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ADVANCE DIRECTIVES AND SUBSTITUTE DECISION-MAKING IN PERSONAL HEALTH CARE

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ALBERTA LAW REFORM INSTITUTE

The Alberta Law Reform Institute was established on January 1, 1968, by the Government of Alberta, the University of Alberta and the Law Society of Alberta for the purposes, among others, of conducting legal research and recommending reforms in the law. Funding of the Institute's operations is provided by the Government of Alberta, the University of Alberta, and the Alberta Law Foundation.

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This report is the second part of a special project funded by the Alberta Law Foundation. As a result of that funding the Institute was able to obtain the services of Professor Gerald Robertson, whose reputation and demonstrated expertise in this area has been a large factor in the implementation of the Enduring Powers of Attorney legislation, and the clarity of the proposals in this report.

PREFACE AND INVITATION TO COMMENT

This is not a final report. It is a report of our conclusions and proposals. The Institute's purpose in issuing a Report for Discussion at this time is to allow interested persons the opportunity to consider these tentative conclusions and proposals and to make their views known to the Institute. Any comments sent to the Institute will be considered when the Institute determines what final recommendation, if any, it will make to the Alberta Attorney-General.

The reader's attention is drawn to the List of Recommendations in Part III. It would be helpful if comments would refer to these recommendations where practicable, but commentators should feel free to address any issues as they see fit.

It is just as important for interested persons to advise the Institute that they approve the proposals as it is to advise the Institute that they object to them, or that they believe that they need to be revised in whole or in part. The Institute often substantially revises tentative conclusions as a result of comments it receives. The proposals do not have the final approval of the Institute's Board of Directors. They have not been adopted, even provisionally, by the Alberta government.

Comments on this report should be in the Institute's hands by March 31st, 1992. Comments in writing are preferred.

ADVANCE DIRECTIVES AND SUBSTITUTE DECISION-MAKING IN PERSONAL HEALTH CARE

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PART I — EXECUTIVE SUMMARY

This report represents the second part of proposals allowing an individual to provide in advance for potential loss of capacity. The first part, enduring powers of attorney in the context of financial planning, was the subject of two reports issued in 1990 and legislation based on those reports was enacted in June of 1991 by the Powers of Attorney Act. The second phase deals with the use of advance directives for personal health care decisions.

The current law is uncertain as to who may consent to treatment on behalf of an incapacitated person and the status of powers of attorney and living wills with respect to such treatment is not at all clear. This presents a practical problem for health care professionals who must face the issue on a daily basis. There is also little, if any, scope within the current law for individuals to plan for their own incapacity.

The report reviews the various options for reform including: leaving the decision entirely in the hands of the attending physician; giving legal authority to the highest person on a statutory list of relatives; and providing for advance directives, partially similar to the living will legislation in a number of other jurisdictions.

Two significant developments have occurred in Canada and the report reviews them. The first is legislation introduced in Ontario, the Substitute Decisions Act (Bill 108) and Consent to Treatment Act (Bill 109). The second is the final report of the Manitoba Law Reform Commission. The various models and the Canadian and other developments are reviewed in chapters 4 and 5 of the report.

This Report for Discussion, on which it is hoped that the Institute will receive wide comment, sets out tentative recommendations in chapter 6. The most significant parts of these recommendations are:

1. Creation of a model which combines the ability of the individual to give instructions for treatment or appoint a health care agent on the one hand, and resort to a statutory list of relatives where the individual has not given an advance directive.

2. Allowing the directive to be as flexible as possible by giving instructions, appointing an agent, or even instructing that certain persons on the statutory list are not to be consulted.

3. The formalities for creation of an advance directive should be as simple as possible, requiring the signature of the individual and one witness.

4. The decision of the substitute should replicate as closely as possible the decision which the individual has made so that

    (a) Clear and unambiguous instructions will be followed.

    (b) The substitute should make the decisions that the individual would have made if competent.

    (c) In the absence of either of the first two propositions, a decision shall be made in the best interests of the patient.

The theme of personal autonomy is carried through the report by providing the individual with the ability to give advance directives, by resort to a statutory list which is likely to produce a decision as close as possible to what the individual would have made, by stipulating a standard of decision that gives priority to the wishes or views of the patient and by providing simple formalities for the creation and revocation of a health care directive.

