

## **Health Care Consent and Advance Care Planning: Fairly Good Law and Good Intent, but Not Always Good Practice**

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### **The Push for “Advance Care Planning”: What is it? Why such a focus on it?**

Advance care planning (ACP) is described in popular literature, health articles, and on many websites<sup>2</sup> as a process of planning by an individual for a time when that person does not have the mental capacity to make decisions about his/her own health care or treatment.

That planning may include the choice of someone to act as Substitute Decision Maker (SDM) for that person should he or she become mentally incapable of giving or refusing consent to health care.<sup>3</sup> The planning may be a communication about a person’s values and beliefs, likes and dislikes, how he or she generally wants to be cared for, where he or she wants to live, as well as communication of specific wishes about health treatments, medications, and end-of-life care.

The advance care plan may be “medically” oriented and specific, particularly if the person has an illness or deteriorating condition and has knowledge about the likely progression of his or her state of health and the types of treatments that may be offered to him or her. The advance care plan may also be more generalized and focus on the values and beliefs and other messages that would help the future SDM feel confident in making treatment

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<sup>1</sup> The Advocacy Centre for the Elderly (ACE) is a community legal clinic that provides a range of legal services to older adults in Ontario. The legal services provided include client services (advice and representation before courts and tribunals), community development, public legal education (both print materials and presentations at conferences, workshops and seminars), and law reform activities. ACE has been in operation since 1984. It is funded by Legal Aid Ontario and operates as an independent non-profit charitable corporation, managed by a Board of Directors, half of whom must be older adults. For more information, please see the ACE website at [www.ancelaw.ca](http://www.ancelaw.ca).

<sup>2</sup> As one example of this, see website for the Canadian Hospice and Palliative Care Association and their “Speak Up” Campaign on advance care planning.

<sup>3</sup> In Ontario, this choice of SDM can be done by either confirming who would be the automatic SDM(s) for the person in accordance with the hierarchy list of SDMs in section 20 of the *Health Care Consent Act* or done by naming someone to be attorney for personal care with authority for treatment and other health care decision making in a power of attorney for personal care.

decisions for the patient when incapable. The person creating the advance care plan ultimately wants to communicate the way he or she would make decisions for him or herself, even if he or she doesn't know the exact decisions that he or she may need to make in the future. Through this communication the patient wants to put the SDM into the position of making decisions for the patient in the same way, or as close to the same way that patient would have if still capable.

However drafted, in Ontario, a "true" advance care plan is NOT a consent or refusal of consent to any specific treatment, even if very specific. It is an expression of "**wishes**" about future care and treatment. It does not replace the requirement for health providers to get an **informed consent or refusal of consent**, which are **decisions**, as distinct from wishes, in real time from the capable patient or the incapable patient's SDM when all the information about a person's current condition and treatment options are known. That is very clear in the *Health Care Consent Act*.<sup>4</sup>

There is, in practice, confusion about what is an advance care plan and what is a consent to a treatment or plan of treatment. Consent or refusal of consent may be obtained "in advance" of a health event, such as a cardiac arrest, if the consent decision is in the context of the person's *current health condition* and the person has been offered the information for an informed consent/refusal and then makes a decision. An example of this would be consent to no resuscitation or consent to allow natural death in circumstances where the patient currently has a serious chronic cardiac problem, would not be a suitable candidate for CPR, and would likely not benefit from such a treatment. In that circumstance, both the capable patient or an incapable patient's SDM could consent to no CPR. The SDM is not "advance care planning" in this scenario but is providing consent/refusal of consent in context of the incapable person's current health condition.

The confusion is that many health providers think of advance care planning as any treatment or care that would take place in the future, whether or not it is a decision in relation to a person's current health condition as opposed to a "wish" about possible future options. They may not make this distinction between consent and advance care planning.

An advance care plan is primarily direction or a guide to the people who will act as SDMs in the future for the person doing the advance care plan. Under the *HCCA*, SDMs are required to make decisions for a patient, in accordance with wishes expressed by that person when capable, or if no wishes applicable to the particular decisions to be made are known, then the SDM is to act in that person's "best interests".<sup>5</sup> Best interests is a defined term under the *HCCA*.<sup>6</sup> Wishes so expressed in any form of advance care plan therefore are important and can have serious impact.

SDMs play an interpretative role in respect to the wishes. They must consider whether a wish is applicable to the particular treatment/health decision they need to make for the patient and also may need to interpret what that person who made the wish meant by the wish as expressed. This can be a challenge and the source of disputes between SDMs, between SDMs and other family and friends of the incapable patient, and between the SDM

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<sup>4</sup> *HCCA*, ss.5, 10 and 11.

<sup>5</sup> *HCCA*, s.21.

<sup>6</sup> *HCCA*, s.21(2).

and health providers of the patient when wishes are generalized such as a wish for “no heroic measures”. What that means to one person may be something quite different to others.

There is, at present, a very strong push from various sectors for people to engage in formalized advance care planning. The reasons for this are many.

The positive intent is to get people thinking about their own future and their own health. With advances in technology and health care, more types of interventions are available to maintain life but the quality of life may not be what they want. Recovery from some health interventions, like resuscitation, is not exactly like what it is on television medical dramas. There is, as there has been for many years, health policy and best practice statements to focus health providers on “patient centred” care, care decisions that include the patient and possibly their family in care planning.

However there is also an emphasis on advance care planning to save time talking to patients and SDMs, and to save money in health care. These also may be good intentions in our time and money stressed health system, however negative practices that have developed include:

- Tick box forms that patients are “required” to complete sometimes as a prerequisite to admission to a particular health facility whether or not the patient wants to do this. No informed consent is obtained but the forms are used then as consents.
- Discussions with patients and or SDMs about advance care planning forms with social workers or volunteers, not the actual health practitioners offering treatments. These social workers and volunteers do not have the details or knowledge of either the patient’s health condition or the treatment options. The forms, which are often very general in scope, as completed, are then used by the health practitioners as consents or refusals of consents without further discussions with the patients or SDMs at the time treatment is delivered.
- Level of care forms that offer four or five choices of general levels of care services are “required” to be completed. The health practitioners then decide on the specifics of the treatments and no informed consent is obtained for specific treatments that compose a level, such as “comfort care”.

Patients may not be transferred to hospital for appropriate treatments if they tick off the level that includes no hospital transfer. The patient may have understand “no hospital transfer” as meaning that they would prefer to stay in the long term care home in which they were living should they be at end of life, rather than be transferred to hospital for their death. They didn’t understand that if they had a treatable condition that the long term care home staff could not manage and that condition required hospital transfer, that the level of care form would be interpreted as then refusing ANY hospital transfer. They would not know that the form would be wrongly interpreted as a refusal of treatment or that treatment would be delayed while what was actually intended when they signed the “advance care plan” was sorted out.

## **Where has Informed Consent gone? Challenges in Informed Consent and in Using and Applying Advance Care Plans in Practice**

In Canada, the details of everything from the formal requirements for a power of attorney for personal care (or equivalent in other provinces) or another form of “valid” advance care plan,<sup>7</sup> who can be named as SDM or who is default SDM if that SDM has not been formally appointed, the authority that such a plan may give to an SDM, how and when the advance plan comes into effect, who takes direction from the advance plan (the SDM only or the health providers only or both), and so forth are all subject of provincial law.

