25 COMMON MISCONCEPTIONS ABOUT THE *SUBSTITUTE DECISIONS ACT* AND *HEALTH CARE CONSENT ACT*

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INTRODUCTION

This paper focuses on common misconceptions or misunderstandings about the *Substitute Decisions Act* (SDA) and the *Health Care Consent Act* (HCCA). All of these misconceptions have been raised by health professionals, community workers, and seniors and their families at education sessions presented by the Advocacy Centre for the Elderly (ACE) and in the course of representation of clients by ACE staff.

This paper is an updated version of a paper that appears in *A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario* edited by Dr. Hy Bloom and Michael Bay.

COMMON MISCONCEPTIONS

CAPACITY

1. If a person is of an advanced age or has a physical or mental disability, then that person is presumed to be incapable.

NO. THIS IS NOT TRUE. *Everyone* is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services (HCCA, s.4(2)). The definition of capacity does not make exceptions for age, physical disability or mental disability. The definition of capacity in the SDA and HCCA is a LEGAL DEFINITION, not a clinical definition, and is not based on a diagnosis. Just because someone has a particular health condition, disease, or even mental disorder does not mean that he or she is necessarily mentally incapable. This is similar to the SDA where the person may be older or mentally ill and may still be capable to make some or all decisions in respect to property and their person.

The key to the legal test for capacity is whether the person understands the information that is relevant to making a decision and is able to appreciate the reasonably foreseeable consequences of the decision or lack of the decision (HCCA, s.4(1)).

A person who is very old may, and most often does, have this capacity. A person with a physical disability, even if that physical disability makes communication difficult, is likely to have this mental capacity. Even a person who has been diagnosed as being mentally ill may still have capacity to make particular property, personal, treatment, admission and personal assistance service decisions.

2. If a health practitioner believes that a person is not capable in respect to treatment, he or she must get a second opinion about that person's capacity from a psychiatrist or special "capacity assessor".

THIS IS NOT TRUE. Section 10 of the HCCA makes it clear that the health practitioner proposing the treatment must decide whether the person is mentally capable to consent to the particular treatment proposed. If the health practitioner wants to get a second opinion, it is open to him or her to do so but this is not a requirement. The health practitioner is deemed to be the "expert" in determining capacity as defined by the HCCA in respect to treatment within his or her own area of practice and expertise.

3. As special "capacity assessors" were created in the SDA, health practitioners who are not qualified as "capacity assessors" can no longer do any assessments of mental capacity.

THIS IS NOT TRUE. Health practitioners who know how to do capacity assessments may continue to do these assessments, even if not qualified as a "capacity assessor" except in those circumstances where the legislation requires that the assessment be done by a "capacity assessor".

Ontario Regulation 460/05 states that:

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.

…

This regulation defines what is called a “capacity assessor” in the legislation. The persons acting as assessors as so defined are required to perform capacity assessments in accordance with the “Guidelines for Conducting Assessments of Capacity” established by the Attorney General. The most recent version is dated May 5, 2005 and it can be found on the internet at http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-06/guide-0505.pdf.

Two of the reasons the classification of "assessor" was created was to improve the quality of mental capacity assessments and to make training available for health professionals and others to help them do better capacity assessments.

Capacity assessors are required to be used for limited purposes under the SDA (e.g., assessment for statutory guardianship). However, for assessments of capacity for other purposes under the SDA, other persons, including health professionals who are not qualified as "capacity assessors", may assess capacity.

For example, a grantor of a power of attorney for personal care (POAPC) may specify in that document that before his attorney may act as his personal decision maker under the authority granted in the POAPC, that the grantor's incapacity for personal decisions must first be "confirmed". The grantor may indicate that he wants his incapacity confirmed by a particular health professional or class of health professionals or even by, for example, his Aunt Martha. He may also choose to direct that a capacity assessor must be used. This is his choice. The confirmation of incapacity does not need to be done by a capacity assessor. If no method is specified, then the grantor who requires that incapacity be confirmed before the POAPC is activated will be assessed by a capacity assessor as stipulated in section 49(2) of the SDA.

Under the HCCA, health professionals assess capacity of the person to whom they are proposing treatment (HCCA, s.10).

A special class of health professionals, called "evaluators", assess the mental capacity of persons for the purpose of decisions for admission to care facilities (i.e., long-term care homes) and for personal assistance services. An "evaluator" is defined as a member of the College of Audiologists and Speech-Language Pathologists of Ontario, College of Nurses of Ontario, College of Occupational Therapists of Ontario, College of Physicians and Surgeons of Ontario, College of Psychologists of Ontario, or a member of a category of persons as prescribed by the Regulations (HCCA, s.2). Regulation 104/96 made under the HCCA adds social workers to this list. A "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.

Note that the assessment of capacity by an evaluator is an assessment of *mental capacity* in accordance with the legal definition of capacity and NOT a functional or clinical assessment. Although some of the evaluators may *also* do a functional assessment of a person for the purpose of admission to a long term care home, this is NOT the same assessment as is done for the purposes of the HCCA. While a person may be assessed as "needing" or being likely to benefit from admission to a long term care facility as he or she is having difficulty coping at home or in their present accommodation, either because of physical or mental issues, that person may be mentally capable in respect to the admission decision. The two assessments are different although the same person may do them.

4. Due to the existence of the HCCA and the SDA, physicians may not give opinions in respect to capacity for the purpose of the *Old Age Security Act* or the *Canada Pension Plan Act*.

THIS IS NOT TRUE. Human Resources Development Canada says that a Certificate of Incapacity (or Certificate of Incapability), a special form created by the Income Securities Branch, be completed to appoint a trustee to manage an incapable person's Old Age Security (OAS) and Canada Pension Plan (CPP) pension cheques. The OAS and CPP legislation does not specify that a particular health professional must perform the assessment of capacity. The legislation only requires that the evidence of incapacity must satisfy Human Resources Development Canada. This was done to accommodate people in communities in all regions of Canada, including the far north and isolated areas in every province in which health professionals may not be easily accessible. The Certificate of Incapacity is often completed by a health practitioner (e.g., physician, psychologist or nurse) but it could be completed by an engineer, a teacher, or a religious leader if a health professional is not available.

