SDMs and Health Decision Making

Judith Wahl
Wahl Elder Law
wahlelderlaw@gmail.com
416-209-3407

Disclaimer

- This presentation and any material provided for this presentation is not legal advice but is only legal information for educational purposes

- If you require legal advice, please consult your own lawyer or legal advisor

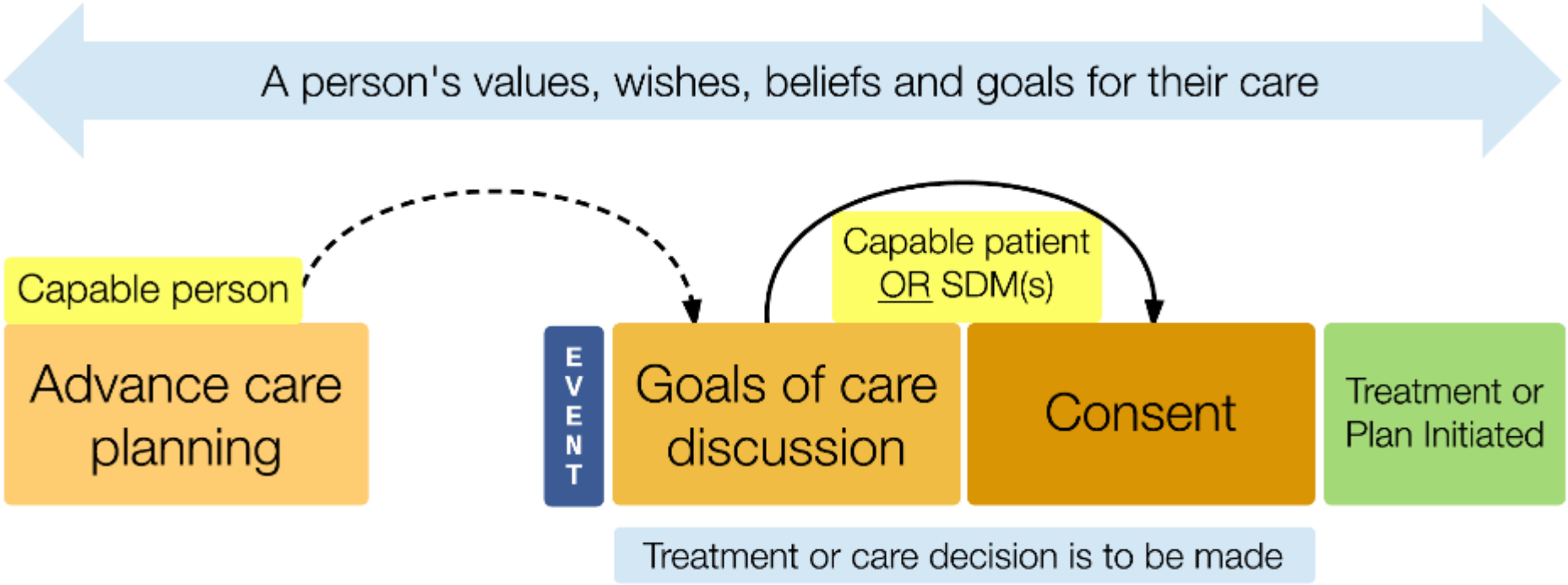
Overview

- Review of Elements of Health decision making

- How “wishes” affect treatment options and SDM decision making
- What ACP “wishes” are and who applies them
- SDM’s responsibility to make decisions in accordance with “wishes” expressed when capable or “best Interests”

- What Health practitioners may do if they think SDMs are not fulfilling their responsibilities
(Form G and alternatives to Form G applications)

Components of Person-Centred Decision-making



Health Decision Making

- Before treatment is provided , Health Practitioners must get an INFORMED CONSENT

- A Consent / Refusal of Consent is a DECISION
- That decision must be INFORMED

- That decision must come from
  - **the patient, if capable, or**
  - **the incapable patient's SDM**

