the patient's relationship with his or her relatives.[80] Professor Lalit Krishna (personally and as a co-author) has proposed a theory of personhood in a series of articles published in medical journals.[81] Krishna and his collaborators call this the Ring Theory of Personhood which is presented in the form of concentric circles.

Under this Ring Theory of Personhood, the concept of personhood is conceived as four concentric rings—Innate, Individual, Relational, and Societal Rings. Krishna, Watkinson and Ng explain:

The Innate Ring highlights the dignity and rights owed to all as a result of Divine and/or human connections "irrespective of their stage of development or deterioration." The Individual Ring is defined by the presence and display of conscious function and a continuing identity over time. The Relational Ring houses "those personal relationships that the patient considers important," while the outermost ring, the Societal Ring, contains "the social, professional and familial expectations and standards that the patient and those within their various rings are subject to.[82]

Krishna, Watkinson and Ng argue all four domains are of equal importance. For persons 'who are unable to maintain psychological continuity or are incompetent, personhood is endowed by those within their Relational and Societal Rings'.

Krishna et al. are well aware of the family overwhelming the individual's interest. A potential problem with a relational theory of autonomy is the danger that 'the family unit becomes the main arbiter of a

patient's care needs, sometimes to the detriment of a patient's right to self-governance'.[83] Sometimes, the interest of the family unit is not aligned with the rights of the individual. Recognizing this potential conflict, Krishna et al argue that a multi-disciplinary team should be employed to determine the best interest of the patient. The multi-disciplinary team comprises a group of people of different healthcare disciplines who meet to discuss the diagnostic and treatment decisions of a given patient. While the multi-disciplinary team should '[a]cknowledge reciprocal filial obligations and obedience by patients to their family',[84] the multi-disciplinary team will 'allow for better understanding of the various pressures confronting the family'.[85] The multi-disciplinary team would take the view that the patient's family is not best placed to make decisions for the patient in appropriate cases. Mariana's case is an example where the family's wishes was overruled because their wishes were not in the best interest of the patient.

In contrast to Krishna's and his collaborators' approach, Chan, Peart, and Chin advocate the development of 'a reflective, negotiated model of interaction to help healthcare professionals deal adequately with this complexity in medical decision making'.[86] Chan, Peart, and Chin argue as follows:

'This model promotes patient empowerment in healthcare by offering disclosures of diagnosis, prognosis and treatment options to a competent patient at various intervals, while allowing patients to freely decline or delegate these offers to others. The open-endedness of the model offers flexibility to adapt professional interactions with patients and families in accordance with perception of a patient's character, attitudes and patterns of communication within the family and with healthcare providers.'

Both Krishna et al's and Chan et al's proposed approaches are plausible justificatory models for the appropriate 'tuning' in relation to the application of Mental Capacity Act in Singapore. From the literature in medico-legal journals, it appears that reality on the ground is that the family plays a central role in the decision-making process of an individual in Singapore and healthcare professionals have been accommodating the wishes of the family without thinking too deeply about the provisions of the Mental Capacity Act. For the sake of consistency, Singapore's Code of Practice in relation to the Mental Capacity Act should be amended to provide concrete, workable, and practical guidance for healthcare professionals as to what is acceptable and unacceptable practices when dealing with an individual's family. Even in situations where the person has not lost capacity, it could be that healthcare professionals have put great weight on the family's wishes as exemplified by Mariana's case.

In adopting a justificatory model which allows for the family to play a role in an individual's decision-making process, care must be taken not to idealize family involvement. Although some family influence

is benign and meant to promote the individual's best interest, some familial relationships are toxic and abusive. While the present author is sympathetic to using the concept of relational autonomy due to the lived reality of most people in Singapore, the argument that is advanced is that medical professionals should be alive to the concern of abusive relationships and undue influence. Hence, medical professionals should not reflexively adopt the idea of relational autonomy or the concept of negotiated consent in the context of medical decision-making and mental capacity issues without weighing the corresponding risk of abusive relationships and undue influence.