The HCCA and SDA did not affect the *Old Age Security Act* or the *Canada Pension Plan Act* and in particular did not remove the opportunity for a health practitioner to give an opinion in a Certificate of Incapacity about the capacity of a person to handle their finances.

5. If a person has been "assessed" by a health professional as being mentally incapable for some purpose, then he or she is mentally incapable for all purposes.

THIS IS NOT TRUE. If a person has been assessed as being mentally incapable for some purposes, that same person may still be capable for other purposes. Remember that capacity is issue specific. It relates to a particular task at hand. It is not uncommon to find that somebody is not capable with respect to finances, but still retains capacity

with respect to treatment, admission to long-term care, personal assistance services or other personal decisions. In other words, a person may be incapable in respect of one treatment, but still be capable in respect of other treatments (HCCA, s.15). Even if incapable for a treatment at one time, that same person may become capable again (HCCA, s.15). In that case, the person's decisions in respect to treatment must be followed even if a substitute decision-maker (SDM) had previously given or refused consent on behalf of that person.

Health practitioners should not make assumptions about capacity based on previous assessments. One health practitioner may disagree with an assessment of capacity done by another health practitioner. It is the responsibility of the health practitioner proposing the treatment to make the decision in respect to the person's capacity in respect to the treatment (HCCA, s.10).

Although the health practitioner proposing the treatment must make the decision about a person's capacity in respect to treatment, he or she may rely on another health practitioner's assessment of capacity. For example, in some cases, one health practitioner may wish to get a second opinion or a facility policy, rather than law, may require that the staff consult with particular health practitioners who have expertise in assessing mental capacity; however, the health practitioner who relies on the opinion of another health practitioner is still responsible for that assessment of capacity if he or she relies upon it.

6. If a resident is in a long-term care home or a patient in a psychiatric facility, then it can be presumed that the person is incapable in respect to health decisions.

THIS IS NOT TRUE. The place where a person resides or is temporarily living does not determine whether they are capable or incapable in respect to some or all decisions they are making. Just because a person has consented to move to a long-term care home and requires a variety of care services and treatments, there is no automatic implied consent to the treatment. Proper informed consent to the treatments delivered to that person in the long-term care home must be obtained from the resident, if he or she is mentally capable for this purpose, or from the proper SDM if the resident is not mentally capable. Even if a person has been treated as though he was incapable in a long-term care home and then that same person becomes a patient at a hospital, it is up to the health practitioner providing that person with treatment at the hospital to reach her or his own opinion as to whether that person is capable or not.

Although section 12 of the HCCA says a health practitioner is entitled to presume that consent to a treatment includes consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change of the setting in which it is administered, this does not mean that the health practitioner providing treatment in

the new setting (i.e. the hospital) may not conclude that the person is now capable, although previously determined to be incapable.

Section 16 of the HCCA is clear that if, after consent to a treatment is given or refused on a person's behalf in accordance with the HCCA, and the health practitioner is of the opinion that the person is now capable with respect to the same treatment, the person's own decision to give or refuse consent to the treatment governs. Therefore, even if consent was previously given by a SDM, if the health practitioner believes that the person is now capable, the health practitioner should turn to the person for the consent or refusal of consent to treatment when the treatment is delivered.

7. The presumption of capacity in the HCCA means that if a person does not object to the treatment (or admission to a care facility or consent to a personal assistance service), then he or she is capable in respect to that particular decision.

THIS IS NOT TRUE. The presumption of capacity means that a person is presumed to be mentally capable with respect to treatment, admission to a care facility, and personal assistance services (HCCA, s.4(2)). This presumption is intended to give the benefit of the doubt to the individual, to respect an individual's right to control his or her own life and to honour that person's power over decisions that are being made with respect to his or her own person.

What does it mean to be "mentally capable"? "Capacity" under section 4 of the HCCA means that the person "is able to understand the information that is relevant to making a decision about the treatment, admission, or personal assistance services, as the case may be, and is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision".

Capacity focuses on both the ability to understand and the ability to appreciate the consequences of a decision or lack of decision. This is a two-part test. A person is not capable if he or she fails either part of the test.

The first branch of the test is a cognitive test. A person must have the cognitive ability to process, retain and understand the relevant information. The fact that a person is passive does not mean that he or she understands and appreciates the decision that is being made. A lack of response from a patient does not mean that the health practitioner may presume that the person is capable. Likewise, the passivity does not mean that the person is incapable. All it means is that he or she is PASSIVE!

The second branch of the test includes two elements. First, the person must be able to recognize that he or she displays a certain kind of behaviour or physical condition. Second, the person must be able to appreciate the consequences of treatment or non-treatment for that behaviour or physical condition.

The legislation and the case law emphasizes that the health practitioner must look at the individual who is in front of her from whom he or she is seeking a decision and evaluate that person's ability to understand and appreciate the particular decision that is at hand. The presumption is that a person does "understand and appreciate" however if the health practitioner has reason to believe that that person is not capable, then the health practitioner should advise the individual of the finding of incapacity and right of review, and turn to the proper SDM for the consent or refusal of consent to treatment. Please see Misconception #21 for more details about a health practitioner's duty to provide information of the finding of incapacity and the right of review to a person believed to be incapable.

8. There is no need to inform a person that they are going to undergo a capacity assessment. If you tell that person, he or she is likely to refuse to be assessed and that would defeat the purpose of doing an assessment.

THIS IS NOT CORRECT. Section 78 of the SDA states that a "capacity assessor" SHALL NOT perform a capacity assessment of a person's capacity if the person refuses to be assessed. Before the assessment may take place, the assessor must explain to the person that he or she will be assessed the purpose of the assessment, the significance and effect of a finding of incapacity or capacity, and the person's right to refuse to be assessed. Although there is not a similar section in the HCCA, in a case called *Re Koch*, (1997) CanLII 12138 (ON S.C.), the court stated that this same obligation should lie on persons doing "evaluations" of capacity under the HCCA. In fact, the court also gave the opinion that a person being assessed is entitled to have his or her lawyer or friend or relative present during the assessment if he or she so wishes.

