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for community workers and advocates who
work with low-income and disadvantaged
communities in Ontario.



About our presenter...

Judith Wahl has been the Executive Director and Senior Lawyer at the Advocacy Centre for the Elderly (ACE) since 1984. ACE is a community legal service for low income seniors that focuses on legal issues that have a greater impact on the older population.

Judith has organized and taught numerous public legal education programmes on legal issues that arise in day to day work with seniors, including Advance Care Planning - Physicians' Training Ontario College of Family Physicians and Alzheimer Society of Ontario; Gerontology Programme at McMaster University, Faculty of Social Sciences; the Diversity Training Course at C.O. Bick Police College; as well as Continuing Legal Education Programmes for the Law Society of Upper Canada, Ontario Bar Association, the former Canadian Bar Association – Ontario, and the Canadian Bar Association National.

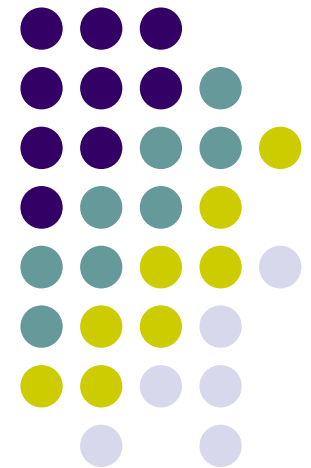


Health Care Consent and Advance Care Planning - Getting it Right

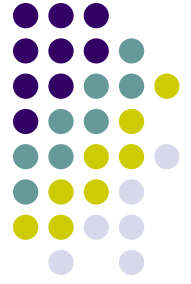
Part I – Health Care Consent Basics

Part II- Advance Care Planning CLEONet

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Advocacy Centre for the Elderly



- Legal advice and representation
- Public legal education programs
- NEW website address - www.ancelaw.ca
- Mailing address: 2 Carlton Street, Suite 701
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416-598-2656

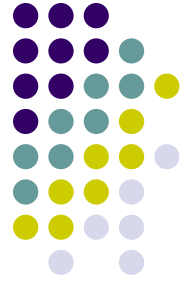
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Today's Webinar Part I of 2

Health Care Consent and Advance Care Planning

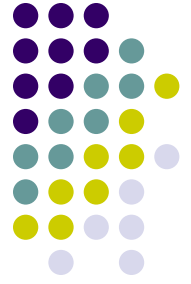
- Getting it Right

Part I – Health Care Consent Basics



- Introduction – Health Care Consent and Advance Care Planning
- Basic principles of health decision making
- What are health decisions?
- What is consent and informed consent?
- Who Gives or refuses consent?
- What is capacity to consent?
- Who assesses capacity to consent?
- SDMs for health decision –Who is the right SDM?
- How does a SDM make a decision for an incapable patient?

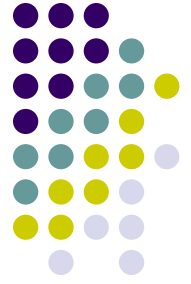
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Next Webinar Part 2 of 2
Health Care Consent and Advance Care Planning
- Getting it Right
Part 2 – Advance Care Planning



- The relationship between Health Care Consent and Advance Care Planning
- What is advance care planning?
- Who can advance care plan?
- Options for advance care planning
- Who do advance care plans "speak" to?
- Difference between advance care plans and health care consent
- Applications to the Consent and Capacity Board about health care decisions



Questions during Webinar

- Please write your questions in the chat box during the presentation
- We will also break for questions twice during the presentation
 - after the explanation of the legal context for health decision making
 - after the explanation of consent and informed consent
- We will also take questions at the end



Legislation

- Health Care Consent Act (HCCA)
- Substitute Decisions Act (SDA)

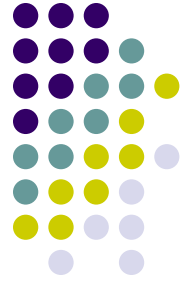
See “Laws” on the Ontario Government website at www.gov.on.ca

Do You or Your Organization/Facility understand Health Care Consent and Advance Care Planning (ACP)?



