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Advance Care Planning
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- Hospice of Waterloo Region
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- General Public
- Community Professionals
- Health Care Providers

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What kind of animal are you?

A fun way to start thinking about Advance Care Planning

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“Who can make my healthcare decisions for me when I can’t make them for myself?”
Health Care Decision-making Basics on Consent, Goals of Care, Advance Care Planning and Medical Assistance in Dying

Judith A. Wahl
Wahl Elder law
wahlelderlaw@gmail.com
416-209-3407
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- This presentation contains legal INFORMATION for educational purposes and not legal advice
- If you need legal advice for a particular situation, please consult your own legal advisor
This Workshop – Goals and Objectives

- Overview of health care consent, goals of care, and advance care planning (the legal framework and what that means to you as a consumer of ILC services and to ILC providers of services). This will include discussion of DNR which is consent to not have the treatment of resuscitation.

- Information on how this relates to / connects with personal support services.

- Overview of the law related to medical assistance in dying and how that applies to consumers entering into agreements for services and persons providing services through the ILC.
Health care consent primarily applies to “health care” which is “treatment” and “admission to a LTC home”

“treatment” means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan,…”
(Health Care Consent Act s. 2)

This health care described above requires an informed consent to a treatment or a plan of treatment of to an agreement for admission, subject to the emergency exception (more later on this)
Health Care Consent and Difference with Consent for Personal Support Services

- Personal Support services also require consent but this is not the informed consent” described in the Health Care Consent Act that applies to health care.

- Consent is required because these services are provided by an AGREEMENT to an Individual Service Plan between a service provider and a consumer.

**Personal support services**

(6) For the purpose of this Act, the following are personal support services:

1. Personal hygiene activities.
2. Routine personal activities of living.
3. Assisting a person with any of the activities referred to in paragraphs 1 and 2.
4. Training a person to carry out or assist with any of the activities referred to in paragraphs 1 and 2.
5. Providing prescribed equipment, supplies or other goods.
6. Services prescribed as personal support services.

(Home care and Community Services Act) s. 2(6) ”
Home Care and Community Services Act

Bill of Rights

3. (1) A service provider shall ensure that the following rights of persons receiving community services from the service provider are fully respected and promoted:

2. A person receiving a community service has the right to be dealt with by the service provider in a manner that respects the person’s dignity and privacy and that promotes the person’s autonomy. …

5. …. a person who is determined under this Act to be eligible for a community service has the right to participate in the service provider’s development of the person’s plan of service, the service provider’s review of the person’s requirements and the service provider’s evaluation and revision of the person’s plan of service.

6. A person has the right to give or refuse consent to the provision of any community service.
Advance Care Planning for HEALTH CARE is knowing who would be your Substitute Decision Maker automatically for health care and planning to appoint someone else if you don’t want that person(s) to be your SDM for health care.

It is also telling that SDM or explaining to that SDM what are your WISHES, VALUES and BELIEFS that would guide them to make the best health decisions for you if you were not able to do so for yourself.
Advance Planning for OTHER decisions

- The term “advance care planning” is PRIMARILY used in context of and related to health care decision making BUT you can do planning for yourself about non-health care related decisions.

- This could include planning for who might act as your SDM for finances (property), for personal care that is not health care (this includes personal support services), for other things that are important to you and would impact on your life. This then could also involve explaining to that future SDM(s) what are your wishes, values, beliefs about all these non health care matters.
Terminology

- I will be using the word “patient” when explaining health care consent and ACP and Goals of Care as related to health decision making.

- I will be using the word “consumer” when explaining consent and advance planning in context of personal support services and other non-health care decisions.
Health Care Consent, Goals of Care, and Advance Care Planning in the context of HEALTH DECISION MAKING
What is required to GET THIS RIGHT?

