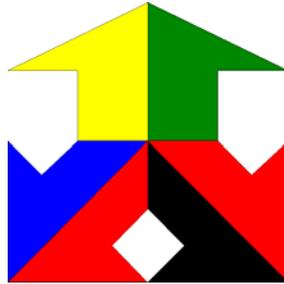


SOUTH AFRICAN LAW COMMISSION



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INCAPABLE ADULTS

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Introduction

The South African Law Commission was established by the South African Law Commission Act, 1973 (Act 19 of 1973).

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The researcher allocated to this project is Ms A-M Havenga.

Preface

This issue paper was prepared to serve as a basis for the Commission's deliberations.

The issues raised need to be debated thoroughly. The comments of all parties who are interested in these issues are of vital importance to the Commission.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are marked confidential. Respondents should be aware that the Commission may in any event be required to release information contained in representations under the Promotion of Access to Information Act, 2000 (Act 2 of 2000).

Respondents are requested to submit written comment, representations or requests to the Commission by **28 February 2002** at the address appearing on the previous page. Any request for information and administrative enquiries should be addressed to the Secretary of the Commission or the researcher allocated to this project, Ms A-M Havenga.

This document is also available on the Internet at: www.law.wits.ac.za/salc/salc.html.

Contents

	Page
Introduction	i
Preface	ii
Background	1
Purpose of this issue paper	1
Questionnaire	2

Background

The South African Law Commission is currently involved in an investigation on the need for measures to protect the interests of adults whose capacity to act and to litigate has for some reason been diminished. The investigation is aimed at enhancing such diminished capacity or dealing with it in ways that will assist such persons, their families and caregivers.

This investigation does not deal with the care (including reception and detention in institutions), treatment and rehabilitation of mentally ill persons. These issues are regulated by the Mental Health Act, 1973 (Act 18 of 1973 [the Mental Health Act]) which is in the process of being updated and replaced by the Mental Health Care Bill, 2001 (B 69-2001 [the Mental Health Care Bill]), currently before Parliament. The investigation is also not concerned with the rights of the elderly in general. Draft legislation on the status of the elderly, following on the Report of the Ministerial Committee on Abuse, Neglect and Ill-treatment of Older Persons published in February 2001, is currently being developed by the Department of Social Development. These developments have been noted and will be taken into account in the course of the Commission's investigation. The investigation is limited to "adults": for purposes of this investigation persons of 21 years and above – the age at which the law currently confers full capacity to act and to litigate. The Commission is currently considering the protection of the rights of children in general under its review of the Child Care Act, 1983 (Act 74 of 1983). A Discussion Paper in this regard is currently being prepared.

Purpose of this issue paper

The issue paper aims to announce the investigation on incapable adults, clarify its aim and extent, and suggest broad possible options available for solving existing problems. Its purpose is to initiate and stimulate debate, to seek proposals for reform and to serve as a basis for further deliberation.

Following the issue paper, the Commission will publish a discussion paper setting out preliminary recommendations and draft legislation, if necessary. The discussion paper will take the public response on the issue paper into account and will test public opinion on solutions identified by the Commission. On the strength of these responses a report

will be prepared with the Commission's final recommendations. The report (with draft legislation, if necessary) will be submitted to the Minister of Justice for his consideration.

The issue paper is presented in the form of a questionnaire. It includes questions relating to the need for reform in general, and to specific issues relevant to decision-making capacity (including matters relating to personal welfare, financial matters, and health and medical matters). It raises questions regarding possible solutions in the form of provision for substitute decision-makers and future incapacity. It also poses the question whether reform should encompass issues related to behaviour by mentally incapacitated persons.

Respondents are requested to respond as comprehensively as possible and are invited to raise additional issues which are not covered in the questions, should they wish to do so.

The Commission especially invites persons with early stage dementia (a broad term referring to a condition in which a person's cognitive functions decline) and families, caregivers and friends of persons with dementia to respond to this call for comments.

