Undue influence from the family in declining COVID-19 vaccination and treatment for the elderly patient

Abstract:

This paper examines a patient with borderline mental capacity, where the healthcare team is conflicted about how to proceed. This case demonstrates the complicated intersection between undue influence and mental capacity, allowing us to explore how the law is applied in clinical practice.

Patients have the right to decline or accept medical treatments offered to them. In Singapore, family members perceive a right to be involved in the decision-making process for sick and elderly patients. Elderly patients, dependent on mainly family members for care and support, sometimes submit to their overbearing influence resulting in decisions that fail to protect the patients' own best interests. However, the clinicians' own well-intentioned influence, driven by a desire for the best medical outcome can also be undue, and neither influence should seek to be a substitution for the patient's decision.

Following Re BKR, we are now obliged to examine how mental capacity can be affected by undue influence. A lack of capacity can be found when a patient fails to appreciate the presence of undue influence or is susceptible to undue influence due to their mental impairment causing their will to be overborne. This then paves the way for the health care team to decide based on best interests, because the patient is determined to be lacking in mental capacity.

Keywords: Undue Influence, Clinical Ethics, Autonomy, Singapore, Law, Capacity

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Patients with mental capacity have the right to decline or accept medical treatments offered to them. Mental capacity, though rebuttable, must be presumed. In Singapore, this fundamental principle is protected by the Mental Capacity Act 2008 (MCA SG) on the assumption that such

treatment decisions are made voluntarily by the patients. In reality, however, medical decisions for the sick and elderly in Singapore are frequently made together with families, and seldom individualistic in nature. Family members perceive that they too have a right to participate in the choices to be made for the patient. Elderly patients, dependent on family members for care and support are sometimes the weaker parties in such joint decisions, even if ostensibly the decisions are theirs to finally make.

What can the health care team do to protect the patient from making a bad decision of refusing treatment, under the shadow of undue influence from family members? We use a case to illustrate the impact of undue influence from the son in a patient's refusal of COVID treatment and examine whether and how treatment can be ethically and legally justified and given.

Case

Mdm C, 75 year old widow, not fully vaccinated, was admitted for COVID. Her son Mr S, a casual labourer, was her only source of support. Mr S chose not to be vaccinated because he did not believe COVID was serious. He was the dominant communicator during consultations, while Mdm C was reticent. He said reliance on natural immunity was the best. He also tendered the view that Mdm C herself was not keen to have the anti-COVID treatment. Mr S said he could not afford the treatment for Mdm C. Her usual medical bills were already costly despite state subsidy. He had been contributing his own Medisave savings and more, for her care all these years.

Mdm C had recurrent admissions in the past for poor control of diabetes. Prior to the current admission, Mdm C, although frail, was independent in activities of daily living. She had no notable visual or hearing impairment.

Mdm C accepted the views of her son and decided to forgo COVID treatment. Nevertheless, she related that she was told, and hopeful, of the possibility of surviving without taking the anti-COVID medications. She was tearful when told about the possible consequences of her decision,

including deterioration and death. Mdm C and her son were also informed that failure to treat risked her having 'long' COVID (Greenhalgh et al. 2022). *The primary team, responsible for managing COVID cases, referred Mdm C to the psychiatrist Dr P1, who decided that the patient had mental capacity to decline treatment.*

Two days later, while waiting for discharge, she developed breathlessness. Her oxygen saturation was 92% (*normal level is 95% or higher*). *When told she was not medically fit for discharge and needed monitoring and treatment, she declined and said that she understood she might die as a consequence. When asked if her decision was made because she was fearful of her son getting angry, she shook her head and did not answer. The nurse sensed an air of resignation.*

The primary team was keen to detain her against her wishes to start the standard intravenous treatment at that time (*remdesivir*). *Detaining her would pose no challenges as realistically, she was in no physical state to resist. The nurses were sure that Mdm C's decision was made out of fear of Mr S and being a burden to him. The medical social worker commented that Mdm C was not vulnerable in the 'legal' sense of the word under the Vulnerable Adults Act 2018 and was unlikely to fall under the remit of the Adult Protective Services, so there was no justification for state intervention under these safeguarding mechanisms.*

Some members felt they had failed Mdm C when they did not treat upon admission and it was against their conscience not to treat before the window of opportunity completely shut. They were prepared to administer the treatment, notwithstanding the opinion of Dr P1, citing as a basis the medical necessity of saving lives. Others objected and had also objected to a second psychiatric referral, as they felt this was tantamount to 'seeking and shopping' for another opinion just because they did not like the first. On this latter objection, they were overruled by the majority. It was decided that they needed a clearer understanding of her mental capacity against the background of family dynamics in the treatment decision.

