When I say:

Advance Care Planning??

What does this mean to you?

Advance Care Planning

In Ontario, Advance Care Planning is a process that involves YOU when *mentally capable* :

Identifying YOUR substitute decision maker(s) (SDM)

- The person(s) who would make health care decisions on your behalf if you became mentally incapable to make any health decision

Discussing YOUR wishes, values & beliefs with your Future SDM(s)

- Including preferences for how you would like to be cared for if you were not capable to give or refuse consent

Who may do Advance Care Planning?

- Only YOU, when CAPABLE, may do advance care planning (Both confirming or choosing your future SDM and expressing your wishes, values, beliefs about future care)

- Your SDM cannot do advance care planning for you. SDMs only make decisions for you if you should become an incapable and can't make health decisions for yourself

Substitute Decision Makers and the HCCA

- The Health Care Consent Act has in it a hierarchy (list) that ensures every person has an automatic SDM

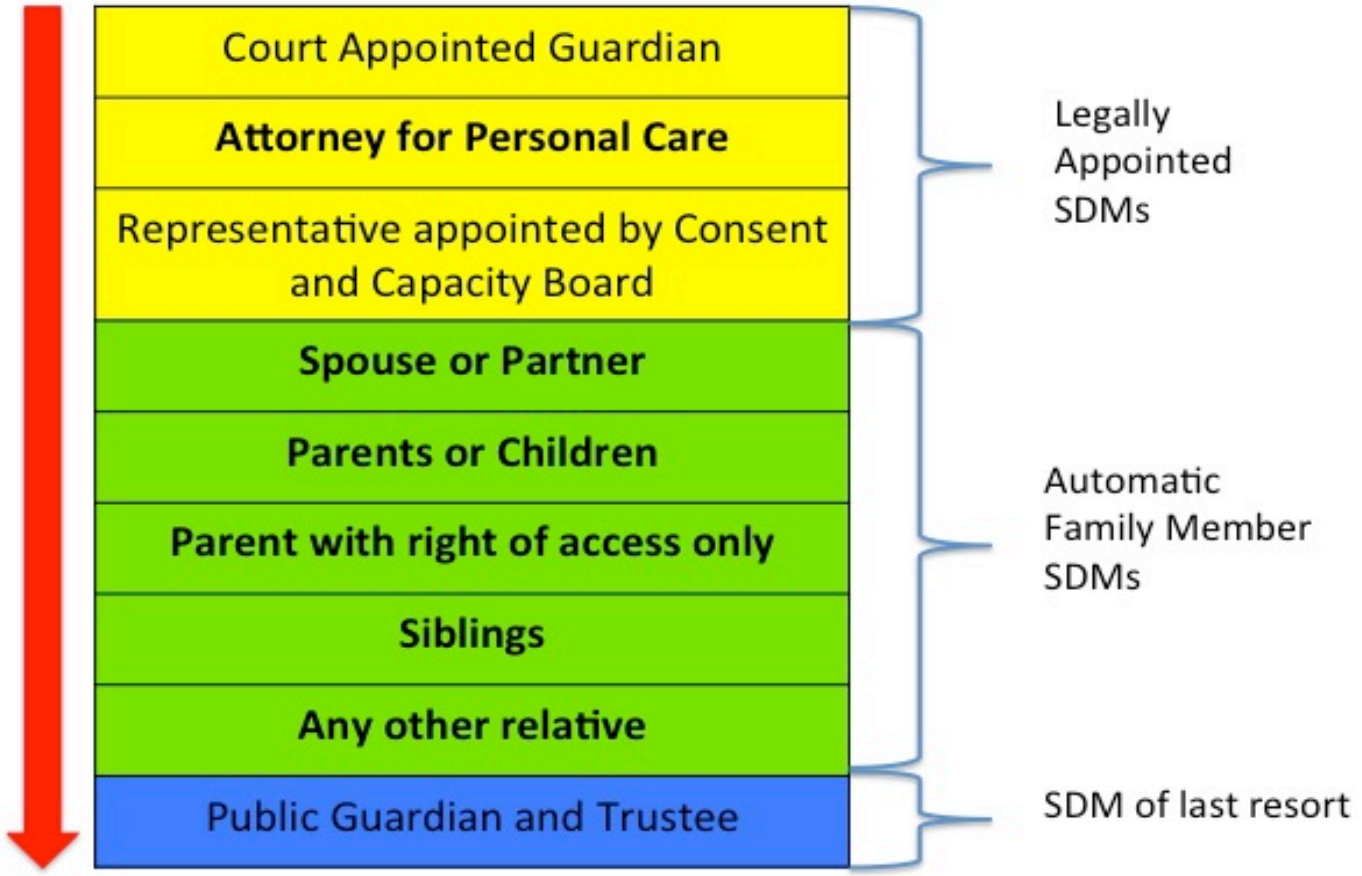
- The first part of ACP is IDENTIFYING your future SDM(s) by either