Questionnaire

1. The need for and possible scope of reform

Diminished capacity can be the result of mental illness, inability to communicate because of a physical or other disability, head injury, stroke, learning disability, a specific disease (including diseases such as Alzheimer's and Parkinson's diseases) or may be related to ageing in general. In some cases incapacity is relatively short-term, in others mental capacity is lost and may never be recovered, while some people have never had the capacity to make decisions about their own affairs because of congenital conditions or conditions which developed early in their lives. In the case of older persons or persons with diseases such as Alzheimer's, incapacity develops gradually and unpredictably and depends not only on the specific patterns of cognitive impairment characteristic to the individual's condition, but also on the specific decisions he or she is facing.

Since incapacitation can result from unexpected acute illness or injury as well as long-term degenerative conditions, every competent individual is to some degree vulnerable to the possibility of becoming incapable. The probability of incapacitation however increases with age – while actual life expectancy has increased, the expectancy of life without disability has not. Furthermore, current medical science holds out little hope that the chronic, non-lethal degenerative diseases of old age can be significantly prevented or delayed.

The principles governing mental incapacity are the same, irrespective of how the incapacity was caused.¹ Any mental incapacity that affects a person's intellect and judgment will in terms of South African private law affect his or her capacity to act in the legal sense (eg to enter into a contract) and to litigate (i e to appear in court as a party to a suit). These capacities depend on whether the person in question is "insane" or not at the relevant time. A person is insane if he or she is incapable of managing his or her affairs. An insane person's capacity to act is

¹ For the general legal position see DSP Cronjé and Jacqueline Heaton **The South African Law of Persons** Durban: Butterworths 1999 33-35, 113-121; Belinda van Heerden et al **Boberg's Law of Persons and the Family** Second edition Kenwyn: Juta & Co 1999 105 et seq.

determined by common-law principles as extended by the courts and is currently not all regulated by legislation. Current statutory measures applicable to mentally ill persons (the Mental Health Act) must be distinguished from the common-law principles and apply to the reception, detention and treatment of mentally ill persons.² Measures contained in the Act concerning the care and administration of the property of a mentally ill person likewise only relate to “patients” (i.e. persons detained, supervised, controlled and treated in terms of the Act).

At present the legal solution to the problem of persons who cannot manage their own affairs takes the form of curatorships: A curator can be appointed by the court to an individual’s person (a *curator personae*) to see to his or her personal welfare (including making decisions eg on where the person should stay, and whether he or she should be admitted to an institution or undergo medical treatment). A *curator bonis* can be appointed to protect the proprietary interests of a mentally incapacitated person. In addition to these, an individual can allow another to act on his or her behalf, for certain purposes or generally, through a power of attorney. However, for a power of attorney to be valid, the person granting the power must have contractual capacity. A change of status (which could be caused by insanity) will thus terminate the agency.

The existing system of curatorships has been criticised on the ground that it suffers from a number of serious and frustrating difficulties.³ These include difficulties relating to high costs, prolonged procedure, their paternalistic nature, and potential for abuse. The problem of a power of attorney ceasing on incapacity has also caused concern. As early as 1988 the Commission undertook an investigation with a view to improving the plight of mentally incapacitated persons. The Mentally Ill Persons’ Legal Interests Amendment Act, 1990 (Act 108 of 1990), which amended the Mental Health Act, was adopted as a result of the Commission’s recommendations. This amendment addressed the

² The objects of the Mental Health Care Bill (“(T)o provide for the care, treatment and rehabilitation of persons who are mentally ill”) are similar (see the long title of the Bill).

³ See eg C Neumann “Curatorship – a Test of Endurance” in **De Rebus** June 1998 61-64; Harry Barker “On General Powers of Attorney” **De Rebus** April 1996 259-260.

need for a simple and inexpensive procedure for the appointment of a curator of property to a person who is *not declared* to be mentally ill, but whom the applicant believes to be suffering from mental illness to such an extent that the person is incapable of managing his or her own affairs. Recommendations by the Commission for the provision of *enduring* powers of attorney (i.e. for providing that a power of attorney remain in force despite the fact that the principal has become mentally incapacitated) were, however, not promoted by the government at the time.

The number of persons suffering from diminished capacity are increasing world-wide and also in South Africa. The aged population (i.e. the elderly over pensionable age) in South Africa currently consists of about 7% of the total population.⁴ Many of these persons will gradually lose their ability to administer their assets and to care for themselves. The number of persons with dementia are also increasing and although little is known about the specific prevalence of dementia in South Africa, it is expected that it would increase because of the ageing of the population in accordance with world-wide trends.⁵ Moreover, in 1996 7% of the South African population was classified as disabled. These included persons suffering from disabilities relating to sight and hearing as well as mental disabilities.⁶

Section 27 of the Constitution⁷ guarantees the right of all citizens to have access to health care services and to social security, “including, if they are unable to support themselves and their dependants, appropriate social assistance”. Moreover, it obliges the government to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.