There are differences in this type of legislation across Canada. Research and literature on advance directives, or advance care planning, no matter how “correct” it is within the jurisdiction it was prepared, does not necessarily translate from province to province because it is based on provincial specific differences. Materials and tools from American sources or from Alberta or British Columbia have been used in Ontario facilities without amendment or adjustment to accommodate Ontario law because those tools were referenced in medical literature and validated in research in some way.

Some research and literature in medical and other health journals has been based on erroneous assumptions of the applicable provincial law – or does not consider the provincial law at all, approaching the issue from an ethical or practice perspective that may differ from the applicable provincial law. The health providers reading the literature and research may not be able to identify the flaws in the research as these flaws are rooted in misunderstanding or misinterpretation of the provincial law applicable to the jurisdiction in which the research was done or the literature was created.

Some research and literature emphasizes advance care planning as if it's the advance care plans, not the informed consents to treatment, that are most important. Informed consent is given a back seat and replaced by forms and documents or tick box sheets of future plans and wishes which are then used as if they were equivalent or better than an informed consent to treatment. The advance care plans may be prepared by a patient when the patient doesn't have all the information about their current health conditions, or information on the possible treatment options and their benefits, risks, side effects, alternatives and what would happen if they didn't agree to any of the treatment options. These plans then are not consents and are not a plan of care or treatment and should not be used as such but may be interpreted as if they were just as good as an informed consent.

Many health providers have general understandings of the principles behind advance care planning but do not necessarily know all the details of the legal framework applicable to the jurisdiction in which they practice. Also they may not fully understand the process for getting an informed consent. As the details are significant in operationalizing the advance care plan, unnecessary conflicts may arise between patients or their SDMs and the health

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<sup>7</sup> The term “advance care plan” is being used here instead of “advance directive” as the latter term usually refers to some form of written document whereas in some jurisdictions (e.g., Ontario), wishes about future health care may be expressed orally or by other means: *HCCA*, s.5. The “advance care plan” in Ontario may be a power of attorney for personal care but may also include any documents in which a patient expresses wishes or any oral statements or communication by the patient through a computer or through communication aids.

providers. The “blame” is placed on the lawyers that drafted the document or the law itself as not reflecting the reality of health practice.

Some health providers confuse “care planning”, the process that practitioners follow to discuss with patients their goals and objectives of treatment and use to determine what treatments to offer patients, with “advance care planning” which is the process that patients follow to express their “wishes” about future health care. Care planning is part of getting consent to treatment and decisions about treatment options. With care planning, the health practitioners communicate with the patient or the patient’s SDM about the patient’s present health condition and the possible options for treatment based on the patient’s health condition. Some of the treatment options may be forward thinking, discussing treatments that the patient can give consent to at this time although the actual treatment could take place in the future, such as decisions about CPR based on the patient’s present health condition. In contrast, advance care planning is usually much broader in scope and a great deal more speculative as the patient is expressing wishes about future care without full knowledge of his or her present health condition or full knowledge of his or her possible treatment options. These are two different processes.

Lawyers drafting documents for clients may not appreciate or understand the health practice problems faced by health practitioners. They may not understand or appreciate that health practitioners often work in “systems” – in facilities with policies and standardized practices that may incorrectly state the correct legal framework, but with which the health provider is expected to comply because that is the facility (or hospital, long term care home, health network, regional health authority and so forth) in which they practice.

Lawyers may not understand the full extent of the scarcity of resources and the pressures under which the health practitioners work which impact on how they are able to deal with issues related to health care consent. Hospitals don’t necessarily have social workers or other staff to mediate between or even converse with the stressed feuding family of the mentally incapable patient who are arguing over everything from who is the decision maker for the incapable patient through to what decisions should be made.

Nurses in many jurisdictions don’t have the time to get to know the patients that are moving quickly through the hospital beds and through the places in which health care is delivered. The bedside providers of care may not be able to get an understanding of what the patient, when capable, actually wants or doesn’t want in their care, other than getting a general “consent” to the care to be provided. As they don’t necessarily get to know the patient, when the patient later lacks capacity and other persons become responsible for giving or refusing consent, the bedside health providers may not be in a position to help interpret what the patient put into an advance care plan, whether written or oral, expressed by the patient while still capable, about their changing health needs.

In fact, the limited resources of staff in many facilities and health centres may mean that the health providers don’t know if the patient had prepared a power of attorney for personal care and named someone to be their SDM, or expressed wishes when capable about future care either in writing, or orally, or by other means, or whether he or she created any advance care plans, or changed those advance care plans during the course of their illness. The documents that the lawyers have drafted may not even be in either

the hands of the health providers or the patient's potential substitutes. And in jurisdictions that allow for capable oral overrides by the patient of previously executed written directives, disputes may arise between health providers and families as to whether the patient had expressed wishes after executing the directive that changes the original advance care plan.

Some lawyers use stock phrases such as "I don't want extraordinary measures to be used on me" in drafting a written advance care plan, but fail to detail what the particular client means by that phrase. They don't include the interpretation of that phrase in the drafted document so the document doesn't communicate what the client wanted, or didn't want, in a practical way. Some lawyers don't assist or encourage the client to discuss their interpretation of this statement with their future SDM, as well as with other family members that may challenge the SDM's interpretation of the statement at a time of crisis. How are the client's wishes going to take effect unless the person making the decision for the client understands the expressed wishes?

If the law in a particular jurisdiction provides that the advance care plan is not "interpreted" by the SDM, but requires the health provider to directly interpret the document, and take direction from the document, the specific words of the written directives need to be drafted, keeping in mind how the health provider will understand the words and infer consent, or lack of consent to treatments from the directive. In those jurisdictions, it may be necessary for the lawyer to get consent from a client to discuss the draft advance care plan with the client's primary health provider to provide some assurance that the document will communicate what is needed and address the directions that the health provider may need to get from the document.

In those jurisdictions that permit the health providers to take direction from the written document, if the written directions are "consents", the health providers may not understand how to distinguish between written "wishes" and written "consents". This distinction may be very important as ultimately, in all jurisdictions across Canada, health providers are required to get informed consent before providing treatment to any patient.

The other problem that will likely arise in these jurisdictions is that the directive may be understood by the patient's primary health care provider but there is no guarantee, particularly in busy health facilities, or in emergencies, that the present primary health care provider will end up being the health care provider to that patient when he or she is not capable in respect to treatment and needs to rely on the advance directive to express his or her wishes.

Health providers may say that the problem is with how a lawyer or the patient drafted the document – it's not specific enough, it doesn't use the right medical terminology, it names two or more SDMs that can't agree and therefore are not able to direct the health practitioner, it's too vague or difficult to interpret, and so forth. From the lawyers' perspective, the health provider may have failed to understand the legal framework on health consent and advance care planning.