A person's values, wishes, beliefs and goals for their care

Info guides future decision-making

Info directly informs decision-making

Future Care

Advance Care Planning Conversations

Goals of Care Discussion

Decision-Making or Consent Discussion

Current Care

Treatment Decisions to be made

Figure: Relationship between three discussions that contribute to informed consent

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Health Care Consent – Who must Get Consent to Treatment?

ALL Health practitioners must get an **informed consent** from the appropriate person

- **Patient who is mentally capable to make treatment decisions**
  or
- **their SDM**, if patient has been found incapable for treatment decisions

BEFORE providing treatment to a person

Why?

- Requirement of the **Health Care Consent Act (HCCA)**
- Regulated Health Professionals Practice Guidelines and Regulated Health College Policies
What is Health Care Consent?

- Health care consent is an **informed and contextualized DECISION**, in contrast to Advance Care Planning which is not about decisions but is about WISHES.

- This is the same whether treatment about end of life care or treatment under any other circumstances.
What is Valid Consent?

- HCCA, s. 11(1)

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?

HCCA s. 11(2)

The 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
Duties of the Health Practitioner

- To determine whether the PATIENT is MENTALLY CAPABLE of giving or refusing consent to the treatment

- To determine WHO is the patient’s RIGHT SDM if the patient is incapable

- To inform the treatment decision maker – whether the Patient or the SDM about the PATIENT’S CONDITION and the possible TREATMENT OPTIONS

- To get an informed consent (subject to emergency exception) from the capable patient or the incapable patient's SDM following the rules in the Health Care Consent Act
Capacity to consent

- Health practitioner offering the treatment is responsible to determine if the patient is capable in respect to treatment

- One Health Practitioner on behalf of the team when there is a Plan of Treatment may assess the capacity of patient

- This is NOT DONE by “Capacity Assessor” as defined by Substitute Decisions Act

- Not the score on the MMSE, MOCA, ACE etc.
- Not a diagnosis
- Capacity may fluctuate
Informed Consent – the RIGHT to know

When seeking consent, health practitioners have a duty to COMMUNICATE with patients (or the incapable patient’s substitute decision-maker) about the patient’s present condition and the available treatment options.

Information needed to be communicated includes info on the
- risks,
- benefits,
- side effects,
- alternatives to the treatment, and what happens if the treatment is refused.

The Patient or the Patient's SDM also has the RIGHT TO ASK QUESTIONS and get answers form the Health practitioner.
Informed consent vs. ACP Wishes

- Consent ALWAYS comes from a person, not a piece of paper - not from a patient’s written “advance care plan” nor from patient’s wishes noted in medical records

- Advance Care Planning Wishes are not Consents
How “Wishes” affect Treatment options

- Even if a patient has provided some form of “Advance Care Plan” 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 options.

- PATIENTS may CHANGE THEIR MINDS after getting all the INFO to make an informed consent.
How Consent relates to “Goals of Care”

- Goals of care are NOT the treatment options but help health practitioners understand how a patient thinks about and understands (or not) his or her own health and the goals the patient has for his/her care based on his/her current quality of life.

Goals of Care are NOT health decisions but lead to and help shape the health decisions.
Treatment taking place in the future is NOT necessarily advance care planning

- 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
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.

• BOTTOM LINE: PLANS OF TREATMENT MUST BE GROUNDED IN THE PATIENT’S PRESENT HEALTH CONDITION. This is NOT a Preconsent. This is NOT an advance care plan. Both Patients and SDMs (where appropriate) may CONSENT to Plans of Treatment
Refusal of Treatment

- A patient, if capable, may refuse treatment

- Health practitioners should make certain that patients understands their condition and treatment options particularly if the patient is refusing a treatment
What about Emergencies?

- 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 the proposed treatment.
What is an Emergency?

- **Meaning of “emergency”**
  S.25(1) … there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.
What is Advance Care Planning in Ontario?

1. The Capable Person identifying who would be their future SDM, by either
   a) confirming that he / she is satisfied with their automatic Substitute Decision-Maker as determined by law in the Health Care Consent Act
   
   OR

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

2. Wishes, Values, and Beliefs – the capable person informing their future SDM about his/her wishes, values and beliefs, and more generally how he/she would like to be cared for in the event of incapacity to give or refuse consent.