A second psychiatrist, Dr P2, therefore was called. In Dr P2's assessment, Mdm C lacked mental capacity because her mental state was overwhelmed by the situation of her illness and the influence of her son, thus sanctioning treatment based on best interests as determined by the team. Mr S disputed this and wanted to bring the patient home. He said that there would be 'consequences' if this was not allowed.

An urgent Clinical Ethics consultation was requested to resolve the conflicting psychiatric opinions and discuss the dilemma of whether the primary team could proceed with ethical and legal justifications for treatment.

Background factors

In Singapore, it is an expected norm for family members to shoulder the lion's share of caring responsibilities. Filial piety has always been a very much revered social value. Individual identities are also subsumed into the matrix of connectedness to family, so that the relationship is idealized as mutually reciprocal. The elderly patient is thus negotiating a middle path that is sensitive to the needs of the family and is secure in her status as someone whose interests will be protected by her family members. Recognition of this relational identity helps to preserve 'patients' agency' (Ho 2008). In Singapore it also means that most doctors would find it difficult to proceed with treatment until the family is in agreement, even if the patient has the mental capacity to decide for herself.

A relational account of autonomy also fits into the national narrative in Singapore, which takes a cautious approach towards state welfarism, and where social structures facilitate the participation of families in the care and support of the patient. Where filial piety as a moral force is not heeded, the law (Maintenance of Parents Act 1995) can serve to impose such obligations. The state administers compulsory contributions from her citizens to a health care scheme, Medisave, which can then be transferred within families to meet the financing needs in a collective way, such as in

the case of Mdm C. The State also assists in further subsidies for the most needful through Medifund, for which Mdm C was not eligible, as Mr S was employed.

The Adult Protective Service in Singapore, exercising its powers under the Vulnerable Adults Act 2018, may intervene when there are concerns about vulnerability leading to neglect, self-neglect or abuse. These powers are for cases at the extreme end of the spectrum (Chan 2020). The everyday friction, strife and even bad tempers in domestic life rarely warrant its application. In Mdm C's case, the assessment of the Medical Social Worker did not yield major concerns necessitating intervention as her needs had been reasonably provided for.

Although she did not qualify for 'State intervention', the notion of 'undue influence' might offer an alternative route for exploration of legitimately providing treatment to Mdm C. Undue influence is improper influence that deprives a person of freedom of choice or substitutes another's choice or desire for the person's own (Stewart and Lynch 2003). Undue influence, which we know now to be context specific (Craigie 2021, Conceptualising 'undue influence' in decisionmaking support for people with mental disabilities Medical Law Review, Vol. 29, No. 1, pp. 48–79), subject to different interpretation in different jurisdictions (Chen-Wishart, 2013 Legal transplant and undue influence: lost in translation or a working misunderstanding? ICLQ vol 62, January 2013), had its provenance in contract law (Royal Bank of Scotland PLC v Etridge (No 2) [2002] 2 AC 773). If proven, it results in the transaction being voided. In contract law, the claimant seeks to void the contract on the basis of undue influence exerted on her. In the medical context, it is the health care team making the claim of undue influence on behalf of the 'unduly influenced' patient. Furthermore, medical decisions are time sensitive and unlike other transactions cannot be retroactively retracted or nullified. Thus there is no easy parallel to draw in undue influence with regards to mental capacity in the medical context in Singapore till recently in *Re BKR(Re BKR*). An earlier case in English law had lent persuasion that undue influence can invalidate a refusal

of treatment (*Re T. 1992. EWCA Civ*.) This was the final determination after an emergency court hearing, something not tested in Singapore before.

While financial exploitation is common in many cases of undue influence in contract law, it is not always the case with medical treatment decisions. Mr S could rightfully claim that in fact he had been financially supporting Mdm C all these years. However, this also demonstrated an inequality of power in their financial relationship, which may be leveraged by Mr S to pressure Mdm C into making uncomfortable decisions. Nonetheless, unequal power in relationships is common in many family structures and in itself, not indicative of undue influence.

