

CONSENT, CAPACITY & SUBSTITUTE DECISION- MAKING IN ONTARIO



Advocacy Centre for the Elderly

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Disclaimer

- This presentation and any material provided for this presentation is not legal advice but is only legal information for educational purposes
- Legal issues are **FACT SPECIFIC** and require factual information in order to provide legal advice to resolve an issue/problem/determine your rights
- If you require legal advice, please consult your own lawyer or legal advisor

Advocacy Centre For The Elderly

- Community Legal Clinic
- Opened in 1984
- Funded by Legal Aid Ontario
- Offers a range of legal services including
 - Client advice and representation
 - Public Legal Sessions and materials
 - Law reform and Community development work
 - Legal information and referral

Legislation

- *Substitute Decisions Act*
- *Health Care Consent Act*
- *Mental Health Act*
- *Personal Health Information Protection Act*
- *Long-Term Care Homes Act*

Substitute Decisions Act

- Powers of Attorney
 - Continuing Power of Attorney for Property
 - Power of Attorney for Personal Care
- Guardianship
 - Property
 - Personal Care
- Statutory Guardianship
 - Property
- Urgent Investigations
 - Property
 - Personal Care

Health Care Consent Act

- Informed consent
- Capacity to consent to treatment, admission to a long-term care home and personal assistance services in a long-term care home
- Substitute decision-making in these three areas
- Applications to the Consent and Capacity Board
- Consent and Capacity Board
- Admission to a secure unit in a long-term care home – not yet proclaimed

Mental Health Act

- Assessment and involuntary admission to a psychiatric facility (Forms 1, 3 & 4)
- Community treatment orders
- Capacity to manage property
- Treatment
 - Rights Advice sections specific to psychiatric facilities

Personal Health Information Protection Act

- Collection, use and disclosure of personal health information
- Capacity to consent to the collection, use and disclosure of personal health information
- Substitute decision-making related to collection, use and disclosure of personal health information

Long-Term Care Homes Act

- Informed consent to admission
- Residents' rights related to consent
- Regulated documents
 - Must be certified by a lawyer
 - No penalty for not consenting, refusing to consent or withdrawing consent to a treatment
- Transfer to a secure unit – not yet proclaimed

Scope of the *HCCA*

- Treatment
- Admission to Long term Care
- Personal Assistance Services

- Defined in the *Health Care Consent Act (HCCA)*
- To review legislation please see:
 - <http://www.e-laws.gov.on.ca>

- Clothing
- Nutrition (usually)
- Shelter – including admission to a retirement home (admission to a long-term care home IS under the *HCCA*)
- Safety
- Hygiene
- Visitors

Guardianship Only?

- Visitors?
- Detention (except Ulysses contract)
- Travel?

Key Issues in Consent

Capacity

- What is Capacity for Treatment
- How is this capacity determined/ assessed?
- Who assesses this capacity?

Consent

- What is Consent and Informed Consent?

SDMs

- If the patient is not Capable who is the patient's SDM?

Conflicts

- What are the options if there is a conflict about capacity for treatment?
About who is the SDM? About whether the SDM is making decisions appropriately?

Treatment

- anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose
- includes a course of treatment, plan of treatment or community treatment plan
- does not include,
 - Assessment of capacity,
 - Assessment/examination to determine person's condition
 - Taking of health history,
 - Communication of assessment or diagnosis,
 - Admission of a person to a hospital or other facility,
 - Personal assistance service,
 - Treatment that poses little or no risk of harm

Consent

- HP must obtain consent **prior** to treatment **UNLESS** emergency
- Consent must be obtained from patient where competent
- Consent must be obtained from SDM if patient not competent
- **PIECES OF PAPER ≠ CONSENT**

Who Consents to Treatment?