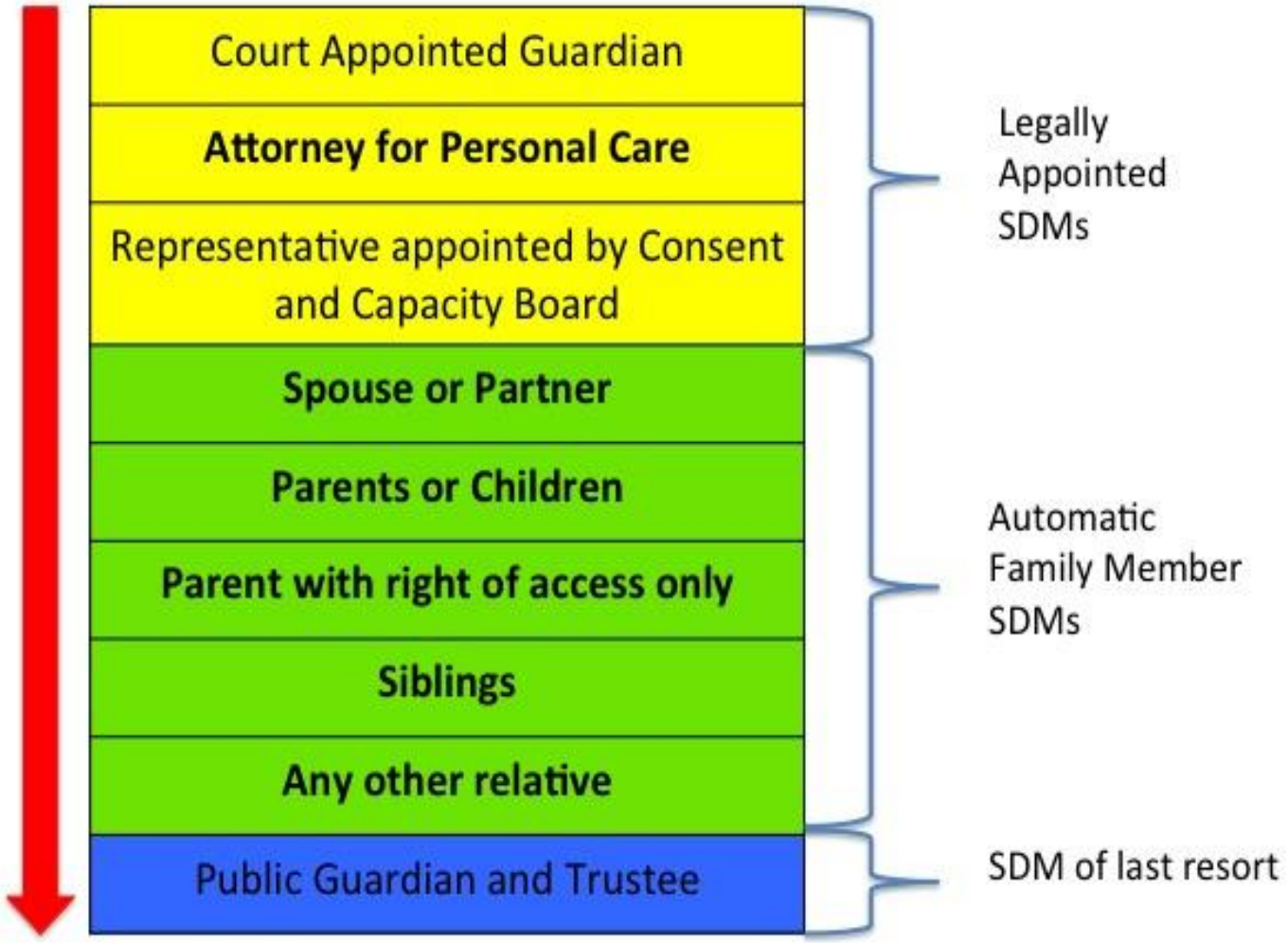
Capable Patient

- Capable patient is the decision maker even if that patient has prepared a POAPC or expressed wishes about future care
- Capable patient is decision maker even if that patient gets support/ advice from their future SDM when making decisions
- Capable patient cannot “assign” decision making to their SDM or anyone else
- Capacity of the patient for health decision making is determined by the health practitioner offering the treatment

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 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 (including via electronic communications); and,
e) Willing to act as SDM.

It is the obligation of the health practitioner obtaining consent from an SDM to ensure these requirements are met.