The proposal made by the present author is that for a model based on relational autonomy or negotiated consent to work, a formal protocol for doctors needs to be constructed to sieve out relationships which may be considered to be undue influence. Such guidance, on how to sieve out undue influence, exists for lawyers advising family members when providing security or guarantees to financial institutions in the pre-existing case law and there is no reason why it could not be adapted for doctors in this context.[87] As Dr Anita Ho alerts us 'patriarchal and other oppressive relationships often disguise manipulation, exploitation, control and abuse as love and familial bond'.[88] The challenge is to draw the line between enabling family influence and when such conduct falls under the category of undue influence.[89] However, such a line of enquiry is difficult to achieve in practice. Ho points out that while at a societal level more should be done to eradicate patriarchalism and oppression, 'it is unclear that the battle against familial subordination is best carried out at the bedside by professionals who are likely unfamiliar with the patient's family dynamics'.[90] In a similar vein, Dr Hyun asks rhetorically: how are healthcare professionals to know whether a patient's request to defer to her family's wishes is truly authentic?[91]

Jillian Craigie has recently mapped out six models that conceptualize undue influence in relation to support for people with mental disabilities in terms of: mode of influence; an overborne will; an inference from the situation; an overborne will understood as a mental incapacity; an overborne will in connection with vulnerability; and impaired discursive control.[92] She concludes that within the framework of supported decision-making required by the UN Convention on the Rights of Persons with Disabilities, the 'overborne will', 'inference based' and 'discursive control' models may potentially fit within the Convention. It is beyond the scope of this article to assess which model is suitable to the context of Singapore. Nevertheless, the argument made here is that based on any of Craigie's models, some formal protocol should be adopted by healthcare professionals *before* including the family in the decision-making process to sieve out the spectre of undue influence. In other words, it is suggested that a code of conduct should be followed before involving a patient's family members in the decision-

making process where the patient has mental capacity. Such a code of conduct aims to further the patient's autonomy and prevent undue influence.

In financial matters, the law has prescribed that solicitors must give a 'core minimum advice' to a person who is providing guarantees or security for another family member to prevent undue influence.[93] Similarly, it is argued that healthcare professionals should also provide such core advice before involving family members in the decision-making process. Drawing from the jurisprudence of undue influence in property matters and the work of Dr Krishna, Chan, Peart and Chin, and Dr Ho, the proposed code of conduct by healthcare professionals should be as follows:

a. Have a meeting with the patient face-to-face, in the absence of the family members. Discuss with the patient his or her goals and family dynamics. Tell the patient that he or she has a choice over the medical decision and that the decision is patient's alone;
b. If the patient wishes to involve his or her family members in the decision-making process, then the patient should be informed that this wish will be respected;[94]
c. If the patient wishes to involve family members, the healthcare professionals should check the extent of the participation the patient wish for their family members to be involved. In certain circumstances, the patient may choose not to know about his or her diagnosis or delegate the decision-making process entirely to family members;
d. If the patient would like to be free of familial influence, the healthcare professional should discuss with the patient various ways to support his or her decision without creating undue familial animosity. Familial animosity and possibly abandonment may cause distress and anguish to the patient. This concern is especially acute if the patient has to rely on their family for caregiving upon their discharge. In appropriate circumstances, the healthcare professionals may activate a multi-disciplinary team to support and deal with the family. Where possible, family members should be counselled to accept the patient's choice;
e. The wishes of the patient should be properly documented; and
f. If the healthcare professionals suspect that the family members are exerting undue influence in relation to the decision-making process, the healthcare professionals should respect the patient's expressed wishes which were made in private to the healthcare professional.

These steps should be formalized as a protocol within Singapore's Code of Practice published by the Office of Public Guardian. Such a protocol would provide a valuable workable guidance to busy healthcare professionals navigating the tricky minefield of patient autonomy and familial influence and alleviate some pressures that a patient may face in the decision-making process. Further, if such a

protocol is formalized, then this would prevent healthcare professionals from being accused of being unduly prying and paternalistic.

V. CONCLUSION

This article has explored the process of the adoption and adaptation of a Western regime of adult guardianship law to an Asian country. In adapting the legislation, the policymakers have not adopted the various provisions meant to facilitate the human rights of persons lacking in capacity. Singapore's Mental Capacity Act remains very much a work in progress. The examination of how the law operates in the setting of medical decision-making process has also shown that a literal application of the adult guardianship provisions is incompatible with the central role of the family in the Singapore context. This article has argued that a code of conduct should be formalized by either Office of Public Guardian or professional bodies as to how healthcare professionals should behave in relation to family involvement in medical decisions.