There is an argument that this part of the decision (that evaluators under the HCCA must provide the same information to a person before assessment as capacity assessors do under the SDA) is not the *ratio decidendi* of the decision (the core of the decision) but is *obiter* (and therefore is, in effect, not a "mandatory" step in the assessment process despite what the court said). However, it can still be argued that the court stated forcefully that there must be procedural fairness when assessments are done. Assessments may be subject to challenge if not done in a fair manner, which should require telling the person to be assessed the same information set out in section 78 of the SDA, although the assessment may be under the HCCA.

For assessments of capacity in respect to treatment, health professionals are required to provide information about the consequences of a finding of incapacity as required by their professional College guidelines (HCCA, s.17). This is a minimum standard which should be considered in conjunction with the words of the court in the *Koch* decision to ensure that capacity assessments are done in a fair manner considering the context of the particular person being assessed and the fact that the result of an assessment is a loss of liberty and decision making authority.

9. All advance directives are powers of attorney for personal care.

THIS IS NOT TRUE. The term "advance directive" is a generic term that applies to any kind of document or other means of communicating wishes with respect to future treatment or health care. Section 5 of the HCCA states that wishes may be expressed in a power of attorney for personal care, in a form prescribed by the regulations (no such form exists to date), in any other written form, orally or in any other manner. For example, some people may choose to express their wishes by audio or videotape.

A POAPC is a document by which a person names a SDM for personal decisions. Personal decisions are decisions in respect to health care, nutrition, shelter, safety, clothing and hygiene. For a document to be a power of attorney for personal care, it must meet the technical requirements as listed in the *Substitute Decisions Act*. For instance, it must name a person to act as attorney. The grantor of the POAPC may name more than one attorney to act jointly (together) or severally (all named attorneys have equal authority so they may act either together or separately). The grantor may also provide for substitute attorneys in the event that the named attorney or attorneys are not available, willing or able to act at the necessary time. The substitute attorneys may replace the original attorneys if the named attorneys resign.

The POAPC must also be properly witnessed by two witnesses who must sign as witness in the presence of and at the same time the grantor executes the document. There is no longer a requirement that the witnesses confirm that they have no reason to believe that the grantor was not capable of executing a POAPC at the time he or she executed it. However, as the validity of the power of attorney for personal care depends on whether the grantor was mentally capable to give power of attorney for personal care at the time he or she signs it, it will not be unusual to see witness statements attached to powers of attorney for personal care that confirm that the witnesses had no reason to believe that the person was not incapable at the time of execution of the document.

The document must also have been executed by the grantor (the person making the power of attorney) when the grantor was capable of giving a POAPC in order for it to be valid.

The attorneys named in a power of attorney for personal care only get authority to act as SDM if the grantor is:

(a) incapable for the purposes under the HCCA; or
(b) otherwise incapable in respect to personal decision-making.

Under the HCCA, if a person is found incapable in respect to treatment, admission into a long-term care home or for personal assistance services, the person seeking the consent in any of these three areas turns to the incapable person's SDM. If the proper SDM is the attorney in a power of attorney, then the attorney gets the authority to make the decision for treatment, admission or personal assistance services. Until the person

is found incapable in accordance with the HCCA, the attorney does not have authority to be the decision-maker for these purposes.

For all other personal decision that are not covered by the HCCA, the attorney does not get authority to make personal decisions for the grantor until either the attorney determines that the grantor is incapable or, if the power of attorney document so specifies, until after the grantor's incapacity has been "confirmed".

The grantor may include a provision in the POAPC that it does not come into effect unless the incapacity of the grantor is confirmed by either the method specified in the power of attorney for personal care OR by the method specified in the SDA (by a capacity assessor). The POAPC may provide that the incapacity must be confirmed by a particular health professional, a particular class of health professionals or any other means that the grantor may directs (e.g., the grantor's Aunt Martha). This is the option of the grantor.

The capacity to give a power of attorney for personal care is defined in the SDA as the ability to understand whether the proposed attorney has a genuine concern for the person's welfare and the ability to appreciate that the person may need to have the proposed attorney make decisions for the person (SDA, s.47). This is a fairly low level of capacity. However, if the grantor wishes to include specific directions in respect to personal decision making, such as instructions to the substitute in respect to treatment, the grantor must be capable also for that purpose for which they are giving instructions in order to include these in the power of attorney for personal care.

Another form of advance directive is a "living will". This is commonly defined as a document in which a person does not necessarily name a SDM, but includes directions or expresses wishes in respect to future treatment or health care. A SDM is required to follow the wishes as expressed in a living will, although a living will is not a POAPC.

10. If a person has executed a "power of attorney" document, then the health practitioner should only deal with the named attorney to get consents or refusals of consents for treatment, admission, and personal assistance services, and not the individual.

THIS IS NOT TRUE. Before taking consent or refusal from the attorney, the health practitioner must do the following:

> STEP 1: Determine if the individual is or is not mentally capable with respect to the decision to be made (treatment, admission to long-term care or personal assistance services);
>
> STEP 2: If the individual is incapable, determine if there is a Guardian of the Person with authority to give or refuse consent in priority to the attorney;

STEP 3: If there is no Guardian of the Person with authority to give or refuse consent, determine:

(i) if the attorney is an attorney in a power of attorney for personal care (POAPC) as opposed to a power of attorney for property (POAP);

(ii) if there is a POAPC, whether the attorney has the authority to give or refuse consent to treatment, admission, personal assistance services, depending on the type of decision that needs to be made; and

(iii) whether the attorney meets the requirements for a substitute decision-maker under section 20(2) of the HCCA.

