



Advocacy Centre
for the Elderly

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February 20, 2015

VIA EMAIL: EOLpolicy@cpsso.on.ca

Attention: Policy Department
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2

Dear Sir/Madam,

Re: Comments on Draft Planning for and Providing Quality End-of-Life Care Policy (Approved by Council for Consultation – deadline February 20, 2015)

The following are the Advocacy Centre for the Elderly's comments on the Draft Planning for and Providing Quality End-of-Life Care policy for your consideration.

About the Advocacy Centre for the Elderly (ACE)

To put our comments in context, we provide relevant information about the Advocacy Centre for the Elderly (ACE).

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE staff have extensive experience in issues related to health care consent and advance care planning and have been involved in many of the law, policy, and education initiatives related to these issues that have taken place in Ontario over the last 30 years. These have included:

- participating as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992* and subsequently the *Health Care Consent Act, 1996*;¹
- acting as one of the principal writers of the training materials for health professionals that were produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;
- participating on the Ontario Medical Association Presidents Advisory Committee on Palliative Care and Advance Care Planning;
- participating currently on the Advisory Committee for the Law Commission of Ontario Project on Legal Capacity, Decision-making and Guardianship;
- engaging presently and for the past two years in a number of education initiatives for health care practitioners on health care consent and advance care planning. These include but are not limited to initiatives in the Erie-St Clair LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN, and Northwest LHIN. These initiatives have involved interactive, detailed training sessions as well as production of an on-line training course on health care consent and advance care planning that is also a requirement of the Long-Term Care Home Service Accountability Agreements in the HNHB LHIN; and,
- co-authoring (with the law firm of Dykeman Dewhirst O'Brien LLP) a major research paper on health care consent and advance care planning for the Law Commission of Ontario.²

Commentary on the Draft Planning for and Providing Quality End-of-Life Care Policy

We thank you for taking into consideration ACE's submissions dated November 22, 2013 in revising the Draft Planning for and Providing Quality End-of-Life Care policy. While this version of the policy accurately reflects the law on **consent at end of life** as set out in the *Health Care Consent Act* ("HCCA"), we do not believe that the policy accurately reflects the law relating to what is generally called "advance care planning". It does not distinguish between "care planning" that is part of the informed consent process from "advance care planning" nor does it provide sufficient information on why wishes expressed in an advance care plan is not an informed consent. Further, as the recent Supreme Court of Canada decision in *Carter v. Canada (Attorney General)* was only released on February 6, 2015, the Draft policy does not include information on this decision in respect of physician-assisted dying.

¹ *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (HCCA)

² Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship*, Law Commission of Ontario: January 2014, available at: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

We would therefore like to make comment on the following sections:

- lines 34-35: Purpose of the Policy
- lines 37-40: Definition of Advance Care Planning
- lines 48 -50: Definition of Life-Sustaining Treatment
- line 55: Definition/Discussion of DNR orders
- lines 108- 152: Communication and Advance Care Planning
- line 200: Nutrition and Hydration
- lines 246-249: Life-Saving and Life-Sustaining Treatment
- line 293: Certification of Death
- lines 323-334: Euthanasia and Physician-Assisted Death
- lines 331-334: SDMs' Access to Personal Health Information
- lines 360-362: Conflicts with SDMs
- lines 366-377: Documentation

Our recommendations are based on our extensive experience conducting educational seminars for physicians on health care consent and advance care planning and in drafting the report referenced above on health care consent and advance care planning for the Law Commission of Ontario. These experiences have helped us ascertain the common misunderstandings of physicians in the area of advance care planning in order to prevent them from inadvertently falling afoul of Ontario law on health care consent. While ACE has made comments on the CPSO Draft Consent to Treatment policy in a separate letter, it is vital to demonstrate the link between advance care planning and health care consent in this Draft policy in a way that physicians can effectively put into practice.

Prior to ACE's comments on specific sections of the Draft policy, the following is a summary of Ontario law on "advance care planning " and how advance care planning interconnects with informed consent from patients or incapable patients' substitute decision-makers (SDMs). This section will contextualize our specific comments on the Draft policy.

What is Advance Care Planning in Ontario law?