- Are you familiar with the *Health Care Consent Act* (HCCA)?
- Do you look at the Act when trying to figure out problematic situations?
- If you are advising a patient, do you understand health care consent ?
- If you work in a health facility or health organization, does your facility/ organization policies about health consent and advance care planning comply with the HCCA?
- Do you understand the difference between informed consent and ACP?
- Do you understand what to do if the patient has expressed wishes about treatment/admission but you think the SDM (Substitute Decision Maker) is not following those wishes?
- Does your organization/facility or the organization/facility in which your client resides use any type of ACP “forms” and do you think that they comply with the HCCA?

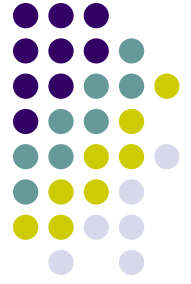
General Challenges to Patient-Physician Communication



- Time constraints
- Language differences
- Mismatch of agendas
- Lack of teamwork
- Discomfort with strong emotions
- Quality of physician training
- Resistance to change habits

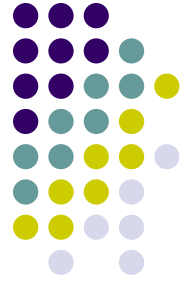
Buckman (1984), Ford et al (1994), Buss (1998)

Problems in Health Consent and Advance Care Planning



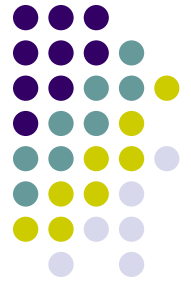
- Facilities/organizations/health providers are not always getting informed consent before treatment
- Organizations/ Health practitioners are misusing ACP – using it as a replacement for informed consent – ACP documents and advance wishes are NOT consents

Problems in Health Consent and Advance Care Planning



- Organizations/Health practitioners are using patient's "wishes" inappropriately instead of making application to the Consent and Capacity Board when the health practitioners disagree with SDMs
- A number of organizations use "levels of care forms" inappropriately as consents or as ACP documents
- Some organizations try to get "preconsent" – not legal!
- Some Health practitioners/ facilities mistakenly still think that the Attorney is a POA personal care is the "only" SDM for health care

Health Care Consent – The Framework



- a) What is health care?
- b) Who is the decision maker for treatment/no treatment/admission – the patient, SDM or health practitioner? Why?
- c) What is informed consent/refusal to consent to treatment/admission?
- d) What is ACP in Ontario and does it fit into/affect the consent and admission process? How is ACP different from a plan of treatment ? How is ACP difference from care planning?



What is Health Care?

- Treatment
- Admission to long-term care homes
- Personal assistance services in long-term care homes

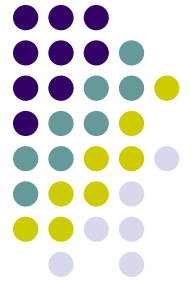


Definition Of Treatment

- HCCA, s.2:

Anything done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or health related purpose and includes a course of treatment or plan of treatment but does not include:

Definition Of Treatment (cont'd)



Treatment does not include:

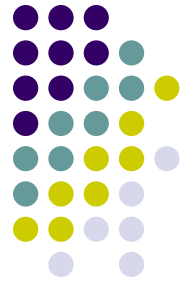
- a) capacity assessments under either the HCCA or *Substitute Decisions Act* or for any other purpose
- b) examination to determine general nature of person's condition
- c) taking of health history
- d) communication of diagnosis
- e) admission to hospital or other facility
- f) personal assistance services
- g) treatment that in the circumstances poses little or no risk of harm to the person
- h) anything prescribed by the regulations as not constituting treatment



