

*Research Paper for the Law Commission of Ontario:*

# HEALTH CARE CONSENT AND ADVANCE CARE PLANNING IN ONTARIO

**January 6, 2014**

## **EXECUTIVE SUMMARY**

Judith A. Wahl  
Executive Director  
Barrister and Solicitor  
**Advocacy Centre for the Elderly**

Mary Jane Dykeman  
Partner  
**Dykeman Dewhirst O'Brien LLP**

Brendan Gray  
Staff Lawyer  
Barrister and Solicitor  
**Advocacy Centre for the Elderly**

**ACE**  
Advocacy Centre  
for the Elderly

 **DYKEMAN  
DEWHIRST  
O'BRIEN**  
HEALTH LAW

## EXECUTIVE SUMMARY

This Paper focuses on the interrelationship between health care consent and advance care planning under Ontario law, and on related misconceptions of health practitioners and health care organizations.

At common law and under Ontario legislation, informed consent is required before a health practitioner can provide treatment to a patient. Importantly, where a patient is incapable, the requirement to obtain informed consent is not abrogated, but instead the informed consent is obtained from communications with substitute decision-makers (SDMs).

There has been an increasing emphasis in Ontario, and other common law jurisdictions, on encouraging patients to pre-plan for future treatments that may become necessary if and when the patient becomes incapable. This often means that health practitioners will solicit patients' wishes, values and beliefs relevant to future care decisions, and then record such wishes, values and beliefs in the patient's health record. Unfortunately, at the time of these future care discussions, health practitioners and patients do not always turn their minds to how these wishes, values and beliefs will affect future health care decision-making. Similarly, health practitioners do not always provide patients with sufficient information in order to express informed and robust wishes about future care. In Part 1 of this Paper, we explain our concerns arising from this trend.

As set out in Part II of this Paper, the increasing emphasis on uninformed future care wishes creates a tension between two sides of the principle of patient autonomy. On the one hand, patients have the right to give informed consent to treatment: health

care consent will only be legally valid if the health practitioner discusses the nature, risks, benefits, side effects of, and alternatives to, a particular treatment. On the other hand, patients have a right to express wishes regarding the care they may someday receive when they are incapable, and to have those wishes complied with in certain circumstances. Where a patient has expressed an uninformed wish about future care, these two sides of patient autonomy come into tension. In Ontario, this tension has been resolved by requiring that SDMs give informed consent on behalf of incapable patients. In giving or refusing informed consent, SDMs are mandated to follow the patient's applicable prior capable wishes. Not all jurisdictions have balanced these competing interests in the same manner as Ontario.

In Part III of this Paper, we provide an in-depth summary of the law of Ontario on health care consent, capacity and substitute decision-making. This Part concludes that, under Ontario legislation, with the narrow exception of treatment in emergencies, informed consent must always be obtained from a patient (or if incapable, his/her SDM) before treatment is administered). The patient (or SDM) can only lawfully give informed consent to treatments that relate to the patient's current health condition. Where a patient is incapable, an SDM is required to determine whether the patient has expressed applicable prior capable wishes (which must be followed by the SDM), or otherwise has expressed other wishes, values, and beliefs (which must be considered), in giving or refusing informed consent.

In Part IV, we explore how advance planning fits into Ontario's laws on health care consent, and summarize how different examples of advance care planning have been interpreted by Ontario Courts and administrative tribunals. We also recognize that

advance care planning encompasses a myriad of statements and documents. Under Ontario law, all wishes, values and beliefs must be analyzed to determine whether they are sufficiently specific to be “wishes” or are merely the patient’s “values and beliefs”. If “wishes”, the incapable patient’s current clinical picture must be carefully considered by the SDM to determine if these “wishes” are “applicable to the circumstances” (and must be followed) or are merely “with respect to the treatment” (and must be considered along with the patient’s values and beliefs). The SDM is the primary interpreter of the incapable patient’s wishes, values and beliefs. However, SDMs cannot themselves advance care plan on behalf of patients. Importantly, except in emergencies, advance care planning can only be given effect through informed consent to treatment.

In Part V, we examine the relationship between health care consent and advance care planning in several extra-provincial and international jurisdictions. We conclude that the relationship between health care consent and advance care planning in Ontario law is somewhat unique. Unlike other jurisdictions, Ontario law:

- (a) does not allow prior capable wishes to be given effect without interpretation by an SDM (except in emergencies),
- (b) does not prioritize formalized ‘advance directives’ over informally expressed wishes, values and beliefs, and,
- (c) places a great deal of emphasis on contextualizing health care decision-making in the patient’s current health condition.

We express our preference for Ontario law over the other statutory models examined - because Ontario’s legislation appropriately balances informed consent to treatment with the applicability of prior statements made by the patient.