The term "advance care planning" does not appear in the *HCCA* and is not specifically defined in the legislation or the common law. The Ontario Medical Association definition is not a "legal" definition and, in our opinion, does not accurately reflect what advance care planning is under Ontario law.

Advance care planning is a term generally used to describe the process whereby the patient does two things:

1. **Identifies who the patient would want as their future SDM should they become incapable of consenting to a treatment:** This is done by either confirming that the patient is satisfied with their default or automatic SDM in

accordance with the hierarchy provided in the *HCCA*³ or by the patient choosing someone to be their SDM by preparing a Power of Attorney for Personal Care.

2. **Communicates their wishes, values and beliefs to their future SDM:** These words “wishes, values, and beliefs” are also not defined terms in the law. These terms are intended to capture anything that the patient wants to communicate about their future care including wishes about specific treatments, wishes about their care in general, wishes about where they want the care to take place, information about what they consider quality of life to mean to them, any information about their values, and information about beliefs whether religious or of other types.

The purpose of this communication of wishes, values and beliefs is to assist the patient’s future SDM when that SDM must give or refuse consent to treatment on behalf of the patient, if and when that patient becomes incapable of making treatment decisions for themselves.

This communication is primarily to the patient’s future SDM and family, not to the physician or other health practitioners because it is the SDM that must determine:

- whether the wishes of the patient were expressed when the patient was still capable (and were expressed voluntarily);
- whether the wishes were the last known capable wishes;
- what the patient meant in that wish;
- whether the wishes are applicable to the particular decision at hand; and,
- if there are no applicable or capable wishes, how the patient’s values, beliefs, and incapable or inapplicable wishes apply to determining the patient’s best interests.

Advance care plans are not informed consents. Physicians do not take direction from the advance care plans. Under the *HCCA*, physicians must obtain an informed consent from the patient, if capable, or from the incapable patient’s SDM, not from a piece of a paper or from wishes recorded in the patient’s chart.

Another way of explaining this is that the informed consent process results in patients or SDMs communicating informed **decisions** about treatment that are made in context of the patient’s condition at the time of treatment. This is contextualized decision making.

In contrast, the advance care planning process results in the expression of **wishes** about future care and treatment based on speculation about a patient’s possible future condition. No decisions are made in advance care planning because the patient does not yet have all the information about what their health condition would be or about the possible options for treatment of that future condition. This is why advance care planning does not result in consent because it is not “informed”.

³ *HCCA*, *supra*, note 1, section 20

Advance care planning regarding a capable patient's wishes is still an important and helpful process as it can result in the communication of information between the patient and their future SDM to help prepare the SDM to eventually make informed decisions on behalf of the patient if and when the patient is incapable. It helps guide the SDM and gives them confidence that they are making decisions for the patient that the patient would likely have made for themselves if capable, and if the patient had all the information about their health condition and treatment options that the SDM now has.

What is a “Plan of Treatment” in Ontario law?

If a patient is at end of life, the conversations that the physician has with the patient or the patient's SDM are in **the context of the patient's present condition**. Therefore, these conversations are not “advance care planning” but involve obtaining informed consent to treatments or a plan of treatment.

It should be noted that the *HCCA* definition of “plan of treatment” provides as follows:

“plan of treatment” means a plan that,

- (a) is developed by one or more health practitioners,
- (b) deals with one or more of the 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
- (c) 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;⁴

A plan of treatment could include treatments for health problems the patient is likely to have in the future given their current health condition. For example, a plan of treatment could accommodate a refusal of resuscitation should the patient experience a cardiac arrest, although that event will take place “in the future” and not at the immediate moment that consent is obtained.

Consent to a plan of treatment therefore involves “care planning” which includes discussions and making decisions about goals of care and future treatments in context of the patient's present condition. This is different than “advance care planning” which is expressing wishes (not decisions) about what the patient may want if they had a particular health problem.

⁴ *Ibid.*, section 2(1)

In context of this explanation, we make the following comments on the Draft policy.

1. Purpose of the Policy (Lines 34 to 35)

The purpose of the policy indicates that the policy sets out the CPSO's expectation of physicians regarding planning for and providing quality care at the end of life. However, the purpose should indicate that the policy is to assist physicians in facilitating the conversation between patients and SDMs regarding the patients' wishes about their end of life care. The purpose should further indicate that the policy is to provide physicians with the legal framework regarding health care consent in Ontario in order that they can communicate with capable patients or incapable patients' SDMs to obtain informed consent to end-of-life treatment.

