

Advance Care Planning in Ontario

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Over the last few years, there has been an increased interest in advance directives from hospitals; long-term care facilities, community-based health services and health care practitioners in Ontario. Many facilities, services and even whole communities have developed advance directive policies and forms, with the intent of promoting patients' rights as well as of trying to limit the liability of health providers for "no treatment", particularly where CPR may not be advisable or appropriate for the patient or where patients have refused treatments although offered.

Although the overall intent is good, a number of legal problems have been identified in the development and implementation of these advance directive forms and policies.

Some of these problems are as follows:

1. Some of the forms contain statements that try to override provisions in the *Health Care Consent Act*. One hospital policy asked patients to give authority to the health team to make treatment decisions for the patient in the event that the patient was not mentally capable and had no person to act as substitute except the Public Guardian and Trustee of Ontario. This type of override is NOT possible.
2. Some policies try to get around getting consent from substitute decision-makers when the patient has given a written advance directive, later becomes incapable, and it is a non-emergency situation. The Ontario law REQUIRES that the health practitioner seek consent or refusal of consent to treatment from the substitute decision maker and it is up to the substitute to INTERPRET the advance directive, not the health care team.

Note that if the health practitioner believes that the substitute decision maker is not following the last capable wishes of the patient (however expressed) when making the treatment or admission to long-term care decision, the health practitioner may apply to the Consent and Capacity Board for an order that the substitute comply with the patient's express wishes. The Board may direct the substitute to comply if appropriate or may substitute its direction for that of the substitute to the health practitioner. The Board can also decide that the substitute is not acting in accordance with the legislation requirements for a substitute and find that that person cannot so act. This application is a protection for both the patient who has expressed wishes in respect to treatment while capable and the health practitioner who is aware of wishes that the substitute now is refusing to follow.

3. Some policies fail to acknowledge that the patient is THE decision maker, the person who must give or refuse consent to treatment, not just a “participant” in the decision making process about treatment. The health practitioner provides advice as to what treatments are recommended to the patient. The health practitioner sets out the options for the patient and gives an opinion as to what the patient should do. The health practitioner gives the patient the information that the patient needs to make an informed consent.

But the health practitioner does not “decide” (consent) to what treatment that the patient will receive – the PATIENT decides to give consent or refuse consent to the treatment.

4. Some policies leave the impression that advance wishes for future treatment MUST be in writing, and once written may be changed only by another written document. In fact the *Health Care Consent Act* makes it clear that wishes of a patient in respect to treatment may be in any form - oral, written, communicated by alternative means (i.e. Bliss Boards etc). These wishes may be changed at any time by a patient that is mentally capable in respect to the treatment concerned. This change may also be in writing, be oral; be communicated by alternative means. The later capable communication, no matter what form it takes, OVERRIDES the wishes expressed in the written document.
5. Some policies make it a requirement or show a strong (“almost” mandatory) preference for the hospital/facility approved form, discouraging patients from using other forms and documents to express their wishes. In fact, patients may communicate these wishes for future care in any way they want and using any form they want – or no form at all. Requiring the facility/hospital form is not “patient-centred” and patient focused.
6. Some facilities have included the facility advance directive as one of the documents that must be completed on admission. Signature of an advance directive cannot be required as a condition of admission by any long-term care facility or hospital. Also, the time of admission is, in and of itself, a difficult time for any patient/resident and probably is one of the worst times for patients to be asked to make decisions about future care or end of life care. On its face, it's not very welcoming for patients to be greeted at the door with a No CPR document!
7. Some policies/facilities require patients to meet with special “trained” personnel who assess their capacity to make an advance directive and assist in the completion of the hospital/facility-approved form. This may be of assistance to some patients and the facility but care must be taken to ensure that this practice is not “required” before a patient expresses wishes and the

health team honours these wishes should an emergency arise before this internal process comes to its conclusion.

Of course, this personnel must also be trained not only in the use of the facility form but also to ask questions to identify when the patient has a power of attorney for personal care or other documents that already express advance wishes. This is important so that they don't unintentionally create a conflict situation between substitute decision makers, particularly if one set of documents appoints one person as the substitute and the second set of documents created with the facility staff assistance appoints a different substitute, unless that is what the patient actually wants. Some health care providers fail to understand that a power of attorney for personal care document may very well be an "advance directive".

Also, the "trained personnel" must not give incorrect or misleading legal information to the patient when assisting them to execute the document. The trained personnel must be able to answer all the patient's questions about the patient's care options to the satisfaction of the patient so that the patient has the correct information on which to express future wishes.