The primary team was also concerned about the views of Mr S regarding COVID, unsupported by facts and clearly with the potential for harm, being imposed on Mdm C. The team and Dr P2 felt that Mdm C would have wanted treatment if such a decision was supported by Mr S. This not being so, the outcome from evaluating the role of undue influence and mental capacity is therefore crucial in determining whether or not she may have a chance of accessing treatment and being saved.

Assessing mental capacity

Mental capacity assessment is a two-step process. The first step requires a determination of whether the patient has 'an impairment of or disturbance in the functioning of the mind' (MCA SG s4). The second step is an assessment of the patient's ability to understand, remember, weigh, and communicate (MCA SG s4). These two steps have been referred as the clinical and functional components respectively (*Re BKR* at [55]). The patient who passes step 1, having no mental impairment or disturbance, would find that there is no case to answer in step 2. It is also the case that a mental impairment or disturbance does not necessarily bar one from having mental capacity to decide on the matter at hand, as long as the functional competence are met.

Establishing a lack of mental capacity necessitates failing the functional component, despite assistance, which itself is dependent on finding of an impairment or disturbance in the functioning of the mind (the clinical component). Absent this impairment or disturbance, then it is not a failure of the functional component, but an irrational or bad decision (in the eyes of the health care team). In practice, these two steps are conducted concurrently and are dynamically assessed in their relationship to each other.

It is trite law in Singapore that when the patient lacks the mental capacity to consent to or to refuse any treatment that has been offered, doctors shall make the final treatment decision in the best interests of the patient(Code of Practice, MCA SG, s6). In deciding what is in the best interests of the patient lacking mental capacity, the health care team must take into account the views of those involved in the welfare of the patient and consider if these views are congruent with the best interests of the patient (Code of Practice, MCA SG, s6.5.5).

The contrasting assessments of Dr P1 and Dr P2

According to the assessments, Mdm C did not have depression, delirium, dementia or any psychiatric history. Both Dr P1 and Dr P2 also observed that there was no fluctuating or altered level of consciousness, disorganized thinking, or gross inattention. Dr P1 concluded that Mdm C was aware of her son's views over the matter and that her decision was hardly involuntary.

Dr P2 assessed Mdm C several days later. At times, her attention appeared to drift and retention of information was suspect. When asked to repeat the information given to her about COVID, the risks and benefits of recommended treatment and the consequences of not having treatment, Dr P2 observed that there were moments when she was silent and pensive-looking, and when asked about her own treatment preference, she simply said her son would decide.

Both Dr P1 and Dr P2 conducted bedside cognitive tests (Modified Mini Mental State Examination [MMSE]) on Mdm C. These tests provided objective snapshots of Mdm C's general cognition at

the times of assessment. Her scores suggested that she did not suffer from major neurocognitive impairment or delirium. Mdm C scored 26/30 in Dr P1's MMSE assessment (orientation 10/10, memory 5/6, attention and calculation 3/5, language 7/8, design copying 1/1) and 24/30 in Dr P2's assessment (orientation 10/10, memory 5/6, attention and calculation 2/5, language 7/8, design copying 0/1). Both were within normal range for a community-dwelling elderly like Mdm C (Feng et al. 2012) and the two-point drop in the second test, together with the overall clinical picture, did not point towards a diagnosis of delirium. While MMSE is a widely used test to screen for cognitive impairment, and at the low cut-off of <20/30 is fairly specific for lack of medical decision making capacity (Pachet, Astner, and Brown 2010), the reverse is not necessarily true (Marrodán et al. 2018). In other words, Mdm C's score of 24/30 was an important deterioration but not by itself deterministic for the lack of mental capacity for the particular decision to be made.

The score of 24/30 taken together with the clinical condition which caused defects in her understanding, remembering, weighing and communicating led Dr P2 to conclude that Mdm C did not meet the threshold of mental capacity required for this specific medical decision. This could have even been so if he had seen her earlier, as COVID is known to have acute effects on the brain (Ellul et al. 2020). Alternatively, an actual decline in cognitive functioning from the time of Dr P1's assessment could also have occurred as a result of clinical deterioration of respiratory function and oxygenation.