Endnotes

1 Cap 177A, 2020 Revised Ed. Although the Act passed in 2008, it only came into force in 2010. It is speculated that the delay could be explained on the time needed to draft the Code of Practice and set up the Office of the Public Guardian before the Act came into force. For an overview of Singapore's Mental Capacity Act see T.E. Chan, 'The Elderly Patient and the Healthcare Decision-Making Framework in Singapore' in W.C. Chan (ed.), *Singapore's Ageing Population [:] Managing Healthcare and End-of-Life Decisions* (Routledge, 2011) Ch 8; S. Menon, 'The Mental Capacity Act: Implications for Patients and Doctors Faced with Difficult Choices' (2013) 42 *Annals of the Academy of Medicine of Singapore* 200.

2 For convenience, the Mental Capacity Act 2005 will be referred to the English Act for the rest of this article.

3 For an overview of Hong Kong's position see D. Cheung, 'Bringing the Adult Guardianship Regime in Line with the UNCRPD: The Chinese Experience' (2021) 35 *International Journal of Law, Policy and The Family* 1.

4 Full speech by Minister of Community Development, Youth and Sports, Dr Vivian Balakrishnan, Second Reading of Mental Capacity Act, 15 September 2008 (available on Lawnet).

5 See J. Yin, 'Law May Let You Pick Guardian Before Dementia Strikes' *Today* (Singapore), 9 March 2007 (Factiva).

6 Ibid.

7 Cap 178, 1985 Revised Ed. See also R. Ho et al, 'An Overview of Mental Health Legislation in Singapore' (2015) 12(2) *BJPsych. International* 42; J. Abrey and Y.H. Chua, 'A Law to Support Dignified Living—Singapore's Mental Capacity Act 2008 Has Plans to Move on' (2016) 3 *Elder Law Journal* 235.

8 The literature on legal transplant is voluminous. See generally A. Watson, *Legal Transplants: An Approach to Comparative Law* (University of Georgia Press, 1993) outlining the transplant of law through the movement of rules); P. Legrand, 'The Impossibility of 'Legal Transplants' (1997) 4 *Maastricht Journal of European and Comparative Law* 111 (disagreeing with the idea of legal transplants because rules do not travel).

9 I. Hussin, 'Circulations of Law: Cosmopolitan Elites, Global Repertoires, Local Vernaculars' (2014) 32 *Law and History Review* 773, 774–75. See H.W. Tang, 'From Waqf, Ancestor Worship to the Rise of the Global Trust: A History of the Use of the Trust as a Vehicle for Wealth Transfer in Singapore' (2018) 103(5) Iowa Law Review 2263 for the example on how English trust law travelled to Singapore.

10 The Trustees Act for example: *Ernest Ferdinand Perez De La Sala v Compañía De Navegación Palomar* [2020] 1 SLR 950, [24]. Another example would be the Evidence Act which was based on a codification of English evidence law in the 1800s: B. Tan, 'Reflections on s 2(2) of Singapore Evidence Act and Role of Common Law Rules of Evidence' (2018) 30 *Singapore Academy Law Journal* 224, [14]—[15]. See also A. Phang, 'Reception of English Law in Singapore: Problems and Proposed Solutions' (1990) 2 *Singapore Academy Law Journal* 20.

11 For example, Singapore's Land Titles Act (Cap 157, 2004 Rev Edn) was modelled after the New South Wales Torrens system. See J. Baalman, *The Singapore Torrens System* (Singapore Government Printer, 1961). On Torrens jurisprudence see generally H.W. Tang, 'Beyond the Torrens Mirror: A Framework of the In Personam Exception to Indefeasibility' (2008) 32(2) Melbourne University Law Review 672.

12 E. Örücü, 'Law as Transposition' (2002) 51 *International and Comparative Law Quarterly* 205.

13 The literature on the Mental Capacity Act in England and Wales is voluminous. See e.g. E. Cave, 'Determining Capacity to Make Medical Treatment Decisions: Problems Implementing the Mental Capacity Act 2005' (2015) 36 *Statute Law Review* 86; B.A. Clough, 'New Legal Landscapes: (Re)Constructing the Boundaries of Mental Capacity Law' (2018) 26 *Modern Law Review* 246; J. Coggon and C. Kong, 'From Best Interests to Better Interests? Values, Unwisdom and Objectivity in Mental Capacity Law' (2021) 80 *Cambridge Law Journal* 245.

14 For an overview see A.K.P. Sng and K.W. Tan, 'The Deputyship Regime under Singapore's Mental Capacity Act: An Introduction' (2020) 32 *Singapore Academy Law Journal* 167.

15 See section 3 of the Mental Capacity Act (Cap 177A, 2010 Revised Ed). See also S. Menon, 'The Mental Capacity Act: Implications for Patients and Doctors Faced with Difficult Choices' (2013) 42 *Annals of the Academy of Medicine of Singapore* 200.