CONFIRMING your automatic SDM(s)	**CHOOSING** someone else and **COMPLETING** a *Power of Attorney for Personal Care* document

Substitute Decision Maker Hierarchy

Confirm automatic SDM(s)

Choose someone else and **Prepare** a *Power of Attorney for Personal Care* document



Ontario Health Care Consent Act, 1996

Requirements for SDM: HCCA s.20

An SDM in this list may give or refuse consent only if he or she is:

I. capable (him or herself) with respect to treatment,

II. 16 unless parent of incapable person,

III. no court order or separation agreement prohibiting access to incapable person or giving or refusing consent on his or her behalf,

IV. is AVAILABLE, and

V. **Willing to assume responsibility of giving or refusing consent**.

Terms

- What's an Attorney for Personal Care and what's a Power of Attorney for Personal Care ?
- What's a Guardian of the Person and what's a Representative?
- What's a Spouse? If I am married but separated, is that person still my spouse?
- What's a Partner?
- Who is a Relative?
- Who is the PGT (Public Guardian and Trustee) ?

What if..

- If your highest ranking SDM is not capable to make treatment decision OR
- If your SDM not available OR
- If your SDM not willing to act as SDM

  – Then next SDM on the list that meets the requirements to be an SDM is your decision maker

What if …

- Multiple equal ranking SDMs – who Decides?

- If you have more than one SDM at the same rank on the list, THEY must decide amongst themselves if all will be your SDMs together, or one or more will be your SDMs and the others will drop out .

  If more than one acts and the ones acting can't agree, then the health practitioner must turn to the Public Guardian and Trustee if the disagreement cannot be resolved.

How does your SDM make decisions for you in the future?

Wishes

- Must consider patient present condition
- what wishes patient made when capable that would apply
- what were LAST capable wishes if patient had changed his/her mind

If there are no applicable wishes or wishes are IMPOSSIBLE, then SDM must act in best interests

Best interests

- Person's values and beliefs, and
- Risks and benefits of treatment etc.
- See Best Interests Definition in next slides

How Your SDM makes Decisions for You

Your SDM is the “interpreter” of your wishes, values and beliefs and must determine:

- Whether you expressed your wishes when you were still capable (and that you said these things voluntarily);
- Whether the wishes are your last known capable wishes;
- What you meant in that wish;
- Whether the wishes are applicable to the particular decision at hand; and,
- If there are no applicable/capable wishes, how your values, beliefs, and incapable/inapplicable wishes would apply to your “best interests.”

What are "Best Interests"?

Your SDM must consider:

a) your values and beliefs
b) other wishes you made when not capable
c) whether the treatment is likely to:
    i) improve your condition
    ii) prevent condition from deteriorating
    iii) reduce the extent or rate of deterioration
d) whether your condition is likely to improve or remain the same or deteriorate without the treatment
e) if benefit outweighs risks
f) whether there is a less restrictive or less intrusive treatment as beneficial as treatment proposed

May your SDM NOT follow one of your wishes?

- If your SDM believes that you would have **changed your wish** if you knew what your present health condition would be and the possible treatment options, your SDM may go to Consent and Capacity Board to ask that they not be required to follow that original wish

- If your SDM believes that a wish made by you is **impossible** to follow then your SDM does not need to follow it and does not need to go to the Consent and Capacity Board to not follow it

Advance Care Planning Wishes and Health Care Consent

- Under Ontario law, your advance care planning wishes help PREPARE your SDM for their future role as your health decision maker
- Your SDM, NOT your health practitioners, **take directions** from your advance care planning wishes because your SDM is in the best position to put into context your previous wishes in relation to your present health condition
- Advance Care Planning discussions about your wishes, values, and beliefs should help your SDM make better decisions for you if you should become incapable to speak for yourself
- Advance care planning wishes are NOT a “preconsent” or an “advance consent” or any form of consent

How do you DO Advance Care Planning?

