The Use and Misuse of Advance Directives

In Ontario, an expression of an individual's wishes with respect to future health care decisions is generally referred to as an 'advance directive.' These wishes may also be referred to as personal directives, treatment directives or proxy directives. A 'living will' is not a binding legal document but another form of advance directive, which sets out an individual's wishes in relation to a terminal illness.

The *Health Care Consent Act* (HCCA), which is the legislation governing consent to treatment in Ontario, does not refer to the term advance directive, but rather speaks in terms of 'wishes.' The legislation recognizes that a person may, while capable, express wishes with respect to treatment decisions that are to be made on his or her behalf in the event that he or she becomes incapable. A person is capable if he or she has the ability to understand the information relevant to the treatment decision and to appreciate the reasonably foreseeable consequences of the decision or lack of decision.

Wishes may be expressed in a power of attorney for personal care, made under the *Substitute Decisions Act*. Wishes can be expressed in any written form, orally or in any other manner (i.e., by gesture or assisted forms of communication). Later wishes expressed by a capable person prevail over earlier wishes, regardless of form.

What does an advance directive do?

An advance directive speaks to the substitute decision-maker and guides the treatment decisions that he or she makes on behalf of an incapable person. The HCCA sets out who may act as substitute decision-maker, as well as the principles for decision-making.

by Kathryn Frelick

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The substitute decision-maker is required to make treatment decisions in accordance with an individual's prior capable wishes, if known; or, if otherwise, in the person's best interests as defined by legislation.

Wishes in the form of advance directives or otherwise do not constitute consent for treatment. Consent for treatment, including the withholding or withdrawal of treatment, must be obtained at the time the treatment is proposed—from the resident, where capable, or the substitute decision-maker where the resident is incapable.

Must a health care provider follow an advance directive?

The one time that an advance directive may influence a health care provider directly is in an emergency situation where the resident is incapable and a substitute decision-maker is unavailable to provide consent. In that situation, the health care provider proposing the treatment may refer to an advance directive in order to determine whether the resident has expressed any wishes while capable that are relevant to treatment in the particular situation. Health care providers may not administer emergency treatment if they have reason to believe that such treatment is contrary to the wishes of the individual.

The Ontario Court of Appeal has looked at this issue relative to the refusal of blood products. An individual who was a Jehovah's Witness was brought to the emergency room of a hospital and required an immediate blood transfusion. The unconscious patient had a signed card in her purse stating that she was not to be given a blood transfusion. The physician was not satisfied that the signed card expressed the patient's current wishes and gave her a blood transfusion. The patient subsequently sued the physician.

The Court of Appeal confirmed that a capable adult is entitled to reject a specific treatment or all treatment, even if the decision may entail risks as serious as death. The court stated that unless the doctor had reason to believe that the instructions in the signed document were not valid instructions then he was obliged to honour those instructions. Without contrary evidence, such instructions should be taken as validly representing the patient's wishes. Although the physician saved the patient's life, he was found liable for damages for administering treatment contrary to her wishes.

As a final point, if a health practitioner believes that the substitute decision-maker is not acting in accordance with the person's prior capable wishes, the practitioner may request a hearing before the Consent and Capacity Board to seek further direction. In an emergency situation, if consent to treatment is refused or withdrawn by the substitute decision-maker, health practitioners may administer treatment despite the refusal if they are of the opinion that the substitute decision-maker is not complying with the principles for decision-making.

What do long term care homes need to have in place around advance directives?

At a minimum, long term care homes should have processes in place to ensure that there is appropriate communication around advance directives. For example, where an advance directive accompanies a resident, it should be reviewed with the resident to ensure that the wishes expressed are current. The advance directive may be placed on the health record or flagged in some manner. Information regarding wishes set out in the advance directive must be communicated effectively to the health care team. Wishes communicated orally must also be effectively communicated to the substitute decision-maker and the health care team.

It is not uncommon for long term care homes to develop their own form of advance directive. Residents are not required to use any particular form, nor are they required to provide an advance directive. It is important to explore each resident's wishes at the outset. By initiating these discussions, the long term care home can try to address these issues as early as possible.

If a particular form of advance directive is being offered, the wishes identified should be clear and specific. Statements regarding the provision of 'heroic measures,' for

example, can lead to many different interpretations and it may be unclear whether they are applicable in the circumstances. For example, different people may disagree on whether treating pneumonia with antibiotics would be considered 'heroic measures' in any situation or in the particular context.

