ACE
Advocacy Centre for the Elderly

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VIA EMAIL: consent@cpso.on.ca

Attention: Policy Department
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario M5G 2E2

Dear Sir/Madam,

Re: Consultation on *Consent to Medical Treatment*, Policy #4-05

We write further to your online request for stakeholder feedback on the College of Physicians and Surgeons of Ontario Policy entitled *Consent to Medical Treatment* (the "Consent Policy")

Please accept the below comments for consideration.

About the Advocacy Centre for the Elderly (ACE)

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE staff have had extensive experience in issues related to health care consent and advance care planning and have been involved in many of the law, policy, and education initiatives related to these issues that have taken place in Ontario over the last 30 years. These have included:

- participation as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992* and subsequently the *Health Care Consent Act, 1996*[i];

- acting as one of the principal writers of the training materials for health professionals that were produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;

- currently participating on the Advisory Committee for the Law Commission of Ontario Project on Legal Capacity, Decision-making and Guardianship; and,

- currently participating on the Ontario Medical Association Presidents Advisory Committee on Palliative Care and Advance care Planning.

Commentary on the Consent Policy

The Consent policy accurately reflects the law on consent as set out in the *Health Care Consent Act* (the "*HCCA*") except for one point. We also would like to suggest two additions to the policy based on our experience in doing education for physicians on health care consent and advance care planning. That experience has helped us identify common misunderstandings that the College may want to address in this policy.

1. Critique: When Physician believes the SDM is not complying with the Principles for Substitute Decision-Making in the HCCA

The one critique of the Consent policy, where we would submit that it is not correct, is on Page 6, fourth Paragraph. That paragraph states:

> A physician must consider whether the substitute decision-maker is complying with the principles set out in the HCCA. If a physician is of the view that the substitute decision-maker is not acting in accordance with the HCCA, he or she can call the Office of the Public Guardian and Trustee.

This section refers to a role for the Office of the Public Guardian and Trustee (the "OPGT") that we do not believe is set out in legislation. This section should also reference the obligation of a physician to advise SDMs of the principles they are required to follow when making decisions on behalf of incapable patients and does not reference the specific remedy (an application to the Consent and Capacity Board) set out in the *HCCA* for when a physician believes that an SDM is not acting in accordance with these decision-making principles.

a) OPGT's Role

It is unclear what role the OPGT would play when contacted by a physician pursuant to the above paragraph. We are not aware of any provision in the legislation that gives the OPGT any role or particular authority when contacted by a physician. Presumably, this paragraph envisages that the OPGT will either educate SDMs on what the law states

they need to consider when making decisions for patients, or to direct SDMs to make decisions in a particular way. If the OPGT is indeed acting in such a role, we are not aware of it. We suggest that the CPSO speak with the OPGT to determine whether they offer any services in this respect that would assist physicians.

According to the *HCCA*, the OPGT is the SDM of last resort if the patient has no other SDM that is higher ranking on the SDM hierarchy (as correctly stated on page 5 of the Consent policy). As well, the OPGT must act as SDM for the patient if equal ranking SDMs disagree and that disagreement cannot be resolved (see *HCCA* s. 20(6)). However, this is different from the OPGT being contacted by the physician where the physician believes an SDM is not acting in accordance with the *HCCA*.

> ***Recommendation:*** ***Unless the OPGT advises the CPSO that they are willing to act in the role as described in the existing Consent Policy, we would suggest that this statement as it is worded now be removed from the Consent Policy .***

On a related point, the Consent Policy contains a Statement about the Role of the OPGT when equal ranking SDMs disagree (page 6):

> If there is disagreement between persons described in the same paragraph, which cannot be resolved, then the Public Guardian and Trustee may be called upon to make the decision. [Emphasis Added]

We suggest that the word "may" in this sentence be changed to "must" We suggest this change because the wording in s. 20(6) of the *HCCA* is that the OPGT must act as SDM

> **Conflict between persons in same paragraph**
> 20…(6) If two or more persons who are described in the same paragraph of subsection (1) and who meet the requirements of subsection (2) disagree about whether to give or refuse consent, and if their claims rank ahead of all others, the Public Guardian and Trustee shall make the decision in their stead.

