The Health Care Consent Act and the Substitute Decisions Act - Who Decides What When?

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

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This paper focuses on common misconceptions or misunderstandings about the Substitute Decisions Act (SDA) and the Health Care Consent Act (HCCA). Many of these misconceptions relate to patients/residents rights and wishes. 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 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, 1996 Thomson Canada Limited, Carswell Professional Publishing , edited by Dr. Hy Bloom and Michael Bay.

COMMON MISCONCEPTIONS

Capacity

1. **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 persons 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 patient 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 before treatment is administered to the person. 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.

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2. 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 293/96 as amended by O.Reg 239/00 states that:
1. (1)A person is qualified to do assessments of capacity if he or she,
(a) satisfies one of the conditions in subsection (1.1);
(b) has successfully completed a training course for assessors,
(i) given or approved by the Attorney General, as described in section 3, or
(ii) given by the Attorney General under Ontario Regulation 29/95 before this Regulation comes into force; and
(c) is covered by professional liability insurance of not less than $1,000,000.

(1.1) 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.
…
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 and dated June 7, 1996.

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. A Code of ethics and protocols for assessments were developed as part of this process.

Capacity assessors are required to be used for limited purposes under the SDA (e.g. for 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 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 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 s. 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 mental capacity of persons for the purpose of decisions for admission to long-term care 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 Health Care Consent Act 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 is 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 facility, this is NOT the same assessment as is done for the purposes of the HCCA. 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 problems, however, that same person may be mentally capable in respect to the admission decision. The two assessments are different although the same person may do them.

3. With the proclamation of the HCCA and the SDA, physicians may no longer 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 requires 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 OAS and CPP pension cheques. The OAS and CPP legislation does not specify that a particular health professional must do 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. Often the Certificate of Incapacity is completed by a health practitioner, such as a physician, psychologist, or nurse however 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.

4. 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. A person of advanced age or persons with physical or mental disabilities may still be capable of making all or some decisions for themselves. 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 in respect to treatment, admission to long term care or to personal assistance services. This is similar in the SDA, where the person may be old or mentally ill and may still be capable to make some or all decisions in respect to property and their person.

The key 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.

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.

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, and to personal assistance services, or even to other personal decisions. The 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 patient may become capable again (HCCA s.15). In that case, the patient's decisions in respect to treatment must be followed even if a substitute had previously given or refused consent on behalf of a patient.

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. Also, as capacity relates to the specific treatment, one health practitioner may find that a patient is capable in respect to the treatment he or she is proposing but is not capable in respect to the treatment proposed by the other type of health practitioner. It is the responsibility of the health practitioner proposing the treatment to make the decision in respect to the patient's capacity in respect to the treatment (HCCA s.10).

Although the health practitioner proposing the treatment must make the decision about a patient'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 on a patient's capacity from a second health practitioner or by policy, rather than by law, a facility may require that the staff at that facility 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 patient/resident is in a long-term care facility or a mental health facility, then it can be presumed that they are incapable in respect to health decisions.

THIS IS NOT TRUE. The place where a person resides or is living temporarily does not determine whether they are capable or incapable in respect to some or all decisions they are making. The test of capacity applies to all situations wherever the person lives or is receiving treatment. Just because a person has consented to move to a long-term care facility 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 facility must be obtained from the resident, if he or she is mentally capable for this purpose, or from the proper substitute decision maker if the resident is not mentally capable. Even if a person has been treated as though he was incapable in a long-term care facility 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 under s. 12 of the HCCA, 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 a consent was previously given by a substitute decision maker, if the health practitioner believes that the person is now capable, the health practitioner should turn to the patient 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 patient does not object to the treatment (or other decision to be made), 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. This presumption is intended to give the benefit of the doubt to the patient or resident, 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 s. 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 the ability to understand and the ability to appreciate the consequences of a decision or lack of decision. This is a cognitive test. The fact that a person is passive does not means 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!