The report contains 26 recommendations.

PART II — REPORT FOR DISCUSSION

CHAPTER 1 — INTRODUCTION

A. History and Scope of the Project

This Report for Discussion represents the second phase of a two-part project relating to substitute decision-making and mental incapacity. The first part of the project dealt with enduring powers of attorney in the context of financial planning, and culminated in a Report for Discussion (published in February 1990)[1] and a final Report (published in December 1990).[2] Legislation based on the recommendations contained in these reports was enacted on June 25, 1991.[3]

This second phase of the project expands the discussion into the context of personal care, and in particular health care. Its primary focus centres on two fundamental questions. First, who should make health care decisions on behalf of patients who lack the mental capacity to make these decisions themselves? Second, what, if any, legal mechanisms should exist to enable individuals to exercise autonomy and self-determination in respect of health care decisions made after they become mentally incompetent?

The project has been funded by a grant from the Alberta Law Foundation's Special Projects Fund.

B. Methodology

(1) Research

Many of the issues addressed in this Report, such as living wills and powers of attorney for health care, are extremely topical and have attracted

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[1] *Report for Discussion on Enduring Powers of Attorney* (Report for Discussion No. 7, 1990).

[2] *Report on Enduring Powers of Attorney* (Report No. 59, 1990).

[3] *Powers of Attorney Act*, S.A. 1991, c. P-13.5.

considerable media attention, particularly in recent months.[4] They have also generated an extensive body of literature, on which we have drawn in conducting our research. A bibliography of the relevant literature is contained in Part IV of the Report.

We have also considered reports from other law reform agencies as well as legislation in other jurisdictions. Although not as numerous as in the case of enduring powers of attorney for financial matters, these reports and statutes were still of considerable assistance in preparing our Report. Of particular importance are the recent report of the Manitoba Law Reform Commission[5] and the proposed legislation presently before the Ontario legislature,[6] both of which are discussed in detail in Chapter 5 of this Report.

(2) Consultations

In the first part of the project, dealing with enduring powers of attorney for financial matters, we consulted extensively with many interested groups and individuals (both in Alberta and elsewhere) prior to preparing our Report for Discussion. These consultations led us to believe that our recommendations would likely receive widespread support, and this is in fact what occurred. As a result, the final Report was relatively brief and simply restated (with a few minor changes) the recommendations made in the Report for Discussion.

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[4] See e.g. "Bioethics: The Living Will Debate", *Edmonton Journal* (7 July 1991) at Section E; "Living Wills Becoming Thorny Issue" *Toronto Globe and Mail* (24 April 1991) at A1; "Theologians Give Guarded Support to Living Wills for Terminally Ill" *Western Catholic Reporter* (25 March 1991) at 20. There have also been many recent articles in medical and legal professional journals: see e.g. "Doctor Recommends Wider Use of 'Living Wills'" *National (Canadian Bar Association)* (February 1991) at 4; R.H. Fisher & E.M. Meslin, "Should Living Wills be Legalized?" (1990) 142 Canadian Medical Association Journal at 23; "Ethicist Calls for Advance Directives Laws" *HospitAlta* (April 1991) at 5.

[5] Manitoba Law Reform Commission, *Report on Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Report No. 74, 1991) (hereafter "Manitoba Report"). See also the Commission's earlier publication, *Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care* (1990) (hereafter "Manitoba Discussion Paper").

[6] *Consent to Treatment Act*, 1991 (Bill 109); *Substitute Decisions Act*, 1991 (Bill 108).

A different approach has been adopted with the present Report, because the issues are more complex and attract a much wider range of opinions. Although we have consulted with a number of interested groups, the extent of these consultations has been much more limited than with the first phase of the project. Accordingly, this Report in much more of a report *for discussion* than with phase one. The recommendations are tentative, reflecting the present views of the Institute, and their aim is to generate discussion and feedback with a view to preparing a final report at a later date.

C. Outline of the Report

With the exception of Chapter 3, which discusses the need for reform, the first five Chapters of the Report are largely descriptive. Chapter 2 examines the present law relating to mental incapacity and substitute decision-making in health care, including the present law concerning living wills and enduring powers of attorney for health care. Chapter 4 then considers four possible models for reform, namely, professional judgment, nearest relative, living wills, and enduring powers of attorney for health care. Chapter 5 outlines the proposed Ontario legislation and the recent report from the Manitoba Law Reform Commission. Finally, Chapter 6 explains the position adopted by the Institute, and discusses in detail the various recommendations which we are putting forward.