STEP 1: Under the HCCA, if the health practitioner, capacity assessor or evaluator seeks consent to treatment, admission to a care facility, or to personal assistance services, he or she must first determine if the person is capable in respect to the particular type of decision to be made (treatment, admission or personal assistance services).

Only then, if the health practitioner, capacity assessor or evaluator believes that the person is incapable in respect to the decision to be made, can he or she turn to a SDM. An attorney in a POAPC does not get authority to make substitute decisions for the grantor unless the grantor is not capable. Just because a person has executed a POAPC does not mean that he or she is incapable.

STEP 2: The second step is to determine who is the proper SDM. It may or may not be the attorney named in the power of attorney. Section 20 of the HCCA sets out the list of people who may give or refuse consent to treatment. These are, in order of priority:

1. The incapable person's Guardian of the Person (with authority to consent or refuse consent to treatment, admission or personal assistance services).

   Note that there are TWO types of Guardians - Guardians of the Person and Guardians of Property. More people have Guardians of Property than of the person. A Guardian of Property is not the decision-maker in the HCCA list. Even if the person is a Guardian of the person, he or she may NOT have this authority to consent or to refuse consent to treatment/admission/personal assistance services as that authority was not included in the court order naming her as Guardian of the person.

   A health practitioner is entitled to rely on the assertion by the SDM that he or she is a "person described in section 20(1)" unless it is not reasonable to do so in the circumstances. What does this mean? It is submitted that the health practitioner must ask the proper questions of the potential SDM to be able to rely on the SDM's assertion.

   It is not good enough to ask, "Are you the Guardian for this person?" The health practitioner should be asking "Are you the Guardian of the person for this patient and does your court order naming you Guardian give you authority to make

treatment decisions?" Unless the proper questions are directed to the SDM, it would "not be reasonable" to rely on the assertions of the SDM. The protection for the health practitioner against liability exists only if the health practitioner acts properly. The prudent thing to do is to ask to look at the court order to confirm the authority of the Guardian.

2. The incapable person's attorney for personal care with authority to give or refuse consent to the treatment.

3. The incapable person's representative (with authority to give or refuse consent to treatment). This is a person appointed by the Consent and Capacity Board to act in this capacity. The person will therefore have a copy of the decision of the Board that sets out his or her authority.

4. The incapable person's spouse or partner.

5. A child or custodial parent or Childrens' Aid Society.

6. A parent with a right of access.

7. A brother or sister.

8. Any other relative.

STEP 3: If there is no Guardian of the Person with authority to make the type of HCCA decision that is needed to be made (treatment, admission or personal assistance services), is the person an attorney in a POAPC rather than a POAP? Like Guardians, there are two types of attorneys, one for property and one for personal care. The grantor may name the same person to be both or may name different people to fulfil these functions. The grantor may name more than one person to be attorney in a POAPC, to act jointly, or severally, or both. The grantor may name substitute attorneys in the event that the named attorney is unable or unwilling to act.

Does the attorney in the POAPC have the authority to give or refuse consent to treatment? A grantor may decide that he or she wants an attorney in a POAPC to make other personal decisions for him or her, such as decisions in respect to nutrition, safety and clothing but NOT decisions about health care or treatment. The attorney only gets the authority specified in that particular document. Therefore, the health practitioner needs to ask the right questions to determine if the attorney is an attorney in a POAPC and has the authority to give or refuse consent to treatment. It is preferable to see the document to determine if the attorney has the authority that is required rather than relying on oral assertions of the authority to act decision-maker.

Even if the attorney is named in a POAPC and has the authority to give or refuse consent to treatment, does the attorney meet the requirements to be a SDM under section 20(2) of the HCCA? The attorney must: be capable in respect to the treatment

proposed for the incapable person; be at least 16 years of age, unless he or she is the incapable person's parent; not be prohibited by a court order or separation agreement from having access to the person or of giving or refusing consent to treatment on his or her behalf; be available; and be willing to assume the responsibility of giving or refusing consent. If the attorney does not meet these qualifications, then the health practitioner must turn to the next person on the list who has the highest priority and meets these qualifications.

11. If a person has executed a power of attorney for personal care, an advance directive, a living will or some other kind of document in which he or she expresses his or her wishes in respect to treatment, admission to a care facility or a personal assistance service, the health practitioner does not have to get the consent or refusal of consent from the individual or from the attorney or other substitute decision-maker from the list in section 20 of the HCCA. The health practitioner is entitled to follow the instructions in the document.

THIS IS NOT TRUE. The HCCA requires that a health practitioner obtain the consent or the refusal of consent to treatment from the patient or from the proper SDM if the person is not capable. The fact that a written document exists that contains wishes or directions in respect to treatment, admission, or a personal assistance service does not mean that the health practitioner may get direction from that document in lieu of speaking to the person or proper SDM.

POAPCs and other forms of advance directives and living wills "speak" to the SDM, NOT to the health practitioner, except in an emergency situation where it is likely not possible to get consent or refusal of consent from the person or a SDM in a timely fashion.

In emergency situations, a health practitioner may provide treatment to an incapable person or a capable person without consent in the circumstances described in section 25 of the HCCA. Section 26 goes on to say that a health practitioner shall not administer treatment, even in the emergency situation, if the health practitioner has reasonable grounds to believe that the person, while capable and after obtaining sixteen years of age, expressed a wish applicable to the circumstances to refuse consent to the treatment.

Therefore, in those circumstances, if the health practitioner has knowledge of the contents of the power of attorney for personal care or other form of advance directive, or has knowledge of wishes of the individual expressed while competent that are relevant to the treatment at hand, he or she may rely upon those express wishes. Note that the express wishes need not be in a written form but may have been communicated in any form, including orally and by alternative means (e.g., Bliss Boards).

Other than in an emergency, the health practitioner must get consent from the person or from the proper substitute decision-maker (HCCA, s.10).

A SDM, in giving or refusing consent on behalf of the incapable person, is required to follow s.21 of the HCCA. This means that he or she must give or refuse consent in accordance with the wishes of the incapable person expressed while capable, after attaining sixteen years of age. If the substitute decision-maker does not know any wish applicable to the circumstances, then the substitute decision-maker shall make a decision in the best interests of the incapable person ("best interest" is defined in section 21(2) of the HCCA).