The purpose statement, as presently written, may lead to the misunderstanding that (1) the patient must come up with a "plan" to be followed at end of life, rather than wishes about their treatment (2) that the "plan" is to be interpreted by the physician rather than providing wishes to be interpreted by the SDM of an incapable patient.

We recommend amending the purpose of the Draft policy to read: "regarding facilitating the communication of wishes to SDMs by capable patients, communicating with capable patients or incapable patients' SDMs to obtain informed consent to end-of-life treatment, and providing quality care at the end of life."

2. Definition of Advance Care Planning (Lines 37 to 40)

The definition of advance care planning outlined in the Draft policy indicates that advance care planning is a process of reflection and communication regarding treatment a patient may want at the end of life. The definition also indicates that advance care planning involves a deliberation and communication of wishes, values and beliefs between the individual, their loved ones, their substitute decision-maker and their health care provider(s) about end-of-life care.

This definition is useful in that it portrays advance care planning as communication of wishes, values and beliefs. However, the description is too general and does not indicate how advance care planning fits into the legal structure of treatment decision making as set out in the *HCCA*. Therefore, this definition does not assist physicians in the practical aspects of advance care planning and in seeking consent to treatment under Ontario law.

This definition does not refer to the identification of the patient's future SDM. This is a fundamental element of advance care planning that physicians need to understand and assist patients in completing because physicians do not take direction from a patient's advance care plan. Physicians are required to obtain an informed consent from the patient if capable or from the patient's SDM if the patient is not capable.

The definition in the Draft policy may lead to a misunderstanding that the wishes, values and beliefs, once communicated to the health care provider, can be interpreted by the health care provider. However, the physician cannot take direction from a document or from a wish in whatever form it is communicated. Health care providers must understand that advance directives are to be interpreted by the patient's SDM.

The definition in the Draft policy seems to indicate that an advance care plan must include a discussion of specific treatments. However, it is very difficult to anticipate what treatments a patient would require as patients do not know how their health condition would progress or what the effect of particular treatments may be. Discussion of particular treatments may be part of the advance care planning discussion but it does not need to be. Physicians should encourage patients to discuss "wishes, values, and beliefs" about health with their SDMs and family, not just specific treatments.

ACE's description of advance care planning, above, assists physicians in operationalizing advance care planning by addressing who would be the patient's future SDM, should the patient become incapable. It also encourages physicians to talk with the patient and, if the patient consents, with the patient's future SDM and family, about the patient's wishes, values, beliefs.

We recommend amending the definition of advance care planning to include decision-making as to who the patient's SDM would be if they should become incapable, and clarifying that advance care planning involves patients communicating any wishes they have about future treatment and care as well as their values and beliefs to assist their SDMs if and when their SDMs must make decisions on their behalf.

3. Definition of Life-Sustaining Treatment (Lines 48 to 50)

The definition of life-sustaining treatment should be clarified to indicate that such treatment could be temporary or permanent. The difference is essential as the treatment decisions to be made are different depending on the expected longevity of the life-sustaining treatment.

We recommend amending the definition of life-sustaining treatment to read "any medical procedure or intervention which utilizes mechanical or other artificial means to temporarily or permanently sustain, restore, or supplant a vital function essential to the life of the patient..."

4. Definition/Discussion of Do-Not-Resuscitate Orders (Line 55)

There is no mention of Do-Not-Resuscitate order (DNR order) in the definitions and no general discussion of DNR orders in the policy, other than a statement in the section entitled "Dying at Home", late in the Draft policy, in respect of emergency services personnel. This is an omission in the policy and a core end-of-life issue such as a DNR order requires a more fulsome discussion. A definition should be included which indicates that a DNR order documents a patient's decision regarding his/her desire to

avoid cardiopulmonary resuscitation (CPR) or that CPR is to be withheld from the patient as part of a plan of treatment. It should be specified that a DNR order should not be mistaken as an order not to provide treatment or a consent to withdraw treatment. A DNR order is specific only to CPR, such as chest compressions, defibrillation, and artificial ventilation.