CHAPTER 2 — THE PRESENT LAW

A. Self-Determination and Consent to Treatment

It is well established that, in the absence of an emergency where medical treatment is immediately necessary to preserve the life or health of the patient, treatment cannot be performed without consent.[7] The requirement of consent reflects (and protects) the patient's right to self-determination in matters of health care, and ensures that it is the patient rather than the physician who ultimately decides whether treatment is to be performed. As Mr. Justice Robins stated in *Fleming v. Reid*:[8]

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care.

According to *Fleming v. Reid,* not only is the right of a competent adult to refuse medical treatment firmly entrenched in the common law, it is also protected by the Constitution. The Ontario Court of Appeal in *Fleming* held that certain provisions of Ontario's *Mental Health Act*[9] dealing with consent to psychiatric treatment are contrary to section 7 of the *Charter* and thus are of no force and effect. In particular, the Court held that to require a mentally incompetent patient to undergo psychiatric treatment, where previously the patient (while competent) has indicated that he or she does not wish to have that

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[7] *Hopp v. Lepp,* [1980] 2 S.C.R. 192; *Reibl v. Hughes,* [1980] 2 S.C.R. 880. See generally E.I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed., 1984, Toronto: Carswell), c. 3.

[8] (1991) 4 O.R. (3d) 74 at 85 (C.A.). See also *Malette v. Shulman* (1990), 72 O.R. (2d) 417 at 424 (C.A.).

[9] R.S.O. 1980, c. 262, ss 35(2)(b)(ii), 35a [en. 1987, c. 37, s. 12].

treatment, infringes the patient's right to life, liberty and security of the person, and that in the case of the Ontario legislation this infringement was neither in accordance with the principles of fundamental justice nor justifiable under section 1 of the *Charter.*

B. Consent and the Mentally Incompetent Patient

(1) Common Law

In Alberta, if an adult is mentally incapable of consenting to health care, the only person who has legal authority to consent on his or her behalf is a guardian appointed under the *Dependent Adults Act.*[10] If the person does not have a guardian, no-one can lawfully consent to the treatment,[11] not even a spouse or nearest relative.[12] Unlike some provinces,[13] Alberta does not have legislation expressly authorizing family members to provide substitute consent,

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[10] R.S.A. 1980, c. D-32. If the patient is a minor who is not sufficiently mature to be capable of giving a valid consent, the parents have legal authority to consent on the child's behalf—Picard, *supra,* note 7 at 60. A minor who is capable of understanding the nature and consequences of the proposed treatment can give a valid consent: *C. (J.S.) v. Wren,* [1987] 2 W.W.R. 669 (Alta. C.A.).

[11] See G. Sharpe, *The Law & Medicine in Canada* (2nd ed., 1987, Toronto: Butterworths) at 78-79; B.M. Dickens, "The Role of the Family in Surrogate Medical Consent" (1980) 1 Health Law in Canada at 49; M.E. Schiffer, *Psychiatry Behind Bars* (1982, Toronto: Butterworths) at 187; L.E. Rozovsky, "Consent to Treatment" (1973) 11 Osgoode Hall Law Journal 103 at 110; K. Evans, "The Law of Consent" (1990) 10 Health Law in Canada 227 at 228; K. Evans, "Mental Competence, Treatment and Substitute Consent: A Lawyer's Perspective" (1988) 8 Health Law in Canada 96 at 97.

[12] In *Ciarlariello v. Schacter,* unreported, 3 November 1987, No. 7448/81 and 11750/81, 7 A.C.W.S. (3d) 51 (Ont. H.C.), *aff'd sub nom. Ciarlariello Estate v. Schacter* (1991), 76 D.L.R. (4th) 449 (C.A.), the trial judge observed (transcript judgment at 45-46) that substitute consent may be given by a family member if the patient "is too ill or sedated to consent". Although the trial judge made no mention of any statute or regulation, it is likely that he was alluding to the statutory position in Ontario (discussed *infra,* Chapter 4) rather than purporting to state a common law rule. On appeal the Ontario Court of Appeal did not discuss the issue of substitute consent.