This legislation emphasises what was already in the common law and what was in the now repealed Consent to Treatment Act, namely, 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 patient of the finding of incapacity and right of review***, and turn to the proper substitute decision maker for the consent or refusal of consent to treatment. *** see # 19 for comments about a health practitioners 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. The Substitute Decisions Act, s. 78 states that a "capacity assessor" as defined by that Act 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 will be assessed the purpose of the assessment, the significance and effect of a finding of incapacity or capacity, and the persons right to refuse to be assessed. Although there is not a similar section to SDA s.78 in the Health Care Consent Act, the Honourable Mr. Justice Quinn of the Ontario Court (General Division) stated in the Koch Decision (March 21st, 1996) that this same obligation should lie on persons doing "evaluations" of capacity under the Health Care Consent Act. 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) but it can still be argued that Mr. Justice Quinn 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 S.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 Mr. Justice Quinn 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.

Powers of Attorney for Personal Care and Advance Care Planning

9. If a patient has executed a Power of Attorney document, then the health practitioner should only deal with the attorney so named to get consents or refusals of consents for treatment, admission, and personal assistance services, and not the patient.

NOT TRUE. Before taking consent or refusal from the attorney, the health practitioner must:
STEP 1. determine if the patient is mentally capable or not in respect to the decision to be made (treatment, admission to long term care, personal assistance services);

STEP 2. if the patient is incapable, determine if there is a Guardian of the Person with authority to give or refuse consent in priority to the attorney;

STEP3. 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 as opposed to a power of attorney for property
(ii) if there is a power of attorney for personal care, 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.
(iii) whether the attorney meets the requirements for a substitute decision maker under HCCA s.20(2)

STEP 1 - Under the HCCA, if the health practitioner (or person seeking authority for admission or personal assistance services) seeks consent to treatment, admission to a care facility, or to personal assistance services, then the health practitioner (or evaluator) must first determine if a patient is capable in respect to the particular type of decision to be made (treatment, admission, personal assistance services).

Only then, if the health practitioner believes that the person is incapable in respect to the decision to be made, is when the health practitioner may turn to a substitute decision-maker. An attorney in a power of attorney for personal care does not get authority to make substitute decisions for the grantor of the power of attorney unless the grantor is not capable. Just because a person has executed a power of attorney for personal care does not mean that he or she is incapable.

STEP 2 - The second step is to determine who is the proper substitute decision-maker. 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 persons 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 s. 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 patient?". 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 persons attorney for personal care with authority to give or refuse consent to the treatment. (see STEP 3 below)

3. incapable persons 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. incapable persons spouse or partner

5. child or custodial parent or Childrens' Aid Society

6. parent with right of access

7. 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, personal assistance services), then is the person an attorney in a POAPC rather than in a power of attorney for property? 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, clothing, but NOT decisions in respect to 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 HCCA S.20(2)? The attorney must be capable in respect to the treatment proposed for the incapable person, be at least 16 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 patient or of giving or refusing consent to treatment on his or her behalf, must be available, and must 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 in highest priority that meets these qualifications. (see HCCA s.20)

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

THIS IS NOT TRUE. The HCCA, like the now repealed Consent to Treatment Act (CTA), requires that a health practitioner obtain the consent or the refusal of consent to treatment from the patient or from the proper substitute decision maker if the patient 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 patient or proper substitute decision maker.

Powers of Attorney for Personal Care and other forms of advance directives and living wills "speak" to the substitute decision maker, 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 patient or a substitute decision maker 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 s. 25 of the HCCA. Section 26 states 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 patient 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 (ie Bliss Boards etc.)

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

A substitute decision-maker, 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 interest of the incapable person. The term "best interest" is defined in HCCA s. 21 (2).

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

NOT TRUE. The preparation of an advance directive or a power of attorney for personal care 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 substitute decision maker 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 power of attorney for personal care 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 in respect to treatment.

The person executing the advance directive or power of attorney for personal care 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. The specific definition of capacity to execute a power of attorney for personal care is described in the Substitute Decisions Act.