These are used as a guide for the SDMs NOT the Health practitioners.
Who does Advance Care Planning?

- Only a person when capable can prepare a POA Personal Care

- Only a person may express his or her own wishes about future care and treatment

- SDMs cannot do Advance Care Planning and ONLY provide consent or refuse consent to treatment on behalf of a patient incapable for treatment

- ACP is not just about end of life care
Health care practitioners must always obtain informed consent or refusal before treatment from either the mentally capable patient or their substitute decision maker (SDM).

Advance care planning wishes may be inappropriately used as consents when the health practitioners don’t have a good understanding of how Informed consent and ACP are related.
How does Health Care Consent relate to Advance Care Planning?

- Under Ontario law, advance care planning is part of the law of informed consent.

- Patient “wishes” are interpreted 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”
Wishes do not need to be expressed in writing.

Wishes may be expressed in any form at any time when a person is 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
ACP “Wishes”

- Advance Care Planning does not need to be about specific treatments that a person would want to not want.

- It is very difficult to anticipate what treatments one would want for themselves as people don’t know how their health condition will progress or what the effect of particular treatments would be.

- ACP Wishes and explanations of a person’s values and beliefs may help the SDM make better decisions for the patient as these wishes help the SDM understand:
  - who the patient is,
  - how they make choices for themselves,
  - what they think is important to themselves what influences their decision making.
What about “Advance Directives” and “Living Wills”? 

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

- This terminology should NOT be used in documents/ records

- Instead – use terminology such as “advance care planning” or “capable wishes” or “wishes, values, beliefs”

- 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 just an expression of wishes, to be interpreted by the 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
Substitute Decision Makers for Health Care
Are SDMs the same as “Next of Kin”? 

Are all SDMs attorneys in Powers of Attorney for Personal Care? 

If a person has not prepared a POA Personal care naming someone to be an SDM, may the health practitioners decide what treatments the patient gets?
Who is the YOUR future SDM for Health Care and what is the SDM’s role?
Substitute Decision Maker Hierarchy

**Confirm** automatic SDM(s)

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

- Court Appointed Guardian
- Attorney for Personal Care
- Representative appointed by Consent and Capacity Board
- Spouse or Partner
- Parents or Children
- Parent with right of access only
- Siblings
- Any other relative
- Public Guardian and Trustee

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.
What if..

- If highest ranking SDM is not capable to make treatment decision – Then the health practitioners must turn to the next SDM on the list

- If SDM not available – then the health practitioners turn to next ranking SDM

- If SDM not willing to act, then the health practitioners turn to next ranking SDM

- If a person claims to be the attorney in a POAPC, that attorney should be able to show that document
SDMs

- Health practitioners should only turn to an SDM for consent when the patient has been lawfully found incapable.

- List is hierarchical (i.e., start at the top and work your way down).

- All persons on the same rung rank equally (i.e., all brothers and sisters are equally SDMs).

- Every person ALWAYS has an SDM if they are incapable.

- The Ontario Public Guardian and Trustee is required to act as the SDM if no one on the hierarchy is available or if there is a conflict between equally ranked SDMs.
May an SDM refuse to act as SDM if he/she was named as Attorney in a POA Personal care?

YES- then Health practitioner turns to next highest ranking SDM

May an SDM refuse to act if highest in hierarchy for a patient?

YES- if not willing then Health Practitioner turns to next highest ranking
Multiple equal ranking SDMs

If Multiples and equal ranking, THEY must decide amongst themselves if they all want to make the decisions together, or if one or more will be the 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 OPGT Treatment Decisions Unit if the disagreement can’t be resolved.