[13] See *infra,* Chapter 4.

except in relation to treatment given to a mentally incompetent person who is detained in a psychiatric facility as a formal patient under the *Mental Health Act*.[14]

The *Criminal Code* imposes a duty to provide one's spouse and others under one's charge with necessaries of life,[15] including necessary health care.[16] A similar obligation exists under provincial legislation.[17] Arguably, the *obligation* to provide health care implies a *power* to provide it, thereby empowering a spouse or other relative to provide substitute consent on behalf of a mentally incompetent patient. This conclusion has been reached in a number of cases in the United States,[18] but the issue has not been addressed by a Canadian court. On balance, the weight of authority supports the view that family members do not have the power under Alberta law to consent to health care on behalf of an adult patient who is incapable of giving personal consent.

(2) *Dependent Adults Act* Certificate

Section 20.1 of the *Dependent Adults Act*[19] provides an exception to the general requirement of consent. Where an adult person, who has no guardian with authority to consent to health care, is incapable by reason of physical or mental disability of understanding and consenting to an examination or to medical, surgical, obstetrical or dental treatment, and two physicians (or in the case of dental treatment, two dentists) certify that the person needs treatment, the treatment can be performed without anyone's consent, unless the patient has previously withheld consent to that treatment.

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[14] *Mental Health Act*, S.A. 1988, c. M-13.1, s. 28 [proclaimed in force January 1, 1990].

[15] *Criminal Code*, R.S.C. 1985, c. C-46, s. 215(1).

[16] *R. v. Tutton* (1989), 48 C.C.C. (3d) 129 (S.C.C.).

[17] *Maintenance Order Act*, R.S.A. 1980, c. M-1, s. 2(1).

[18] See e.g. *Ritz v. Florida Patient's Compensation Fund*, 436 So. 2d 987 (Fla. App., 1983); *Farber v. Olkon*, 254 P. 2d 520 (Cal., 1953). We are grateful to Dean Wilbur Bowker for bringing these cases to our attention.

[19] R.S.A. 1980, c. D-32, s. 20.1 [en. R.S.A. 1980, c. 6 (Supp.), s. 16]. This provision was originally enacted in 1974 [1974, c. 26, s. 3] as part of the *Emergency Medical Aid Act*, R.S.A. 1970, c. 122. It was repealed in 1980 and re-enacted in the *Dependent Adults Act* the same year.

(3) Doctrine of Necessity and *Re F.*

At common law, if a patient is mentally incapable of consenting to medical treatment which is immediately necessary to preserve the patient's life or health, the treatment may be performed without consent.[20] This principle was recently given a very broad interpretation by the House of Lords in *Re F.*.[21] The House of Lords held that treatment can be given to a mentally incompetent patient without consent, *regardless of whether the situation is one of emergency,* so long as the treatment is in the patient's best interests. Whether the treatment is in the patient's best interests depends on whether, in deciding to administer the treatment, the physician acted reasonably (judged by the traditional standard of the reasonable physician in similar circumstances). Indeed, the House of Lords indicated that the physician has not only the power but also the duty to administer the treatment.

In arriving at its decision the House of Lords emphasized two particular concerns, the first being the dilemma faced by health care professionals in dealing with patients who lack the capacity to consent to treatment. In the words of Lord Bridge:[22]

> It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking the capacity to consent to treatment they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care owed to the patient.

The House of Lords' other major concern involved the need to ensure that mentally disabled people are not denied necessary health care. Lord Jauncey emphasized that:[23]

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[20] See Picard, *supra,* note 7 at 45-46.

[21] [1990] 2 A.C. 1 (H.L.).

[22] *Ibid.* at 52.

[23] *Ibid.* at 83.

> I should like only to reiterate the importance of not erecting such legal barriers against the provision of medical treatment for incompetents that they are deprived of treatment which competent persons could reasonably expect to receive in similar circumstances. The law must not convert incompetents into second class citizens for the purposes of health care.