⁴ “Mothers and Fathers of the Nation: The Forgotten People?” **Report of the Ministerial Committee on Abuse, Neglect and Ill-Treatment of Older Persons** Department of Social Development: February 2001.

⁵ “The Demography of Ageing around the World” **Factsheet 4** Alzheimer’s Disease International: March 1999.

⁶ **Census in Brief** (Based on “The People of South Africa - Population Census 1996” Report 03-01-11 [1996] published by Statistics South Africa) 33.

⁷ The Constitution of the Republic of South Africa, 1996 (Act 108 of 1996).

In several comparable legal systems enduring powers of attorney have been introduced in the 1980's. More recently comprehensive legislative schemes to deal with the problems faced by incapable adults, their families and caregivers have been introduced through law reform. The latter include reform in England, Australia, Canada and most notably and recently in Scotland. In some of these countries completely new systems comprising substitute "decision-makers" have replaced old and intrusive systems which required appointment of public officials where it was unnecessary. The Commission is guided by the reform done in these countries in conducting its investigation.⁸

Questions

- 1.1 Do you regard the existing common-law measures applicable to incapable adults as appropriate and sufficient in view of world-wide law reform and the increase in the ageing population?
- 1.2 What are the practical problems encountered by incapable adults that should be dealt with by the law?
- 1.3 Are new measures necessary to replace, enhance or supplement the system of curatorships? What form should these measures take and how comprehensive should they be, or should they be limited to the introduction of enduring powers of attorney as recommended by the Commission in 1988?
- 1.4 Are there any empirical or other studies available that demonstrate the extent of the problems faced by persons who lack decision-making ability in South Africa?

⁸ Cf The Law Commission Consultation Paper No 119 **Mentally Incapacitated Adults and Decision-Making: An Overview** London: HMSO 1991; The Law Commission Consultation Paper No 128 **Mentally Incapacitated Adults and Decision-Making – A New Jurisdiction** London: HMSO 1992; Scottish Law Commission Discussion Paper No 94 **Mentally Disabled Adults – Legal Arrangements for Managing their Welfare and Finances** Scotland: HMSO 1991; Scottish Law Commission **Report on Incapable Adults** Edinburgh: HMSO 1995; Scottish Executive **Making the Right Moves – Rights and Protection for Adults with Incapacity** Scotland: The Stationary Office Ltd 1999; Queensland Law Reform Commission Report No 49 **Assisted and Substituted Decisions** Brisbane: The Print People 1996.

2. The concept of capacity

Traditional approaches to “competence” (or capacity) assumed that competence is determinate and discoverable and that the legal concept of competence is an either/or position. However, the medical fraternity does not agree and knows that what the law calls “competency” is in fact “a set of deductions from a variety of clinical data that can be as subject to influence and change as the more basic mental attributes on which it is based”.⁹ The commonplace conception of competence presupposes that it has an essence and that this essence is static and definable. However, there is a vast array of diminished mental states which vary not only from person to person but within individuals. Inquiries concerning competence are thus intensely contextual and a definition applicable to every individual or situation is not easily achieved.

In comparable legal systems where reform has been effected, defining “competence” or related concepts has proved to be a major problem.

Questions

- 2.1 Is the current approach of the law in defining “competence” (or capacity) still appropriate?
- 2.2 Is there a need for mechanisms to identify more clearly “capacity” for legal purposes? Are the current legal “tests” for capacity accessible to lay people?
- 2.3 How should “capacity” (or “incapacity”) be defined in the context of lack of decision-making ability? What should be the premise or crucial aspects of such definition?