12. A health practitioner may get consent or refusal of consent from any family member of the incapable person that is physically present at the time the consent is needed. "Available" means physically present.

THIS IS NOT EXACTLY TRUE. If consent is needed for an incapable person, the health practitioner must turn to the person highest in ranking on the list that meets the requirements of section 20 of the HCCA. A person lower on the list gets authority to act only if there is no person higher on the list that meets the requirements to be an SDM as set out in section 20(2) of the HCCA (HCCA, s.20(3)).

The word "available" is defined in the legislation (HCCA, s.20(11)). If it is possible to communicate with the proper SDM on the list and to obtain a consent or refusal within the time reasonable under the circumstances, then that person is "available". Telephones and other methods of telecommunication are wonderful tools of communication and should be used to contact the proper SDM, even if another possible SDM is present with the patient at the time the consent is needed.

There is an exception to the above-noted rule (HCCA, s.20(4)). If a person on the section 20 list is present or has been otherwise contacted, he or she may give or refuse consent IF he or she believes that no person described in an earlier paragraph or same paragraph of the list exists, or although that person exists, the person is not a guardian of the person, an attorney in a power of attorney for personal care or a Board appointed representative with authority to consent to treatment and would not object to him or her making the decision. This means that if the incapable person's child is present or contacted, can state that there is no guardian, attorney or representative, and that the spouse or partner and other children and parents of the incapable person would not object to him or her giving or refusing consent to treatment, then the health practitioner may get the consent from that person.

The health practitioner is protected in relying on these assertions only if he or she asks the right questions. For example, is there a guardian of the person? Is there an attorney in a POAPC? Is there a representative? Is there a spouse? Is there a partner? Are there other children or parents and do they object to a particular person acting? Just because the person is present is not enough. Just because the person is

"family" is not enough. Just because a certain person on the list agrees with the health practitioner is not enough if there is a person higher in ranking that meets the qualifications as an SDM. Health practitioners cannot “shop" for the person who he or she feels is the best SDM.

Spouses and partners rank above other family members. Spouses include married persons, as well as common law spouses who have lived together for at least one year, had a child together or entered into a cohabitation agreement (HCCA, s.20(7)). Persons are *not* spouses if, although married, they are living separate and apart as a result of a breakdown of their relationship (HCCA, s.20(8)). Partners are defined as persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives (HCCA, s.20(9)). Partners include same-sex partners.

If there is no person on the list that meets the requirements, the health practitioner must turn to a provincial government organization, the Office of the Public Guardian and Trustee (HCCA, s.20(5). If there are two or more persons at the same ranking who would be entitled to give or refuse the consent, they must agree. If they disagree, the Public Guardian and Trustee should be contacted to make the decision (HCCA, s.20(5)). If there is more than one child, they are all equally ranked. The oldest child or the male child does not get special preference.

13. If a patient signs a confirmation that he or she wants the health care team to make decisions for him or her in the event that he or she becomes mentally incapable or unable to communicate his or her wishes, there is no need for the health practitioners to get consent from the persons substitute or family. Or, if the person has no substitute or family, there is no need to obtain consent from the Office of the Public Guardian and Trustee.

THIS IS NOT CORRECT. Health practitioners cannot act as SDMs for individuals unless they are one of the people in the list of SDMs in section 20 of the HCCA (e.g., spouse, partner, parent, children, brother, sister or relative). Section 46 of the SDA also specifically prohibits certain persons from making substitute decisions. For instance, persons who provide health care to the grantor for compensation or who provide residential, social, training or support services to the grantor for compensation, are not permitted to be named as attorney in a POAPC unless that person is the grantor's spouse, partner or relative.

Any forms that purport to give authority to name any member of the health team providing health services to a patient as SDM for that patient or as having any decision making powers for that patient when that health team member is not a relative of the patient are not enforceable and are legally wrong. For example, health providers that attempt to use such a form to justify making health care decisions for the patient are not getting an informed consent as required by the HCCA. Treatment without consent (except in emergency situations) may be considered battery.

If a patient is incapable in respect to treatment and does not have anybody listed in the HCCA list of SDMs, then the health practitioner must get consent or refusal of consent from the Office of the Public Guardian and Trustee. Forms that state that the health team will make certain decisions for a patient "because the Public Guardian and Trustee will not" are incorrect in all situations and should not be used as these forms.

14. A relative of an incapable person may prepare an advance directive or a power of attorney for personal care on behalf of an incapable person.

This is NOT TRUE. The preparation of an advance directive or a POAPC may be done ONLY by the person to whom it applies. These are personal documents, just like a will. Only you can sign a will that describes how you wish your property to be distributed after your death. Only you can sign an advance directive that describes to your SDM what health care you wish in the future in the event that you are not mentally capable of consenting or refusing consent to treatment. Only you can sign a POAPC for yourself.

Powers of attorney for personal care and advance directives are documents that contain YOUR wishes in respect to treatment. Only YOU can express your wishes with respect to treatment.

The person executing the advance directive or POAPC MUST be mentally capable at the time the document is executed. This means that the person must be able to understand and appreciate the consequences of signing an advance directive or power of attorney for personal care (SDA, s.47).

If a person includes instructions to the attorney (substitute) in the POAPC or prepares an advance directive, the person executing the document must be mentally capable in respect of the matter on which he or she is providing instructions. For example, if a person wants to give directions as to future health care either in a POAPC or in an advance directive, he or she must be mentally capable in respect to those treatments for which the instructions apply at the time the document is executed.

A substitute cannot execute an advance directive or POAPC on behalf of another person. A substitute may only give an informed consent in respect to treatment or admission or personal assistance services at the time the treatment, admission or personal assistance service decision needs to be made. The *Health Care Consent Act* does provide that a person, when capable, or a substitute, when the person is not capable, may consent to a plan of treatment however this is not the same as preparing an advance directive. Please see Misconception #19 for a discussion of the scope of a plan of treatment.