Both Dr P1 and Dr P2 agreed that mental capacity assessment in medically ill patients, with their varied interpersonal and internal psychological dynamics especially at times of crisis, may pivot on subtle distinctions. Body language and the nuances of interaction often color its interpretation and two doctors can reasonably come to different conclusions based on enquiries of the same patient. Some doctors may be more forgiving of the slowness, seeming lack of cooperation, or inaccuracies of recall which may be remedied by some coaxing, while others may adopt a stricter attitude.

Undue influence, mental capacity assessment, and inherent jurisdiction

Following *Re BKR*, we are now obliged to examine how mental capacity can be affected by undue influence. Although *Re BKR* dealt with the defendant's mental capacity and aspects of undue influence in the structuring of a trust for disposition of assets, it also focused on the purpose and scope of the MCA SG. It is expected that the application of these principles could be extended to other decision-making situations such as for medical treatment.

Re BKR affirmed that undue influence is relevant in the assessment of capacity in three ways (*Re BKR* at [125]-[127]). The person's mental capacity would be in question if firstly she does not appreciate that undue influence is being exerted, secondly this susceptibility to undue influence is being caused by a mental impairment and thirdly the person was unable to obtain assistance in making decisions. In the case of Mdm C, there was doubt that she appreciated that undue influence, with interests opposed to hers, was being exerted. Her air of resignation suggested to the team a surrender or possibly a habitual acquiescence to the dominion of Mr S. Secondly, her mental impairment would have made her uniquely vulnerable to that influence to the extent that any will of hers, even if present would be overborne. No attempt was made by Mr S to foster Mdm C's own decision-making.

Another possible avenue of recourse outside of the MCA SG is to appeal to the inherent jurisdiction of the Courts to decide on medical treatment. In Singapore, such an appeal was last heard in *Re LP* in 2006, concerning a patient who was in sepsis and lacking in mental capacity (*Re LP*). *Re LP* predated the MCA SG. Notably, in the UK, the inherent jurisdiction of the court has continued after the passing of their MCA. Inherent jurisdiction has been deployed to good effect for the protection of those making decisions resulting from 'constraint, coercion, undue influence or other vitiating factors' but who do not suffer from mental incapacity *(DL v A Local Authority*). Whether the Singaporean courts will follow suit in future medical cases of 'pure' undue influence remains to be seen. We can only speculate that the seeming reluctance of the Singapore

court to exercise its inherent jurisdiction in such cases is because it might appear as a disregard of patient autonomy. Linking to mental incapacity makes for firmer ground for decisions to be made in the name of best interests.

Ethics deliberations, alternative scenario and recommendations

The above case demonstrates the struggle healthcare teams face when trying to protect patients from harmful decisions on one hand while balancing this against the need to respect relational autonomy on the other. How should the Ethics consultants respond to the appeal of last resort in the face of such conflicting opinions between Dr P1 and Dr P2?

Dr P2's assessment, besides having more regard to the influence of Mr S that Mdm C was subjected to, was the more contemporaneous with unfolding events. Yet some might argue that Dr P1's opinion should hold sway because it was only a few days preceding the expected deterioration. It could also be said that Mdm C's opinions during Dr P1's consultation represented an advance planning while she was assessed as having mental capacity, which should not have been disregarded. This may have been so, but the MCA SG Code of Practice specifically addresses this issue, stating that while past wishes must be accorded heavy weight by caregivers when determining best interests, there is no absolute obligation to follow them (Code of Practice, MCA SG, s6.5.2e).

There was sufficient agreement between Dr P2 and the team that Mr S, even if not hindering, was also not helping Mdm C to come to her own decision. It was reasonable to form the impression that Mdm C did not have the ability to develop her own views about COVID. In this respect, the Ethics consultants felt that Mr S did not actively help Mdm C to come to her own decision (Code of Practice, MCA, s3.4.1). It was disingenuous of Mr S to put his views across as Mdm C's decision - this above all else was the fatal flaw that made his influence undue and uacceptable.

COVID is known to have effects on the brain, but to the extent that mental capacity for medical decision making for treatment is affected is still uncertain territory (unlike e.g. dementia) especially for one who was alert. Mental capacity will also deteriorate as untreated serious illnesses progress. Dr P2 was unable to separate the two strands, preferring the view that it was likely a combination of both. Dr P2's conclusion, on the basis of his findings was valid and sound.