Duties of Health Practitioners when getting Consent to Treatment

Determine who is health decision maker by assessing capacity of resident

* Capable patient
or
* Incapable resident's SDM

Provide Information about:

- Illness
- Treatments options offered

(Includes: risks, benefits, side effects, alternatives, what may happen if treatment is refused)

Discuss Goals of Care

IF talking to SDM – explain requirement to make decisions following wishes/best interests of patient

Get Decision (informed consent or refusal)

From patient

or

Incapable patient's SDM

How “Wishes” affect Treatment options

- Even if a patient has provided some form of “Advance Care Plan” to the long term care home/ health providers and expressed “wishes” about future care, those wishes should not be used to determine / limit treatment options offered
- Wishes may have been expressed out of context without knowledge of how the patient’s condition has changed/ developed and without knowledge or understanding of possible treatment option
- Patients may CHANGE THEIR MINDS after getting all the INFO to make an informed consent

Wishes and SDMs

- Even if a patient has expressed wishes to health providers and to their SDM about future care, those wishes should not be used to determine/ limit treatment options offered to the SDM for the incapable patient
- Wishes may have been expressed out of context without knowledge of how the patient's condition has changed/ developed and without knowledge or understanding of possible treatment option
- The SDM, not the health practitioner, has the responsibility to apply the previous capable wishes of the patient to the treatment options
- **MORE on how the SDM applies the wishes later …**

Advance Care Planning

In Ontario, Advance Care Planning is a process that involves the *mentally capable* person:

Identifying their substitute decision maker(s) (SDM)

- The person(s) who would make health care decisions on behalf of someone who is mentally incapable – either AUTOMATIC SDM or SDM chosen (in POAPC) or appointed by Court or CCB

Discussing their wishes, values & beliefs with their SDM(s)

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

How does Health Care Consent relate to Advance Care Planning?

- Under Ontario law, advance care planning is related to the law of informed consent but is NOT informed consent itself.
- Patient's "wishes" are APPLIED by the SDM – not the health practitioner.
- Advance Care Planning discussions about wishes, values, and beliefs should help the SDM make better decisions for the patient when the patient may be incapable
- Advance care planning wishes are NOT a "preconsent" or an "advance consent"
- Even if ACP wishes are KNOWN BY HEALTH PRACTITIONER, health practitioners MUST still get an informed consent from the capable patient or incapable patient's SDM (subject to emergency exception)

How does the SDM make decisions?

- In making decisions on behalf of an incapable patient, SDMs have to:
  - **Follow any applicable wishes that were expressed by the patient when capable; or**
  - **If no applicable wishes were expressed when the patient was capable, make decisions in the patient's best interest (including considering the patient's values, beliefs and any other wishes expressed by the patient)**

Duty of Health practitioner to inform SDMs of how they are required to make decisions (Benes case**)**

How an SDM is Required to Make Decisions – HCCA s. 21

Principles for giving or refusing consent

21 *(1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:*

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1).

Best Interests Definition HCCA s.21(2)

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

Best Interests Definition HCCA s.21(2) cont'd

(c) the following factors:

1. Whether the treatment is likely to,

i. improve the incapable person's condition or well-being,

ii. prevent the incapable person's condition or well-being from deteriorating, or

iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

May SDM NOT follow a wish when deciding for the Patient?

- If SDM believes that patient would have changed her wish to refuse a treatment if she knew what her present health condition would be and treatment options, SDM may go to Consent and Capacity Board asking them to permit SDM to not follow that wish and to consent to the treatment (HCCA s. 36 (1))

- If SDM believes that a wish is impossible to follow then SDM does not need to follow it
  (HCCA s. s.21(1)2.)

Role of the SDM******

- **SDM is the "interpreter"of the patient's wishes, values and beliefs and must determine:**
  - whether the wishes of the patient were expressed when the patient was still capable (and were expressed voluntarily);
  - whether the wishes are 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/capable wishes, how the patient's values, beliefs, and incapable/inapplicable wishes would apply to the patient's best interest.

What if …

- What if the Health Practitioner believes that the SDM is not making decisions following the patient's previous capable wishes or is not acting in the best interests of the incapable patient?

- Ultimate remedy – Form G Application, BUT
- OTHER steps to consider in between

Application to Consent and Capacity Board by Health Practitioner – Form G

Application to determine compliance with s. 21

37 *(1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21(wishes/ best interests), the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.*

Form G Application – Powers of the CCB

Power of Board

(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.

Directions

(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.

Time for compliance

(5) The Board shall specify the time within which its directions must be complied with.