3. Personal care and welfare

The law currently provides for a *curator personae* to be appointed by the court to an individual’s person to see to his or her personal care, custody and welfare. A

⁹ R Rubinson “Construction of Client Competence and Theories of Practice” **Arizona State Law Journal** Spring 1999 121-159 at 126.

curator personae is usually appointed where, because of advanced age or mental or physical incapacity, a person is found to be incapable of managing his or her own personal and health affairs and can be appointed either generally or for a specific purpose. Rule 57 of the Uniform Rules of Court¹⁰ prescribes the procedure for such appointment. A substantial degree of evidence is required before appointing a curator. Having a curator appointed to an individual's person constitutes a serious inroad into rights and liberties and drastically diminishes his or her legal status, and our courts are reluctant to make these appointments. A *curator personae* will typically have to take decisions regarding where the person should live; whether he or she should be admitted to an institution or be cared for at home; whether he or she should undergo medical treatment or an operation and by whom it should be performed. There are limits to the scope of a *curator personae*'s functions: some acts are of too personal a nature to be performed by a legal representative (eg contracting a marriage, seeking a divorce, exercising parental power and making testamentary dispositions on behalf of the person under curatorship).

As indicated under paragraph 1 above, the system of appointing curators to persons has in general been criticised because of its expense, because it is time-consuming and cumbersome, because the person in respect of whom the curator is to be appointed invariably has very little say in the choice of curator and because it restricts personal liberty. Calls for a readily available, inexpensive measure which would clearly define the powers of the curator or decision-maker have been made since the 1980's.

Questions

- 3.1 The current system of appointing *curators personae* to assist mentally incapacitated persons with decisions regarding their care and personal welfare, is not being utilised by incapable adults, their families and caregivers. In your experience, what might be the reasons for this?

¹⁰ The Rules Regulating the Conduct of the Proceedings of the Several Provincial and Local Divisions of the Supreme Court of South Africa **Government Gazette** R 48 of 12 January 1965, as amended.

- 3.2 What are the practical problems experienced by incapable adults that should be catered for by a system of substitute decision-making regarding personal care and welfare?
- 3.3 Would you suggest that the current system of *curator personae* be replaced or done away with? What type of mechanism do you envisage should take its place?
- 3.4 To what extent could the introduction of enduring powers of attorney assist in alleviating problems currently experienced with the curatorship system?
- 3.5 In many cases a close friend or family member will be the obvious choice for appointment as decision-maker regarding an incapable adult's personal care and welfare. Some legal systems have general restrictions against people whose interests are likely to conflict with those of the incapable adult. Should the role of family members and/or caregivers be acknowledged by granting them a formal role in decision-making regarding personal care and welfare of incapable adults?
- 3.6 Is there a need for emergency procedures to protect an incapable adult, eg from neglectful or exploitative relatives or caregivers, or someone who is able to care for him or her but is not fit for this purpose?

4. **Managing property and financial affairs**

Under current law a *curator bonis* may be appointed by the court to take care of a mentally incapacitated person's property and supplement the person's lack of capacity to contract. As is the case with the *curator personae*, a *curator bonis* may be appointed on application of any interested person when an individual is found to be incapable of managing his or her own financial or property affairs. A *curator bonis* must defer to the incapable individual should the latter's legal capacity revive during a lucid interval. (A *curator bonis* may also be appointed in

terms of the Mental Health Act to administer the property of a mentally ill patient or a person suffering from a mental illness.¹¹⁾

The criticisms levelled at the curatorship system in general (expensive, prolonged and cumbersome) and referred to above under paragraphs 1 and 3 also apply in respect of curatorship of an incapable adult's property and financial affairs. In addition, the fact that it concerns a fiduciary relationship has also elicited the following concerns which emphasise disadvantages for the individual concerned as well as the curator:

- In spite of many safeguards and controls of the curator's functions through the Master's office,¹² there remains the potential for abuse, neglect or maladministration.
- The process of preparing the required annual account¹³ is time-consuming and often does not warrant the curator's statutory fee.
- The *curator bonis*, in spite of being limited to administering the property of the incapable person, cannot avoid becoming involved in the day-to-day needs of the patient which are financially related.

Questions

- 4.1 The current system of appointing a *curator bonis* to administer the property of a mentally incapacitated person is not utilised by incapable adults, their families and caregivers. In your experience, what might be the reasons for this?
- 4.2 What are the practical problems experienced by incapable adults and their curators that should be catered for by a system of substitute decision-making regarding the administration of property?