The response to the claims of vagueness or lack of medical terminology or specificity to the particular medical condition that the patient has, may be that the health practitioner does not understand that the health provider does not need to interpret the document



since the law states in that jurisdiction that document must be interpreted by the SDM only, who then gives or refuses consent to the health provider on behalf of the incapable patient.

However, even in Ontario, where the “wishes” are primarily guides to the SDMs, health practitioners may see the patient’s wishes and then think the SDM is not following the wishes. The health practitioner may then consider applying to the Consent and Capacity Board to ask for a review of whether the SDM is acting in accordance with the *HCCA* provisions that require them to make decisions in accordance with the wishes of the patients, and if none are relevant or applicable to the decision, to act in the best interests of the patient. The health practitioner then is still struggling to figure out what a document may mean when considering whether the SDM is acting appropriately. The health practitioner cannot fulfill his or her role as “check and balance” for the patient’s rights if he or she doesn’t understand the patient’s documents.

It is impossible to draft advance care plans, especially medical model ones, that anticipate all health problems that a patient may experience in the future. Who really knows if, or when, they will end up in an ICU with a major health problem or will experience a health catastrophe for which their SDMs will need to make difficult choices for them about their care? It may be impossible to draft the type of specific advance care plan that some health providers seem to want their patients to have, except where a patient has a type of condition where he or she can anticipate the possible changes in his or her health.

The conflict between SDMs is usually not the fault of the drafting itself but of the fact that no document can effectively address what are often long standing family differences that come out at times of stress, such as at the end of life of a parent, when both adult children think that they each know what treatment (or not) that the parent would have wanted.

Advance care planning is at the intersection of law and medicine. A health practitioner needs and wants to get proper informed consent from his/her patient or the patient’s SDMs if the patient is incapable, before delivering treatment. Advance care planning should help patients get appropriate treatment, as well as what treatment they want or don’t want, particularly at end of life since good advance care planning should involve communication between the patient and their future SDM. This should help the health system as less interventionist treatments may be delivered since the patient, when capable, has thought about the potential consequences of the continuation of invasive treatments and the impact on their quality of life. This should help reduce disputes at the bedside if the patient is not capable, as the process of advance care planning usually results in clear identification of the SDM and the SDM has some guide from the wishes, values and beliefs to consider when required to give or refuse consent.

Lawyers assisting clients in drafting advance directives, or other documents that have legal authority to express wishes about future health care, want to help their clients communicate their wishes effectively to whomever has authority or responsibility to speak for them or to make treatment decisions if and when they become incapable and unable to speak for themselves. These documents should help clients to have their rights respected within the health system, clarifying who is the proper SDM, as well as the scope of authority of the SDM to exercise these rights. The advance care plans should reduce family conflict or at least, clarify to the health providers who the SDM is with

authority to give or refuse consent, allowing them to deal with the appropriate person rather than getting caught within the family conflict.

Lawyers need to understand not only the law in respect to advance care planning but also how health facilities and health professionals understand, or may misunderstand, the fundamentals of health care consent and advance care planning. Lawyers also need to consider the potential problems, stresses, and strains faced by health practitioners in practice, so that they can provide appropriate advice to clients and draft documents that will meet client's needs when interacting with the health system.

### **The Ontario Legal Framework of Health Consent and how Advance Care Planning fits into that Framework**

To understand advance care planning in Ontario, it is necessary to understand the legal framework in respect to health care consent and how advance care planning fits into that framework. Advance care planning is not a separate process from health consent, but if done, is an element of the consent process.

The framework can be explained in three steps.

#### **First Step: The Role of the Health Practitioner**

A health practitioner proposes a treatment to a patient. Before administering that treatment, the health practitioner must get consent to the treatment.<sup>8</sup> That consent must come from the patient if mentally capable for the treatment, or from the patient's SDM, if the patient is mentally incapable for that purpose.<sup>9</sup>

In an emergency, health practitioners may provide treatment to a patient without consent.<sup>10</sup> There is an emergency "if the person for whom the treatment is proposed is apparently experiencing suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."<sup>11</sup> In providing treatment in an emergency, health practitioners are required to follow any known wishes of the patient applicable to the circumstances. They shall not administer a treatment in the emergency if the patient had expressed a capable wish prior to the emergency to not consent to the needed treatment.<sup>12</sup>

Furthermore, if an SDM refuses treatment for the patient in an emergency, the health practitioner may treat despite the refusal if the health practitioner proposing the treatment believes that there is an emergency and that the SDM is not in compliance with section 21 of the *HCCA*, that is, that the SDM is not making decisions for the patient in accordance with the patient's wishes, and if no wishes are known, then in the best interests of the patient.<sup>13</sup>

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<sup>8</sup> *HCCA*, s.10(1).

<sup>9</sup> *HCCA*, s.10(1).

<sup>10</sup> *HCCA*, s.25(2)-(3).

<sup>11</sup> *HCCA*, s.25(1).

<sup>12</sup> *HCCA*, s.26.

<sup>13</sup> *HCCA*, s.27.



One example of this would be if the SDM makes the decision to not consent to a treatment despite the fact that the patient had expressed a capable wish to consent to that same treatment prior to the emergency. In both these situations, in an emergency, the health practitioner would rely on the patient's prior capable wishes, or advance care plans, when determining whether to treat or not treat in the emergency. This is the only time that health practitioners in Ontario follow the advance care plans of a patient directly and interpret the advance care plans themselves. In other circumstances, the health practitioner must get the consent or refusal of consent from the SDM, if the patient is not mentally capable to consent.

The health practitioner therefore must get a decision (not a wish) from a capable patient or the incapable patient's SDM. This is a DECISION which is the informed consent that is obtained after the patient/SDM is provided with the information about the patient's condition, the treatment options, and the risks, benefits, side effects, alternatives to the treatment and what could happen if the patient refuses the treatment offered.

In getting consent, the health practitioner is talking to a person – not looking at or taking direction from a paper or any other form of advance care plan. If the health practitioner is aware of the patient's previously expressed wishes, values, beliefs, the health practitioner may want to discuss with the patient or their SDM as to whether the patient still has (or had while capable) these same wishes, values and beliefs or whether the patient had changed these. The health practitioner may want to discuss with the SDM for the incapable patient, while talking about treatment options whether the patient had wishes about the possible treatments being offered. But through this process, the health practitioner is working to get a consent or refusal of consent from a person – the patient or the SDM where appropriate, not from the advance care plan, however that has been expressed. If there is an advance care plan, that is used by the health practitioner to help understand the patient and help communicate with the SDM in order to come to a decision.

## **Step Two: The Role of the Patient**

The patient, if capable for the treatment decision,<sup>14</sup> is the decision maker to whom the health practitioner must turn to for consent or refusal of consent. It is the health practitioner offering the treatment that must determine whether the patient is capable in respect to the treatment being offered and must provide rights advice to the patient, if found incapable, in accordance with the guidelines established by the governing body of that health practitioner's profession.<sup>15</sup>

A patient may also express wishes about future health care when capable. This is the advance care planning. These wishes may be expressed in writing, in a power of attorney for personal care (POAPC), or in any other written form, orally, or in any other manner.<sup>16</sup> "Any other manner" can be by any means that that patient uses to communicate. This was included in the legislation to capture the methods that persons with disabilities may use if they are unable to write or communicate orally.