If a person includes instructions to the attorney (substitute) in the power of attorney for personal care 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 Power of attorney for Personal care or in an advance directive, then that person must be mentally capable in respect to those treatments/health care in respect of which the instructions apply at the time the document is executed.

A substitute cannot execute an advance directive or power of attorney for personal care 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 patient, when capable, or a substitute, when the patient is not capable, may consent to a plan of treatment however this is not the same as preparing an advance directive. See Misconception 17 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 Health Care Consent Act.

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

THIS IS NOT CORRECT. A physician, and every type of health practitioner listed in the HCCA, is 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 a consent to treatment. An advance directive is a statement of a person's wishes in respect to future treatment.

Wishes in respect to future treatment may be similar to a consent if a patient's health condition is well known and the patient's course of treatment and options are clear (and limited). However, in most cases, a patient completes an advance directive "out of context" of a specific diagnosis or understanding of their health condition and without the specific information that is required to be communicated as part of an informed consent. Besides the fact that the advance directive primarily "speaks" to the patients substitute decision maker and NOT to the health practitioner as explained in # 10, 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 a proper and necessary consent.

13. 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 in 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 (to date no such form exists), 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 power of attorney for personal care is a document by which a person names a substitute decision-maker 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. It must name a person to act as attorney and must be properly witnessed. The document must also have been executed by the grantor when the grantor was capable of giving a power of attorney for personal care in order for it to be valid.

The grantor of the power of attorney for personal care may name more than one attorney to act jointly (together) or severally (can act separately and all attorneys so named have the equal authority to act). 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 as attorney at the necessary time. The substitute attorneys may replace the original attorneys if the named attorneys resign.

The attorneys named in a power of attorney for personal care only get authority to act as substitute decision-maker IF the grantor is:
(a) incapable for the purposes under the HCCA or
(b) otherwise incapable in respect to personal decision making.

Under the Health Care Consent Act, if a person is found incapable in respect to treatment, or incapable in respect to a decision for admission into a long term care facility or for personal assistance services in the method as provided by that act, the person seeking the consent in any of these three areas turns to the incapable person's substitute decision maker. If the proper substitute decision-maker is the attorney in a power of attorney, and 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 power of attorney for personal care 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 Substitute Decisions Act (by a capacity assessor). The power of attorney for personal care may provide that the incapacity must be confirmed by a particular health professional, by a particular class of health professionals, or by any other means that the grantor may direct. (i.e. by his or her Aunt Martha). That is the option of the grantor.

The document must also be properly witnessed by two witnesses who must sign as witness to the power of attorney for personal care in the presence and of the same time the grantor executes that 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 power of attorney for personal care 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 capacity to give a power of attorney for personal care is defined in the Substitute Decisions Act 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 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 substitute decision maker, but includes directions or expresses wishes in respect to future treatment or health care. A substitute decision-maker is required to follow the wishes as expressed in a Living Will, although a Living Will is not a power of attorney for personal care.

14. 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 in respect to health care and treatment, may or may not name a substitute decision-maker. If it names a substitute decision maker, it is not a power of attorney for personal care unless it meets the requirements for a power of attorney for personal care as defined in the Substitute Decisions Act as described above in Misconception 11. It is possible that a Living Will may name a substitute decision maker, not meet the requirements of a power of attorney for personal care, and, therefore, the named substitute decision maker is not the proper substitute decision maker, 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 obligation is on the health practitioner to ensure that he or she is dealing with the proper substitute decision-maker. Although the health practitioner may rely upon the assertion of the substitute decision maker that he or she is the proper person as described in section 20 as the substitute (HCCA s. 29 (6)), the health practitioner still must ask the appropriate questions to determine whether the substitute decision maker is an attorney in a power of attorney for personal care or is only the substitute decision maker named in a Living Will.