Admission

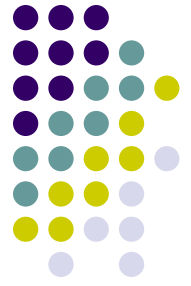
- HCCA, s. 38 - Admission to a care facility
 - Also see Long Term Care Homes Act s 46
- HCCA, s. 2(1) - Care facility is a nursing home, home for the aged, or charitable institution (these will all be referred to as “long term care homes” after July 1, 2010)
- Consent to admission is required in the existing long term care legislation and is also required in the new *Long Term Care Homes Act* coming into effect on July 1, 2010

Legal Context of Decision-making (1)

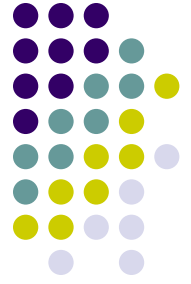


- Before providing treatment, health care providers must get **an informed consent or refusal of consent** to a treatment from the patient, if capable
- If the patient is not capable, the consent is given by the patient's SDM – consent **ALWAYS** comes from a person, not a piece of paper!!!

Legal Context of Decision-making (1)



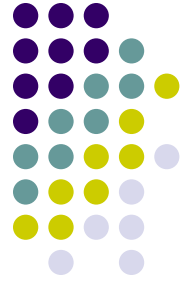
- In an **EMERGENCY**, health care providers do not need consent in order to treat
- But, they must follow any known wishes of the patient in respect to treatment
- HCCA s. 26
Not treat capable or incapable person in emergency if Health practitioner has reasonable grounds to believe the person expressed wishes while capable to refuse consent to the treatment.



What is an emergency?

- HCCA s. 25 Definition of emergency:

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

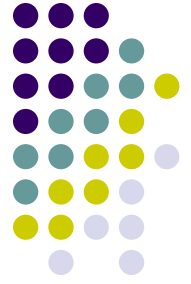


Emergency treatment without consent

- **INCAPABLE PERSON**

Treatment without consent of INCAPABLE PERSON if emergency and delay to obtain consent or refusal will prolong suffering or put the person at risk of serious bodily harm.

Emergency Treatment without consent



- **CAPABLE PERSON**

Treatment without consent of CAPABLE PERSON if:

- a) emergency
- b) no communication due to language or disability that prevents communication
- c) steps reasonable to enable communication to take place tried but no means has been found
- d) delay to enable communication will prolong suffering or put person at risk of serious bodily harm
- e) no reason to believe person does not want treatment.

Emergency treatment despite refusal of consent by SDM



- HCCA s. 27

Health practitioner may treat despite refusal of SDM if:

- a) emergency and
- b) SDM not acting in accordance with wishes of the incapable person or not acting in person's best interest if wishes are not known



Legal Context of Decision-making (2)

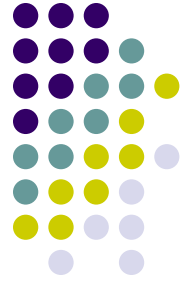
- A patient, if mentally capable for treatment decision-making, is the decision-maker
- A patient can also express **WISHES** about future health treatment (ACP). These wishes can be expressed orally, in writing, or communicated by any other means
- ACP is **NOT** a consent – wishes are **NOT** decisions. Even if an advance care plan exists, the consent/ refusal of consent must come from a person

Legal Context of Decision-making (3)

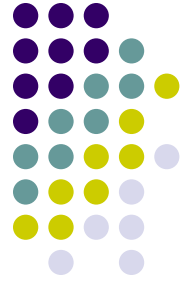


- If the patient is not mentally capable, then his or her SDM, is the decision-maker
- SDMs can only consent or refuse consent to treatments and **cannot Advance Care Plan**
- SDMs must follow the wishes (ACPs) of a patient when making treatment decisions for the patient if known. If no wishes are known then the SDM makes decisions in the “best interests” of the patient.

Questions?



- Any questions about legal context for health care decision making?



What is Valid Consent?

- HCCA, s. 11
 1. Must relate to **the treatment**
 2. Must be **informed**
 3. Must be given **voluntarily**
 4. Must not have been obtained through **misrepresentation or fraud**

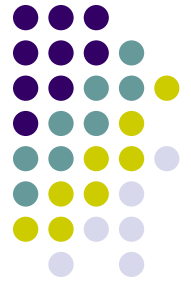


What is Informed Consent?