- **Wishes do not need to be in a written form.**

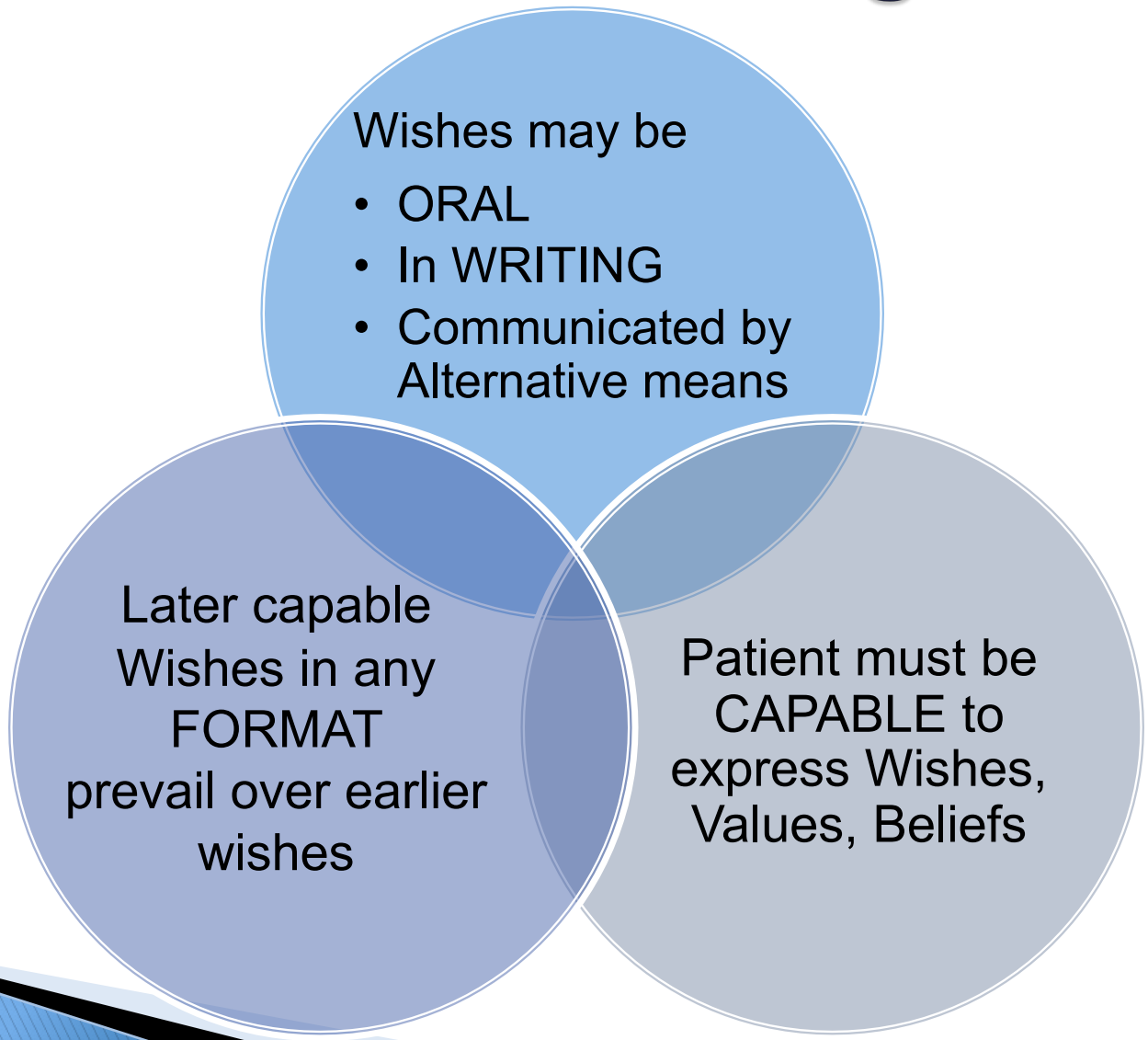
  Wishes may be expressed in any form, at any time, when you are mentally capable (Oral, written, communicated by other means)

- Later wishes, however communicated, expressed while capable prevail over earlier wishes.