The health practitioner should ask the person claiming to have the authority under a power of attorney for personal care whether the document is a power of attorney for personal care 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 its 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 the person as the attorney and whether the document is properly witnessed by two witnesses and was executed by the person when that person was mentally capable.

If the advance directive or Living Will is not witnessed, then it will not be a power of attorney for personal care. If the advance directive does not name the substitute decision-maker, but only gives instructions in respect to health care, then the document is not a power of attorney for personal care. If the substitute decision-maker does not state that the person was capable at the time of execution of the power of attorney for personal care, then it is not a valid power of attorney for personal care.

If the document is a Living Will and names a substitute decision maker, but it is not a power of attorney for personal care, then the health practitioner must turn to the person highest on the list in HCCA section 20 who meets the requirements to be the proper substitute decision maker. 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 substitute decision maker in that document.

It is advisable for the health practitioner to review the document to ensure that it is a power of attorney for personal care and is valid on its face if a person is claiming authority to act based on that document.

15. Health facilities or health practitioners may require persons to execute powers of attorney for personal care as a condition of getting treatment, admission, and personal assistance services.

THIS IS NOT TRUE. Preparation of a POAPC is NOT a precondition to admission to a health facility or a condition of continuing residence. Nor is it a precondition to getting health services in Canada.

The preparation of a POAPC or Power of Attorney for Property is a very serious and personal undertaking. It is a personal choice and persons should execute such documents only if they want to, and only after they understand the authority they are or may be giving to a second person. It is advisable for people to get proper legal advice before executing such a document. These documents are easily abused. Powers of attorney for property, 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. Note that abuse of a power of attorney is a Criminal Code offense. There are profound legal implications of executing these documents.

Health practitioners and health facilities may make information available to patients and residents about these documents as an information service however 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 form of advance directive or an advance directive form that they promote. This is inappropriate and potentially harmful to that resident. If the form meets the requirements of a POAPC, then preparation of that form could result in the revocation of another POAPC that the person had previously executed. Execution of a second POAPC revokes the first one if the form does not contain a clause that states that the person wants to have multiple POAPCs. The facility may be doing a disservice to the resident by this activity.

Some facilities promote certain "kits" for POAPCs. Some of these kits and POAPC booklets are NOT accurate in law. Some do not meet the requirements of the SDA. Some promote the execution of multiple copies of POAs without the necessary proviso in the documents for multiple documents (resulting in confusion as to which POA is the "REAL" POA that is still in effect and possible loss of any POA as no one can figure out which is the one that is in effect). These are some of the many reasons that people should get legal advice before signing either a continuing POA for Property or a POAPC.

It is possible that if a facility promotes or requires the use of their own form or recommended form of 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.

16. 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 15, 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 to the community standard form 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 don't have the standard form that very intrusive and invasive treatment will be delivered to them despite any oral wishes expressed. This is not appropriate, is misinformation and is wrong in law.

Too often the standard forms "take over" and become the procedure and forms that must be completed rather than being an option. Rather than the communication taking place between the health practitioner and the patient, and the patient and his or her future substitute decision maker, 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 get heeded as they don't fit on the form. The paper document becomes the directing force, not the patient's own words or the substitute decision-maker'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 in promoting a standard form in a community so that it is clear that it is ONLY ONE of MANY OPTIONS for people in that community, that there is NO REQUIREMENT for such forms to be completed by anyone in order to get services, that health practitioners will NOT use the most aggressive treatments that may not be medically indicated for that particular patient just because the patient has not signed the form.

It must also be remembered that just because a patient completes a 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 by a particular form. If a standard form is promoted, great care must be taken to ensure that all persons using the form, patients, substitute decision makers, health practitioners MUST 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 get a proper capable INFORMED CONSENT to any treatment, from the patient or, if the patient is not capable, from the patient's substitute decision-maker as determined by the HCCA, subject to the emergency exception.
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

17. 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 style 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". The plan must relate to the current health condition of the patient. 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.

Remember 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.(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 is information in respect to 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.