Patient must receive information on the:

- Nature of the treatment
- Expected benefits of the treatment
- Material risks of the treatment
- Material side effects
- Alternative course of action
- Likely consequences of not having the treatment

Consent to One treatment or to a Plan of Treatment



- Consent can be to one specific treatment; OR
- Consent can be to a **PLAN OF TREATMENT**

Plan of Treatment – HCCA, s.2(1)



- Developed by one or more health practitioners
- Deals with one or more of health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
- Provides for the administration to the person of various treatments or courses of treatment and may, in addition, provides for **withholding or withdrawal** of treatment in light of person's **current health condition**.

Decisions can be for present care and care in the future



- Plan of treatment(may) deal with one or more of the health problems that the person is likely to have in the **future** given the person's **current health condition, and**
-may, in addition, provide for **withholding or withdrawal** of treatment in light of person's **current health condition**



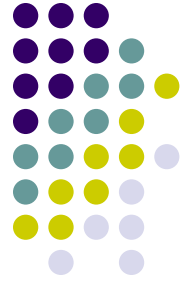
Treatment in the future is NOT necessarily ACP

- A person can give an informed consent to a treatment that takes place or is withheld in the future if the decision for that treatment is relevant considering the persons **PRESENT HEALTH CONDITION**
- This is not ACP but consent

Who Gives or Refuses Consent?



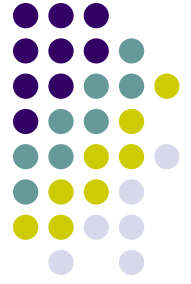
- In Ontario, consents and refusals of consent come from PEOPLE – not pieces of paper or advance directives
- Who gives or refuses the consent – the patient or SDM?
 - Depends on whether the patient is **mentally capable** for treatment
- What does **capacity** mean in this context?



Capacity- Legal Definition

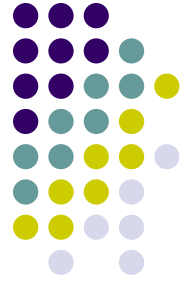
- Mental capacity is a socio-legal construct and its meaning varies over time and across jurisdictions
- Assessment/evaluation refers to a **legal assessment** that the health practitioner does - not a clinical assessment
- Clinical assessments underlie diagnosis, treatment recommendations and identify or mobilize social supports
- Legal assessments remove from the person the right to make decisions in specified areas

Definition of Capacity with respect to Treatment, Admission to Care Facilities, and Personal Assistance Services



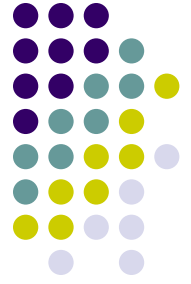
- HCCA, s.4:
Able to understand the information that is relevant to making a decision about the treatment, admission, or personal assistance service as the case may be and able to appreciate the reasonable foreseeable consequences of a decision or lack of decision.

Mental Capacity for Treatment



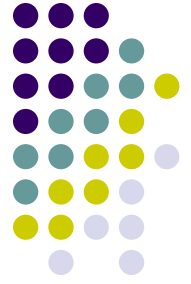
- Not the score on the MMSE or any other test
- Not a diagnosis
- It is an analysis/determination based on your own conversations and observations with persons
- Just because a person is old, does NOT mean that they lack decisional capacity
- Just because a person is a resident in a long-term care home, does NOT mean that they are incapable to make treatment decisions

Pocket Tool on Capacity and Consent



- A pocket tool on Capacity and Consent created by ACE is available from the
 - National Initiative for Care of the Elderly
222 College Street Suite 106
Toronto, Ontario M5T 3J1
 - 416-978-2197
 - www.nicenet.ca
 - This describes how to assess capacity as well as outlines the basic steps in consent

Who Assesses Capacity with Respect to Treatment?