The policy implications underlying *Re F.*, and the criticisms which have been advanced against the decision, are discussed later in this Report.[24] It is unlikely, however, that *Re F.* represents current Canadian law. The Canadian cases have taken a much narrower view of the doctrine of necessity in the health care context, applying it only where there is a true emergency in the sense of there being an immediate danger to the life or health of the patient.[25]

C. Living Wills

"Living will" is the term most commonly used to describe an advance directive which expresses the writer's preferences and instructions with respect to future medical treatment. Until recently it has generally been assumed that such a document has no legal force in the absence of special legislation. Several writers, both in Canada[26] and in England,[27] have expressed the view that living wills are not legally binding at common law, and this appears to have been the assumption made by the Law Reform Commission of Canada in its Working Paper published in 1982.[28] At the present time, Alberta has no legislation dealing with living wills.

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[24] See *infra*, Chapter 4.

[25] See e.g. *Malette v. Shulman*, *supra*, note 8 at 424-25; Picard, *supra*, note 7 at 45-46; Sharpe, *supra*, note 11 at 79.

[26] See e.g. Sharpe, *supra*, note 11 at 79.

[27] See e.g. I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (1988, Oxford: University Press) at 328; Age Concern Institute of Gerontology (England) & Centre of Medical Law and Ethics (King's College, London), *The Living Will: Consent to Treatment at the End of Life* (1988, London: Edward Arnold) at 48; but *contra* P.D.G. Skegg, *Law, Ethics, and Medicine* (rev. ed., 1988, Oxford: University Press) at 116.

[28] Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Working Paper No. 28, 1982).

The assumption that living wills have no legal force at common law is now questionable in light of the decision in *Malette v. Shulman*,[29] in which a doctor was found liable in battery for having performed a life-saving blood transfusion on an unconscious Jehovah's Witness patient.[30] The Ontario Court of Appeal held that the card which the patient had in her possession, stating her religion and indicating that she did not wish to be given blood or blood products, constituted a valid and legally binding refusal of consent and ought to have been respected.

In delivering the judgment of the Court in *Malette*, Mr. Justice Robins emphasized that the decision should be limited to its own facts. In particular, he noted that "we are not concerned with a patient who has been diagnosed as terminally or incurably ill who seeks by way of advance directive or 'living will' to reject medical treatment so that she may die with dignity".[31]

Despite this caveat, it is difficult to see what principled distinction can be drawn between the "no blood" card carried by Mrs. Malette and any other type of written advance directive in which the writer indicates his or her desire not to have certain specified medical treatment. It is true, as is discussed later,[32] that one of the inherent problems with most living wills is that they tend to be written in generalized and imprecise language, because of the difficulties which the writer has in anticipating his or her future medical condition and available treatment options. As a result, living wills often fail to provide a clear and unambiguous indication of the patient's wishes. However, if the living will were to be clear and unambiguous, there would certainly appear to be a strong argument that the reasoning in *Malette* should apply and the living will should be legally binding.

This view gains further support from the Ontario Court of Appeal's recent reiteration of the principle in *Malette v. Shulman*. In *Fleming v. Reid*,[33] a case

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[29] *Supra*, note 8.

[30] For a criticism of the decision see N. Siebrasse, "Malette v. Shulman: The Requirement of Consent in Medical Emergencies" (1989) 34 McGill Law Journal at 1080.

[31] *Supra*, note 8 at 428.

[32] See *infra*, Chapter 4.

[33] *Supra*, note 8.

concerning the constitutional validity of provisions of Ontario's *Mental Health Act* dealing with consent to treatment,[34] Mr. Justice Robins stated that:[35]

> A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instruction, even in an emergency. The patient's right to forego treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others.

In light of these recent pronouncements of the Ontario Court of Appeal, it can no longer be stated with any degree of certainty that living wills have no legal force at common law. It may well be that a living will, if expressed in clear and unambiguous terms, constitutes a legally binding refusal of consent to the specified treatment.[36]

D. Powers of Attorney for Health Care

There is some uncertainty whether the common law permits the appointment of an "attorney for health care", that is, an agent having authority to make health care decisions on the principal's behalf in the event of the principal's mental incapacity. At common law, certain powers (for example, the power to make a will or consent to marriage) are regarded as so personal that they cannot be delegated to an agent, and the power to consent to health care may fall within

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[34] R.S.O. 1980, c. 262, ss 35(2)(b)(ii), 35a [en. 1987, c. 37, s. 12].

[35] *Supra*, note 8 at 85-86.