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<sup>14</sup> See *HCCA*, s.4 for definition of "capacity".

<sup>15</sup> *HCCA*, ss.10 and 17.

<sup>16</sup> *HCCA*, s.5.

Later wishes expressed when capable prevail over earlier wishes. This would mean that wishes communicated orally after a patient has completed a POAPC or any other written documents trump the written wishes.<sup>17</sup> This is one reason why the health practitioners must turn to the patient, if capable, or the patient's SDM, if the patient is incapable, for the consent to treatment despite the existence of the written advance care plan. The patient may have changed his or her mind about what was written down so the health practitioner must talk to a person rather than take directions from a document.

The *HCCA* does not use the words "advance care plan" in respect to future health care. It only uses the word "wishes". The expression of "wishes" is the way that a person in Ontario may advance care plan. As a wish is expressed often without knowledge of all the details of what the patient would need to know to provide an informed consent, advance care plans are "wishes" about future treatment rather than "decisions" about present treatment or decisions about future treatments that are made in context and with knowledge of the patient's present health condition, such as many decisions about resuscitation at end of life.

Advance care planning is a voluntary process. A person may decide to not formally advance care plan.

A major reason that people advance care plan is to name a particular person or persons to be their SDMs for health care for the patient, in the event that the he or she is not mentally capable for health decision making. In Ontario, this is done through the preparation of a power of attorney for personal care, the only document under Ontario law that can authorize the appointment of an SDM for health care decisions.

However even if a person does not prepare a POAPC, Ontario law provides that every patient, if incapable, automatically has a health care decision maker. The *HCCA* includes a drop down hierarchy list of SDMs that are authorized by statute to act in this role. This hierarchy is explained later in this paper. The patient may be content with the person highest in the SDM hierarchy acting as SDM for him or her, and therefore may not want to prepare a POAPC appointing that person as attorney. This is because the SDM the patient already wants has authority to make the health decisions, as described in the *HCCA*, for the patient.

This person who does not want to do a POAPC could still be encouraged to communicate to his/her future SDM what he or she would want as care or, at a minimum, communicate to the SDM what are his or her values and beliefs. This can be done in an informal way or through oral discussions and not through specific documents if the person so wishes.

A person may decide to not advance care plan because he or she has specific religious beliefs or cultural beliefs and feels that advance care planning is in contradiction to these beliefs. Some persons choose not to advance care plan because they are superstitious and think it is "tempting fate" to advance care plan.

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<sup>17</sup> *HCCA* s.5(3).

Others do not want to advance care plan beyond choosing a SDM because of the inherent problems with advance care planning. People's wishes about future health care often change as they age or as health conditions change. Some persons that express wishes that they would not want to live if they suffered major injuries, find that they can live lives that are meaningful even if they have a disability and therefore then want treatments and assistance that they did not earlier believe that they would want.

It is not possible to anticipate any given illness and therefore it is impossible to advance care plan to predetermine all the many different types of health decisions that would need to be made if the person suddenly experienced a health crisis.

Advance care plans are criticized because of vague language that leads to possible misinterpretation of wishes. Because it is difficult to articulate what you want or don't want in any particular health situation, some people fear that the wrong interpretation of their words will be made.

Treatments change as science advances therefore a person's wishes may have been different if he or she could have anticipated the advances.

The inherent problems in advance care planning were considered when the *Consent to Treatment Act*, the predecessor legislation to the *Health Care Consent Act* was drafted. Therefore a substitute decision scheme was incorporated into the Ontario legislation, as opposed to a health directives format. This scheme was continued in the *HCCA* when it came into effect in 1996.

The substitute decisions scheme means that health practitioners must get consent from a **person** – either the patient if capable for the treatment or the patient's SDM if the patient is incapable – rather than from a document, except in the emergency as described above. The advance care planning in Ontario is primarily done as a communication to a SDM, to assist or guide the SDM when he or she is making decisions for the patient.

As advance care planning is voluntary, health facilities and services cannot require patients to advance care plan as a condition of admission into a particular facility or to get a health service.<sup>18</sup> Neither can they require patients/ residents to execute powers of attorney for personal care. Likewise, health facilities and services cannot require patients to use only an advance care plan form that that facility or service has designed, should the patient want to express wishes in another form of advance care plan.

In particular, there are no requirements in the legislation, regulations or standards applicable to long term care homes or hospitals in Ontario that they must have residents execute advance care plans or DNR (do not resuscitate) or No CPR directives on admission or at any time after admission. Some long-term care home staff and administration contend that they must have residents complete such forms because the

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<sup>18</sup> ACE has observed that consent and advance care planning forms used in some long-term care homes may also contain clauses that do not comply with Ontario law. These types of documents are defined as "regulated documents" under section 80 of the *Long-Term Care Homes Act* and the licensees of these homes are required to have their legal counsel "certify" the forms as being in compliance with the applicable legislation, including the *Health Care Consent Act*. When advocating for clients in these circumstances, it may be useful to ask if such documents have been so certified and by what lawyer.

Ministry of Health and Long-Term Care requires it or that this is a requirement of the accreditation process, and that they will be subject to sanction by the compliance unit of the Ministry if they do not enforce this “requirement”. No such standard exists to the best of the writer’s knowledge.

If faced by such a request to complete such forms, residents or their SDMs should ask for production of such a requirement. If such a document is produced, the SDMs or residents may wish to make further inquiry with their own legal counsel before signing any such documents as a condition of admission or of getting health services.

**An advance care plan is not consent.** It is clear in the legislation that the health practitioner must get consent from a person<sup>19</sup> – the patient, if capable for the treatment or the patient’s SDM, if the patient is not capable. It is only in the emergency that the health practitioner must follow wishes of the patient to not consent to a treatment if the health practitioner knows of the wishes applicable to the circumstances.

The word “wishes” was deliberately used in the legislation rather than “decisions” as a patient is only “wishing” when advance care planning and is not giving or refusing consent. He or she does not have all the information required to give an informed “consent” when he or she is wishing. A patient may express wishes broadly about future health care or specifically, expressing that he or she does not want a particular treatment, but in both cases, the patient is expressing a wish without all the information necessary to make an informed decision about specific treatment at a particular time.

Patients do have the right to express wishes about future health care without having all information although it is preferable that a patient be as informed as possible about his or her own health condition as well as possible options for treatment before expressing specific wishes about treatments. These wishes must be taken very seriously as the SDM, when making decisions for a patient, is required to follow any wishes the patient expressed while capable although the patient may not have had all the information to make an informed consent or refusal.<sup>20</sup> This poses the challenge in drafting written advance directives and raises the issue of whether it is advisable to be too specific in an advance care plan.

Because the health practitioner must get consent or refusal of consent from a “person” – the patient or the SDM if the patient is not capable – the patient has the opportunity to reconsider wishes expressed in an advance care plan, after getting all the information to make an informed consent. The health practitioner must still get consent from the capable patient even if he or she has prepared an advance directive.