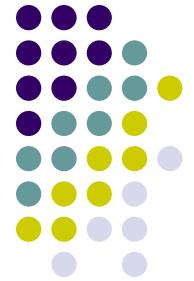
- The health practitioner who proposes a treatment is required to form the opinion about the capacity of the patient to consent to treatment
- If a plan of treatment is proposed, one health practitioner on behalf of all the health practitioners involved in the plan may determine the patient's capacity for treatment

If the patient is assessed as not mentally capable for treatment, then....



- If the health practitioner is of the opinion that the patient is not mentally capable to make the treatment decision, then he or she
 - must inform the patient of the finding
 - give the rights advice required by his or her Health College. such as advising the patient that he or she will be turning to the patient's SDM for the decisions on the treatment and that the patient has a right to apply to the Consent and Capacity Board for a review of the finding of incapacity

Decisions (Consents) vs. Wishes



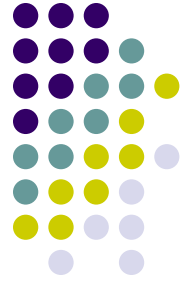
- Health practitioners must get **CONSENTS** which are **DECISIONS** that are obtained from patients after the patients have the necessary information on their **PRESENT** health condition on which to make an informed decision
- **Wishes are NOT Decisions** – Wishes are speculative/ made without all the information . Wishes are speculative – made up based on “if” scenarios – “If I have a terminal condition.. If I am in pain.. If I have dementia...” – not on facts

Questions?



- Any questions about the consent or informed consent or capacity or assessment of capacity?

SDMs

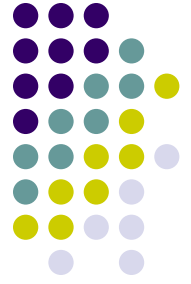


- If patient not mentally capable to consent to a particular treatment or plan of treatment, then the health practitioner must turn to the patient's SDM



Hierarchy of SDMs

1. Guardian of person
2. Attorney in POAPC
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child or parent or CAS (person with right of custody)
6. Parent with right of access
7. Brother or sister
8. Any other relative
9. Office of the Public Guardian and Trustee

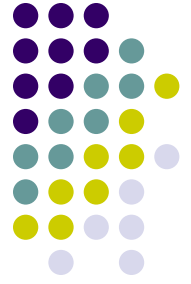


Definition of Spouse

HCCA, s. 20(7) – Opposite or Same Sex Spouse

- (a) married to each other; or
 - (b) living in a conjugal relationship outside marriage and,
 - i) have cohabited for at least one year, or
 - ii) are together the parents of a child, or
 - iii) 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.

Definitions - Partner and Relative



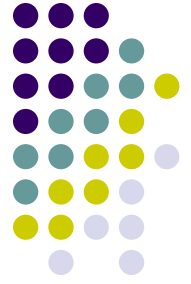
- **PARTNER:**

HCCA, s. 20(9) – lived for at least one year and have a close personal relationship that is of primary importance in both person's lives

- **RELATIVE:**

HCCA, s. 20(10) – relatives if related by blood, marriage or adoption

SDMs



- List is hierarchical
- All persons on same level have equal right to be SDM (ie. all brothers and sisters equally rank)
- Person **ALWAYS** has SDM if incapable as OPGT is SDM if person has no one higher on hierarchy or if conflict between equal ranking SDMs

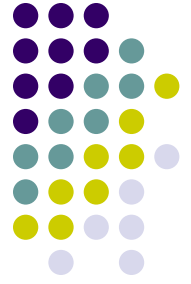
Requirements for Person to be an SDM



The person highest in the hierarchy may give or refuse consent only if he or she is:

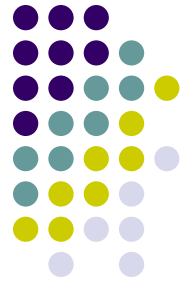
- a) Capable in respect to the treatment
- b) At least 16 years old unless the parent of the incapable person
- c) Not prohibited by a court order or separation agreement from acting as SDM
- d) Available
- e) Willing to act as SDM