Further, the Draft policy should indicate that, prior to making a DNR order, the physician must obtain consent for the order from a patient, or the patient's SDM if the patient is not mentally capable, although the patient does not have the right to require CPR when CPR is not medically appropriate. A copy of the Ontario Ministry of Health and Long-Term Care "Do Not Resuscitate Confirmation Form",⁵ which is confirmation of the consent that resulted from the discussion between the health care provider and the patient or incapable patient's SDM, should be appended to the policy.

We recommend including a definition of a DNR order in the definition section which reads "a written medical order which documents a patient's decision to avoid CPR or that CPR is being withheld from the patient as part of a plan of treatment. It is not an order not to treat a patient or a consent to withdraw treatment."

We also recommend that a section be added to the Draft policy on DNR orders which includes that the physician must seek consent for the DNR order from the capable patient or the incapable patient's SDM.

5. The Link between communication, advance care planning and consent (Lines 108 to 190)

Although the CPSO has a policy regarding consent to treatment, this Draft policy must clearly detail the link between advance care planning and health care consent. In our experience in conducting research for the Law Commission of Ontario report referred to above, we found that there were persistent misconceptions in Ontario regarding the relationship between health care consent and advance care planning.

For example, physicians may be using forms in advance care planning which are not applicable to Ontario. In other Canadian jurisdictions, a written "advance directive" is equivalent to informed consent to treatment and these directives are interpreted and applied by physicians. However, Ontario law requires consent even where a patient has engaged in advance care planning or has an "advance directive".⁶ Advance care plans and directives are "wishes" under the *HCCA*,⁷ and, as such, are to be interpreted by the SDM in providing consent to treatment.

⁵ Ontario Ministry of Health and Long-Term Care "Do Not Resuscitate Confirmation Form", available at: [http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-4519-45~1/\\$File/4519-45.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-4519-45~1/$File/4519-45.pdf)

⁶ The term "advance directive" is not contained in the *HCCA* and should not be used in Ontario as it causes confusion. Health care providers may believe they must take "direction" from the document, rather than seeing the document as the expression of a wish to be interpreted by a SDM.

⁷ *HCCA*, *supra*, note 1, section 21

Legal liability may arise where health practitioners incorrectly believe that they have obtained or do not need to obtain informed consent because they have an advance care plan or where health practitioners incorrectly withhold treatment because they do not realize they have already obtained an informed consent through a plan of treatment. Clarity should be provided on advance care planning and its link to health care consent to ensure that physicians do not fall into this trap.

At present, the Draft policy does not clearly link advance care planning with consent or differentiate between wishes and consent. It does not indicate that these advance care plans should be interpreted by SDMs, that they are not directions to a health care provider, or that physicians should be “care planning” as part of obtaining consent for a particular treatment. The Draft policy also does not clearly state that SDMs cannot “advance care plan”, and does not clearly differentiate between an advance care plan and a plan of treatment, to which a capable patient or an incapable patient’s SDM can consent.

Owing to the misunderstandings discussed above, we suggest drafting a section in the Draft Policy bridging the sections on advance care planning and consent, with the following elements:

- ***Informed consent is required for treatment; advance care planning is not consent:***

When a patient has an advance care plan about a potential future health condition, consent has not been acquired and consent must still be acquired from the patient or the SDM (if the patient is incapable) except in emergencies.

Physicians may believe that all end-of-life treatment discussions are done through “advance care planning,” when in fact physicians should be obtaining informed consent from the patient, when capable (for example, to a DNR). A patient’s wishes are only relevant where a patient is incapable and is therefore unable to provide informed consent at that time. In that case, the wishes “speak” to the SDM who must then provide consent based upon the requirements of the *HCCA*.

The communication section in the Draft policy speaks to an essential aspect of consent. Informed consent requires a physician to communicate regarding risks, benefits, side effects, alternatives to the treatment and the health consequences if treatment was refused.

The Draft policy should also note that SDMs cannot “advance care plan” and express wishes for a patient, but must always make decisions (give informed consent) for a patient in the context of the patient’s present health condition. If a patient is at end of life, much, if not all, of what a SDM is doing is giving or refusing informed consent to treatments (for example, such as refusing resuscitation).