- This is true **even if the previous wishes were in writing and the later wishes are oral**

- **HOWEVER , you must prepare a Power of Attorney for Personal Care (a document) if you want someone to be your SDM that is not your Automatic SDM**

Advance Care Planning Wishes



ACP "Wishes"

- Advance Care Planning does not need to be about specific treatments that you would want or not want

- It is very difficult to anticipate what treatments you would want for yourself because you won't know how your health condition will progress or what the effect of particular treatments would be

- ACP Wishes and explanations of your values and beliefs may help your SDM make better decisions for you as these wishes help the SDM understand:
  - who YOU, the patient are as a person,
  - how YOU make choices for themselves,
  - what YOU think is important to you and what influences your decision making

What about “Advance Directives” and “Living Wills”?

- The terms “advance directive” and “living will” do NOT appear in Ontario Law.

- The *Health Care Consent Act* only refers to the word “wishes”.

  If a document says it is an ‘advance directive” or a “living will”, under Ontario law it is still an expression of wishes, to be interpreted by your SDM alongside other oral and written expressions of wishes.

- **BUT NOTE - Only a formal written Power of Attorney for Personal Care gives authority to name an SDM**

Not Helpful Consent and ACP Conversations…

Commonly used	Think about it for a moment…
"No heroics and no machines"	Ever? Or when there is no chance of recovery? What about a 90% chance?
"No tubes"	What if the circumstances were short term and reversible… would a "tube" be acceptable?
"Do everything"	What does this mean? What "state of being" is to be achieved? How will the SDM know when everything has been done?

Helpful Consent and ACP Conversations…

	Explore further
"No heroics and no machines"	What experiences have you had to bring you to this? What is it about "heroics and machines"?
"No tubes"	What is it about a tube that makes you not want one?
"Do everything"	What does it mean to not "do everything"? What worries or fears come to mind? How should we approach reconciling this?

DNR Confirmation Form - DNR(c)

- Only applies to paramedics and firefighters who are emergency responders
- By law emergency responders are REQUIRED to provide resuscitation unless they have direction from an appropriate regulated health practitioner
- This form confirms that YOU or your SDM has consented to no resuscitation or that the physician believes that CPR will not benefit you, that CPR is not part of your plan of treatment AND the physician has discussed that with You or your SDM

DNR(c) Form

- Form may be relied upon by emergency responders to not resuscitate

- DNR(c) form is NOT a DNR order that may be relied upon by health practitioners in a hospital or other health facility – when you get into hospital, the health practitioners should talk to you again about DNR because your health condition has changed since you previously consented to No CPR

Why does it matter to GET THIS RIGHT?

- Under Ontario Law, Advance Care Planning is part of the Health Care Consent Act

Health care professionals must always obtain informed consent or refusal before treatment from either the mentally capable patient or their substitute decision maker (SDM)

Do you need to write out your wishes about health care ?

- No – as valid if communicate orally or communicate by alternative means
- May decide to write out wishes if will help future SDM understand your wishes or to help support SDM if possible conflicts with other family that may disagree with the SDM when SDM is just trying to honour your wishes
- Risks of written wishes – may be misunderstood, are subject to interpretation, may change and may not be what you want yet still in written form so its looks like that is still your wish although wishes have changed
- You may revoke / change wishes orally EVEN IF previously in writing

Other Resources On HCC and ACP

- A LOT of material on the internet about Health Care Consent and ACP is either not applicable to Ontario – the law related to this is provincial so it varies across Canada and across jurisdictions- or even if Ontario based, it contains errors so anything you find on the internet should be read with a critical eye

- The legislation – the Health Care Consent Act and Substitute Decisions Act – may be found at https://www.ontario.ca/laws

Law Commission Of Ontario Reports and Papers

- **Improving the Last Stages of Life Project (in process)**
  https://www.lco-cdo.org/en/our-current-projects/improving-the-last-stages-of-life/

- HEALTH CARE CONSENT, ADVANCE CARE PLANNING, AND GOALS OF CARE PRACTICE TOOLS: THE CHALLENGE TO GET IT RIGHT
  Improving the Last Stages of Life December 2016
  Wahl, J; Dykeman, MJ; Walton, T.
  https://www.lco-cdo.org/wp-content/uploads/2010/10/ACE%20DDO%20Walton%20Formatted%20Dec%202%2C2016%20LCO.pdf

- **Legal Capacity, Decision-making and Guardianship - Final Report March 2017**
  https://www.lco-cdo.org/en/our-current-projects/legal-capacity-decision-making-and-guardianship/

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Questions and Discussion