- Capable patient
- SDM if patient determined not capable by the HP proposing treatment
- SDMs **CANNOT** consent for a capable patient **EVEN** if
 - they are named in a power of attorney for personal care **OR**
 - the patient wants them to

Documents

- Documents such as “Level of Care”, “Advance Care Plans”, “Living Wills” are not in legislation
- **ARE NOT CONSENTS**
- Only **expressions of wishes**
- Cannot be completed by SDM
- “Speak” to SDM who must interpret any wishes expressed in them and consent/refuse consent accordingly
- **May** provide direction to HP in an emergency situation only

DNR Confirmation Form

- EMS workers are not HPs
- They cannot use clinical judgement
- Are required to treat and resuscitate
- EXCEPTION is if this document is provided
- Must be part of the Plan of Care and Consented to by patient or SDM
- Patient/SDM can always revoke

Do Not Resuscitate Confirmation Form

To Direct the Practice of Paramedics and Firefighters after February 1, 2008
Confidential when completed

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and **will** provide necessary comfort measures (see point #2) to the patient named below:

Patient's name – please print clearly	
Surname	Given Name

1. "Do Not Resuscitate" means that the paramedic (according to scope of practice) or firefighter (according to skill level) **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) such as:
 - Chest compression;
 - Defibrillation;
 - Artificial ventilation;
 - Insertion of an oropharyngeal or nasopharyngeal airway;
 - Endotracheal intubation;
 - Transcutaneous pacing;
 - Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents and opioid antagonists.

2. For the purposes of providing comfort (palliative) care, the paramedic (according to scope of practice) or firefighter (according to skill level) **will** provide interventions or therapies considered necessary to provide comfort or alleviate pain. These include but are not limited to the provision of oropharyngeal suctioning, oxygen, nitroglycerin, salbutamol, glucagon, epinephrine for anaphylaxis, morphine (or other opioid analgesic), ASA or benzodiazepines.

<p>The signature below confirms with respect to the above-named patient, that the following condition (check one <input checkbox"="" checked="" type="checkbox>) has been met and documented in the patient's health record.</p> <p><input type="/> A current plan of treatment exists that reflects the patient's expressed wish when capable, or consent of the substitute decision-maker when the patient is incapable, that CPR not be included in the patient's plan of treatment.</p> <p><input type="checkbox"/> The physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the substitute decision-maker when the patient is incapable.</p>
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Check one <input checked="" type="checkbox"/> of the following: <input type="checkbox"/> M.D. <input type="checkbox"/> R.N. <input type="checkbox"/> R.N. (EC) <input type="checkbox"/> R.P.N.
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Print name in full	
Surname	Given Name
Signature	Date (yyyy/mm/dd)

- Each form has a unique serial number.
- Use of photocopies is permitted only after this form has been fully completed.

DNR Confirmation Forms

- Are NOT:
 - “Do Not Treat” forms
 - “Do Not Transfer” forms
- Only relate to Emergency Responders not having to provide certain specified procedures

Level of Care Forms

- Are **NOT** consents
- **May** be statement of wishes if signed by the competent person
- **Cannot** be signed by a substitute decision-maker
- **Should not be used**
 - Too restrictive
 - Are confused with being consents

ACE

Level One - Supportive / Comfort Care

This includes, but is not limited to, the provision of measures available within the resources of the facility such as:

relief of pain; administration of oral fluids
positioning; mouth care; treatment of fever;
oxygen administration (if available);
suctioning.

Diagnostic interventions and transfer to hospital will not normally be utilized for residents who request this level of Advance Directives. No cardiopulmonary resuscitation is requested.

Level Two - Limited Therapeutic Care

Care measures will include all procedures utilized in Supportive/Comfort Care as well as the administration of antibiotics if indicated. Transfer to hospital may be arranged to provide measures of comfort or treatment that cannot be given at the facility according to the direction of, and at the discretion of, the physician. No cardiopulmonary resuscitation is requested.

Level Three - Transfer to Acute Care Hospital

If symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment should be made in the acute care hospital emergency department and a decision made whether to admit the resident or return him/her to the Extendicare facility. No cardiopulmonary resuscitation is requested and no admission to an acute care intensive care unit.

Level Four - Transfer to Acute Care with CPR

Transfer to an acute care hospital will be arranged immediately. Cardiopulmonary resuscitation (CPR) will be provided by qualified staff, if available, and by ambulance personnel.