- ***Consent always comes from a person, not from a piece of paper, such as an advance care plan:***

Only a capable patient or, if the patient is incapable, a SDM, can provide consent. Consent is a **decision** made in the context of the patient's present condition, while advance care plans are **wishes**, which are speculative, without full knowledge of what the patient's condition will be at some future time. Section 5(2) of the *HCCA* provides that wishes need not be expressed in writing but can be expressed orally or in any other manner.⁸ Please note that line 185 of the Draft policy indicates that wishes can be expressed only in writing or orally.

A physician cannot use the advance care plan as a "consent" to treatment. Only a SDM can interpret the advance care plan in accordance with the principles used to interpret wishes, values and beliefs outlined above.

- ***Informed consent includes planning about a patient's present health condition***

A plan of treatment discussing immediate care options but also setting goals for care and preparing plans of care⁹ related to the patients' present health condition is not advance care planning. In the course of our other work we have identified that many physicians believe that any "care planning" –talking with patients about goals of care even if it is in the context of the patient's present condition – is "advance care planning" rather than part of the consent process. For example, patients at the end-of-life can refuse resuscitation. This is because this decision is made in the context of the patient's present condition.

Care planning by providing information regarding risks, benefits, side effects, alternatives to the treatment and the health consequences if treatment was refused in relation to the patient's present health condition is part of obtaining consent to a plan of treatment from a capable patient or a SDM if the patient is incapable.

Further, footnote 8 in this section provides reference to materials by Speak Up! The physicians should be directed to the Speak Up! Materials which deal with Ontario, accessible at:

http://www.advancecareplanning.ca/media/73433/acp_ontario_workbook_final-rev2013-web.pdf

We recommend that the Draft policy be amended to include a section bridging the sections on advance care planning and health care consent indicating that informed consent is required for treatment; advance care planning is not consent, that consent must come from a capable patient or a SDM, not through an advance care plan, and that a plan of treatment about a patient's present health condition is not an advance care plan, and consent can be sought on the plan of treatment.

⁸ *Ibid.*, section 5(2)

⁹ *HCCA, supra*, note 1, section 2(1). Definition of Plan of Treatment

We also recommend that line 185 of the Draft Policy be amended to include that wishes can be expressed in writing, orally or in any other manner.

We also recommend that footnote 8 refer specifically to Speak Up's Ontario materials.

6. Withdrawal of Nutrition and Hydration (Line 200)

The policy does not include a discussion of the withdrawal of nutrition and hydration in the context of the section titled "interventions and care management." A reference should be made to section 215 of the *Criminal Code* which indicates that a person has a legal duty to provide the necessities of life to a person under one's charge if that person is unable to withdraw himself or herself from that charge and is unable to provide himself or herself with the necessities of life.¹⁰ Nevertheless, it is not an offence to not perform that duty if the person has a lawful excuse, such as the consent of a capable patient or an incapable patient's SDM. Therefore, it would be imperative to remind physicians of the importance of informed consent in this regard.

We recommend that a section be included in the Draft policy on the withdrawal of nutrition and hydration referring to section 215 of the *Criminal Code* and the importance of obtaining informed consent to the withdrawal of the necessities of life.

7. Life-Saving and Life-Sustaining Treatment (Lines 246 to 249)

The Draft policy indicates at line 246 that owing to the fact that patient's or substitute decision-maker's decision concerning life-saving and life-sustaining treatment might change over time, a physician should "reassess" the decisions with patients. However, the words "revisit" or "review" would be better words than reassess. The word reassess misstates the role of the physician in the treatment-decision-making process. Decisions about treatment ultimately rest with the patient or, if the patient is incapable, the SDM. Further, the Draft policy at line 249 states that there needs to be consensus between the physician and the patient or SDM regarding the treatment, which similarly distorts the role of the physician in the decision-making process.

We recommend that the word "reassess" in line 246 be changed to "revisit" or "review" and that the line 249 be revised to read "if there is disagreement about the treatment provided", rather than using the term consensus.