¹¹ See section 56 and 56A of the Mental Health Act. The Mental Health Care Bill contains broadly similar provisions with regard to the appointment of an *administrator* for the care and administration of property of mentally ill persons or persons with severe or profound intellectual disabilities (clause 59).

¹² Refer to Chapter IV of the Administration of Estates Act, 1965 (Act 66 of 1965 [the Administration of Estates Act]) for provisions regulating the functions of curators.

¹³ See section 83 of the Administration of Estates Act for requirements regarding the annual account.

- 4.3 Would you suggest that the current system of *curator bonis* be replaced or done away with? What type of mechanism do you envisage should take its place?
- 4.4 Is it practical to draw a distinction or make division between the care of an incapable adult's financial affairs and property, and his or her personal care and welfare? For instance, how is it possible in practice for a curator who has no control over the adult's finances, to make a meaningful decision about where he or she should live? Does strict separation of these powers make sense?
- 4.5 To what extent could the introduction of enduring powers of attorney assist in alleviating problems currently experienced with the curatorship system?

5. Medical and health-related decisions

Medical and health-related issues that involve decision-making capacity could include decisions regarding routine medical treatment, participation in medical research, and end-of-life decisions. The Commission dealt with end-of-life decisions in respect of incompetent persons in its Report on Euthanasia and the Artificial Preservation of Life which was published in 1998 and this issue will not receive attention under the current investigation.¹⁴

¹⁴ The Commission at the time recommended the enactment of legislation to give effect to certain principles. The Commission's Report with proposed draft legislation was referred to the Minister of Health in 1999. The Report was tabled in Parliament in 2000. The proposed legislation has not been implemented yet. As far as the position of mentally incompetent patients (i.e. patients who cannot make their own decisions) who have no prospect of recovery or improvement are concerned, the following was recommended (see p x-xxvi, 19, 153-188, 188-205 and 206-208 of the **South African Law Commission Report on Euthanasia and the Artificial Preservation of Life** R/P 186/1999):

Refusal or cessation of life-sustaining medical treatment:

- * Where there *is* an advance directive (living will) or power of attorney regarding the refusal or cessation of medical treatment or the administering of palliative care, a medical practitioner may under specified circumstances give effect to these instructions provided that they have been *issued by the patient while still mentally competent*.
- * Where there is *no* advance directive (living will) or power of attorney, a medical practitioner may under specified circumstances cease or authorise the cessation of such treatment provided that his or her conduct is in accordance with the wishes of the family (i.e. spouse, parent, child, brother or sister) of the patient, or authorised by a court order.
- * In the case of a person in respect of whom a curator to the person has been appointed and in respect of whom no advance directive (living will) or power of attorney has been

The current principles that apply to the appointment of a *curator personae* have been discussed in paragraph 3 above. One of the areas in respect of which a *curator personae* may make decisions on behalf of the incapable individual is medical treatment. A *curator personae* could thus decide on whether a person under his or her curatorship should undergo medical treatment or an operation. (The Mental Health Act contains specific provisions with regard to consent to medical treatment of or an operation on a “patient” [i.e. a mentally ill person who is detained or treated in an institution under the Act].¹⁵)

The same criticism levelled at the curatorship system in general, and specifically at the appointment of *curators personae* as discussed in paragraphs 1 and 3 above, will apply in respect of decisions regarding medical treatment.

As regards consent to participation in research, the position is less clear.¹⁶ In comparable legal systems different approaches have been followed: In Scotland,

issued, the decision-making regarding refusal or cessation of life-sustaining medical treatment shall, in the absence of any court order or the provisions of any other Act, vest in such curator.

Active euthanasia (i.e. making an end to a patient's suffering, or enabling the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent):

The Commission did not make specific recommendations in this regard, but set out different options to deal with the issue. None of the options suggested allowed for active euthanasia to be performed on a mentally incompetent person.

¹⁵ Section 60A provides that a *curator personae*, or the patient's spouse, parent, major child or brother or sister (in this order of preference) may consent to medical treatment or an operation on a patient who on account of his or her mental illness is not capable of consenting.