HCCA REQUIRES OPGT to step in. (HCCA s.20(6))
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)
Best Interests Definition
HCCA s.21(2)

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
If SDM believes that patient would have changed his/her wish if he/she knew what his/her present health condition would be and treatment options, SDM may go to Consent and Capacity Board asking that they will not follow that wish.

If SDM believes that a wish is impossible to follow then SDM does not need to follow it.
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.
Everyone talks about advance care planning “wishes”, but few talk about consent and confirmation or choice of future SDMs.

Patients are often immediately asked to express future care wishes but patients are rarely told how their statements will be used.

Advance Care Planning is important but doesn’t replace having conversations that lead to an informed consent.
What is required across all care settings to GET THIS RIGHT?

A person's values, wishes, beliefs and goals for their care

Info guides future decision-making

Info directly informs decision-making

Future Care

Advance Care Planning Conversations

Goals of Care Discussion

Decision-Making or Consent Discussion

Current Care

Treatment Decisions to be made

Figure: Relationship between three discussions that contribute to informed consent

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Not helpful Consent and ACP Conversations…

<table>
<thead>
<tr>
<th>Commonly used</th>
<th>Think about it for a moment…</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No heroics and no machines”</td>
<td>Ever? Or when there is no chance of recovery? What about a 90% chance?</td>
</tr>
<tr>
<td>“No tubes”</td>
<td>What if the circumstances were short term and reversible... would a “tube” be acceptable?</td>
</tr>
<tr>
<td>“Do everything”</td>
<td>What does this mean? What “state of being” is to be achieved? How will the SDM know when everything has been done?</td>
</tr>
</tbody>
</table>
## Helpful Consent and ACP Conversations…

<table>
<thead>
<tr>
<th>Explore further</th>
<th>What experiences have you had to bring you to this? What is it about “heroics and machines”?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No heroics and no machines”</td>
<td>What is it about a tube that makes you not want one?</td>
</tr>
<tr>
<td>“Do everything”</td>
<td>What does it mean to not “do everything”? What worries or fears come to mind? How should we approach reconciling this?</td>
</tr>
</tbody>
</table>
Do Not Resuscitate (DNR)

- Resuscitation is a treatment

- Physicians are encouraged to discuss with patients, particularly those with health conditions where resuscitation would be a relevant treatment choice, about whether they would or would not want that treatment.

- A DNR order may be placed on a patient’s chart after the physician has obtained an informed consent to do so from the patient or incapable patient's SDM.
What if Physician does not think that CPR should be provided to the patient? Is a Physician REQUIRED by Law to get a Consent to no CPR(DNR)?

- The College of Physicians and Surgeons of Ontario take the position that the legal requirements regarding consent to a no-CPR order are currently unclear.

- Therefore the College requires physicians

  “to discuss a no-CPR order with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity, to explain why CPR is not being proposed, and to engage in conflict resolution practices if the patient or substitute decision-maker disagrees with the no-CPR order and insists that CPR be provided”
If an event requiring CPR occurs while conflict resolution is underway, physicians must provide CPR unless the patient’s condition would prevent the intended physiologic goals of CPR from being achieved.

In these cases, physicians may make a decision about whether or not to provide CPR while attending to the patient. In those instances where physicians must provide CPR, they must do so in good faith and use their professional judgment to determine how long to continue providing CPR.
If the patient or substitute decision maker disagrees with the recommendation that a no-CPR order be written and insists that CPR be provided even when the patient’s condition will prevent the intended physiologic goals of CPR from being achieved, physicians may not write the no-CPR order and must engage the patient or substitute decision-maker in conflict resolution.
CPR in an Emergency when Physician doesn’t KNOW the patients wishes or consents about CPR

- This is different from an emergency situation where a patient experiencing a cardiac or respiratory arrest presents to a physician and the physician is not aware of the patient’s wishes and there is no substitute decision-maker to ask.