If it is the SDM that must give or refuse consent when the patient is not capable, the SDM has the opportunity to interpret the wishes of the patient to consider the relevance of the wishes to the particular consent/ refusal of consent requested for the specific treatment. The SDM may also apply to the Consent and Capacity Board (CCB), an administrative tribunal, to get directions about the wishes or to depart from the wishes if it can be argued that the patient, if capable, would probably give consent because the likely result of the

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<sup>19</sup> HCCA, s 10(1).

<sup>20</sup> HCCA, s.11(3).

treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.<sup>21</sup>

This is different than in those jurisdictions where the advance directive “speaks” to the health practitioner. In Ontario, the legislation was drafted to ensure that patients could express wishes, and in this way advance care plan, but the framework created a system of substitute decision making in which a substitute decision maker, not a piece of paper, would “speak” for the patient who becomes incapable.

### **Step Three: Role of the Substitute Decision Maker**

This then takes us to the third step in the framework – the role of the SDM. As repeatedly stated, if the patient is not capable in respect to the treatment then the patient’s SDM is the decision maker. In making decisions for the patient, the SDM must follow the last known capable wishes of the patient. The patient’s advance care plan is the road map for the SDM, guiding the SDM in decision-making for the patient. If no wishes applicable to the specific decisions are known, then the SDM must act in the “best interests” of the patient, taking into consideration the patients values and beliefs and the other factors described in the definition of best interests in section 21(2) of the *HCCA*. “Best interests” is defined in the *HCCA* as follows:

21(2) In deciding what the incapable person’s best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,
  - i. improve the incapable person’s condition or well-being,
  - ii. prevent the incapable person’s condition or well-being from deteriorating, or
  - iii. reduce the extent to which, or the rate at which, the incapable person’s condition or well-being is likely to deteriorate.
2. Whether the incapable person’s condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

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<sup>21</sup> *HCCA*, ss.35 and 36

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

SDMs can only give or refuse consent to treatment, admission to long-term care, or personal assistance services in long-term care, they cannot advance care plan or express wishes for a patient. SDMs are decision makers and do not “wish”. Their role is to consider all the information required in giving an informed consent, and then make a decision, following the wishes of the patient or in the best interests of the patient if there are no known wishes applicable to the decision to be made.<sup>22</sup>

Some health practitioners and health facilities misunderstand the role of the SDM in advance care planning. A number of health facilities request patients’ SDMs to execute advance directives on behalf of the mentally incapable patients. This is an inappropriate practice.

This misunderstanding may arise in Ontario as a result of misunderstandings about the definitions of “treatment” and “plan of treatment” in the *HCCA* and how end of life care fits into these definitions. Many health practitioners interpret advance care planning as including directions about end of life care, such as DNR or no CPR. Wishes expressed about this type of care may be advance care planning if the patient expressing these wishes is healthy and not at end of life. However, the patient, for who end of life treatment decision making is a real option in relation to their current health condition, is actually giving or refusing consent to treatment when giving directions about end of life care and is not advance care planning. Likewise an SDM acting for this same patient, who then becomes incapable, when making decision for that patient about end of life care is not advance care planning but is giving or refusing consent to treatment.

“Treatment” means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purpose and includes a course or treatment, a plan of treatment or community treatment plan.<sup>23</sup> Treatment includes end of life care.

A “plan of treatment” means a plan that deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have **in the future** given the person's **current** health condition, and provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's **current** health condition.<sup>24</sup>

SDMs may consent or refuse consent to various types of end of life care or the withholding or withdrawal of treatment and may consent to plans of treatment that include plans about treatment for health problems that the incapable person is likely **to have in the future** given the **incapable person's current health condition**.

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<sup>22</sup> *HCCA*, s.21.

<sup>23</sup> *HCCA*, s.2.

<sup>24</sup> *HCCA*, s.2.



This is not advance care planning although the treatments, or in some cases the refusal of consent to the possible treatments, will take effect in the future. This is not advance care planning because the SDM must give or refuse consent in the context of the incapable person's current health condition and with the information about the nature of the treatment proposed for the incapable person, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses for action, and the likely consequences to the incapable person of not having the treatment. SDMs therefore can make decisions about end-of-life care for an incapable person at end of life in the context of consent instead of advance care planning. Otherwise, SDMs may not advance care plan for patients. Only a person, when capable, may advance care plan for him or herself. Attached as Appendix A to his paper is a summary explanation sheet about the role of the SDM in consent and advance care planning.

### **Who are the Substitute Decision Makers?**

Under the HCCA, a person always has an SDM if he or she is not mentally capable of giving or refusing consent to treatment, even if he or she has not prepared a POAPC. Although this legislation has been in effect since 1995, some health practitioners and health facilities in Ontario still do not understand the SDM hierarchy in section 20 of the HCCA. Some health practitioners/health facilities believe that only an attorney named in a POAPC may act as SDM for treatment/admission/personal assistance services for an incapable patient. Lawyers should be aware of this when explaining the hierarchy to clients and when advising the client as to whether he or she should prepare a POAPC.

The hierarchy of SDMs is as follows:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.

8. Any other relative of the incapable person.<sup>25</sup>

The person highest ranking in the incapable patient's life is entitled to act as health care decision maker only if he or she:

- (a) is capable with respect to the treatment;
- (b) is at least 16 years old, unless he or she is the incapable person's parent;
- (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
- (d) is available; and
- (e) is willing to assume the responsibility of giving or refusing consent.<sup>26</sup>

A number of these terms (spouse, partner, child, relative, available) are specifically defined in the *HCCA*.<sup>27</sup>

There can be multiple people at any level in the hierarchy. If two or more persons at the same ranking meet the requirements to be an SDM, they are all entitled to act as SDM. They may decide amongst themselves that one will act, or some of them will act as SDM however the health practitioners cannot choose which one of them may act. They must decide this amongst themselves.

If multiple people at the same ranking want to act, and are at the highest ranking, and disagree about whether to give or refuse consent, the Public Guardian and Trustee shall make the decision in their stead.<sup>28</sup>

If the client decides not to prepare a POAPC, being satisfied with the person that will act for him or her as SDM for health decisions as listed in the hierarchy, that person's future SDM should be prepared to explain to health providers their authority to act by being highest ranking in the hierarchy.

Common misunderstandings about who can act as SDM include:

- a) That if the highest ranking SDM for the patient is also incapable in respect to the treatment decision then that the patient has no SDM or that the patient's SDM is the Ontario Public Guardian and Trustee even if other lower ranking SDMs in the hierarchy areas are available, willing and eligible to make the treatment decision for the patient. This is incorrect. If the highest ranking person in the hierarchy is not mentally capable in respect to the health decision that needs to be made, that person does not qualify to act as the SDM under section 20(2), in that he or she is not mentally capable in respect making a

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<sup>25</sup> *HCCA*, s.20(1).

<sup>26</sup> *HCCA*, s.20(2).

<sup>27</sup> *HCCA*, s.20(7)-(11).