Thus, where a patient is making an unwise or foolish decision, the treatment team could theoretically choose to wait until the patient declines to a point where their cognitive function is lost and she loses capacity, but is still be able to respond to treatment, before intervening in her best interests. These forms of intervention based on loss of mental capacity are dubious and susceptible to abuse. Concerns about undue influence cease to be pertinent when it is clear that mental capacity is irrevocably lost due to the disease progression and when the patient is no longer susceptible to being 'influenced'. The Ethics consultants were satisfied that the Mdm C was not at this stage at the time of the psychiatric assessments.

In Mdm C's case, we hold that there was an ethical justification to call for a second opinion because there was reasonable doubt, seeded by undue influence, about her mental state, her choice and intentions. The fact that Dr P1 did not pay much attention to this was a cause of concern for the primary care team.

In *Re BKR*, weighing of a decision was ascertained by reference to reasons given as evidence by the individual in the court. Such forensic exactness cannot be replicated in the hospital ward. The desire to live and the refusal for treatment does not necessarily imply a failure to make sense and to weigh. Patients in a state of denial, vacillation, avoidance, or stoic acceptance of their fate may feel this way. Even irrational decisions barring those that are outrageously so (*Re MB (Medical Treatment*) need to be respected. The important point in Mdm C's case was her inability to shed even the faintest light on the apparent inconsistency between her implied wish to live and

her refusal to accept a simple and minimally invasive treatment. On balance, this could be explained by her lack of mental capacity.

Overall, the Ethics consultants were persuaded that there were sound and ethically defensible reasons for accepting Dr P2's assessments. There were sufficient grounds to accept as a fact that Mdm C's mental state, being compromised by COVID, had been affected to the extent that she was incapable of making a proper decision when undue influence was present. This then paved the way for the primary team to administer the treatment lawfully and ethically.

The Ethics consultants also took the opportunity to address the medical team's concerns about the doctrine of medical necessity to save lives and the threat of legal consequences. The doctrine of necessity, borne of common law might have had relevance prior to the MCA both in the UK and Singapore. Saving lives or not, based on best interests, is now codified into the Act, with strict parameters for its application limited mainly to patients without mental capacity in emergencies, requiring objective evidence to support the absence of mental incapacity. This doctrine of necessity is now therefore neither applicable without such evidence, nor needed if such evidence is demonstrated.

Treating or even touching a patient without consent can give rise to a civil claim of battery or criminal liability of assault. These concerns underline the importance of establishing the mental capacity status of the patient, lack of which then justified the treatment to proceed lawfully. Her cooperation with treatment should be carefully monitored, considering her weakened state of health. The healthcare team should always be mindful of the law and proceed in a manner that can be justified in future if necessary.

Lastly, the Ethics consultants also considered how the approach should be in the alternative of Mdm C being ascertained as having mental capacity. She should be put on notice about the potential undue influence followed by encouragement and support for an independent decision.

This could be conducted by hospital staff not directly involved in the clinical care e.g., medical social workers or the hospital psychologist and in the absence of the source of such undue influence. The position in *Re BKR* is that capacity may be regained (if not present previously) once undue influence is removed(*Re BKR* at [126]-[127]). However, we must be mindful that while physical presence is easily prevented, psychological presence may yet linger.

If Mdm C did not have a mental impairment, it should not be for the doctors to override her decision on the basis of undue influence alone. *Re BKR* has not established a basis for permitting this. While the treatment team would prefer Mdm C accepting treatment, any intervention must be made with the ultimate goal of facilitating her autonomous decision-making, rather than changing her mind. For now, absent case law on inherent jurisdiction, the MCA SG would be the first and possibly only port of call if a decision was to be made by the doctors on behalf of the patients. An existence of an impairment of the mind, in addition to and interacting with undue influence must be present. Conjoined together, it may result in a lack of mental capacity.

The Singapore Medical Council Handbook on Medical Ethics 2016 also made reference to the effects of pressure and duress exerted by other parties. It states that: *'If time does not permit (for example, in an emergency), or the patient remains impaired by these or other factors (meaning subject to pressure and duress), you may proceed in patients' best interests. If possible and there is time, you should obtain a second opinion from an appropriate colleague or send the patient for a formal assessment of mental competency'*. *Re BKR* affirmed that overriding of a patient's wishes still requires them to lack mental capacity, and so the safer choice would be to assess their capacity before proceeding with treatment.