As in all emergency situations, in this case if there is no reason to assume the patient does not want the treatment and the physician has made a reasonable effort to confirm that there is no substitute decision-maker available to discuss the treatment decision with, then the physician may rely on his or her judgment in determining what care to provide.
DNR(c) Form

- DNR Confirmation form was created to enable health practitioners (Physicians, RNs, RN(EC) and RPNs) to communicate with emergency responders (Paramedics and fire firefighters) when patients/SDMs have provided an informed consent to No CPR to a health practitioner.

- 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.
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 is that direction as it confirms that the person or the SDM has consented to no resuscitation or that the physician believes that CPR will not benefit the patient, that CPR is not part of the plan of treatment AND the physician has discussed that with the patient or the SDM
DNR and Personal Support Service Providers

- DNR(c) form does not apply to Personal Support Providers

Why not?

- Not emergency responders that form/ policy applies to

- Not regulated health practitioners themselves
By contract with Consumers,

Attendants are required to “initiate the Emergency Response System by providing First Aid and calling 911 when appropriate. If a Living Will (advance care plan wishes) exists it will be forwarded to the hospital with the ambulance attendants.”
Medical Assistance in Dying (MAID)
What is MAID?
Criminal Code s. 241.1

*medical assistance in dying* (MAID) means

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.
Who is eligible for MAID

Criminal Code 241.2

(1) A person may receive medical assistance in dying only if they meet ALL of the following criteria:

(a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;

(b) they are at least 18 years of age and capable of making decisions with respect to their health;

(c) they have a grievous and irremediable medical condition;

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.
Eligibility
Health insurance and Age

- Must have OHIP coverage OR be eligible for OHIP (but for the minimum period of residence or waiting period), or have health insurance coverage from another government in Canada.

- Must be at least 18 (note this is different than Health Care Consent Act which has no specified age to consent to health care).
What is Capacity to consent to MAID?

- Person must be able to understand and appreciate the certainty of death upon receiving the MAID medication.
There is NO substitute consent to MAID – Substitute decision makers have NO authority to consent to MAID on behalf of a person that is incapable.

If a person is not mentally capable to consent to MAID it cannot be administered.

The law in Ontario already specifies that a person cannot provide an “advance consent” to any health treatments.

Advance care planning in Ontario which includes expressing wishes about future health care does not constitute “advance consent” to any treatments.

This is the same for MAID – A person CANNOT provide advance consent to MAID.
Capacity

- Person consenting to MAID must be capable BOTH
  - At the time of the request for MAID and
  - At the time MAID is administered (after the waiting period of 10 clear days between the day on which the request for MAID was signed by or on behalf of the person and the day on which the medical assistance in dying is provided)

WAITING PERIOD - If the medical practitioner or nurse practitioner administering the MAID medication AND the medical practitioner or nurse practitioner that provided the second written opinion that the person is eligible for MAID are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent they can shorten the waiting period to a period that they think appropriate in the circumstances – **THIS is a decision of the medical or nursing practitioners involved** – **No court application required**
Eligibility
Grievous and Irremediable Medical Condition

Criminal Code 241.2

(2) A person has a grievous and irremediable medical condition only if they meet ALL of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
What is a Grievous and Irremediable Medical Condition?

- CPSO MAID Policy states that to determine this criteria physicians must use their professional judgment.

- Federal government has stated that the person does not need to have a terminal illness but that there must be a real possibility of death evidenced by the person’s irreversible decline within a period of time that is foreseeable in the not too distant future.
Eligibility
Voluntary Request

- Person must make a voluntary request for MAID “that, in particular, was not made as a result of external pressure”

- Obligation on medical practitioner or nurse practitioner to determine the voluntariness
Eligibility
Informed Consent

- Person must understand their health condition
- Person must understand the options for treatment of their condition
- Person must be informed and understand the means that are available to relieve their suffering, including palliative care.
- Person must be able to understand and appreciate the certainty of death upon receiving the MAID medication
Person’s Options if found not eligible for MAID

- Get second opinion
- Ask for a referral
- Complain to health professional’s College?
- Depends on grounds not found eligible
Safeguards: Request in Writing

The medical practitioner or nurse practitioner must ensure that the person’s request for MAID was

(i) made in writing and signed and dated by the person or by another person in the person’s presence, on the person’s behalf and under the person’s express direction.