[36] It is interesting to note that the Voluntary Euthanasia Society in the United Kingdom obtained an opinion from senior counsel which concluded that living wills are legally binding under English law despite the absence of legislation—*The Independent (England)*, July 26, 1991, at 13.

this category. Some American writers disagree,[37] and argue that health care decision-making is distinguishable from the kinds of actions which have traditionally been viewed as non-delegable.

Even if this argument is correct, the appointment of an attorney for health care, to act in the event of the principal's mental incapacity, would be ineffective under present Alberta law. This is because at common law the authority of an agent terminates upon the mental incapacity of the principal.[38] In order for the appointment of an attorney for health care to survive the mental incapacity of the principal under existing law, Alberta's enduring power of attorney legislation[39] would have to be interpreted as applying to such an attorney. Although the equivalent legislation in some U.S. states has been interpreted in this way,[40] the wording of the Alberta statute (and in particular, explanatory notes 1 and 2 contained in its Schedule) clearly indicates that the Act was intended to apply only to attorneys for financial matters.

E. Summary

In summary, the present law of Alberta in this area is as follows:

1. If an adult patient (other than a formal psychiatric patient) is mentally incapable of consenting to medical treatment, the only person who has legal authority to consent on the patient's behalf is a guardian appointed under the *Dependent Adults Act*.

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[37] See e.g. M. Fowler, "Appointing an Agent to Make Medical Treatment Choices" (1984) 84 Columbia Law Review 985 at 1009-12; D.L. Moore, "The Durable Power of Attorney as an Alternative to the Improper Use of Conservatorship for Health-Care Decisionmaking" (1986) 60 St. John's Law Review 631 at 655.

[38] This common law rule is discussed in detail in our Report for Discussion, *supra*, note 1 at 12-14.

[39] *Powers of Attorney Act*, S.A. 1991, c. P-13.5.

[40] *Re Westchester County Medical Center*, 534 N.Y.S. 2d 886 (Ct. App., 1988); *Re Peter*, 529 A. 2d 419 (N.J., 1987). See also Fowler, *supra*, note 37 at 1012-20; Moore, *supra*, note 37 at 655; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* (1982), vol. 1, at 159-260.

2. Treatment can be given to a mentally incompetent patient without anyone's consent (a) if the treatment is immediately necessary to preserve the life or health of the patient, or (b) if the patient has no guardian and two physicians issue a written certificate stating that the patient is in need of the treatment and is incapable of consenting to it.

3. It is generally assumed that an advance health care directive (a "living will") has no legal force in the absence of legislation, but recent case-law from Ontario casts significant doubt on this assumption. The position under Alberta law remains uncertain.

4. The appointment of an attorney with authority to make health care decisions on behalf of the principal in the event of the principal's mental incapacity is ineffective under current Alberta law.

CHAPTER 3 — THE NEED FOR REFORM

A. The Health Care Professional's Dilemma

As we have seen, Alberta law does not provide for substitute health care decision-making (other than by a guardian) on behalf of a mentally incompetent patient. This gives rise to significant problems in practice if the patient has no guardian. On the one hand the law requires the physician to obtain valid consent before treating the patient, yet on the other hand it fails to provide a mechanism for obtaining that consent. Moreover, even if the patient requires the treatment, the situation may not be so urgent as to come within the emergency exception which would justify proceeding without consent. Thus, the physician is faced with the dilemma of either performing the treatment without consent (thereby risking liability for battery) or not performing the treatment at all (thereby risking liability for negligence).[41]

Health care professionals are confronted with this problem every day. In practice the attending physician will often obtain the consent of the patient's nearest relative (if there is one), but from a strictly legal standpoint this consent is invalid. As is discussed in the previous Chapter, the *Dependent Adults Act*[42] does provide that the treatment may be given without consent if two physicians issue the appropriate certificate. However, it appears that in practice this provision is seldom used, perhaps because many physicians are not aware of its existence or tend to view it as a temporary solution to be used only in an emergency.[43]

In our view the present position is unacceptable and must be corrected. It is essential that the law be amended to provide clarification as to who may consent to health care on behalf of a mentally incompetent patient. As Professor Dickens points out:[44]

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[41] See *Re F., supra,* note 21 per Lord Bridge at 52.

[42] R.S.A. 1980, c. D-32, s. 20.1 [en. R.S.A. 1980, c. 6 (Supp.), s. 16].