The welfare bias

'Not letting the tail of welfare wag the dog of capacity' *(Heart of England NHS Foundation Trust v JB* at [7]) is a warning to resist the temptation of labelling patients as lacking mental capacity

because of decisions deemed foolish or irrational by the health care providers. In a similar vein, following *Re BKR*, doctors might be tempted to find family influence to be undue in refusal of treatment, in order to gain an opening to the door of a mental capacity assessment, the lack of which then makes treatment permissible.

In reality, disregarding welfare is difficult especially in Mdm C's case, where potential benefits far outweigh the burdens of treatment. Disregarding the attacks on the moral conscience of the team would be demoralizing to the profession. Maximizing welfare will always be part of the health care relationship but must be balanced against autonomy, relational or otherwise.

Re BKR can in a way risk facilitating the welfare bias. A mental impairment which by itself does not result in a lack of capacity can be the substrate upon which an undue influence can act to turn the result the other way round. Satisfying the presence for mental impairment is not insurmountable. In *Re BKR*, the requirement for the respondent's mental impairment in the first limb of the test was satisfied without specifying whereupon it was situated between mild cognitive impairment and dementia (*Re BKR* at [172]-[173]). Recognition for mental impairment at common law has included 'needle phobia' (*Re MB*), severe fatigue or pain (*Re T* at [28]). *Re T* involved an adult female who declined blood transfusion. Whether she had mental capacity was equivocal, however, the conclusion resting on doubtful adequacy of the information given, the depth of her Jehovah faith and the undisputed undue influence of her mother was also strongly driven by the welfare bias to save her life. The phrase 'impairment of or disturbance in the functioning of the mind or brain' in the MCA is vague and does not necessitate a settled or formal diagnosis that accords with the DSM-5 (American Psychiatric Association 2013). This vagueness could be seen as a gift of latitude to clinicians, to allow the 'tail of welfare' to covertly wag 'the dog of capacity.' However, just because it is possible, does not mean that it is encouraged.

Health care teams must be mindful that pushing decisions made in the name of welfare puts them at risk of hubris or worse becoming a competing source of undue influence that seeks to

overwhelm the will of the patient, even if ‘well intended’ (Craigie 2021), and ultimately aiming to substitute their preferred decision for the patient. This would lead to unwarranted interference with every unwise decision, of which the MCA SG was enacted to prevent.

As much as clinicians may know best medically, each individual has her own beliefs and values. The responsibility is shared between the healthcare provider and patient to choose a course of action that best aligns with those beliefs and values. It must be accepted that families will play a dominant role in these beliefs and values. The role of the health care team is to facilitate independent decision making and objectively assess for mental capacity when external pressures are brought to bear on a patient whose mental state to objectively evaluate this influence is questionable.

Conclusions and summary

The effects of family influence can cross the line from being constructive and helpful to being an undue influence that substantially undermines the patient’s own will. *Re BKR* has made clear that when determining mental capacity in cases of suspected undue influence, its interaction with a mental impairment can and should be considered. This is a critical step as the best interest decision taken on behalf of patients is predicated on the lack of mental capacity.

There can be no denying that welfare considerations played a role. However, more important, there were doubts about Mdm C’s mental state under suspected undue influence. Seeking a second opinion from Dr P2 on that basis was correct. The answer from Dr P2 was welcomed but not planned.

The Ethics consultants were also mindful that the decision to treat has landed the team on a collision course with Mr S. If Mr S chose to go down the confrontational route, the hospital should have systems in place to support the health care team and protect the future welfare of the patient.

Some may take an uncharitable view towards Mr S. However, the hardships, especially for those in precarious economic situations, caused by the COVID-19 pandemic, call for empathy.

Ironically, many cases of undue influence can also arise from good intentions by family members who think they know best. Equally, self-righteous and judgmental health care teams are also not infrequently encountered. Ideally we want families to be allies in the health care journey. The taint of undue influence in relational autonomy, which otherwise is a force for good, should be responsibly managed within ethical and legal boundaries.

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