16 There is uncertainty as to whether Singapore's Mental Capacity Act is consistent with Article 12 of the United Nation Convention on the Rights of Persons with Disabilities. The Singapore Government's position is that the Mental Capacity Act is compliant with the Convention. See *Implementation of the Convention on the Rights of Persons with Disabilities [:] Initial Report Submitted by States Parties Under Article 35 of the Convention—Singapore* (30 June 2016) UN Doc CRPD/C/SGP/1 45–47. However, this view is contentious given that the Mental Capacity Act operates on a substituted decision-making model instead of a supported decision-making model. See generally P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2018) 75 *Modern Law Review* 752; B.A. Clough, 'New Legal Landscapes: (Re)Constructing the Boundaries of Mental Capacity Law' (2018) 26 *Modern Law Review* 246.

17 See section 13 of the Mental Capacity Act (Cap 177A, 2020 Revised Ed). This is slightly different from the English Mental Capacity Act 2005. Under the English position, a lasting power of attorney for property and affairs (but not for health and welfare) *can* come into effect prior to loss of capacity. The Singapore position provides that a lasting power of attorney may only come into effect only after loss of capacity.

18 For an extremely contentious application to appoint a deputy see *ReBKR* [2013] 4 SLR 1257.

19 This is unsurprising given Singapore's history of advancing an Asian values approach to human rights. The debate on human rights and Asian Values is succinctly explained by L. Thio ''Pragmatism and Realism Do Not Mean Abdication': A Critical and Empirical Inquiry into Singapore's Engagement with International Human Rights Law' (2004) 8 *Singapore Year Book of International Law* 41.

20 The UK has implemented such a scheme. See for example: *In re J (An Adult) (Deprivation of Liberty: Safeguards)* [2015] 3 WLR 683, [95]–[97].

21 Mental Capacity Act 2005, sections 24–26. See e.g. *HE v A Hospital NHS Trust* [2003] EWHC 1017; *A Local Authority v E* [2012] EWHC 1639 (COP) for examples of litigation under these provisions.

22 Mental Capacity Act 2005, section 25. See *An NHS Trust v D* [2012] EWHC 885 (COP) where the absence of a witness invalidated an advance decision refusing life-sustaining treatment.

23 See T.E. Chan, 'The Elderly Patient and the Healthcare Decision-Making Framework in Singapore' in W.C. Chan (ed.), *Singapore's Ageing Population [:] Managing Healthcare and End-of-Life Decisions* (Routledge, 2011) 113, 128.

24 Cap 4A, 1997 Rev Ed. Noted by K.L. Ter and S. Leong, 'Advance Medical Directives in Singapore' [1997] MLR 63.

25 See section 3(1) of the Advanced Medical Directive Act (Cap 4A, 1997 Rev Ed).

26 S. Menon et al, 'Advance Care Planning in a Multicultural Family Centric Community: A Qualitative Study of Heal Care Professionals', Patients', and Caregivers' Perspectives' (2018) 56 *Journal of Pain and Symptom Management* 21.

27 Mental Capacity Act 2005, sections 30–34.

28 Mental Capacity Act 2005, section 31(2).

29 Mental Capacity Act 2005, section 31(4).

30 Mental Capacity Act 2005, section 31(5).

31 Mental Capacity Act 2005, section 31(6).

32 Mental Capacity Act (Cap 177A, 2010 Revised Ed) section 6(5A)(*a*).

33 Mental Capacity Act (Cap 177A, 2010 Revised Ed) section 6(5A)(*b*).

34 Application no. 45508/99, (2005) 40 EHRR 32.

35 For an excellent overview see P Bartlett and R Sandland, *Mental Health Law [:] Policy and Practice* (OUP, 2014), 208–235.

36 Cap 178A, 2012 Rev Ed.

37 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 7.

38 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 8.

39 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 9.

40 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 10(1).

41 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 10(2).

42 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 10(3).

43 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 10(5).

44 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 10(6).

45 Mental Health (Care and Treatment) Act (Cap 178A, 2012 Rev Ed) section 13.

46 Mental Capacity Act 2005, section 35. See also M Redley et al, 'Mental Capacity Act (England and Wales 2005: The Emergent Independent Mental Capacity Advocate (IMCA) Service' (2009) 40 *British Journal of Social Work* 1812.