¹⁰ *Criminal Code*, R.S.C. 1985, c. C-46, section 215

8. Certification of Death (Line 293)

Line 293 and footnote 36 of the Draft policy is incomplete. Although section 10(1) of the *Coroners Act*, is cited by the policy, section 10(2) is omitted. Section 10(2) provides that:

(2) Where a person dies while resident or an in-patient in,

- (a) Repealed: 2007, c. 8, s. 201 (1).
- (b) a children's residence under Part IX (Licensing) of the *Child and Family Services Act* or premises approved under subsection 9 (1) of Part I (Flexible Services) of that Act;
- (c) Repealed: 1994, c. 27, s. 136 (1).
- (d) a supported group living residence or an intensive support residence under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*;
- (e) a psychiatric facility designated under the *Mental Health Act*;
- (f) Repealed: 2009, c. 33, Sched. 18, s. 6.
- (g) Repealed: 1994, c. 27, s. 136 (1).
- (h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),

the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.¹¹

We recommend that the Draft policy include section 10(2) of the *Coroners Act* at footnote 36.

9. Euthanasia and Physician Assisted Death (Lines 323 to 334)

The Draft policy will likely be revised in light of the Supreme Court of Canada's decision in *Carter v. Canada*.

The Court in *Carter v. Canada* determined that physician-assisted dying should not be prohibited by the *Criminal Code* where "(1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability)."¹²

While the ban on physician-assisted dying continues for 12 months while the federal and provincial governments prepare legislation to respond to this judgment, much of the effect

¹¹ *Coroners Act*, R.S.O. 1990, c. C.37, section 10(2)

¹² *Carter v. Canada (Attorney General)*, 2015 SCC 5, at paragraph 4

of the Court's decision will depend on the laws that the governments draft and on their implementation.

The Court, in its decision, emphasized that the person making the decision to have a physician assist in their death must be competent and must clearly consent to the termination of life. It is unclear at this stage whether substitute consent would be permitted in physician-assisted dying. In any event, the role is given to physicians to assess the patient's capacity to consent, to confirm that the patient was not being coerced or unduly influenced into seeking to die and to ensure that patients are fully informed about their diagnosis and prognosis and the range of available options for medical care, including palliative care. As such, it continues to be of paramount importance for physicians to follow the legal regime for obtaining consent to treatment as outlined in the *HCCA*.

We recommend that any CPSO policy responding to the *Carter v. Canada* decision underscore the importance of obtaining informed consent to physician-assisted dying, given the nature of the treatment which, if not policed, could seriously compromise the right to life of vulnerable adults.

10. SDMs' Access to Personal Health Information (Lines 331 to 334)

The Draft policy provides at lines 331 to 334 that the patient has a right to access his or her personal health information. However, it does not indicate that a SDM is entitled to access the personal health information of an incapable patient required for an informed consent.¹³

We also recommend that the Draft policy indicate that a SDM is entitled access the personal health information of an incapable patient required for an informed consent.

11. Conflicts with SDMs (Lines 360 to 362)

The language of the Draft policy, which discusses conflicts with SDMs, misstates the law on an application to the CCB under section 37 of the *HCCA*. It should instead read that if the physician is of the opinion that the SDM did not comply with the principles for providing consent outlined in section 21 of the *HCCA*, physicians are advised to apply to the Consent and Capacity Board for direction.

We recommend that, instead of stating "When conflicts arise because a substitute decision-maker has not met the requirements set out in the *HCCA*", lines 360 to 362 be amended read "if the physician is of the opinion that the SDM did not comply with the principles for providing consent

¹³ *HCCA*, *supra*, note 1, section 22

outlined in section 21 of the HCCA, physicians are advised to apply to the Consent and Capacity Board for direction.”

12. Documenting advance care plans (Line 371 to 373)

The Draft policy indicates that advance care plans must be documented in patient records.

While it is useful to have capable wishes documented, it must be clear in the patient's records that the advance care plan is not consent. As such, it would be useful to have advance care plans recorded on forms which clearly indicate that that the plan is not be used as consent to treatment and that consent must still be obtained from a capable patient, or if incapable, from a SDM.

We recommend that advance care plans be recorded on forms which state at the outset that the plan is not consent.

Conclusion

We would like to thank the CPSO for this opportunity to provide feedback on Draft Planning for and Providing Quality End-of-Life Care policy, and would be pleased to clarify or discuss any aspect of this commentary going forward.

Yours truly,
ADVOCACY CENTRE for the ELDERLY