<sup>28</sup> *HCCA*, s. 20(6).

decision about the health treatment that is being proposed for the patient. The health practitioner should then continue down the hierarchy to the next highest ranking person that meets the qualifications to be the SDM.

- b) That a same sex spouse does not qualify to be the SDM under the definition of spouse. Although the definition of spouse changed in 2005 to include same sex, married and common law spouses that have been cohabiting at least one year and same sex spouses that are parents to a child together or have entered into a cohabitation agreement, some health facilities or health practitioners may not be aware of this change. Same sex spouses may want to name each other in POAPCs as SDM for health care or be prepared to show other documentation to prove that they are spouses to avoid this problem.
- c) That if the patient does not have anyone in their lives in the hierarchy willing to act as SDM, then that person has no SDM and the health practitioner or health facility administration will act as SDM for that person. This is not correct. Section 20(5) makes it clear that in these circumstances, the Ontario Public Guardian and Trustee is required to act as SDM for the patient for the treatment decision or the decision in respect to admission to long-term care.
- d) That if the patient has a friend willing to act as SDM, and that friend is immediately available, the health practitioner may turn to that friend to make treatment decisions on behalf of the patient. This is not correct. The friend may act as SDM for the patient only if that friend is the attorney named in a valid POAPC or if that friend applies to the court to be named as guardian of the person for that patient or applies to the CCB to be named as representative for the treatment decision.
- e) That a caregiver daughter/son is the SDM when there are multiple children and all rank equally on the hierarchy. This is not necessarily the case. The fact that the patient has previously resided with one adult child who acted as caregiver to the patient does not mean that caregiver gets authority to act as SDM if there are multiple children that qualify as SDM, unless the parent has previously executed a POAPC to name the caregiver child as attorney for personal care, and no other person has obtained an order to be the guardian or the representative for the patient.

If there is no POAPC, no guardianship order and no order naming someone as a representative, the equally ranking children can decide amongst themselves that the caregiver child should act as SDM. The health practitioner, before taking the consent/refusal of consent from the caregiver child, must inquire of the caregiver child whether the other equally ranking children would object to the caregiver acting as SDM.<sup>29</sup> If the caregiver child represents that there would be no objection, the health practitioner may then take directions from that child unless he or she receives information that the other equally ranking children object to the caregiver so acting. If this

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<sup>29</sup> HCCA, s.20(4).

disagreement cannot be resolved, the health practitioner may turn to the Ontario Public Guardian and Trustee to give or refuse consent on behalf of the patient.<sup>30</sup>

The most common problem in health facilities in respect to SDMs and advance care planning is the practice by health facilities to have SDMs complete some form of advance directive for the incapable patient. The argument by health facilities, and particularly long-term care homes, for such a practice is that the health facility staff need to know what treatment should be delivered to a patient in the middle of the night should a health crisis occur. This is, in part, a fair argument. Although the health practitioners may treat without consent in the emergency, or decide to not offer particular treatments such as CPR if not medically appropriate for the patient, the health facilities and health practitioners would prefer to have some understanding of the patient's/SDM's preferences even in the emergency.

However in the end, they do have legal authority under the emergency provisions in the legislation to treat or to decide to not treat in an emergency, making decisions based on the patient's health condition whether or not they have some knowledge of the patient's wishes or have communication from the SDM.

The lack of specific direction does not stop them from treating the patient.

In many of these situations what the health practitioners or health facilities should be seeking in advance is consent or refusal of consent to **a plan of treatment** and not an advance care plan. An SDM is not advance care planning (expressing wishes) for the incapable patient when he or she is provided with the information about the person's present health condition and the possible health problems that the person may likely have in the future given the person's current health condition, and then consents to a plan of treatment that provides for the administration to the person of various treatments or courses of treatment and may also provide for the withholding or withdrawal of treatment in light of the person's current health condition.<sup>31</sup>

Some of the forms that facilities use that are called "Advance Care Plans by SDMs" could be changed into consent forms for plans of treatment, if modified and made more specific to the individual patient's health condition and treatment options.

Unfortunately, many of the forms are tick box forms that are broadly drafted and lack the specificity to meet the standard to be a proper consent. As well, the forms are being used without providing the SDMs with the necessary information to provide an "informed consent". That information would need to be provided if the directions for these treatments would be valid consents or refusals of consent. Informed consent must be given or refused to the plan of treatment in the same way that informed consent must be given or refused to specific treatments. A plan of treatment form that lacks specificity and is based on statements such as "I consent to anything that the health practitioner may order" does not provide valid consent.

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<sup>30</sup> HCCA, s.20(6).

<sup>31</sup> HCCA, s.2.

Some of the forms that health facilities ask patients to sign are in fact powers of attorney for personal care, although titled “advance care directive” or “living will”. In these circumstances, execution of such a form by a patient/ resident may result in the revocation of a previously executed POAPC.<sup>32</sup> Lawyers advising clients on POAPCs should make clients aware of this possibility so that they can exercise caution when asked to engage in advance care planning in a health facility or when doing advance care planning on their own without advice from a lawyer.

### **Communication of Wishes**

When doing advance care planning, some people want to communicate specific wishes about treatment, such as what drugs or what treatments (e.g., CPR, dialysis) the SDM should or should not consent to on their behalf if they are incapable.

Some lawyers do not feel comfortable or professionally competent preparing documents that reflect a medical model directive because they do not feel that they can give adequate advice about the consequences of expressing such wishes, other than advice on the obligations such a directive places on the SDM. The *HCCA* states that the SDM is required to follow a patient’s capable wish when giving or refusing consent to treatment, therefore the consequences of expressing such a specific wish that is not subject to some interpretation could be profound. In these circumstances, the client may want to discuss such specific directions with his or health practitioner as well as his or her lawyer before including such specifics in a POAPC. The lawyer may also need to get consent from his or her client to talk about the client’s specific wishes about particular medical treatments and the client’s health condition in order to properly draft specific directions about particular medical treatments.

A way of avoiding this drafting problem and the possibilities of misinterpretation of medically specific directives is for the client to execute a POAPC indicating who he or she wants as SDM but leave the further directions on such details to an oral communication with the future SDM or in a separate written document that is only an advance directive on the wishes so that that document could be changed periodically by the client as wishes change and health changes without the need to change the POAPC.

Also, in drafting such specific directives, the directive should provide for some “wiggle room” for the SDM to interpret the specific directions and consent to similar but not exactly the same directions to account for changes in treatment options, advances in medical treatment, complications and changes in the client’s care needs.

The client may also want to communicate information to the future SDM about his or her values and beliefs to help guide the SDM. The purpose of an advance care plan is to communicate to the future SDM information about the patient so that the SDM, to the greatest degree possible, can make the same decisions that the patient would have made if capable. It may be more important and more useful for the patient therefore to communicate information about what the patient believes is important in life, what is “quality of life”, what the patient fears in going through treatments or fears in his or her

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<sup>32</sup> *Substitute Decisions Act*, s.53.

illness. If the patient is religious, the patient may want to communicate how his or her beliefs and faith impact or guide his or her own decision making so that the SDM can take this into consideration when deciding for the patient. Some patients, particularly at end of life, may want to communicate what he or she considers to be a “good death” or communicate what goals he or she has before death so that treatment decisions may be made in that context, if possible.