Form G Application – If SDM does not comply with Order

Deemed not authorized

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).

Subsequent substitute decision-maker

(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

Legal Issue if CCB Application - Example

"The legal issue for the Board to determine at this point was whether LF expressed a prior capable wish applicable to the circumstances (as set out in Section 21) or if not or if it was impossible to comply with the wish, what was in LF's best interests."

LF(Re),2010 CanLII 56501 (ON CCB)

Steps to Consider before CCB application – 1. Valid Consent

- Does the health practitioner need to get a consent from the SDM or does the Health practitioner already have an informed consent from the patient when capable that is still valid although the patient is now incapable?

- Informed Consent vs. wish

Treatment taking place in the future is NOT necessarily an advance care plan

- A patient can give an informed consent to a treatment that takes place or is withheld in the future if that treatment relates to the patient's **PRESENT HEALTH CONDITION**
- This is not Advance Care Planning, but is Consent
- **Patients at end of life can CONSENT to No CPR/DNR and this is NOT advance care planning**

Steps to Consider before CCB application – 2. SDM

- Is health practitioner talking to the RIGHT SDM?
- Does the SDM meet the requirements to be an SDM?
- Just because an SDM disagrees with the health practitioner, does not mean that the SDM is “incapable”

Steps to Consider before CCB application – 3. Info to SDM

- Does the SDM understand the resident's state of health – illness understanding - and treatment options?

- Does SDM have all the info on which to make a decision?

Steps to Consider before CCB application – 4. Does the SDM KNOW their Legal Responsibilities

- In M.A. v Benes, 46 O.R. (3d) 274 (Ont. C.A) the Ontario Court of Appeal interpreted the requirement of obtaining consent "in accordance with this Act" as imposing on the health practitioner an obligation to make sure the substitute decision maker understands the Section 21 HCCA criteria when deciding whether consent to a proposed treatment should be given or refused.

  "What is important is that SDM.'s be made aware of the requirements of s. 21 when deciding whether to give or refuse consent to a proposed treatment. As indicated, s. 10(1)(b) of the Act sees to that. The Board only becomes involved if a health practitioner concludes that an SDM.'s decision does not accord with the principles in s. 21. …"

Steps to Consider before CCB application
5. Are there any prior capable wishes of the patient applicable to the circumstances?

- Are there any prior capable wishes of the patient expressed when capable?
- Why does the health practitioner believe that the SDM is not making decisions that follow the patient's previous capable wishes?
- Does the SDM know of later capable wishes of the patient– that the health practitioner doesn't know about ?

- If no, then are the health practitioner and SDM interpreting the same wishes in different ways?

- **"…prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed."**
  ***Conway v Jacques* 2002 CanLII 41558 (ON C.A.), (2002**

- Is there a wish that is it "applicable to the circumstances" ?

- Does the SDM believe that the wish is impossible to follow and why?

- Does the SDM think that the patient would have consented to a treatment that he or she previously expressed a wish to refuse consent and is the SDM applying to the CCB?
- Is the SDM not certain what a wish means?
- Does the SDM know that he or she may apply to the CCB to get direction on how to interpret that wish?

Steps to Consider before CCB application
6. What is in the Best Interests of the Resident?

- Does the health practitioner believe that the SDM is not acting in the best interests of the resident? WHY?
- Does the Health practitioner understand what “best interests” means?
- Does the SDM understand what “best interests” means?

Case Law on Wishes, Best Interests

- Decisions of the Consent and Capacity Board and the Court can be found on the internet at

The Canadian Legal Information Institute
www.canli.org

LF(Re),2010 CanLII 56501 (ON CCB)

- Resident in LTC Home – very complex health problems – non communicative, not capable, on G tube – Living in this matter for several years
- New Doctor takes over care – SDMs (and other family) ask that G-tube be removed
- SDMs state “we firmly believe and agree among ourselves that this is what our mother would want, and are adamant in our conviction that our mother does not want to continue living in her profoundly disabled condition”

Power of Attorney for Personal Care includes this clause:

.. [if] I am suffering from a terminal injury, disease or illness, and that my death will occur whether or not life sustaining procedures are utilized, and where the application of life sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally and with dignity ...”

- Dr.’s position was that the wishes set out in the Power of Attorney were not applicable to LF’s current circumstances, as LF was not suffering from a terminal injury, disease, or illness.