47 Mental Capacity Act 2005, section 37.

48 Mental Capacity Act 2005, section 38.

49 Mental Capacity Act 2005, section 39.

50 Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 SI 2006/2883. See also M. Redley et al, 'Introducing the Mental Capacity Advocate (IMCA) Service and the Reform of Adult Safeguarding Procedures' (2011) 41 *British Journal of Social Work* 1058.

51 Speech by Minister of Community Development, Youth and Sports, Dr Vivian Balakrishnan, Second Reading of Mental Capacity Act, 15 September 2008 (available on Lawnet).

52 Office of Public Guardian, *2015/2016 Annual Report of the Office of Public Guardian*, 17.

53 See section 3 of the Mental Capacity Act (Cap 177A, 2010 Revised Ed).

54 See generally C. Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2013) 22 *MLR* 48.

55 R. Gilbar, 'Family Involvement, Independence, and Patient Autonomy in Practice' (2011) 19 *MLR* 192. See also Select Committee on Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-legislative Scrutiny* (HL 2013–2014, 139) paras 93–100 on the experience of families in England.

56 J. Herring, *Law and the Relational Self* (CUP, 2019) 111.

57 Ibid, 112.

58 R. Gilbar, 'Family Involvement, Independence, and Patient Autonomy in Practice' [2011] 19 *MLR* 192, 192. See also the excellent work on relational autonomy C. Kong, *Mental Capacity in Relationship* (CUP, 2017).

59 T. Carney, 'A Regional Disability Tribunal for Asia and the Pacific: Changing the Conversation to a 'Conversation'?' (2011) *International Journal of Law in Context* 323.

60 See B. Mahti and S. Mohamed *Unmet Social Needs in Singapore*, (Lien Centre for Social Innovation, 2011); I. Ng, 'Social Welfare in Singapore: Rediscovering Poverty and Reshaping' (2013) 23(1) *Asia Pacific Journal of Social Work* 35.

61 Mahti and Mohamed, ibid, p. 26.

62 See G.C. Pang and H.L. Wang, 'Welfare—Where Does Govt's Role End and the VWO's Begin?' *The Straits Times*, 6 April 1996 (Factiva). On the Singapore government's attitude towards inter alia nonprofit welfare organisations see H.W. Tang, 'Charitable Organizations in Singapore: From Clan Based to State Facilitated Endeavors' (2022) Nonprofit Policy Forum 49.

63 C. Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Puprose?' (2013) 22 *Modern Law Review* 48, 50 expresses the communitarian view of relational autonomy as follows 'no man is an island; that to throw a stone into the societal pool causes ripples that affect everything else in the pool'.

64 See M. Chen Wishart, 'Legal Transplant and Undue Influence: Lost in Translation or a Working Misunderstanding?' (2013) 62 *International and Comparative Law Quarterly* 1 where she demonstrates that the Singapore courts seem to be influenced by the idea of collective family interest in the law of undue influence and guarantees. The outsized role of the family in decision-making appears to be the case in South Asian families as well. See R. Gilbar and J. Miola, 'One Size Fits all? On Patient Autonomy, Medical Decision-Making, and the Impact of Culture' (2014) 23 MLR 375.

65 In England, some healthcare professionals have interpreted section 5 of the Mental Capacity Act 2005 widely and have used this provision, which was meant as a limited defence, to operate as *de*

facto substitute decision making. See A. Ruck Keene, 'Powers, Defences and the 'Need' for Judicial Sanction' (2016) 3 *Elder Law Journal* 244. Section 5 of the Mental Capacity Act 2005 is replicated in section 7 of Singapore's Mental Capacity Act. There has not been any literature in Singapore or reported cases where healthcare professionals have tried to use this section to justify healthcare professionals making substituted decision about the best interests of the person in consultation with the family.

66 J.A. Chong et al, 'Patient and Family Involvement in Decision Making for Management of Cancer Patients at a Centre in Singapore' (2015) 5(4) *BMJ Supportive & Palliative Care* 420.

67 L. Krishna and S. Menon 'Understanding the Practice of Collusion on End of Life Care in Singapore' (2014) JMED Research, DOI: 10.5171/2014.543228. The phenomenon is also observed in other East Asian, South Asian and Middle Eastern societies. See Gilbar and Miola (n 64), 378–379.

68 This case study is narrated in L. Krishna, D. Watkinson and L.B. Ng, 'Limits to Relational Autonomy—The Singaporean Experience' (2015) 22 *Nursing Ethics* 331.

69 On vulnerable persons see J. Lewis, 'Safeguarding Vulnerable Autonomy? Situational Vulnerability, the Inherent Jurisdiction, and Insights from Feminist Philosophy' (2021) 29 *Medical Law Review* 306.