AND

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition.
Signature of a Request for MAID by Another Person

If the person requesting MAID is unable to sign and date the required written request,

another person

- who is at least 18 years of age,
- who understands the nature of the request for MAID
- who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death

may sign and date the required written request

- in the person’s presence,
- on the person’s behalf and
- under the person’s express direction
Safeguards:
Request in Writing – Signature and Witnessing

The medical practitioner or nurse practitioner must ensure that the person’s written request for MAID was:

- signed and dated by the person — or by another person in the person’s presence, on the person’s behalf and under the person’s express direction

- before two independent witnesses who then also signed and dated the request;
Safeguards: Who may be an Independent Witness?

Any person who:

- is at least 18 years of age
- who understands the nature of the request for MAID

EXCEPTION

CANNOT be an independent witness if person
(a) knows or believes that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death;

(b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;

(c) are directly involved in providing health care services to the person making the request; or

(d) directly provide personal care to the person making the request.
Independent Witnesses

Implications

- Medical and Nursing Practitioners involved in MAID must confirm independence

- Witnesses must understand the nature of the MAID request so are not just attesting to the identification of the person requesting MAID and their signature

- Family members of the person who is requesting MAID not prohibited from being independent witnesses BUT could be a beneficiary under the will of the person making the request even if they don’t definitively know that (not seen will document, not informed by person of this etc.) or possible beneficiaries if no will and estate distributed under Succession Law Reform Act?

- Request must be voluntary so does relationship of witness to person seeking MAID raise concerns about influence?
Safeguards:

Person Informed that may withdraw request

The medical practitioner or nurse practitioner must ensure that the person was informed that:

- they may withdraw their request for MAID
- at any time
- in any manner (e.g. orally, in writing, by any other means)
Safeguards:
Written Opinion by another INDEPENDENT MP or NP

The medical practitioner or nurse practitioner must ensure that:

- another independent medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria for MAID
Safeguards:
Requirement for independence of MP or NP giving written second opinion

The medical practitioner or nurse practitioner providing MAID and the medical practitioner or nurse practitioner providing the written second opinion must be INDEPENDENT of each other.

The second MP or NP is INDEPENDENT if they:

- are not a mentor to the other practitioner or responsible for supervising their work;
- do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death, other than standard compensation for their services relating to the request; or
- do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.
Safeguards: Waiting Period

The medical practitioner or nurse practitioner must ensure that:

- there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which MAID is provided

OR

- if they and the other medical practitioner or nurse practitioner giving the written second opinion are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent, the first medical practitioner or nurse practitioner may decide on a shorter waiting period that they think is appropriate in the circumstances
Safeguards: Opportunity to withdraw request and confirm express consent

The medical practitioner or nurse practitioner must ensure that:

- immediately before providing MAID
- Must give the person an opportunity to withdraw their request
  and
- Ensure that the person gives express consent to receive MAID
Safeguards:
Particular attention to Communication

The medical practitioner or nurse practitioner must ensure that:

- if the person has difficulty communicating,
- the MP or NP must take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision
Thank You!
What’s next – Personal Level

1. Identify your Substitute Decision Maker by either:
   I. Confirming person on hierarchy
   II. Doing Power of Attorney for Personal Care

2. Complete the SDM card and keep in your wallet

3. Have the conversations with your SDM and your other loved ones about what is important to you
What’s next – Agency Level

1. Help consumers/clients/patients & staff understand and engage in **Advance Care Planning**

2. Ensure your agency is **recording** the person’s correct **Substitute Decision Maker(s)**

3. Help **SDMs** understand their **roles & responsibilities**
Advance Care Planning
Conversations Worth Having

www.acpww.ca

519-743-4114

@acpww

@ACPWaterlooWellington