¹⁶ It has been said that section 12(2) of the Constitution (which provides that “everyone has the right to bodily and psychological integrity, which includes the right ... not to be subjected to medical or scientific experiments without their informed consent”) implies that only the person who is capable of giving consent to medical research, is the research subject and that surrogate consent to medical research is out of the question. This would however apply only where the research is of a *non-therapeutic* nature (i.e. a procedure that is not expected to provide benefit to individual subjects, but may provide benefit to society). (It should be noted that these remarks have been made with regard to mental “patients” i.e. mentally ill persons detained and treated under the current Mental Health Act.) In response to this view it has been suggested that current ethical guidelines providing for *therapeutic* research (i.e. procedures that holds out the prospect of direct benefit for the individual subject) as well as *non-therapeutic* research on persons who are not capable of consenting to such procedures should be regarded as law of general application for purposes of section 36 of the Constitution (i.e. surrogate consent to medical research for therapeutic and non-therapeutic purposes, presenting negligible risk, should be allowable under certain circumstances) (cf. C van Wyk “Guidelines on Medical Research Ethics, Medical ‘Experimentation’ and the Constitution” *Journal of Contemporary Roman-Dutch Law* February 2001 3-22).

for instance, it has been recommended that medical research should be carried out on adults incapable of consenting to participation under very specific and strict circumstances only - including that the research should be into the causes, treatment or care of the adult's incapacity or disease; that it be carried out only with the written consent of the adult (while capable) or his or her guardian or welfare attorney or, in the absence of any of these, the adult's nearest relative. The adult concerned must not appear unwilling to participate in the research.¹⁷

Questions

- 5.1 Do incapable adults, their families and caregivers use the current system of substitute decision-making in terms of which a *curator personae* can consent to medical treatment of an incapable adult? If not, why not?
- 5.2 Are there any practical problems regarding consent for medical treatment which are not catered for by the current curatorship system, and if yes, what are they?
- 5.3 Would introduction of the concept of enduring power of attorney alleviate any problems regarding consent for medical treatment which may currently exist?
- 5.4 Would an alternative system of decision-making regarding consent for medical treatment better suit the needs of incapable adults and what would the characteristics of such a system be?
- 5.5 What principles should govern the participation of incapable adults in medical research?

6. Provision for future incapacity

It has been widely suggested that the introduction of the device of an *enduring* power of attorney would meet many of the needs of incapable adults in South Africa. As indicated under paragraph 1 above, the availability of an enduring

¹⁷ Scottish Law Commission **Report on Incapable Adults** Edinburgh: HMSO 1995 80-81.

power of attorney would enable an agent to continue acting on behalf of a principal after the principal has become incapacitated.

Internationally, enduring powers of attorney (or similar mechanism) have been implemented to provide for future incapacity of incapable adults. There are several reasons for its popularity:

- It is a convenient mechanism. An agent, for example, who has been managing the affairs of an elderly relative is familiar with the affairs of the principal, is presumably trusted by the principal, and is therefore in the best position to continue the management role after the onset of incapacity.
- It is a device which has the virtues of privacy, simplicity and cheapness - in contradistinction to the complex, cumbersome and expensive court procedure to have a curator appointed.
- It is often difficult to determine at what point a principal becomes incapable. An elderly person, with Alzheimer's disease for instance, will have periods of lucidity and periods of confusion. This can continue for years. Permitting an agent, who has been appointed with this possibility in mind, to continue to operate the power whether the principal is competent or not, avoids the need to determine when the person would be classed as legally incapable.
- It allows the principal to plan for the future.
- It allows the principal to choose who is to manage his or her affairs.
- It avoids the stigma of the principal having to be declared incapable.

Arguments raised against the introduction of enduring powers of attorney when the Commission recommended its introduction in 1988, included the following:

- The concept of enduring power of attorney is foreign to the South African legal system and should therefore not be introduced.
- Introduction of this device would lead to malpractices, abuse and exploitation of mentally incapacitated persons.
- Its application would prove to be severely limited (since it will not offer a solution to those who have suffered from mental incapacity since childhood or those who postpone the granting of such a power until it is too late, and since few people would be prepared to leave their personal affairs in the hands of another). Parliament does not legislate for exceptions.