[43] At the present time we are endeavouring, in consultation with the Alberta Healthcare Association, to determine whether there may be other reasons for this.

[44] *Supra,* note 11 at 50. See also Manitoba Discussion Paper, *supra,* note 5 at 12; Evans, *supra,* note 11 at 97; G.W. Clements, "Does Canadian Law Prepare You for Death?" (1990) 10 Health Law in Canada at 234.

> [I]t is obviously desirable that medical attendants of an incompetent patient have a simple means of knowing from whom effective consent for treatment may come, and whose refusal will exonerate them from liability for the consequences of non-treatment. A legislative or regulatory scheme may offer this certainty.

B. The Patient's Right to Self-Determination

The present law provides very little scope for individuals to plan for their own mental incapacity. This was the central theme of the Institute's two reports on enduring powers of attorney,[45] and although these reports were concerned with financial decision-making, their reasoning applies equally to the health care context. There is a need to protect and promote individual autonomy, dignity and self-determination, by giving people greater control over decisions affecting their own health care after they become mentally incompetent. As the Manitoba Law Reform Commission emphasizes in its recent report:[46]

> The law presently accepts that individuals can control their current medical treatment. It is reasonable and consistent that, to the extent possible, individuals should have the same control over their future medical treatment. Just as they can now consent to treatment, refuse treatment or choose one treatment over another, they should be able to do the same in respect to future care. Just as the principle of self-determination guides the law in respect to current medical care, so should the principle of self-determination guide the law in respect to future medical care.

This is an area of considerable concern to many people, who fear that they will be subjected to inappropriate and overly-aggressive medical treatment during the end stages of life. The increasing public interest in issues such as "living wills" and "death with dignity" is a reflection of this concern.[47] Most people are

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[45] *Supra*, notes 1 and 2.

[46] Manitoba Report, *supra*, note 5 at 4.

[47] This point is made by a number of writers: see e.g. B.M. Dickens, "The Right to Natural Death" (1981) 26 McGill Law Journal 847 at 848; Fisher (continued...)

extremely fearful of the prospect of losing control over decisions which affect them, and nowhere is this more pronounced than in the context of life-sustaining medical treatment. As was stated in the debates in the Nova Scotia House of Assembly during passage of the *Medical Consent Act*,[48] "people are not nearly as fearful of death itself as much as they are fearful of the loss of control over future decision-making that may affect their lives".[49] In the United States, the President's Commission for the Study of Ethical Problems in Medicine described this as a "widespread concern" which justified continued efforts "to find a simple way to extend at least basic self-determination into a period of decisional incapacity."[50] We agree, and consider this to be one of the fundamental aims of reform in this area.

C. Avoiding the Need for Guardianship

In our Report for Discussion on enduring powers of attorney[51] we discussed in detail the problems associated with an application for trusteeship under the *Dependent Adults Act*, and the need to create a meaningful alternative to proceedings under the Act. The same reasoning applies to guardianship. Proceedings under the Act are costly, time-consuming,[52] and emotionally

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[47](...continued)
and Meslin, *supra*, note 4; Kennedy, *supra*, note 27 at 328; Manitoba Report, *supra*, note 5 at 3; D.S. Murray, "The Living Will: A Natural Death", Legal Education Society of Alberta, Banff Refresher Course, Wills and Estates (1990) at 203; R.P. Vance, "Autonomy's Paradox: Death, Fear, and Advance Directives" (1991) 42 Mercer Law Review 1051.

[48] S.N.S. 1988, c. 14 [now R.S.N.S. 1989, c. 279]. This Act is discussed *infra*, Chapter 4.

[49] *Nova Scotia Hansard* (12 April 1988) at 1725.

[50] *Supra*, note 40 at 165-66.

[51] *Supra*, note 1 at 18-21.

[52] This may result in a significant delay in administering necessary medical treatment to a patient, pending the appointment of a guardian: see M. Barkin, "Substitute Consent to Health Care: Patients' Rights vs Responsibility to Provide Care" (1988) 4 Health Law in Canada 87 at 88; L.E. Rozovsky & F.A. Rozovsky, *The Canadian Law of Consent to Treatment* (1990, Toronto: Butterworths) at 41.

traumatic for all concerned, and the absence of any real alternative is inconsistent with the underlying philosophy of the Act, namely, guardianship as a last resort.