- Dr. Birmingham brought a Form G Application to the Board under Section 37 (1) of the *Health Care Consent* Act as he believed there were no capable wishes applicable to this decision despite what SDMs saying and despite what in POAPC

- What do you think was decided?

- Were the statements in the POA "previous capable wishes" to withdraw the G tube?

CCB Analysis

"**Holding that LF's statements set out in her Power of Attorney were applicable to her devastating current circumstance would be too mechanical or literal application of her words with complete disregard for changes in her circumstances.**

We therefore found that LF had not expressed a wish applicable to her current circumstances expressed while LF was capable and after attaining sixteen years of age."

CCB Analysis Of Best Wishes

CCB concluded then it must look at what was in LF's BEST INTERESTS since there were no prior wishes.

Citing another case (*Conway v Jacques*) the CCB stated that to determine best Interests, "It did not mean we would determine what LF would do in those circumstances. "

Looking at the definition of Best Interests in the HCCA, the CCB said:

"We also noted that LF's values and beliefs as well as Dr. Birmingham's comments with respect to the S21 (2)(c) HCCA considerations were factors to be considered in assessing LF's best interests, but not the only considerations. The legislation, and in particular Section 21 did not set out or direct that the considerations therein were the exclusive considerations in determining a person's best interests."

CCB Analysis of Best Interests

"We found that "well-being" involved more than just living, that there were qualitative aspects to it. There was no quality to LF's current existence."

"It was up to the Board to consider and balance the considerations set out in Section 21(2) of the *Health Care Consent Act*.

"We found the benefit LF was expected to obtain from the proposed treatment by way of withdrawal of the g-tube outweighed the risk of negative consequences to her. There was no evidence that continued g-tube treatment would improve LF's underlying medical conditions or prevent further deterioration of her existing conditions or reduce the risk of future infections…"

"How could continued treatment by way of the g-tube be said to benefit LF? We found that the alternative treatment of continued g-tube treatment was not a course of action that is less restrictive. While continuing the g-tube would continue LF's life, we found it would not provide her with comfort or dignity in that state but would continue to subject her to likely infections …"

CCB Analysis of Best Interests and Conclusion

"We found that any current quality to LF's life will further deteriorate. The withdrawal of the g-tube was less intrusive to LF's body. **To the extent that "wellbeing" includes considerations of LF's dignity and potential for improvement in the quality of her life, we believed the withdrawal of the g-tube was more in line with LF's values and beliefs." …**

"Ultimately, we agreed with JW and with the clear, cogent, and compelling evidence that withdrawal of the g-tube was currently in LF's best interests."

DP (Re), 2010 CanLII 42949 (ON CCB) 2010-07-11

- DP a forty seven year old married father of three children – series of events including him going to hospital and being discharged and readmitted several times – then suffered cardiac arrest – then “ischemic anoxic encephalopathy” related to cardiac arrest – then cognition improved but as a result of “gastric perforation and malposition of the PEG tube”, DP suffered a hypoxemic brain injury and remained in hospital in vegetative state for 2 and a Half years

- New head of the Intensive Care Unit ("ICU"), and the Chief of Medicine, and other members of the ICU team, social work and the clinical ethicist call a meeting with SDM (Wife) who says to them that she wants full supportive interventions with the goal of keeping DP alive

- BUT the proposed Plan of Treatment that the Clinicians wanted to discuss with SDM did not exist at time of that meeting with SDM.

- The proposed Plan of Treatment was drawn up sometime in following three months after the meeting and presented to SDM when it was sent to her lawyer three months later together with the Form G Application before the Board.

- What decision did the CCB make?

CCB Analysis

"We initially had to determine when the proposed Plan of Treatment was presented to GP for her consideration in accordance with the Act so that the health practitioner could determine from his perspective that GP either did or did not comply with Section 21 of the *Health Care Consent Act*. "

"**The evidence we received included that hospital staff did not believe GP would consent to any Plan of Treatment other than the plan in place since February 2008**, a plan providing for full supportive measures for her husband. In Mr. Parke's opinion the belief by hospital staff that GP would not consent to any other Plan of Treatment was why **GP did not receive more than one half hour notice of the March 26, 2010 meeting or why she was not advised of the meeting agenda in advance. "**

CCB Analysis

"It was clear to the Board that on reading the *Health Care Consent Act* (including Sections 10-14) and case law such as Benes, **that a health practitioner must inform a substitute decision maker about the rules which govern substitute decision making. ….**"

"….The *Health Care Consent Act* continues in Section 11 (2) **to require that consent to treatment is "informed**" if, before giving it, the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment and the person received responses to his or her requests for additional information about those matters.