Questions

- 6.1 Is there a need for introducing the concept of an ongoing or enduring power of attorney in our law?
- 6.2 What standard of capacity should be required of a principal to execute an enduring power of attorney? Should it be the ability to understand the consequences of entering into a power of attorney, or should the required capacity also include sufficient understanding to comprehend all the activities that the attorney might undertake when using the power?
- 6.3 How broad should the authority to be given to agents under enduring powers of attorney be? Should it be possible to use an enduring power of attorney to provide authority for decision-making on matters relating to an incapable adult's personal welfare and health-related issues; or should enduring powers of attorney be limited to decision-making authority over financial matters?
- 6.4 If enduring powers of attorney are to include authority to make health-related decisions, (i.e. to consent to medical treatment), should consent to sensitive treatments such as sterilisation and chemotherapy be permitted by the legislator?
- 6.5 What safeguards would be necessary in respect of enduring powers of attorney to protect sufficiently the principal who has become incompetent without it becoming a cumbersome, bureaucratic device which is little different from formal curatorship? For instance, requiring all or some of the following: registration; execution formalities (such as independent witnessing or the principal's execution of the enduring power, independent legal advice before execution, and/or notification of the principal's relatives as requirement for validity); certain standards of behaviour from the agent; provision for termination under certain circumstances; requiring the enduring power to be in a standard form prescribed by legislation; and making legislative provision for control over the agent.

6.6 What would be an effective and sufficient supervisory framework for enduring powers of attorney?

7. Other issues of concern

- **Individual autonomy and public safety**

Although this investigation is primarily concerned with the loss of decision-making ability, legal and ethical issues may also arise because of disordered behaviour and mood or psychiatric state of persons with dementia or mental disabilities.

An individual with declining capacity wants to continue to act as he or she always has, but is unable to judge appropriately his or her ability to perform tasks. Activities which could create dilemmas in this regard and which pose safety hazards could include the following: driving a motor vehicle, handling or using dangerous objects (eg a firearm), and practising specific professions (eg medicine).

Questions

7.1 Do practical problems arise with regard to the issues referred to which the law does not currently adequately cover, and could you supply the Commission with information on these problems?

7.2 Is there a need for legislation formally to regulate the behaviour of incapable adults and the possible liability of their family, caregivers or health care providers with regard to the issues mentioned above? What principles should guide restrictions on incapable adults and liability of family, caregivers or health care providers?

7.3 How can the personal autonomy of incapable adults and public safety be balanced in controlling behaviour which may pose a safety risk?

7.4 Should a diagnosis of dementia (or mental illness, or disability which entails incapacity) be reported to a state agency (eg the Department of Health or the traffic authorities)?

- **Issues not covered in this paper**

Questions

7.5 Are there any issues not mentioned in this questionnaire which should receive attention under this investigation with a view to law reform? Please motivate your request/s.

8. Some broad options for reform

Possible broad options for reform in respect of substitute decision-making on behalf of incapable adults could include some or a combination of the following. The decision whether to deal with reform on an ad hoc basis or to deal with it more comprehensively (as discussed under paragraph 9 below) will be indicative of which option (or combination of options) could be a solution.

- **Providing for future incapability**

- ▶ ***Applying the concept of “advance directive”***

The term “advance directive” is more generally used in the context of end-of-life decisions. The concept (to enable competent persons to give instructions about what they wish to be done, or who they wish to make decisions for them, if they subsequently become incapable) can however also be applied to other decisions. Advantages could include the following:

- It could be the least intrusive form of substitute decision-making.
- It can give the person concerned the assurance that his or her expressed wishes will be followed and his or her autonomy respected.
- The incapable adult will have the confidence of knowing that the person he or she has selected will be making decisions on his or her behalf.

- It could provide certainty – third parties will know that wishes have been expressed and that a representative has been selected to act when it becomes necessary.

Disadvantages could include the following:

- Some people will never have sufficient capacity to use advance directives while others will retreat from the idea of planning in advance until too late – use of an advance directive requires forethought and obtaining proper advice.
- The problem of providing for the exact time of onset of the directive will still exist.

► ***Extending the concept of the enduring power of attorney***

The concept of the enduring power of attorney could be extended beyond the scope of financial and property administration and granted also in respect of personal care and welfare, and/or in respect of health and medically related decisions. The characteristics of the enduring power of attorney have been set out in paragraph 6 above. The power of attorney could also be further refined by providing for a “springing” power of attorney which does not, as the enduring power of attorney commence before the principal become incapacitated, but remains dormant until a specific contingency (eg the incapacity of the principal) occurs.