If the substitute knows of any wishes that the person, for whom he or she is acting, expressed while capable in respect to the treatment, admission, or personal assistance service decision that needs to be made, he or she is required to follow that wish and

make decisions on behalf of that person taking into account the wish. The substitute, in making decisions for another person, may communicate that person's wishes to other people however the substitute cannot prepare a power of attorney for that person or express that persons wishes through an advance directive.

There is no such document as a "power of attorney for personal care or an advance directive by a substitute on behalf of an incapable person" and any health practitioner purporting to take instructions from such a document will be in breach of the HCCA.

15. If a physician signs the advance directive completed by either the patient or the incapable person, this form can be attached to the person's chart and be considered to be the physicians' orders.

THIS IS NOT CORRECT. Physicians, and every other type of health practitioner listed in the HCCA, are required to get consent prior to treatment, and cannot take instructions from an advance directive (except in the emergency situation). An advance directive is NOT consent to treatment. An advance directive is a statement of a person's wishes with respect to future treatment.

Wishes regarding future treatment may be similar to a consent if the patient's health condition is well known and his or her course of treatment and options are clear. However, in most cases, a patient completes an advance directive without a specific diagnosis or understanding of his or her health condition and without the specific information that must be communicated as part of an informed consent. Besides the fact that the advance directive primarily "speaks" to the patients SDM and NOT to the health practitioner, the directive is not a consent or refusal of consent to treatment. Having the doctor sign the directive does not change its status and make it into a consent. Health practitioners taking directions from such an "order" will be treating the patient without the proper and necessary consent.

16. If a living will names a substitute decision-maker, then it is a power of attorney for personal care.

THIS IS NOT NECESSARILY TRUE. A living will, a document that includes instructions with respect to health care and treatment, may or may not name a SDM. If it names a SDM, it is not a POAPC unless it meets the requirements for a POAPC as set out in the *Substitute Decisions Act* as described in Misconception #14. It is possible that a living will may name a SDM but not meet the legal requirements of a POAPC. Therefore, the named person is not the proper SDM, as defined in section 20 of the HCCA, to whom the health practitioner must turn to for substitute consent for treatment, admission, or personal assistance services.

The health practitioner has an obligation to ensure that he or she is dealing with the proper SDM. Although the health practitioner may rely upon the assertion of the SDM

that he or she is the proper person as described in the legislation, the health practitioner still must ask the appropriate questions to determine whether the SDM is an attorney in a POAPC or the SDM named in a living will (HCCA, s.29(6)).

The health practitioner should ask the person claiming to have the authority under a POAPC whether the document is a POAPC or a living will. Remember that just because a document is labelled a "living will" as opposed to a POAPC, it does not mean that it is not a POAPC. The question is whether the "living will" document meets the requirements of the SDA in order to be considered to be a POAPC. The health practitioner should ask whether the document names a person as an attorney and whether the document is properly witnessed by two witnesses and was executed by the person when that person was mentally capable of making a POAPC.

If the advance directive or living will is not witnessed, then it is not a POAPC. If the advance directive does not name a SDM, but only gives instructions with respect to health care, then the document is not a POAPC. If the SDM does not state that the person was capable at the time of execution, then it is not a valid POAPC.

If the document is a living will and names a SDM, but it is not a POAPC, then the health practitioner must turn to the person highest on the list in section 20 of the HCCA who meets the requirements to be the proper SDM. That person is then required to follow the instructions and wishes as expressed in the living will document, even if he or she is not the named SDM in that document.

Therefore, it is advisable for the health practitioner to carefully review any documents claiming to be either a POACP or living will to determine its validity.

17. Health facilities and health practitioners may require individuals to execute powers of attorney for personal care and powers of attorney for property as a condition of getting treatment or personal assistance services or being admitted to long-term care.

THIS IS NOT TRUE. Preparation of a POAPC is NOT a precondition to admission to a health facility or a condition of continuing residence. Also, it is not a precondition to obtaining health services in Canada.

The preparation of a POAPC or POAP is a very serious and personal undertaking. It is a personal choice and persons should execute such documents only if they want to and they understand the authority they are or may be giving to a second person. As there are profound legal implications of executing powers of attorney, it is advisable for people to get proper legal advice before executing such documents. POAPs, unless restricted in authority, may be used to sell property, dispose of assets, and commit to contracts and mortgages. POAPCs may be used to authorize treatments, compel admission to health facilities, and limit personal activities. Although effective as planning documents, they should not be entered into lightly. It should be noted that

abuse of a power of attorney can be a criminal offense (see section 331 of the *Criminal Code of Canada*).

Health practitioners and health facilities may make information available to patients and residents about these documents as an information service but they should not, and cannot, require patients/residents to prepare these documents as a condition of service or residence.

Some facilities ask residents to execute their company's own form of advance directive or an advance directive form that they promote. This is inappropriate and potentially harmful to residents. For instance, if the form meets the requirements of a POAPC, preparation of that form could result in the revocation of a previously executed POAPC. The execution of a second POAPC revokes the first one if it does not contain a clause that states that the person wants to have multiple POAPCs. Another problem is that some forms are legally inaccurate as they do not meet the requirements of the SDA.

It is possible that if a facility promotes or requires the use of their own form or recommended form of a POAPC and the person/resident suffers harm as a result of execution of such a document, that the facility could be held liable in damages.

18. Using standard form advance directives or living wills throughout a community and in all hospitals and facilities promotes patient-centred care and should be a requirement for patient care.

THIS IS NOT NECESSARILY TRUE. As stated above in Misconception #17, the completion of an advance directive is not a requirement or precondition for receiving care. In communities where one standard form of advance directive has been promoted, patients may be discouraged from using their own versions of advance directives that they may prefer on the basis that the health practitioners in the community do not understand the patients form but do understand the community form. This is not patient centred care but care on the terms of the provider! The standard form approach discourages people from "opting out", sometimes by telling the patient that if they do not use the standard form, very intrusive and invasive treatment will be administered despite any express oral wishes. This is not appropriate and legally inaccurate.