We recognize that the wording as it is now is correct in that it states that the physician "may" call the OPGT when with a conflict between SDMs. However our experience in education programmes is that physicians have not understood that the OPGT is required to act when contacted. Knowing that the OPGT is required to act as SDM may assist physicians in discussions with SDMs that cannot reach an agreement. Disagreeing SDMs may seek resolution of their differences because they would not want the OPGT to receive authority to act.

b) Responsibility of Physician to Advise SDMs of their Obligations

SDMs do not necessarily understand that they are required by law to follow particular principles for decision-making when making decisions on behalf of the incapable patient.

In the view of ACE, physicians have a legal obligation to advise SDM's of their decision-making obligations. We note that the decision of the Court of Appeal for Ontario in *Benes v. A.M*[ii] places this responsibility on health practitioners.

<u>Recommendation:</u> We would suggest that the Consent Policy be amended to include a statement advising physicians of their obligation to explain these principles to SDMs.

c) Application to Consent and Capacity Board under s. 37 of the *HCCA*

The Consent Policy makes no reference to the availability of an application to the Consent and Capacity Board (the Board) where physicians believe that an SDM is not in compliance with the principles for decision-making as set out in s. 21 of the *HCCA*. That application is detailed in s. 37 of the HCCA.

The parties to the application include the physician, the SDM, the incapable patient and anyone else that the Board specifies. As part of the hearing, the Board will also review the finding that the patient is incapable with respect to the proposed treatment. In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker, may give directions to the SDM, and if the SDM does not comply with the Board's directions within the time specified by the Board, remove the SDM's authority to act on behalf of the incapable patient. The physician would then be able to turn to the next highest ranking SDM for the patient in the hierarchy. Subsequent substitute decision-makers are required to comply with the directions given by the Board on the application

<u>Recommendation:</u> We would suggest that the Consent Policy be amended to include a brief explanation of the s.37 application to the Consent and Capacity Board.

From our experience with education programmes for health practitioners, and particularly for physicians, we have found that there is a common misconception that the OPGT office can and will deal with any conflicts with SDMs, such as disagreements with SDMs about compliance with the principles for decision-making. Physicians also sometimes incorrectly believe they may contact the OPGT to 'take away' authority under a power of attorney for personal care where an SDM does not agree with a treatment recommendation. We believe it would be useful to address these points in the Consent Policy.

2. Suggested Additions to the Policy

a) Include Requirements to be an SDM

The Consent Policy correctly sets out the hierarchy list of SDMs in s. 20(1) of the *HCCA*. However what is not included in the Consent Policy is a reference to the requirements that a person must meet to act as the SDM. The fact that a person is

highest ranking in the list for the incapable patient is not enough. That person must also meet the requirements as set out in s. 20(2) of the *HCCA*:

> 20…(2) *A person described in subsection (1) may give or refuse consent 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.*

In ACE's education sessions, we have frequently been asked by physicians and other health practitioners what they should do if the highest ranking person in the list for the incapable patient is not themselves capable. The answer is simply that the physician may then turn to the next highest ranking person because the person that is incapable cannot meet the requirements to be the SDM. Of course, health practitioners cannot use this authority to select which potential SDM they will deal with.

Health practitioners have also addressed concerns to us about SDMs that are not available or "disappear" when decisions need to be made for incapable patients. Health practitioners should be advised that they may turn to the next highest ranking SDM for the patient in these circumstances if they feel that delay to reaching the first SDM would not be appropriate, considering the patient's needs.

