Options for Advance Care Planning

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There are several different ways a person may do advance care planning. Section 5 of the *Health Care Consent Act* (HCCA) makes it clear that a person may express "wishes" about future health care in a power of attorney for personal care, in any other written form, orally, or in any other manner (i.e. through alternative means of communication such as a Bliss Board). Later wishes expressed while capable prevail over earlier wishes. That would mean, for example, that even if wishes have been expressed in a written form, that later oral wishes may override those earlier written wishes.

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1. WISHES EXPRESSED ORALLY

- Some people may not want to write down any wishes but want to express these wishes orally
- Wishes about future health care may be expressed orally and are just as valid as wishes written in an advance directive form
- A person must be mentally capable about the matter for which they are expressing wishes in order for the wishes to be enforceable
- Written wishes may be changed by wishes expressed orally if the person is mentally capable
- Oral wishes may be recorded in the person's medical chart or plan of treatment

2. WRITTEN DOCUMENTS

(a) Power of Attorney for Personal Care (POAPC)

What is a POAPC?

- A document in which a person (the grantor) names a substitute decision-maker (an attorney) to make personal care decisions, which may include wishes about personal care (advance directive portion);
- May also include a description of personal values and beliefs to guide the substitute decision-maker (SDM) in decision making;
- Personal care includes decisions about health care, nutrition, hygiene, shelter, safety and clothing

Who can make a POAPC?

- The only person who can make a POAPC is the person who is the subject of the POAPC (the grantor). SDMs cannot create POAPCs for an incapable person.

Who can be an attorney?

- An "attorney" does not need to be a lawyer. Persons who provide health care to grantor for compensation or residential, social, training or support services to grantor for compensation cannot act as attorneys unless he or she is a spouse, partner or relative of the grantor
- The grantor can name more than one person as the SDM (attorney). If more than one attorney is named, they must act "jointly" and make decisions together unless document states that may act "jointly or severally". If joint and several, the attorneys may act together or separately.

Capacity

- A person must be mentally capable to execute a POAPC and must have attained 16 years of age
- To express wishes about future care, the grantor must be mentally capable for the matters on which he/she expresses wishes
- Capacity to do a POAPC is specifically defined in the legislation as the "ability to understand whether the proposed attorney has a genuine concern for the person's welfare and appreciates that the person may need to have the proposed attorney make decisions for this person"

Form of POAPC

- No particular form needs to be used to create a POAPC as long as it meets the formal requirements set out in the legislation (*Substitute Decisions Act*):
    (a) must be in writing
    (b) must be signed by the person in the presence of two witnesses
    (c) two witnesses must sign the POAPC as witnesses
- Even if a document is called an advance directive, if it meets these formal requirements and names a SDM, then the document may be a POAPC

When is the POAPC in Effect?

- POAPC comes into effect when the grantor is not mentally capable to make personal care decisions

- The attorney determines when the grantor is not capable for those personal care decisions not covered by the *Health Care Consent Act*, unless the document states otherwise
- The grantor may require that the capacity to make personal care decisions be determined by a particular person or class of persons (i.e. physicians, nurses, social workers) before the POAPC comes into effect
- Person or class of persons chosen to determine capacity need not be health professionals – may be anyone the person selects
- For treatment decisions, the health professional offering treatment determines capacity; if the person is found incapable for treatment and that person has a POAPC, the POAPC is activated by this finding of incapacity
- Wishes expressed in a POAPC must be honoured by the SDM, as well as a health practitioner in an emergency if he or she is aware of the wish

When does a POAPC End?

- The POAPC ends or is terminated when:
  (a) the attorney dies, becomes incapable for personal care or resigns unless the document provides for a substitute attorney or there is more than one attorney named originally and that attorney can still act;
  (b) the court appoints a Guardian of the Person for the person;
  (c) the person signs a second POAPC unless the person states in the document that he or she wants multiple powers of attorney; or
  (d) the POAPC is revoked by the person.