Too often the standard forms "take over" and become the “norm” rather an “option”. Instead of communications taking place between the health practitioner and the patient, and the patient and his or her future SDM, as to what treatment and care the patient may want in the future, the goal of the discussion becomes one of completing the form and of packaging the patient's wishes in a specified format. Options not included on the form are not discussed. Concerns of the individual patient may not be heeded as they do not fit on the form. The paper document becomes the directing force, not the patient's own words or the SDM's interpretation of the advance directive. This may not have been the intent of the people who drafted the standard form, but the process of

getting the forms executed take on a life of their own. Great care must be taken when promoting a standard form in a community to ensure it is clear that it is ONLY ONE of MANY OPTIONS for people in that community and there is NO REQUIREMENT for such forms to be completed by anyone in order to obtain services.

It must also be remembered that just because a patient completes an advance directive form, ORAL CAPABLE WISHES expressed after the document was signed trump the wishes expressed in the advance directive without any need to re-execute a new form. In fact, patients can express wishes in any way they wish – they do not need to do this in any particular way. If a standard form is promoted, great care must be taken to ensure that all persons using the form – patients, SDMs and health practitioners – verify check if any wishes as expressed in the form were overridden by subsequent oral wishes or wishes expressed in any other manner. The key for health practitioners to remember is that they must obtain INFORMED CONSENT to any treatment, from the patient or the patient's SDM, if the patient is not capable, as determined by the HCCA. Can the health practitioner who takes direction from a form of advance directive say that he or she is getting the proper INFORMED CONSENT as required by the HCCA?

PLANS OF TREATMENT

19. As the HCCA provides for consent to a plan of treatment that may "deal with one or more health problems that a person is likely to have in the future given the person's current health condition", then the plan of treatment may be drafted in a general way to cover any and all future treatment that the person may require in order to avoid the need of getting additional consents.

THIS IS NOT TRUE. The definition of "plan of treatment" states that the plan may deal with one or more of the health problems the person is likely to have in the future "given the person's current health condition". Thus, the plan must relate to the current health condition of the individual. The plan cannot be so generally drafted as to provide for consent to treatments not related to or contemplated by the person's current health condition.

Keep in mind that a consent is valid only if it relates to the treatment, is informed, is given voluntarily, and is not obtained through misrepresentation or fraud (HCCA, s.11). A consent is informed if, before giving it the person receives the information required by the Act that a reasonable person in the same circumstances requires in order to make a decision about the treatment and the person receives responses to his or her requests for additional information about those matters.

The information that the person must receive concerns the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, the alternative course of action, and the likely consequence of not having the treatment.

In consenting to a plan of treatment, the person must be given all of this information in respect to the plan. The plan of treatment that is overly broad will not meet this requirement.

20. One health practitioner may – on behalf of all practitioners involved in a plan of treatment, propose a plan of treatment – determine the person's capacity in respect to the treatment referred to in the plan, and obtain a consent or refusal of consent in accordance with section 13 of the HCCA without answering the individual's questions about the plan of treatment.

THIS IS NOT TRUE. Consent to the plan of treatment must still be informed consent. Although only one health practitioner needs to propose the plan, determine capacity and obtain the consent or refusal of consent on behalf of the group of health practitioners, that health practitioner must still obtain informed consent from the individual. Therefore, he or she must be able to provide the information to the individual as required for an informed consent and must be able to answer the person's questions. If the health practitioner is not able to answer, or he or she is not able to evaluate the person's capacity for a specific part of the treatment, he or she must ensure that the information is obtained for the patient or the proper determination of capacity is done.

Consider a situation where the plan of treatment includes a particular medical treatment by a physician, as well as treatment offered by a speech pathologist. If the speech pathologist is the person getting the consent for the plan of treatment, that speech pathologist must be able to determine the person's capacity in respect to the proposed medical treatment and provide the information required to obtain an informed consent of the patient. If the speech pathologist is not capable of doing this, the fact that she or he gets some form of consent from the patient will not be sufficient. He or she must comply with the legislation and get the information the patient requires for a complete informed consent to all the features of the plan. The health practitioners on the team are protected from liability only if the proper consent is obtained to the plan of treatment.

RIGHTS INFORMATION

21. If a health practitioner believes that a person is not capable in respect to treatment, then he or she may automatically turn to the SDM for consent or refusal of consent. The health practitioner does not have to advise the person of the finding of incapacity nor advise the person of the right of review of the finding of incapacity or of other rights of review before the Consent and Capacity Board.

THIS IS NOT EXACTLY ACCURATE – LEGALLY OR ETHICALLY. The law requires the health practitioner to provide information to the incapable person about the consequences of the findings as specified in the guidelines established by the governing body of the health practitioner's profession (HCCA, s.17).

For example, the College of Physicians and Surgeons of Ontario directs physicians to inform the incapable person that a SDM is responsible for making treatment decisions. Where the patient disagrees with the need for a SDM or disagrees with the involvement of the present substitute, the physician must advise the patient of his or her options which "include finding another substitute of the same or more senior rank, and/or applying to the Consent and Capacity Board for a review of the finding of incapacity." A physician has a duty to "reasonably" assist the patient if he or she expresses a wish to exercise these options.

One of the stated purposes of the HCCA is "the enhancement of the autonomy of persons" to whom treatment, admission to a care facility or personal assistance services are proposed by "allowing those who have been found incapable to apply to a tribunal for a review of the finding" and "to promote communication and understanding between health practitioners and their patients or clients" (HCCA, s.1). This section is used to interpret the rest of the Act.

If a health practitioner does not advise a person of the finding of incapacity and does not make them aware of the rights of review, how can these purposes be fulfilled? How is communication between health practitioners and patients improved if health practitioners fail to provide such fundamental information to patients? A health practitioner may be negligent and subject to professional misconduct for failing to advise the person that he or she has been found incapable in respect to treatment if that person then suffers harm from that failure to inform. The harm in this case is the loss of decision-making authority and the fact of being subjected to treatments that he or she may have refused. A health practitioner may also commit a battery if he or she treats a patient without consent if the patient was competent and would have refused the treatment.