Mental Capacity

- **Mental Capacity:** socio-legal construct, meaning varies over time and across jurisdictions
- **Assessment/Evaluation:** refers to a legal assessment not a clinical assessment
- **Clinical Assessments:** underlie diagnosis, treatment recommendations and identify or mobilize social supports
- **Legal assessments:** remove person's right to make autonomous decisions in specified areas

- **Not** the score on the MMSE MOCA or any other test
- **Not** a Diagnosis

Presumption of Capacity

- Person presumed to be capable for treatment
- **EXCEPTION**
 - HP entitled to rely on presumption unless has reasonable grounds to believe the other person is incapable in respect to treatment

Definition of Capacity

- **Ability** to:
 - Understand the information that is relevant to making a decision about the treatment,
AND
 - Appreciate the reasonable foreseeable consequences of a decision or lack of decision.

Who Assesses Capacity?

- HP proposing the treatment assesses capacity
- One HP can determine capacity to a plan of treatment IF they have the knowledge necessary to get informed consent
- NOT a psychiatrist or capacity assessor

Rights Information

- Health practitioner must provide rights information to the incapable person per their professional guidelines (exception under the *MHA*)
- Generally, that:
 - They have been found incapable
 - They can challenge finding of incapacity
 - If they do nothing, that their SDM will make decision on their behalf
 - Provide assistance to apply to CCB where patient unhappy with finding

Consent

- May be to one treatment or to a number of specific treatments or
- May be to a “Plan of Treatment”
 - Developed by one or more HPs
 - Deals with one or more health problems that a person has or may have based on current condition
 - Provides for administration of various treatments/ course of treatments or withholding/withdrawal of treatment in light of person’s current health condition

What is Valid Consent?

- Consent must:
 - relate to treatment
 - be informed
 - be given voluntarily
 - not have been obtained through misrepresentation or fraud

What is Informed Consent?

- Person must receive information about:
 - nature of treatment,
 - expected benefits,
 - material risks,
 - material side effects,
 - alternative courses of action, and
 - likely consequences of not receiving treatment concerning the proposed treatment that the reasonable person would require to make decisions.
- Person must receive responses to further questions they may have about these matters.

What is Advance Care Planning in Ontario?

1. **IDENTIFICATION** of the capable patient's future **Substitute Decision-Maker (SDM)**, by either
 - a) confirming that the patient is satisfied with their default/ automatic Substitute Decision-Maker in the hierarchy list that is in the *Health Care Consent Act*

OR

 - b) Patients choosing someone else to act as SDM by preparing a **Power of Attorney for Personal Care** (a formal written document).

2. **WISHES, VALUES, AND BELIEFS** – discussing with the **capable patient** about his/her wishes, values and beliefs, and more generally how he/she would like to be cared for in the event of incapacity to give or refuse consent.

These are used as a GUIDE for the SDMs NOT the Health practitioners

Wishes

- **Wishes do not need to be expressed in writing. Wishes may be expressed in any form at any time when the patient is mentally capable (Oral, written, communicated by other means)**
- Later wishes, however communicated, expressed while capable prevail over earlier wishes. A recent capable oral wish will trump an older capable written wish.
- **This is true even if the previous wishes were in writing and the later wishes are oral**

ACP “Wishes”

- Advance Care Planning wishes do not need to be about specific treatments that a person would want to not want
- It is very difficult to anticipate what treatments one would want for themselves as people don't know how their health condition will progress or what the effect of particular treatments would be
- ACP Wishes and explanations of a person's values and beliefs may help the SDM make better decisions for the patient as these wishes help the SDM understand:
 - who the patient is,
 - how they make choices for themselves,
 - what they think is important to themselves what influences their decision making

ACP “Wishes”

- Advance care planning “wishes” should not be used to limit/restrict treatment options without first talking to the patient/SDM of the incapable patient about the patient’s PRESENT condition
- Why? Because “wishes” may have been expressed out of context, without information of options, in a summary way, but **with context**, patient is NOW able to give an informed DECISION (consent) and SDM is better able to apply and interpret previous wishes to then make a DECISION (Consent)

Rules for Advance Care Planning

- Only capable patients can ACP (SDMs CANNOT do advance care planning for an incapable patient).
- Capable patients can express “wishes,” which may or may not be “informed.”
- **When a patient has done advance care planning about a potential future health condition:**
 - **Consent has NOT been acquired.**
 - **Consent MUST still be acquired from the patient or the SDM (if the patient is incapable), except in emergencies.**

Consent from a SDM

- If a person has been determined to be incapable to consent to the treatment, admission to a long-term care home or personal assistance service
- Consent must be obtained from the SDM
- Obligation of person proposing treatment/authorizing admission/to ensure valid consent obtained

Hierarchy of SDMS

- Guardian of person with authority for treatment
- Attorney in attorney for personal care with authority for treatment.
- Representative appointed by CCB.
- Spouse or partner
- Child or parent or Children's Aid
- Parent with right of access only
- Brother or sister
- Any other relative.