Some of this communication may be included in a POAPC whereas some clients may want to have that communication in a different way (e.g., orally or in a separate document).

There is often a debate of how much should be written down about “wishes” and how much should be left to oral communication. There is no one right answer for the Ontario system of health care consent and advance care planning. Some people want to write wishes down and that is their option. Others want to leave it all oral and that again is a valid option.

The more likely the SDM is to be challenged by other family members of the incapable patient as to how he or she is making decisions on behalf of the incapable patient, the better it is for the patient to express wishes in writing so that the SDM may use these written wishes to justify and respond to these challenges. The problem is that it is not always possible to anticipate when other relatives who are not the SDM will disagree with the SDM. The disputing family or friends would have to try to trump the SDMs authority by seeking guardianship or other legal authority to act in place of the SDM if they disagree with how the SDM is acting so written wishes could assist the SDM in such proceedings. Other situations where the written wishes may be helpful in addressing conflict include where the SDM chosen by the patient is not family or is not the person that the patient’s family would have expected the patient to select as SDM (i.e., choosing a friend as attorney in a POAPC rather than a spouse) or where the wishes of the patient are possibly controversial (i.e., refusing treatments that otherwise would be lifesaving).

Communication of wishes about future care may be oral, in writing, or through an alternative means such as a communication board or sign language. Written advance directives are not the only means of doing advance care planning. A person may decide what method of advance care planning best suits his or her own needs. Health facilities cannot require patients to use a particular format for advance care planning or require advance care planning at all. It is appropriate that health facilities and health practitioners make patients aware of advance care planning options and the legal framework for health care consent.

To facilitate this education of patients on advance care planning and health care consent, a *Guide to Advance Care Planning* is available at no charge from the Ontario Government. The Guide is available online at <http://www.seniors.gov.on.ca/en/advancedcare/index.php> and can be ordered in hard copy from the Ontario Seniors Secretariat.

The Canadian Hospice and Palliative Care Association is promoting a Speak Up Campaign to encourage people to talk with their family about advance care plans. While they have materials on their website to educate people on this topic, some caution should be used as even the ones listed for Ontario do not necessarily reflect Ontario law. The Alzheimer’s Knowledge Exchange HCC-ACP Community of Practice group revised the



Speak Up campaign workbook to make an Ontario specific version which can be found at: [http://advancecareplanning.ca/media/73433/acp\\_ontario\\_workbook\\_final-rev2013-web.pdf](http://advancecareplanning.ca/media/73433/acp_ontario_workbook_final-rev2013-web.pdf).

Wishes expressed orally or through alternative means of communication are just as valid as wishes expressed in writing. Some people may feel more comfortable writing down their wishes as the written wishes may be clearer and less subject to misinterpretation than oral wishes.

Written documents may be in the form of a power of attorney for personal care or an advance directive/living will.

The formal requirements for POAPCs are detailed in the *Substitute Decisions Act*.<sup>33</sup> POAPCs are documents in which a person can appoint a substitute decision maker (an attorney), set out wishes about care, as well as express values and beliefs and anything else that would be helpful to guide the named SDM in his or her decision-making. POAPCs must be in writing and must be witnessed by two witnesses at the same time that the grantor executes the document. The grantor must be mentally capable of executing the document and mentally capable of making decisions about any of the care and treatments about which the grantor expresses specific wishes in the document.

Neither the *Substitute Decisions Act* nor any other statute in Ontario makes reference to living wills/advance directives; therefore there are no formal requirements for these documents. The term “living will” or “advance directive” is commonly understood to mean a document in which a person expresses wishes about future care, as well as provides information about values and beliefs. This type of document normally does not specify a person to be a substitute decision maker. Even if the advance directive names an SDM, that SDM would not have authority to act as SDM when the patient became incapable unless that advance directive also meets the formal requirements to be a POAPC or that named person has authority to act as SDM by being the highest ranking person for the incapable person as listed in the hierarchy of SDMs in the *HCCA*. Any wishes expressed in the advance directive or living wills are wishes that must be followed by the patient's appropriate SDM as determined by the hierarchy.

POAPCs do not come into effect until the grantor is not mentally capable for some element of personal care. For health care decisions, the health practitioner does not need to start the inquiry as to who is the patient's SDM until he or she is of the opinion that the patient is not mentally capable for the treatment being offered.

It is possible however to draft into the POAPC a requirement that the capacity of the grantor must be “confirmed” before the POAPC comes into effect. If the grantor wants this confirmation requirement, the grantor may indicate in the POAPC who – either an individual or individuals or class of individuals – should do this confirmation. For example, the grantor may want his or her family physician or any physician, or a nurse, or any social worker, or even his or her “aunt Martha”, even if Aunt Martha is not a health practitioner, to do this confirmation. If the grantor only includes a reference in the POAPC that his or her incapacity must be confirmed before the POAPC comes into effect, then a “capacity

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<sup>33</sup> *Substitute Decisions Act*, Part II, s.46 and on.

assessor”, as defined by the legislation, must do the confirmation.<sup>34</sup>

What is key to understand is that even if a POAPC contains such a confirmation requirement, this requirement is not relevant if a health care decision under the *HCCA* needs to be made. The *HCCA* requires that the health practitioner offering the treatment is responsible for determining capacity. If the health practitioner determines that the patient is not capable for treatment, then he or she must determine who would be that patient’s SDM. Section 49(1) of the *Substitute Decisions Act* provides that the POAPC is effective when this finding of incapacity is made, despite any requirements for other confirmation in the POAPC document. The confirmation process does not need to be followed if the *HCCA* applies to the decision to be made. This is one of the most common misunderstandings of health practitioners and health services, as many believe that they need to follow the confirmation process before being able to get consent from the SDM named in a POAPC that contains this type of clause. This confusion is understandable because of the way the section is drafted. The section is included in this paper to help clarify this issue:

49. (1) A provision in a power of attorney for personal care that confers authority to make a decision concerning the grantor’s personal care is effective to authorize the attorney to make the decision if,

**(a) the *Health Care Consent Act, 1996* applies to the decision and that Act authorizes the attorney to make the decision; or**

(b) the *Health Care Consent Act, 1996* does not apply to the decision and the attorney has reasonable grounds to believe that the grantor is incapable of making the decision, subject to any condition in the power of attorney that prevents the attorney from making the decision unless the fact that the grantor is incapable of personal care has been confirmed.

## Conclusion

Advance care planning is heavily promoted to seniors and other patients as a means of choosing an SDM as well as communicating his or her own wishes about future health care. Advance care planning may be a helpful process, a means by which patients can provide supports and direction to their future SDMs so that they can have confidence in the decisions that they make for the patient when incapable; however, it’s not a foolproof process. No one can ever know exactly what another would have decided if he or she actually was making the decisions for themselves.