- **Providing for designated decision-making procedures**

The following three possibilities exist:

- Certain alternative decision-makers, who would automatically make decisions for someone unable to make them, could be identified in legislation. The choice of decision-maker could vary according to the type of decision and might be a single individual or a combination of people. Alternative decision-makers could, depending on the circumstances, include a representative already formally appointed (eg a curator); a responsible professional; the primary caregiver of the incapable adult; a family member; a combination of professional, primary carer and family; a court, tribunal or other authority.
- A particular area for prescribed decision-making without legal formalities could be identified in legislation - eg that of consent for medical treatment

where legislation could regulate who should decide under specific circumstances.

- ▶ A scheme by which the minority of incapable adults is extended would give recognition to a legal role for parents or guardians of mentally incapacitated children beyond the age of 18.

- **Improve existing procedures**

It might be possible to update, upgrade, expand and improve on the existing curatorship system by addressing the various shortcomings identified.

- **Decision-making by a multi-disciplinary committee or tribunal**

The object of this approach would be to provide a single forum (eg a multi-disciplinary committee or tribunal) which would be capable of handling every type of decision on behalf of mentally incapacitated people. Such a forum could, for instance, be the final decision-maker in a graduated decision-making process. This approach should aim to provide a flexible, single-door procedure which enables expertise from a number of different disciplines to be brought to bear upon the particular problem quickly and without undue procedural obstacles or expense.

- **Advocacy**

An advocate would be someone (a relative, volunteer or professional) who undertakes the responsibility of explaining the situation from the patient's point of view, rather than assuming authority over him or her. This may involve pleading his or her case and generally taking such action as may be necessary on the incapable adult's behalf to secure the services required and enabling the individual to enjoy his or her rights in full.

- **A new statutory dispensation**

This would require introducing a completely new and revamped system of substitute decision-making catering for the various and specific needs identified

by the Commission. This approach has been followed for instance in Scotland, where a comprehensive system of protection of the rights of incapable adults has been introduced recently. A major aim of this approach would be to avoid the gaps, fragmentation and confusion which might exist under the present legal system.

Questions

- 8.1 Indicate which of the broad options described would in your opinion and experience be the most suitable to address problems relating to decision-making capacity of incapable adults in our legal system. Please motivate your choice.

9. Possible approaches to reform

It will assist the Commission considerably if it could have a clear idea of what would be realistic to achieve as regards reform of the law in the area under investigation. Although a change to the law could bring relief to incapable adults, their families and caregivers, there could be problems which the law will not be able to solve. Law reform is inevitably influenced by broad social policy issues, professional practice, ethics, and the availability of resources.

In this context the approach to reform could be one of ad hoc amendments or additions to provide for the most pressing needs, for instance by confirming the Commission's 1988 recommendation that the concept of an enduring power of attorney be introduced in our law. This would probably bring speedy relief but will not address the apparent underlying dissatisfaction with the curatorship system. It will not encompass the recommendation of possible alternative systems for substitute decision-making and will not consist of comprehensive reform. On the other hand a review of the law could be necessary or desirable which might, as in certain comparable legal systems, result in recommendations for comprehensive law reform relating to substitute decision-making.

The principles and values which should underpin legislative reform for dealing with the affairs of mentally incapacitated persons have been the subject of much

debate in legal systems where reform has been effected. These principles and values are important, as they may be indicative of solutions to specific problems. Some of the principles and values which have been favoured to a greater or lesser degree in comparable systems include the “best interest” approach (which is basically derived from child-care law and presents a more paternalistic and restrictive approach); the substituted judgment standard (which prefers the decision which the incapacitated person would have made had he or she been competent to do so); and the normalisation approach (i.e. treating incapacitated persons as much like other people as possible and encouraging them, as far as is possible, to make decisions for themselves).

Questions

- 9.1 What would be the appropriate general approach to adopt? Would ad hoc amendments to the current law suffice in addressing the needs of incapable adults, their families and caregivers; or is a more comprehensive review of the law called for?
- 9.2 On what grounds, or when, should the law allow an intervention to be made with regard to an adult’s capacity to act and decide for him or herself?
- 9.3 Are there any specific principles or values that should underpin legislative reform with regard to incapable adults and what are they? Why do you regard these principles and values as important and why should they form the basis of reform?