Portability

- The law about powers of attorney are different from province to province
- If a person has a power of attorney that was prepared in another jurisdiction (another province or country), it may not be valid in Ontario
- However, it MAY be valid if at the time it was prepared and signed, it complied with the law in the place it was executed AND the grantor who signed the power of attorney was either DOMICILED or HABITUALLY RESIDENT in that place (the terms "domiciled" and "habitually resident" have a specific legal meaning)
- It is advisable to get a legal opinion on the validity of a foreign or out-of-province power of attorney before assuming it is valid
- Wishes expressed in an out-of-province power of attorney, even if the power of attorney is not recognized in Ontario as "valid", must still be considered by the SDM highest ranking for the person from the list in the *Health Care Consent Act*
- It is recommended that the person, if capable, create a new Ontario POAPC to avoid any confusion

(b) Advance Directives and Living Wills

What are Advance Directives and Living Wills?

- Advance directives (AD) and living wills are documents in which a person may express his or her wishes about future care
- The terms “advance directive” and “living will” are not specifically defined in the *Health Care Consent Act*, *Substitute Decisions Act* or any other piece of Ontario legislation
- Commonly differentiated from POAPCs as being documents in which the person does NOT name a substitute but only expresses wishes about care. Many documents “labeled” as “advance directives or living wills” are in fact POAPCs since the documents name a SDM, are signed, witnessed and meet the formal standards of POAPCs.
- If an advance directive or living will names an SDM but does **not** meet the formal standards of a POAPC, then the named SDM is **not** the substitute

Who can Make an Advance Directive?

- The only person who may prepare an advance directive or living will is the individual who is the subject of the document if they are capable of doing so
- The SDM cannot sign an advance directive or living will for an incapable person; SDMs can only give or refuse consent to treatments or make personal care decisions for an incapable person

Capacity

- The person who makes an advance directive must be capable for matters about which he/she expresses wishes

Form of Advance Directive

- The legislation does not prescribed a particular form
- The advance directive may be “medical” in format, communicating wishes about specific treatments or procedures: if such forms are used, the person should receive information about these treatments and procedures and understand the risks/benefits/alternatives before signing an advance directive
- Medical advance directives are most useful when the person has a defined condition or knows details of illness and can express an “informed” wish about future treatments and care
- The advance directive may be more oriented to recording values, beliefs, interests instead of specific treatment wishes in order to guide future SDMs; this

type of advance directive useful as many decisions that need to be made for an incapable person cannot be anticipated due to health/illness changes over time

When is an Advance Directive in Effect?

- An advance directive comes into effect when the person is found to be incapable for treatment/health care
- Wishes expressed in an advance directive or living will must be honoured by the proper SDM
- Wishes must also be honoured by a health practitioner in an emergency situation if he or she is aware of these wishes and has no reason to believe that these wishes have changed

When does an Advance Directive End?

- A person can revoke or change an advance directive by oral statements, communicating his or her wishes by alternative means, or making a new statement of wishes in writing
- There is no requirement to execute a "revocation"; however, it is a good idea for the person to tear up the old advance directive and prepare a new written directive in order to make his or her wishes clear (although this is not a necessary step)

(c) Levels of Care Forms

What is a Level of Care Form?

- A level of care form is a type of advance directive – it is a statement about levels of care may be included as part of a more detailed advance directive or POAPC
- It usually sets out a number of "levels of care," ranging from no intervention through to extensive treatment and intervention, from no hospitalization (e.g. a wish to remain at the long-term care home no matter what are the specific health needs of the resident) through to a request for transfer from the long-term care home to a hospital for treatment if care needs exceed that which can be delivered in present setting
- One of the problems with a level of care form is that the levels outlined are arbitrary
- A person signing such a form should be advised that his or her choices for future care are not limited to the three or four levels outlined
- The form is a good starting point for discussions about possible options and the range of options for care but should not be used as a complete definition of the person's choices for future care

- Sometimes, it is used improperly as a consent form – it is not a consent form as it lacks the specificity necessary for a consent

Who can sign a Level of Care Form?

- An expression of wishes for future care can only be made by the person, not his or her SDM

Capacity

- A person who makes a level of care form must be capable for matters about which he or she expresses wishes

Type of Level of Care Form

- Level of care forms are not mentioned in the legislation therefore there is no particular form or signing requirements

When is the Level of Care Form in Effect?

- The level of care form comes into effect when the person is found to be incapable for treatment/health care
- Wishes expressed in a level of care form must be honoured by the proper SDM
- Wishes must be honoured by a health practitioner in an emergency situation if he or she is aware of these wishes and has no reason to believe that these wishes have changed
- Due to a lack of specificity, it may be problematic to interpret level of care forms