PGT SDM of Last Resort

- PGT is SDM if:
 - No person meets requirements, OR
 - Conflict between persons in same category who cannot agree and claim to be SDM above others

Requirements for SDM

- SDM may give or refuse consent only if he or she is:
 - capable with respect to treatment
 - 16 unless parent of incapable person
 - no court order or separation agreement prohibiting access to incapable person or giving or refusing consent on his or her behalf
 - is available, and
 - willing to assume responsibility of giving or refusing consent.

Ranking of SDMs

- Person lower on list may give consent only if no person higher that meets requirements.
- **EXCEPTION**
 - Family member present or contacted may consent or refuse consent if he or she believes:
 - no person higher or in same paragraph exists,
OR
 - if person higher exists, person is not guardian of person, POAPC, Board appointed representative with authority to consent and would not object to him or her making the decision.

Spouse

- married to each other; or
- living in a conjugal relationship outside marriage and,
 - have cohabited for at least one year, or
 - are together the parents of a child, or
 - have together entered into a cohabitation agreement under s. 53 of the *Family Law Act*
- Not spouses if living separate and apart as a result of a breakdown of their relationship

Partner and Relative

- **PARTNER**

- have lived for at least one year, and
- have a close personal relationship that is of primary importance in both person's lives

- **RELATIVE**

- related by blood, marriage or adoption

Available

- Is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal

What Can SDMs Do?

- SDMs can only consent or refuse consent to treatments and **cannot Advance Care Plan**
 - **CANNOT**
 - Sign an “Advance Care Directive”
 - “Level of Care Document”
 - **CAN**
 - Consent/Refuse consent to a treatment plan

How Do SDMS make Their Decisions?

- SDMs must follow the wishes of a patient applicable to the circumstances if known
- If no wishes are known then the SDM makes decisions in the “best interests” of the patient.

Wishes

- While capable, person may express wishes
- Manner of expression of wishes - in POAPC, in form prescribed by regulations, in any other written form, orally, in any other manner
- Later wishes expressed while capable prevail over earlier wishes.
- **Wishes are guide to the SDM** who must determine if they are applicable to the decision to be made
- Wishes are **NOT CONSENTS**
- Health practitioners always must get consent from a **PERSON** except in an emergency

Best Interest

- SDM must consider:
 - values and beliefs
 - other wishes expressed while incapable
 - whether treatment is likely to:
 - improve condition
 - prevent condition from deteriorating
 - reduce the extent or rate of deterioration
 - whether condition likely to improve or remain the same or deteriorate without the treatment
 - if benefit outweighs risks
 - whether less restrictive or less intrusive treatment as beneficial as treatment proposed

Emergency Treatment

- In an **EMERGENCY**, HPs can treat without consent in very limited circumstances
- The treatment is limited to only what is necessary to deal with the emergency

Emergency Treatment

Definition of emergency:

If person is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Emergency Treatment: Incapable Patient

- Can be administered without consent where the HP proposing treatment believes that:
 - There is an emergency
 - Delay required to obtain consent would prolong suffering the patient is currently experiencing or will put patient at risk of sustaining bodily harm

Emergency Treatment: Capable Patient

- Can be administered without consent where the HP proposing treatment believes that:
 - There is an emergency
 - Consent cannot be obtained due to a language barrier or disability
 - Reasonable steps have been taken to communicate but no means found
 - Delay required to obtain consent would prolong suffering the patient is currently experiencing or will put patient at risk of sustaining bodily harm
 - No reason to believe the patient does not want the treatment

Parameters of Emergency Treatment

- Treatment can only continue **for as long as reasonably necessary** to find SDM/practical means of communication in order to obtain informed consent
- HP must comply with any known competent wish of patient
- HP may also treat despite refusal of SDM if they believe:
 - it is an emergency AND
 - SDM not complying with s. 21 of the *HCCA*



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