18. As 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 the HCCA, s. 13, then it is not necessary for that health practitioner to be able to answer all the patient's questions about the plan of treatment.

THIS IS NOT TRUE. The consent to the plan of treatment must still be an 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 get an informed consent from the patient. Therefore, he or she must be able to provide the information to the patient as required for an informed consent and must be able to answer the questions for the patient that he or she may have in addition to that information. That health practitioner, if not able to answer the questions, or if not able to evaluate the person's capacity for a specific part of the treatment, must ensure that the information is obtained for the patient or the proper determination of capacity is done.

For example, the plan of treatment may include 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 medical treatment proposed and must be able to 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 act 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.

Information and Rights Advice

19. 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 tell the person of the finding of incapacity nor has to tell the patient of the right of review of the finding of incapacity or of other rights of review before the Consent and Capacity Review Board.

THIS IS NOT EXACTLY ACCURATE IN THE LAW nor is it ethically appropriate. Although the specific requirement to advise a person of the finding of incapacity or to give rights advice to the person believed to be incapable has been removed from the sections dealing with consent and dealing with when treatment may begin (s. 10 to 19), s17 of the HCCA requires the health practitioner to provide to the person found incapable the information about the consequences of the findings as is specified in the guidelines established for this purpose by the governing body of the health practitioner's profession.

Also section 1 of the HCCA describes the one of the purposes of the HCCA as " the enhancement of the autonomy of persons" to whom treatment (admission, 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". 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. It may also be a battery to treat a patient without consent if the health practitioner treats and it is subsequently determined by the CCB or the court that the patient was competent and would have refused the treatment.

On a practical basis, it would seem prudent to advise the patient of the finding of incapacity, the intent to turn to a SDM and the right of review, and to assist that patient in making contact, if desired, to someone independent who can provide that patient with additional rights advice and assistance to obtain the review in order to avoid possible negligence or battery.

20. The 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 a 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 HCCA s.20. A person lower on the list gets authority to act only if there is no person higher on the list that meets the requirements of an SDM by s. 20(2) (see HCCA s.20 (3)).

Note that the word "available" is defined in 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.

HCCA s20 (4) makes an exception to this rule. If a person on the s.20 list is present or has been otherwise contacted, he or she may give or refuse consent if they believe that no person described in an earlier paragraph or same paragraph of the list exists, or although that person exists, that the person is not a guardian of the person (with authority to consent to treatment), attorney in a power of attorney for personal care (with authority) or a Board appointed representative (with authority) and would not object to him or her making the decision. This would mean that if the child of the incapable person is present or contacted, is asked and can state that there is no guardian, attorney or representative, and that the spouse or partner and the 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 i.e. 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 you acting? Just because the person is present is therefore not enough. Just because the person is "family" is not enough. Just because a certain person on the list agrees with the health practitioner, that is not enough if there is a person higher in ranking that meets the qualifications as an SDM. Health practitioners cannot "SDM shop".

Note that spouses and partners rank above other family members. Partners may be same sex spouses. See definition of "partner" s.20 (9). Also note that a person is NOT a spouse, although married to the incapable person if they are living separate and apart within the meaning of the Divorce Act. (HCCA s.20 (7). Also note that "spouses" include common law spouses who have lived together for at least one year, or have had a child together, or have entered into a cohabitation agreement.

If there is no person on the list that meets the requirements, then the health practitioner must turn to the PGT (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 don't, then the PGT should be contacted to make the decision. (HCCA s.20 (5)). If there is more than one child, they all equally rank. The oldest child or the male child does not get preference.

21. 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 to the health practitioner, then 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 get consent from the Public guardian and trustee.

THIS IS NOT CORRECT. Health practitioners cannot act as substitute decision makers for patients unless they are one of the people in the list of substitute decision-makers in section 20 of the HCCA (ie. A spouse, partner, parent, child, brother, sister, relative) in respect to that patient. The SDA s.46 also specifically prohibits a person who provides health care to the grantor for compensation or who provides residential, social, training or support services to the grantor for compensation from being named as attorney in a power of attorney for personal care 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 substitute decision maker 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 wrong in law. 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 the emergency situation may be a battery. .