The document is a "legal" document and its validity may be questioned if it was signed, based on incorrect information. For example, if the staff person tells the patient that unless they sign the facility advance directive, the hospital staff will have no choice but to take all extraordinary measures to resuscitate the patient, even though CPR is not an appropriate treatment based on their health condition, this would be incorrect.

In fact, health care practitioners may decide independently from the patient that CPR would NOT be an appropriate treatment and not medically indicated, so despite a directive to be resuscitated the health team may conclude that CPR should NOT be given. Likewise, the direction from the patient for no CPR is not necessary when CPR would never have been "offered" as a treatment. Arguably, if treatment (CPR) is given when it's patently not appropriate, the health team could potentially be held liable for treating when it's not medically appropriate.

Note that ETHICALLY it is inappropriate to list a no CPR or a DNR order on a patient's chart until there has been a discussion with the patient, or the patient's substitute if the patient is not mentally capable. However, this does not mean that patient's have the right to require CPR even when CPR is not medically appropriate. This is often a difficult issue for discussion, but an issue that should be discussed if the health practitioners believe that CPR would be inappropriate to meet the patient's needs. It is also inappropriate to do a "slow code" response if the health practitioner believes that no CPR is appropriate but the patient and/or their substitutes want CPR.

8. Some staff at facilities/hospitals do not understand that just because a patient has completed an advance directive or Power of attorney for personal care, that he or she does not lose decision-making authority for treatment/admission/personal assistance services. The authority of the substitute decision-maker named in the document comes into effect only when the patient becomes mentally incapable of making a particular health care decision.
9. Some policies require that the patient's physician "co-sign" the directive before it comes into effect. In one instance, the advance directive stated that when the physician signs the directive that the directive is now "a physician's order" and must then be followed and changed only with a counter order. The *Health Care Consent Act* does not require that patient's wishes be verified by a health practitioner or that a power of attorney for personal care that contains wishes in respect to treatment/health care must be witnessed or confirmed by a health practitioner before it comes into effect or it is considered as the patient's capable wishes.

There is nothing wrong in having the physician sign the directive as an acknowledgment of his or her knowledge of the patient's wishes. However, the absence of the physician's signature does not "take away" the patient's wishes or makes those wishes not enforceable in an emergency.

Also, a patient's wishes about future treatment should not be confused with consent. This confusion may arise if the facility staff believe that the signature of the physician on the advance directive means that the patient has given an informed consent to a treatment. Or if the staff believe that the signature denotes that an "order" has been given and therefore the "treatment" proposed for the future should be given now.

10. Some facilities require that patients/residents or their substitutes execute "levels of care" forms that describe what degree of intervention that the person would want if health problems arise. The forms usually set out four levels of care, from no intervention through to hospital transfer. These forms may be very useful to health care providers in discussions with patients/residents and /or their substitutes about care options however these forms are NOT consents to treatment and cannot be required as a condition of admission to a facility. Patients are entitled to receive the care appropriate to their care needs and the care that is available within the community that they live. That care may be an option other than what is listed on the form. The forms are ordinarily too general and don't reflect the care that a particular individual may require.

As well, these forms are often signed by patients/residents and their families without information on what the levels of care mean in reality. For example, a resident of a nursing home may indicate that he or she would prefer to remain at the nursing home rather than be transferred to a hospital in a crisis situation. However, this decision may have been made without the benefit of information about the differences in care, particularly palliative care and pain management, that may be available at the hospital as opposed to the nursing home. If such forms are used in discussions with patients, full explanations of the implications of any choices must be given.

In the end, it would be more effective and more appropriate to get a proper consent to treatment from a patient/resident rather than use the levels of care forms that are ultimately meaningless except as a vehicle for discussion.

These are only a few examples of identified common problems. There is no question that all hospitals, facilities, and health practitioners who are promoting patients' use of advance directives intend to develop policies and procedures that assist patients and follow the law of Ontario. This paper is intended as an overview of the legislation and problem areas, and a "checklist" of matters to address in these policies for the benefit of BOTH the patient and the health care practitioners.

1. Applicable Legislation:

What legislation applies to advance health directives/living wills/ powers of attorney for personal care? The two key pieces of legislation are:

- * the Substitute Decisions Act
- * the Health Care Consent Act

2. Terminology

There is no reference to "advance directives" or "living wills" in the Ontario legislation. The legislation does refer to Powers of Attorney for Personal Care and "wishes" of the patient for treatment, admission to long-term care, and to personal assistance services. These wishes can be expressed in writing, orally, by alternative means of communication such as Bliss Boards etc.

For a written document to give authority to appoint a substitute decision maker as recognized in the hierarchy in the *Health Care Consent Act*, the document MUST be a Power of Attorney for Personal Care and not just an "advance directive". It does not

need to be called a Power of Attorney for Personal Care on its face but it must meet the technical requirements to be a Power of Attorney for Personal Care (see section 3 below).