Ongoing communication is necessary because residents who have indicated their wishes through a written advance directive may change their mind at a later date. Ontario law upholds a resident's most current wishes, regardless of how those wishes are communicated. To this end, an advance directive should be reviewed with the resident where there have been significant changes to the resident's condition or if there is an indication from the resident that there is a change in his or her wishes.

What are the legal risks for following an advance directive?

The HCCA provides protection from liability for health practitioners who provide treatment or do not administer treatment based on an apparently valid consent or refusal, provided they are acting in good faith. As with any activity, a health practitioner will not be protected from liability where his or her actions are negligent; that is, if they fall outside the standard of care and that breach causes harm or injury to the individual. Similarly, a long term care home can be liable for the negligent actions of its employed staff members or if it does not have reasonable systems in place.

Unfortunately, there is a tension with the federal Criminal Code, which has not been amended to reflect the protections from liability under the HCCA. For example, there is a provision that relates to the duty to provide the necessaries of life and another provision that states that where a person undertakes to administer surgical or medical treatment to another person, that person is under a legal duty to have and to use reasonable knowledge, skill and care. Thus, it is possible that failure to treat in a given situation may result in criminal charges against a physician and the long term care home. The best way to avoid this risk is to ensure that there are proactive strategies in place to deal with these situations at an early stage.

End of life decisions

Many residents entering long term care homes have clear views about the interventions they wish to receive or not receive—including resuscitative interventions. In providing appropriate end of life care, long term care homes should assist residents and their substitute decision-makers to consider these issues and ensure that there is effective communication around the resident's wishes in this regard. Discussions surrounding the resident's wishes should be initiated at an early opportunity, with the involvement of family members and substitute decision-makers where possible.

One of the difficulties surrounding

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Primer on powers of attorney for personal care

A power of attorney for personal care (POA/PC) is a legal document created under the *Substitute Decisions Act* in which the person granting the authority (the 'grantor') names a specific individual or individuals to make health care decisions if, and only if, the grantor is determined under the law to be incapable of making those decisions.

Health care decisions under the *Health Care Consent Act* relate to treatment, admission to a long term care home or personal care decisions in a long term care setting.

Why have a power of attorney for personal care?

A POA/PC permits the grantor to set out specific instructions regarding treatment, admission to a long term care home or personal care decisions in the event that the grantor becomes incapable of making them. The attorney for personal care is required to follow the wishes or advanced directives as set out by the grantor in the POA/PC. Thus, it is a means of enabling residents to retain a measure of control over decisions relating to their health needs up to, and including, end of life decisions.

Is there another way to determine in advance the treatments residents wish to receive in the event they become incapable?

All wishes that are expressed while capable must be followed by a substitute decision-maker in making decisions on behalf of an incapable person. In addition to being set out in a POA/PC, wishes may also be expressed in a separate written document, orally or in any other manner.

Later wishes expressed by an individual while capable prevail over earlier wishes. Therefore, a later verbal directive would prevail over an earlier written directive. However, if the original wishes are in writing, it would be wise to put the later wishes in writing as well, to avoid confusion at a later date. It is essential to date all documents to ensure that individuals making decisions on behalf of the incapable person do so in keeping with the last known, relevant, capable wish.

Does a power of attorney for personal care permit the attorney to make decisions about financial affairs?

No. A separate document called a power of attorney for personal property (POA/PP) must be completed to designate someone to manage financial affairs. Similarly, a POA/PP does not give an individual authority to make decisions about a resident's health care.

resuscitative intervention is the convention that has developed that consent is presumed unless it has been specifically refused. This leads to the expectation that cardiopulmonary resuscitation will always be performed, even where not appropriate as a treatment modality. Given the potential legal liabilities surrounding resuscitative interventions, there should be clear communication about any proposed treatment plans—and whether these include resuscitative interventions or not—and clear direction from residents or substitute decision-makers in regard to their wishes in this regard.

Advance directives can be an extremely effective vehicle to ensure that a resident's wishes relating to future health care decisions are communicated and can be followed at the appropriate time. It involves more than checking off a few boxes on a form. Long term care homes are encouraged to develop effective processes to address issues relating to consent to treatment, substitute decision-making, advance directives and end of life decision-making for their residents. **LTC**