70 Ibid, 333.

71 Ibid, 338.

72 N. Naffine, 'In Praise of Legal Feminism' (2002) 22 *Legal Studies* 71 at 83–84; R. West, 'Jurisprudence and Gender' (1988) 55 *University of Chicago Law Review* 1.

73 M.J. Radin, 'Market-Inalienability' (1987) 100 *Harvard Law Review* 1849, 1904.

74 Ibid, 1904.

75 Kong (n 58), 67.

76 Ibid. Kong writes that 'socialization and relationships can intensify … vulnerabilities and impede the development of autonomy'.

77 Jonathan Herring, *Vulnerable Adults and the Law* (OUP, 2016), 66–67.

78 Herring (n 56), 122.

79 See e.g. See Gilbar and Miola (n 64) for valuable work on reconciling autonomy within relationships. For a recent attempt on constructing a theory of relational autonomy in the context of mental capacity see Kong (n 58).

80 The concept of autonomy and capacity is a contested idea. See P. Skowron, 'The Relationship Between Autonomy and Adult Mental Capacity in the Law of England and Wales' (2019) 27 *Medial Law Review* 32.

81 L. Krishna, D. Watkinson and L.B. Ng, 'Limits to Relational Autonomy—The Singaporean Experience' (2015) 22 *Nursing Ethics* 331; L. Krishna and R. Alsuwaigh, 'Understanding the fluid nature of personhood—the ring theory of personhood' (2015) 29 *Bioethics* 171; L. Krishna et al, 'The Influence of the Family in Conceptions of Personhood in the Palliative Care Setting in Singapore and Its Influence Upon Decision Making' (2014) 31 *American Journal of Hospital Palliative Care* 645; L. Krishna, 'Best Interests Determination within the Singapore Context' (2012) 19 *Nursing Ethics* 787.

82 L. Krishna, D. Watkinson and L.B. Ng, 'Limits to Relational Autonomy—The Singaporean Experience' (2015) 22 *Nursing Ethics* 331, 335.

83 L. Krishna, 'Best Interests Determination within the Singapore Context' (2012) 19 *Nursing Ethics* 787.

84 L. Krishna, D. Watkinson and L.B. Ng, 'Limits to Relational Autonomy—The Singaporean Experience' (2015) 22 *Nursing Ethics* 331, 337.

85 Ibid.

86 T.E. Chan, N.S. Peart and J. Chin, ‘Evolving Legal Responses to Dependence on Families in New Zealand and Singapore Healthcare’ (2014) 40 *Journal of Medical Ethics* 861. Their model is based on H.E. Ern Jr, et al, ‘The Difference That Culture Can Make in End-of-Life Decision Making’ (1998) 7(1) *Cambridge Quarterly of Healthcare Ethics* 27.

87 This is found in the well-known decision of *Royal Bank of Scotland v Etridge (No 2)* [2002] 2 AC 773 which has been applied in Singapore in *Sudha Natraja v Bank of East Asia* [2017] 1 SLR 141.

88 A. Ho, ‘Relational Autonomy or Undue Pressure? Family’s Role in Medical Decision-Making’ (2008) 22 *Scandinavian Journal of Caring Science* 128, 133.

89 *Re T (Adult: Refusal of Treatement)* [1992] 4 All ER 649.

90 Ho (n 88), 133.

91 See also I. Hyun, ‘Waiver of Informed Consent, Cultural Sensitivity, and the Problem of Unjust Families and Traditions’ (2002) 32(5) *Hastings Center Report* 14, 20.

92 J. Craigie, ‘Conceptualising “Undue Influence” in Decision-Making Support for People with Mental Disabilities’ (2021) 29 *Medical Law Review* 48.

93 *Royal Bank of Scotland v Etridge (No 2)* [2002] 2 AC 773, [65]. This has been applied in Singapore in *Sudha Natraja v Bank of East Asia* [2017] 1 SLR 141.

94 Ho (n 88), 133 argues that if the patient wishes to adhere to his or her family’s recommendation, it is counterproductive to reject the patient’s decision. This is because the healthcare professional will be unfamiliar with the patient’s family dynamics. See Hyun (n 91) who comes up with a framework which is similar to the protocol proposed in this article. See also *Re T (Adult refusal of treatment)* [1993] Fam 95 where Lord Donaldson said ‘It is wholly acceptable that the patient should have been persuaded by others of the merits of such a decision and have decided accordingly’.

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