Therefore, if the Hospital/facility advance directive form provides for the appointment of a Substitute decision-maker, why not call the document a Power of Attorney for Personal Care rather than an “advance directive” or “living will”? That would cause less confusion amongst patients, their families and staff.

Just because the document is not called a Power of Attorney for Personal Care, that does not change the status of the document to something other than a Power of Attorney for Personal Care if it meets the technical requirements to be one. Likewise, if it does not meet the technical requirements for a Power of Attorney for personal care, the document called the advance directive will not be successful in giving authority to the person named in it to be the substitute decision maker for the patient.

3. What is a Power of Attorney for Personal Care?

A Power of Attorney for Personal Care

- names a Substitute Decision Maker
- may contain directions and wishes about future health care/treatment/anything else related to “personal care”
- must be witnessed by 2 witnesses
- **must be in writing**

The grantor (the person who gives it) must

- be capable at the time of signature to make a Power of Attorney for Personal Care (see *Substitute Decisions Act* for specific definition of capacity to give a power of attorney for personal care)
- be capable for any particular matter on which he or she has included directions or wishes in the Power of Attorney for Personal Care
- be age 16 or over

4. Who Can Create a Power of Attorney for Personal Care?

ONLY an individual may create a Power of Attorney for Personal Care for him or herself. A Family member or a substitute decision-maker CANNOT prepare a power of attorney for personal care on behalf of another person, whether that person is capable or incapable.

5. Who can create an Advance Directive?

ONLY an individual may create an Advance Directive for him or herself. A Family member or a substitute decision-maker CANNOT prepare an advance directive on behalf of another person, whether that person is capable or incapable.

6. If a patient is incapable, and the Substitute Decision Maker (SDM), as defined by the Health Care Consent Act, knows of wishes about treatment that the patient expressed while mentally capable, can the Substitute decision maker complete any kind of document that confirms these wishes?

The SDM may consent to a **plan of care** that may include future medical treatment HOWEVER these directions **must relate to the patient's present medical condition** not any general wish for future treatment. In many instances, particularly if the patient has a terminal illness or chronic condition, the SDM may be able to give directions that relate to the "what if" kind of scenario that would encompass some future care.

However, the SDM would not be able to give broad-based directions that are general in nature or broad in scope. For example, the SDM for a physically healthy person with Alzheimer's Disease would not be able to direct that if that person developed any kind of physical ailment that he or she should not be treated. If the patient should develop a physical problem, then the SDM would have to consider whether or not to give consent to treatment based on the condition of that person at that time and the treatment offered.

In contrast, a mentally capable individual may write up an advance directive or express wishes in some form (in a Power of attorney for personal care, orally, by alternative means) refusing all future treatments of any type, even if those wishes would be considered unreasonable by others. By restricting the SDM's authority to giving direction on future medical treatment for the incapable person that is related to their PRESENT condition, the SDM must consider the person's actual state of health and apply the wishes and best interest test required in the *Health Care Consent Act* in that context, related to a REAL situation, not a fictional event.

7. What happens if the patient has not named an SDM in a Power of Attorney for Personal Care and the patient is not mentally capable?

A Patient ALWAYS has a SDM for treatment even if he or she has not executed a POAPC as the *Health Care Consent Act* provides for a hierarchy of substitute decision-makers. (see section 20(1) *Health Care Consent Act*)

If a patient has no person as listed on that hierarchy in his or her life, the Public Guardian and Trustee steps in as that person's SDM for treatment.

8. Can the Advance Directive permit the patient to give authority to a health care practitioner or to the health team to make treatment decisions? Can the Advance Directive permit the patient to refuse to have the Public Guardian and Trustee as his or her last resort decision maker (assuming the patient has no one else that is willing to act as his or her SDM other than the health team?)

A Patient cannot name a health care practitioner or the health team or anyone else that provides him or her with health care (or residential, social, training, or support services) as his or her SDM in a Power of Attorney for Personal Care unless that person is the patient's spouse, partner, or relative (see section 46(3) of the *Substitute Decisions Act*). Likewise, unless a particular health practitioner is one of the persons in the patient's life listed in the hierarchy of substitute decision-makers in the *Health Care Consent Act*, the health practitioner cannot act as the patient's substitute.

The Advance directive/ hospital –facility policy cannot override the legislation and cannot block the OPGT from being the patient's last resort treatment decision maker if the patient does not have anyone that he or she can appoint to act as decision maker. This is one of the few limitations on the patient's right of choice that was included in the legislation to ensure that the patient always had an SDM that was independent of the persons providing care to him or her.