> ***<u>Recommendation:</u> We would suggest referencing the requirements to act as an SDM set out in s. 20(2) of the HCCA in the Consent Policy. The Consent Policy should also note that, where an SDM is incapable, the physician may proceed to the next SDM on the hierarchy.***

b) Include Contact Information for the OPGT

We have been advised by physicians that they are not aware of where to call when they need to contact the OPGT for health care decision-making matters. Some physicians have said that they call the OPGT and are advised that the OPGT does not act as SDM. Knowing this to be incorrect, we inquired further of these physicians as to where they called when they got that answer. In more than one instance, the call had not been made to the Treatment Decisions Unit, and they had spoken with someone in another section of the OPGT office that deals with property.

Although these instances where the physician was not properly redirected to the right part of the OPGT office may be rare, this issue has been raised on a number of occasions at physician's education sessions. Also, physicians have told us that they do not call the OPGT although it would be appropriate to do so because the issue they faced needed resolution after 5:00 pm. They assumed that the OPGT Treatment Decisions Unit were available only from 9 to 5, which is incorrect.

It may not be appropriate to include in the policy specific telephone numbers for the OPGT offices as these may change over time, however adding a paragraph to the Consent Policy that provides some direction to physicians as to what part of the OPGT office to contact (Treatment Decisions Unit) , info on the OPGT website where the contact numbers are located, and hours that physicians may expect to reach the OPGT Treatment Decisions Unit would address the questions that are commonly asked about the OPGT office at the education sessions.

<u>Recommendation:</u> We would suggest that the Consent Policy be amended to add information on where and how to contact the OPGT Treatment Decision Units.

c) Authority of Wishes/Directions in an Advance Care Plan

The CPSO has a separate Policy on Decision Making for End of Life that does refer to advance care planning and advance directives. Our comments about that Policy will be in a separate letter. Although this other policy exits, we do suggest that some reference be made in the Consent Policy about advance care planning, and in particular, who interprets the wishes/directions expressed in any advance care plan, whether oral, written, or expressed by other means. The Consent Policy should also note that SDMs cannot advance care plan on behalf of incapable patients.

The End of Life Policy correctly states on page 4 that wishes in an advance directive are to be interpreted by the patient's SDM and are not directions to a health care practitioner and do not constitute a consent or refusal of consent. It may be very worthwhile to include that statement in the Consent policy and reference the End of Life Policy for further details.

We make this recommendation because of the many misunderstandings by health practitioners about advance care planning we have identified in the course of both our education activities, as well as our client work at ACE. Physicians may have experience or training in other jurisdictions where the law may be that health practitioners can take direction from the advance directive and as such, don't know that the law is different in Ontario.

Some physicians have been surprised when we explain Ontario law, as they assume that if something is written down by the patient they are required to take direction from it, like a contract.

When we explain that Ontario law situates such directives within the law of informed consent (except in emergencies), and that informed consent has to come from a person, not a document, physicians understand why the SDM has the authority and responsibility to interpret and apply the directive to determine if it is applicable to the decision to be made. A decision-maker (either the patient if capable, or their SDM if the patient is not capable) can communicate with the physician and contextualize treatment options in the patient's present health condition, consider the applicability of advance directives with that information, and then give or refuse informed consent.

With all the attention presently being paid to advance care planning in Ontario, and the amount of information that is being distributed on advance care planning in health facilities and in the health system, not all of which is legally correct, it would be helpful to clarify this particular point in the Consent Policy as well as provide further explanation in the End of Life Policy.

> ***<u>Recommendation:</u> We suggest that a statement be included in the Consent Policy that wishes in an advance directive are to be interpreted by the patient's SDM and are not directions to a health care practitioner (except in an emergency) and do not constitute a consent or refusal of consent. It should also include a statement that SDMs cannot advance care plan on behalf of incapable patients.***

Conclusion

We would like to thank the CPSO for this opportunity to provide feedback on the Consent Policy, and would be pleased to clarify or discuss any aspect of this commentary going forward.

Yours truly,
ADVOCACY CENTRE for the ELDERLY

Judith A. Wahl
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[i] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A
[ii] 1999 CanLII 3807 (ON CA) at para. 23