In Part VI, we describe the operationalization of the law of health care consent and advance care planning in Ontario. In this Part, we critique some of the key

educational and policy documents governing health practitioners, review standardized forms and systems for recording and implementing health care consent and advance care planning, and describe the results of our survey of health care organizations' documents and our focus groups with important stakeholders.

In Part VII, we identify concerns arising from our research into the operationalization of the law of health care consent and advance care planning in Part VI. We conclude that policies, forms, and health practitioners do not place enough emphasis on informed consent to treatment, and instead focus on the solicitation and recording of patient wishes, values and beliefs. In a similar vein, we note a common misconception in Ontario that formalized 'advance directives' can be acted upon directly by health practitioners where the patient is incapable. In fact, the law in Ontario is that all patient wishes regarding future care must be interpreted by an SDM as part of the process of giving informed consent on behalf of an incapable patient (except in emergencies). Similarly, we note that some health care organizations believe that health practitioners should be pre-screening the treatments proposed to SDMs on the basis of the incapable patient's prior expressed wishes, values and beliefs. In the authors' view, this has the potential to usurp the statutory role of the SDM as the interpreter of the patient's wishes in giving or refusing consent.

We also identify a concern that many health care organizations' advance care planning forms incorrectly provide that they can be completed by SDMs – when under Ontario law SDMs cannot advance care plan on behalf of incapable patients. Lastly, we note our concern that health practitioners in Ontario are uncritically relying on advance

care planning documents and research from other jurisdiction, which may not be applicable in Ontario.

In Part VIII, we make recommendations for addressing the issues identified in Part VII. The overarching goal of these recommendations is to encourage health practitioners and health care organizations to emphasize contextualized patient decision-making over rote recording and application of wishes, values and beliefs:

- **Give Priority to Consent to Treatment:** Institutional and regulatory policies and practices should encourage health practitioners to seek consent to a plan of treatment to the greatest extent possible before soliciting wishes, values and beliefs. While a process that emphasizes the importance of knowing the general wishes of a patient is important, more education is needed about closing the loop by seeking informed consent to a proposed treatment, rather than relying on wishes alone;
- **Use a clarified Advance Care Planning Model addressing its relationship with Health Care Consent:** We suggest closing the loop on how health practitioners think about advance care planning. The current practice in Ontario has advance care planning front-loaded to the point where the ‘back-end’ consideration of patient wishes, values, and beliefs appears to be secondary to their ‘front-end’ expression. More emphasis should be placed on advance care planning at the ‘back-end’: i.e., to the contextualized informed consents or refusals of SDMs (if the patient is incapable). We recommend conceptualizing health care consent with advance care planning as a three part process involving:
  - (1) Identifying the future SDM by the capable patient;
  - (2) Recording wishes, values, and beliefs expressed by the patient when capable; and,
  - (3) Obtaining health care consent from the patient (or SDM if the patient is incapable), even if there is an advance care plan.
- **Use the Terminology in the Ontario *Health Care Consent Act*:** Health practitioners, and institutional policies and forms should use the language expressed in the *Health Care Consent Act* when seeking health care consent and engaging in advance care planning. The use of language such as ‘directions,’ ‘decisions’ and ‘living wills’ should be discouraged in Ontario. Similarly, the term ‘Advance Directive’ should not be used in Ontario on health care forms, institutional policies, or in discussions with patients. These terms

would appear to be transplanted from other jurisdictions where, for example, an advance directive or a living will are specific documents that 'direct' treating health practitioners. The use of these terms could lead patients, SDMs and health practitioners to misunderstand Ontario's legislative scheme for giving and refusing informed consent; and,

- **Revise the *Health Care Consent Act* to make advising the SDM of his/her rights and obligations part of informed consent:** With knowledge of their role to interpret and apply prior capable wishes, and to make decisions in the patient's best interests, active SDMs could help health practitioners ensure that advance care planning tools and forms are used appropriately, and that informed consent is obtained. From a practical perspective, the best way to ensure that SDMs obtain the information they need to make decisions on behalf of incapable patients is for health practitioners to provide this information to them. We recommend that, in addition to health practitioners' current statutory obligation to obtain informed consent, health practitioners also be statutorily obliged to inform SDMs of their role. Where health practitioners fail to comply with this requirement, a consent obtained from an SDM will not be lawfully obtained, with all of the same legal consequences as currently exist.

To address the misconceptions we have identified, we suggest a comprehensive education program for all health practitioners, with specific emphasis on those practicing in hospitals, long-term care homes, and retirement homes (as well as community agencies), providing training on the Ontario law of informed consent to treatment and its relationship to advance care planning. This educational program should be tied to funding of health care organizations. We also provide examples of how this educational program could be mandated legislatively.