If a patient is incapable in respect to treatment and does not have any persons as listed in the HCCA list of substitute decision-makers, then the health practitioner must get consent or refusal of consent from the Public Guardian and Trustee. Forms that state that the health team will make certain decisions for a patient "because the PGT will not" are not correct in law in all situations and therefore should not be used as these forms are inaccurate and misleading and could result in the health team treating without consent.

Admission to Care Facilities

22. Seniors retirement homes are care facilities for the purpose of Part III of the HCCA.

THIS IS NOT TRUE unless these places, properly known as "care homes" are included by regulation. No such regulation exists at the time of writing or updating of this paper. Care homes are covered by the Tenant Protection Act. They offer accommodation and services, including "care" services but are NOT care facilities. Care homes are tenancies. Care homes are required to provide tenants 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, the types of accommodation available. 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 Tenant Protection Act are not enforceable although some care homes do try to included these provisions in the agreements.

The Placement Coordination Service at the Community Care Access Centres that administers admissions into long term care facilities (nursing homes, homes for the aged, and charitable homes for the aged) does not administer "admissions" into tenancies in care homes.

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

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

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

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

Neither can hospitals require patients who are waiting accommodation in a long-term care facility to “wait” their time in a retirement home pending transfer to a long-term care facility. This is inappropriate because retirement homes 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 patient cannot be required to private pay for the accommodation in a retirement home (Remember this is RENTAL accommodation) or to private pay for the care services, which is the normal practice in a retirement home. If a patient is transferred to a retirement home without consent or to “wait out” the period before getting accommodation in a long-term care facility as needed, the hospital or individual hospital staff may be liable for the costs of the care and accommodation for the patient 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 consents if the Health practitioner believes that the incapable person needs treatment. (or admission to long-term care may be forced by the PCS etc.)

THIS IS TRUE IN SOME CIRCUMSTANCES. The HCCA s.37 provides for an application to the CCB by a health practitioner if the SDM refuses consent and the health practitioner is of the opinion that the SDM did not comply with s.21 (the section that describes the principles that are to be followed by SDMs in giving or refusing consent to treatment - wishes and best interests) in making the decision to refuse the treatment.

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 in those circumstances 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 could also apply where the SDM knows of no wishes of the patient but may be clearly acting against the best interests of the patient, such as where the refusal of treatment will result in harm of the patient. Perhaps there is evidence that the SDM is refusing treatment because he or she is motivated by the size of the incapable persons estate, for example.

As this section is in the Health Care Consent Act and no equivalent section existed in the Consent to Treatment Act, it is hoped that the Board will approach these applications in this manner, keeping in mind the stated intent of the act as set out in section 1, the focus on patients' autonomy, the right of the patient to apply to the CCB to have a decision maker of their own choice appointed and the right of patients to use Powers of Attorney for Personal Care to name their own substitutes.

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

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

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

Under the new regulations in respect to admission into long-term care (Spring 2002), a patient may choose up to three long-term care facilities and be on a waiting list for these three facilities. A hospital cannot require the patient to pick a particular facility as one of the three. In fact, a patient may decide to choose only one facility and not use all three choices.

If a bed comes available in a fourth facility not of the patient's choice, the hospital cannot require the patient to select that fourth facility 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.

All health practitioners and health facility administration and anyone who needs to comply with the HCCA and to understand the SDA should get copies of the legislation and read it and refer to it when determining the "rules" in this legislation that must be followed. Beware of relying on articles and publications about the legislation. Many articles written on the SDA and now repealed Consent to Treatment Act and Advocacy Act were inaccurate and the newspaper articles and other publications on the HCCA that contain blatant inaccuracies have been published. Articles are useful to help gain an understanding of the legislation however read them, including this paper, with caution, with an inquiring mind and with reference to the legislation itself.

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

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