9. Who Interprets the Advance Directive/Oral Wishes/ directions in a Power of Attorney for Personal Care?

The SDM interprets the POAPC/Advance Directive/Oral Wishes **NOT the health practitioner** except in an emergency. In an emergency, the health practitioner may follow the last capable wishes of the patient expressed in any form that he or she is aware of. If he or she knows of ORAL wishes that are different than what is in the written advance directive, then he or she must honour the last capable oral wishes.

Health practitioner must get consent or refusal of consent from capable patient, or that patients' SDM if the patient is not capable, even if wishes for treatment have been expressed in some way in writing, orally, or any other way. .

10. How does a patient revoke or change a Power of Attorney for Personal Care? How does a patient change the wishes or directions in respect to treatment, admission to long-term care, or personal assistance services if these wishes have been expressed in a Power of Attorney for Personal Care?

The patient may revoke a POAPC by execution of a revocation (a document in writing that must be witnessed by two witnesses and meet the same technical requirements as a Power of Attorney for Personal Care). Also, if the patient executes a new Power of attorney for Personal Care, and that second Power of Attorney for personal care does not specify that the patient wishes to have multiple powers of attorney for personal care, the first power of attorney for personal care is revoked on execution of the second POAPC.

However, if the patient has expressed wishes about personal care (including health care) in the Power of attorney for Personal Care, the patient does not need to execute a formal revocation to change those wishes. As the *Health Care Consent Act* states that the patient can express wishes about health care in writing, orally, or by alternative means, the patient may simply change the wishes orally without changing the written document. Last capable wishes override previous wishes however expressed. Of course, the patient may want to change the written document if he or she is able to in order to avoid any confusion, however no formal process is necessary for the later wishes not written into the document to be honoured

11. How does a patient change/revoke an advance directive that is not a Power of Attorney for Personal Care?

A patient may change/revoke an advance directive that is not a power of attorney for personal care by making oral statements, by communicating his or her wishes by alternative means, by making a new statement of wishes in writing. The patient does not need to execute a “revocation”. Of course, it would be a good idea for the patient to tear up the old advance directive and prepare a new written one if he or she wants to in order to make his or her wishes as clear but it is not a necessary step to change his or her wishes. A hospital/facility policy cannot require that the patient make changes in his or her wishes only in writing.

12. Can a hospital/facility require patients to execute the facility’s advance directive form as a condition of admission? Can a hospital/facility require that the patient only use the hospital/facility advance directive form and not other forms and not just express wishes orally?

Hospitals/facilities cannot require that patients execute an advance directive as a condition of admission. Likewise, the hospital/facility cannot require that the patient communicate his or her wishes about future treatment is one format, or only the format approved by the hospital/facility policy. The provincial legislation recognized that patients may communicate these wishes in many different ways and the legislation retained that flexibility.

As well, it must be recognized that some people do not want to create an advance directive. It may not be culturally appropriate or fit into their personal system of beliefs. That is one of the reasons that the provincial legislation was drafted to ensure that everyone in the province had a substitute decision-maker. A substitute decision making system ensures that health care practitioners always have someone to turn to get a consent or refusal of consent to treatment in the event that the patient is unable to communicate his or her wishes or is not mentally capable to give or refuse consent to treatment. It is hoped that the substitute has sufficient knowledge of the person's values and beliefs, wishes, personality that he or she can give or refuse consent based on the substitutes understanding of the patient, the patients express wishes or what is in the best interests of the patient considering all the necessary factors. The health care professionals need not rely on paper documents like advance directive forms or struggle with trying to interpret a patient's wishes, however drafted, however expressed. The hospital /facility policies cannot remove this freedom of expression nor override the role of the substitute in giving direction if the patient is not capable of giving or refusing consent to treatment.

Conclusion

Hospitals/facilities/community organizations that want to prepare and promote advance directive policies must ensure that the policies comply with the applicable provincial legislation. The provincial law supports flexibility in expression of wishes and this must be maintained in any hospital/facility policy.

What patients usually want is the COMMUNICATION with health practitioner, the opportunity to express his or her wishes, have his or her concerns about treatment heard. They are generally less concerned with the paperwork and policies. Many patients want communication with their primary health practitioners, including physicians, and other persons directly delivering care. They do not want to have discussions about future health care and treatment just with an "assigned staff" person in the hospital/ facility advance directive policy (often a nurse or a social worker).

Advance directive policies should be used as means of improving patient/family/health practitioner comfort and communication and it should not be just a bureaucratic process that is part of the hospital/facility's risk management programme.

It should not be assumed that advance directives are necessarily part of a "patient centred" approach to health care. Advance directives can assist in improving communication between patients and health practitioners but likewise, the advance directives can become a barrier if the focus is just on a form, on a piece of paper, on a policy rather than on the communication.