Lawyers assisting clients in doing advance care planning should be aware of the misunderstandings in the health system about advance care planning and therefore help their clients understand health care consent and the authority given in a POAPC or the

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<sup>34</sup> It is beyond the scope of this paper to explain the “capacity assessor” system in Ontario. Attached as Appendix to this paper is a chart called “Who Assesses Capacity Under What Circumstances” that includes the definition of capacity assessor and explains when capacity assessors as opposed to other persons must be used to assess capacity under the *SDA* and *HCCA*. It is key to understand is that capacity assessors do not have a monopoly on capacity assessment and need only to be used to assess capacity **when the legislation so requires**. Capacity assessors do not assess capacity in respect to treatment, admission, or personal assistance services and should not be used for assessments of capacity under the *HCCA*.

authority of their SDM so that they can determine whether they need to execute additional documents when asked to do so when interacting with the health system. Health practitioners and health facilities and services of all types should become more knowledgeable on the consent to treatment framework and the *Health Care Consent Act* and relevant key decisions of the court and the Consent and Capacity Board that will help them have confidence in the consent process. Health practitioners need to understand how advance care planning works and fits into the consent process and understand that advance care planning documents are not consents.

Administrators and authorities supervising health facilities need to review consent and advance care planning documents and policies used within their facility or service to ensure that these documents reflect the current legal framework and facilitate the health practitioners and providers working within that facility or service to obtain proper consent, and to respect the advance care planning communications that the patient may have expressed when capable.

## WHO ASSESSES CAPACITY UNDER WHAT CIRCUMSTANCES

PROPERTY	Who Assesses Capacity
<b>A. Contracts</b>	
To make a contract	Parties to the contract (common law)
<b>B. Continuing Power of Attorney for Property</b>	
To make a CPOAP	Person assisting person to make the document
To activate a CPOAP	No assessment required - CPOAP is activated on signature unless it states otherwise
To activate the CPOAP if it contains a clause that it is not to come into effect until incapacity	Person/Professional named in the CPOAP to determine incapacity - If no one or no class of persons is named in the CPOAP to determine capacity, then it would be done by a CAPACITY ASSESSOR as defined by the <i>Substitute Decisions Act</i>
<b>C. Statutory Guardianship</b>	
<b>Psychiatric Inpatient</b> - For property management on admission as an inpatient for <b>care, observation or treatment</b> for a mental health problem	Physician ( <i>Mental Health Act</i> and s.15, <i>Substitute Decisions Act</i> )
<b>Psychiatric Inpatient</b> - For property management on discharge from the psychiatric facility	Physician ( <i>Mental Health Act</i> )
<p><b>Person who is any place other than a psychiatric facility</b> (own home, hospital, long-term care home)</p> <p>NOTE: For the <i>Mental Health Act</i> process to be used, the patient must be an <b>inpatient</b> in a psychiatric facility and must be in the facility for <b>care, observation, or treatment of the psychiatric disorder</b>. This process does <b>NOT</b> apply to elderly patients in hospitals even if the hospital is defined as a "psychiatric facility" under the <i>Mental Health Act</i> unless that elderly patient is in that hospital for CARE, OBSERVATION or TREATMENT of a psychiatric disorder.</p>	Capacity Assessor (s.16, <i>Substitute Decisions Act</i> )

<b>D. Court Ordered Guardianship of Property</b>	
Summary Application (application to court that does not require an appearance before a Judge)	Capacity Assessor and a person who knows the alleged incapable person ( <i>Substitute Decisions Act</i> )
Full hearing before a Judge	Capacity Assessors, other health professionals, others that know the alleged incapable person ( <i>Substitute Decisions Act</i> )

<b>PERSONAL CARE</b>	<b>Who Assesses Capacity</b>
<b>A. Power of attorney for Personal Care</b>	
To make a POAPC	Person assisting person to make document (common law)
To activate POAPC for SDM to make treatment decisions	Health professional proposing treatment ( <i>Health Care Consent Act</i> )
To activate POAPC for SDM to make decisions for admission to a long-term care home	Evaluator (see definition below)
To activate POAPC for SDM to make decisions for personal assistance services in a long-term care home	Evaluator
To activate POAPC for non-health care personal decisions where POAPC does not require an assessment before activation	Attorney named in the POAPC
To activate POPAC for non-health care personal care decisions where POAPC specifies a method of assessment	Person/class of persons specified in the document to do the assessment
To activate POAPC where POAPC silent as to method preferred but does require an assessment before activation	Capacity Assessor (see definition below)
<b>B. Health Care Consent</b>	
Treatment	Health practitioner offering the treatment
Admission to a long-term care home	Evaluator
Personal assistance services in a long-term care home	Evaluator

“Evaluator” means, in the circumstances prescribed by the regulations,

- a member of the College of Audiologists and Speech-Language Pathologists of Ontario,
- a member of the College of Dietitians of Ontario,
- a member of the College of Nurses of Ontario,
- a member of the College of Occupational Therapists of Ontario,
- a member of the College of Physicians and Surgeons of Ontario,
- a member of the College of Physiotherapists of Ontario,
- a member of the College of Psychologists of Ontario, or
- a member of a category of persons prescribed by the regulations as evaluators; (*HCCA*, s.2)

In addition to the health practitioners listed in this definition, social workers are added by Regulation 104/96 as amended by O. Reg. 517/10 under the *Health Care Consent Act* as evaluators. The term "social worker" is defined as a member of the Ontario College of Social Workers and Social Service Workers who holds a certificate of registration for social work.

"**capacity assessor**" is defined in the *Substitute Decisions Act*, Regulation 460/05. This regulation states:

**2.** (1) A person is qualified to do assessments of capacity if he or she,  
(a) satisfies one of the conditions set out in subsection (2);  
(b) has successfully completed the qualifying course for assessors described in section 4;  
(c) complies with section 5 (continuing education courses);  
(d) complies with section 6 (minimum annual number of assessments); and  
(e) is covered by professional liability insurance of not less than \$1,000,000, in respect of assessments of capacity, or belongs to an association that provides protection against professional liability, in respect of assessments of capacity, in an amount not less than \$1,000,000.

(2) The following are the conditions mentioned in clause (1) (a):

1. Being a member of the College of Physicians and Surgeons of Ontario.
2. Being a member of the College of Psychologists of Ontario.
3. Being a member of the Ontario College of Social Workers and Social Service Workers and holding a certificate of registration for social work.
4. Being a member of the College of Occupational Therapists of Ontario.
5. Being a member of the College of Nurses of Ontario and holding a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse.

**(3)** The requirement that the person hold a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse, as set out in paragraph 5 of subsection (2), does not apply to a member of the College of Nurses of Ontario who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act.



(4) Clause (1) (b) does not apply to a person who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act.

### **Guidelines**

Capacity Assessors are required to conduct assessments in the manner and form as described in the “Guidelines for Conducting Assessments of Capacity” established by the Attorney General, dated May, 2005, available on the internet website of the Ministry of the Attorney General at <http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp> are prescribed.

Failure to comply with the prescribed guidelines may result in a complaint to the college of the regulated health profession of which the assessor is a member.