Requirements to be an SDM – Responsibility of Health Care Practitioners



- Health care practitioners must determine who is the proper SDM
- That means then that the health practitioner must determine if the highest ranking SDM meets the requirements to be a SDM

Requirements to be an SDM – Responsibility of Health Care Practitioners



- For example - If the health practitioner believes that the highest ranking SDM is not mentally capable for the treatment decision that has to be made for the incapable patient, the health practitioner should then turn to the next highest ranking SDM for the incapable patient in the hierarchy

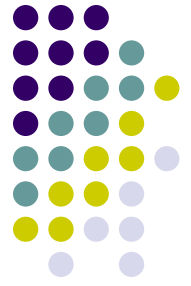


How SDMs Make Substitute Decisions

It is the responsibility of the SDM to make treatment decisions for an incapable person by:

- a) following any **wishes (advance care plans)** of the patient expressed when capable that are relevant to the decision;
and
- b) if no wishes are known or are relevant to the particular decision, to act in the **best interests** of the patient

Best Interests Definition



SDM to consider:

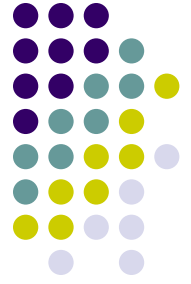
- a) values and beliefs
- b) other wishes (i.e. expressed while incapable)
- c) whether treatment likely to:
 - i) improve condition
 - ii) prevent condition from deteriorating
 - iii) reduce the extent or rate of deterioration
- d) whether condition likely to improve or remain the same or deteriorate without the treatment
- e) if benefit outweighs risks
- f) whether less restrictive or less intrusive treatment as beneficial as treatment proposed



SDM's Role – CONSENT, not ACP

- SDMs **cannot** advance care plan
- However, if the patient's present plan of treatment deals with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
- Provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition, then the SDM can CONSENT or REFUSE consent to these "future" treatments
- **This is NOT advance care planning**

Time that the consent “lasts”



- Consent by a capable patient or SDM “lasts” only as long as the capable patient or the SDM , acting when the patient is not capable, do not change their mind
- There are no specific time limits on a consent
- Consent may also come to an end because the patient’s condition has changed and different treatment options need to be considered

Consent to Plan of Treatment



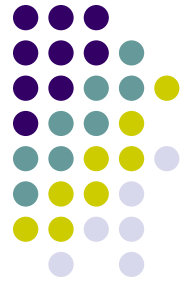
- If the patient's condition has changed and the original plan of treatment that the patient consented to is no longer valid because of that change, and the patient is now mentally incapable to give or refuse consent to treatment, or a new plan of treatment, then a new informed consent must be obtained from the patient's SDM

Applications to Consent & Capacity Board - Treatment

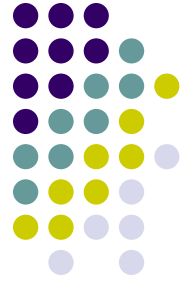


1. By person for review of incapacity in respect to treatment (HCCA s.32)
2. By person for appointment of representative (HCCA s.33)
3. By another to be appointed as representative of incapable person (HCCA s.33)

Applications to Consent & Capacity Board - Treatment



4. By person for review of consent to admission to hospital, psychiatric facility or other health facility for purpose of treatment
5. By SDM for directions in respect to wishes (s.35)
6. By SDM to depart from wishes (s.36)
7. By Health practitioner to determine compliance of SDM with criteria to make substitute consent (s.37)

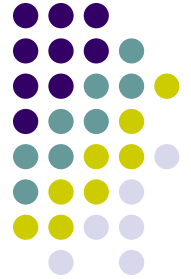


Summary

- Before delivering treatment, health practitioners must get informed consent
 - From the patient if capable
 - From the patient's SDM if the patient is not capable
- Consent does NOT come from an advance care plan
- In an emergency a health practitioner may treat without consent

Questions?

- Any questions on anything that was presented today?



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For more information visit the Health and
Disability section of CLEONet at
www.cleonet.ca

For more public legal information webinars
visit:

<http://www.cleonet.ca/training>