ADMISSION TO CARE FACILITIES (LONG-TERM CARE HOMES)

22. Retirement homes for seniors are care facilities for the purpose of Part III of the *Health Care Consent Act*.

THIS IS NOT TRUE unless these places, properly known as "care homes" are named in the regulations to the HCCA (no such regulation currently exists). Care homes are covered by the *Residential Tenancies Act*. They offer accommodation and services, including "care" services, but they are NOT care facilities. Care homes are tenancies. Tenants must be provided with Care Home Information Packages (CHIPs) that describe the services available to the tenants on-site, including the qualifications of staff, the costs for the various services and the types of available accommodation. As well, care homes must provide tenants with tenancy agreements that detail the terms of the

tenancy. Terms in the agreement that do not comply with the *Residential Tenancies Act* are not enforceable although some care homes do try to include illegal provisions in the agreements.

Community Care Access Centres are responsible for administering admissions into long-term care homes (nursing homes, homes for the aged and charitable homes for the aged) but NOT "admissions" into tenancies in care homes.

23. If a health facility, such as a hospital, is in "financial crisis", it can force a person to be transferred to a care facility without their consent.

THIS IS NOT TRUE. Section 47 of the HCCA authorizes admission into a care facility without the consent of a person found to be incapable by an evaluator for this purpose, if, in the opinion of the person authorizing admission: (1) the incapable person requires immediate admission to a care facility as a result of a crisis; and (2) it is not reasonably possible to obtain a consent or refusal of consent on behalf of the incapable person.

This "crisis" must relate to the condition or circumstances of the person who is to be admitted to the care facility. For example, an incapable person's caregiver may have had a stroke and is admitted to hospital. The incapable person may then be in crisis if there is no alternative caregiver or arrangements to provide services to that person without admission.

The fact that a person is waiting for admission to a long-term care home but is waiting in hospital is not a crisis in and of itself. The financial problems of a hospital cannot be shifted to the patients!

Further, hospitals cannot require patients who are awaiting admission to a long-term care home to “wait” their time in a retirement home pending transfer to a long-term care facility. This is inappropriate because retirement homes are rental tenancies which are not staffed or equipped to meet the health care needs of a person needing long-term care. Even if a particular retirement home has staff or can arrange for staff to provide the required care, a resident cannot be required to privately pay for accommodation in a retirement home or to privately pay for care services (the normal practice in a retirement home). If a person is transferred to a retirement home without consent or to “wait out” the period before getting accommodation in a long-term care home, the hospital or individual hospital staff may be liable for the costs of the care and accommodation for the person as a result of this inappropriate placement.

24. SDMs who refuse treatment on behalf of an incapable person may be forced by the Consent and Capacity Board to provide consent if the health practitioner believes the incapable person needs treatment.

THIS IS TRUE IN SOME CIRCUMSTANCES. Section 37 of the HCCA provides for an application to the CCB by a health practitioner if he or she is of the opinion that the SDM did not comply with the legal principles that are to be followed by SDMs in giving or refusing consent.

This process is not intended as a bludgeon to "force" SDMs to comply with health practitioners. The intent of this section is to provide a method by which SDM refusals may be reviewed where the health practitioner may be aware of wishes expressed by the patient when capable that apply to the treatment being proposed that the SDM is now ignoring or refusing to honour. This process could also apply where the SDM is not aware of any wishes of the patient but may be clearly acting against the best interests of the patient (e.g., the refusal of treatment will result in harm of the patient or there is evidence that the SDM is refusing treatment because he or she is motivated by the size of the incapable persons estate).

25. Hospitals may require individuals to take the first available bed in any long-term care home or in a retirement home or may require patients to select a number of long-term care homes from a short list, even if they do not want admission to these homes.

THIS IS NOT TRUE. There is nothing in the HCCA or SDA or in any legislation dealing with long-term care that would require individuals to comply with these types of policies. In fact, patients or their SDMs must consent to admission to a long-term care home and therefore they may refuse to consent to admission to particular homes that they feel will not meet their needs. Not all long-term care facilities are the same. Some long-term care homes will be unable to meet the needs of a particular person.

Retirement homes are not long term care facilities but tenancies. People cannot be compelled to rent a room or apartment in a retirement home. They must consent to enter into a tenancy agreement in a retirement home. Not all retirement homes will have care services available on site to meet the needs of persons requiring care.

At the same time, it is reasonable to expect individuals who no longer need acute care and are more appropriately accommodated in long-term care to move to a long-term care home. If the patient is acting reasonably, and is agreeable to admission to a number of long-term care homes that could meet his or her needs, then the hospital cannot require that person to take a bed in a long-term care home that either: (a) is not of their choice; or (b) cannot meet the person's needs.

A person may choose up to three long-term care homes and be on a waiting list for these three homes. **A hospital cannot require the patient to pick a particular home as one of the three. In fact, a patient may decide to choose only one home and not use all three choices.**

If a bed comes available in a fourth home not of the patient's choice, the hospital cannot require the patient to select that fourth home unless he or she voluntarily does so. **As well, the hospital cannot charge the patient a per diem at the hospital if he or she refuses a facility placement that is not one of his or her three choices.**

CONCLUSION

Health practitioners, long-term care home administrators, individuals and families should get copies of the HCCA and SDA and refer to it when determining the "rules" that must be followed. Articles are useful to help gain an understanding of the law but it is always important to read the actual legislation!

The best way that an individual's rights and wishes will be observed and honoured by health practitioners and health facilities is if people, who use the law, understand the law.

LIST OF ACRONYMS

HCCA	= *Health Care Consent Act*
SDA	= *Substitute Decisions Act*
SDM	= substitute decision-maker
POA	= power of attorney
POAPC	= power of attorney for personal care
POAP	= power of attorney for property