CCB Analysis

The proposed Plan of Treatment was drastically different than the current Plan of Treatment in place. **With little to no communication in place, the health practitioner had to do more before he could determine that GP "did not comply" in terms of Section 37 of the *Health Care Consent Act*. We found there was no evidence GP did not comply with the proposed Plan of Treatment.**

The current situation driven by a clear lack of communication was not in DP's best interests. Rectification of the current lack of communication must commence with the health practitioner presenting the proposed Plan of Treatment to the substitute decision maker GP, and then GP being permitted a reasonable time to consider it and consult about it, meet to discuss it, have her questions or concerns answered.

Only after the required efforts have been made in accordance with the Act, will the health practitioner be in a position to determine from his perspective the issue of compliance by the substitute decision maker and whether a Form G application was necessary.

CCB Analysis

“The Board recognizes the undeniably important role of health practitioners. In our legislative scheme of health care decision making, and particularly in view of the Purposes and substance set out in the Act, substitute decision makers also have a significant role.”

“The process for the health practitioner to determine compliance set out in the Act must be respected and followed. Clearly in this case what could not be relied upon was a belief that the substitute decision maker would not agree to any other treatment without following the procedure set out in the Act to actually determine the issue of compliance and whether a Form G application should be considered.”

Form G Application was Dismissed

Murray v. Dev, 2017 ONSC 2966

- Withdrawal of Life Support case
- Was there a Prior Capable Wish?
- the CCB considered evidence relating to HM refusing recommended surgery and chemotherapy for rectal cancer, but accepting radiation therapy. The CCB considered that these decisions did not amount to a clearly expressed wish applicable to either staying on, or refusing, life-support measures. “

- “On page 3 of the POA was a clause entitled “*Living Will*” that reads:

- I further state that I have seriously considered the issue of life support systems. I empower my Attorney appointed in this document to make any final decisions regarding the withdrawal of artificial life support systems. If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, then I request that medication be mercifully administered to me to alleviate suffering and that I be allowed to die and not be kept alive by artificial means. “

- "There was evidence given at the CCB hearing by Susan Schell, HM's lawyer who prepared the POA, that she had advised the couple at the time they signed the document that nothing in the clause diminished the Attorney's power to decide when to withdraw life support.

  The CCB held that HM's wish ought to be enforced in the way that he had understood it, in other words, that his wife JM would retain discretion about when to withdraw life support, not that the decision would be made by his doctors or anyone else.

  The CCB recognized that JM would still be bound by the provisions of the *HCCA* and thus required to act in HM's best interests"

- **CCB found no applicable previous capable wishes but found that SDM not acting in best interests**

  "JM and RM both seemed to dismiss the medical information which had been confirmed to them over and over by numerous physicians from early October and on. **They shared an unrealistic hope that HM would somehow awaken and recover enough faculties to enjoy life once again.** They distrusted the prognosis and advice of the Sunnybrook team.

- **The CCB found the medical evidence very compelling in establishing that the proposed treatment plan would improve HM's well-being by ending his suffering and accepting the natural course of death**. The CCB found that without the plan, HM's body would continue to waste away, and more and more interventions would be required, until at last his body would give way to infection or massive organ failure that even medical technology could not prevent. "

Summary

- SDMs must make decisions by following s.21
- **Health practitioners MUST explain to SDM that SDMs must follow s. 21 in making decisions** .
- Must look at previous Capable wishes that are "applicable to the circumstances"

"…prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed."
Conway v Jacques 2002 CanLII 41558 (ON C.A.), (2002

- “If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change, but rather what is in the best interests of the patient..”
  Conway v Jacques 2002 CanLII 41558 (ON C.A.), (2002

- **In determining “Best Interests” the definition of Best Interests in the HCCA should be reviewed CLAUSE by CLAUSE with the SDM**

Judith Wahl

Wahl Elder Law
60 Southport St., Ste. 906
Toronto, Ontario
M6S 3N4
416-209-3407
wahlelderlaw@gmail.com