The primary motivation underlying many guardianship applications is the need to have someone with legal authority to make health care decisions on behalf of the dependent adult.[53] Were it not for the absence of substitute decision-making legislation, many of these applications would not be necessary. Just as the enduring power of attorney legislation will likely reduce significantly the number of trusteeship applications, we believe that substitute decision-making legislation with respect to health care would have a similar effect on guardianship applications.

In conclusion, in our view there is a need to reform the law relating to health care decision-making and mental incapacity. The goal should be to design a model of substitute decision-making which will provide clarification and certainty for health care professionals, and also promote autonomy and self-determination for individuals who are no longer mentally capable of making health care decisions personally.

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[53] We are grateful to the former Public Guardian of Alberta, Ms. Melane Hotz, for providing this information.

CHAPTER 4 — OPTIONS FOR REFORM

A. Introduction

This Chapter examines four possible options for reform: professional judgment, nearest relative, living wills, and powers of attorney for health care. The key aspects of each option are outlined, along with the advantages and problems associated with it.

B. Professional Judgment

This option can be summed up in simple terms: the decision is left entirely in the hands of the attending physician. In essence this is the approach adopted by the House of Lords in *Re F.*[54]—if the patient is mentally incapable of consenting to treatment, the physician is free to administer (without anyone's consent) whatever treatment he or she reasonably believes to be in the patient's best interests. The decision is left solely to the professional judgment and discretion of the attending physician, subject only to the requirement that the physician act reasonably in deciding what is in the patient's best interests.[55]

This approach has attracted considerable criticism. For example, one writer describes *Re F.* as "medical paternalism run amok",[56] while another questions whether "it is fair to expect doctors to shoulder such responsibility".[57] Even the Law Reform Commission of Canada, which expressed support for this approach in the context of discontinuing life-sustaining treatment, recognized that many

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[54] *Supra,* note 21.

[55] This approach also underlies the *Dependent Adults Act,* s. 20.1, discussed *supra,* Chapter 2.

[56] M.A. Jones, "Justifying Medical Treatment Without Consent" (1989) 5 Professional Negligence 178 at 181.

[57] M.J. Gunn, "Treatment and Mental Handicap" (1987) 16 Anglo-American Law Review 242 at 263-64. For other criticism see P. Fennel, "Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder" (1990) 17 Journal of Law and Society at 29. But *contra* Skegg, *supra,* note 27 at 105; P.D.G. Skegg, "A Justification for Medical Procedures Performed Without Consent" (1974) 90 Law Quarterly Review 512 at 519.

people are vehemently opposed to it as being tantamount to "allowing doctors to play God".[58]

Professor Solnick highlights two other concerns with the professional judgment approach.[59] First, he states that physicians tend to have a bias in favour of treatment, which may not coincide with what the patient would have chosen if mentally competent. Second, there is a potential conflict of interest, because the physician who is to act as substitute decision-maker may also be the one who decides whether or not the patient is competent. Thus, if the patient refuses consent to treatment which the physician considers to be in the patient's best interests, there is a danger that this refusal will be viewed by the physician as evidence of mental incapacity, with the physician then having authority (as proxy) to carry out the treatment which the patient has declined.[60]

In terms of the factors which we have identified as underlying the need for reform, it is clear that the professional judgment model can only be, at best, a partial solution. It provides certainty in filling the present legal vacuum with respect to substitute decision-making. However, it does nothing to address our second major concern, namely, the need to promote the patient's autonomy and self-determination in respect of health care decisions after incapacity. The professional judgment model does not enable individuals to decide who will make health care decisions on their behalf, nor does it assist them in exercising any control over how these decisions will be made.

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[58] Law Reform Commission of Canada, *supra*, note 28 at 62. See also the Commission's final report, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Report No. 20, 1983) at 25-27.

[59] P.B. Solnick, "Proxy Consent for Incompetent Non-Terminally Ill Adult Patients" (1985) 6 Journal of Legal Medicine 1.

[60] This concern was also expressed by the English Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper No. 119, 1991) at 43. See also Kennedy, *supra*, note 27 at 337; S.V. McCrary & A.T. Walman, "Procedural Paternalism in Competency Determination" (1990) 18 Law, Medicine & Health Care 108.

C. Nearest Relative

(1) Definition

This approach involves a statutory list of relatives in descending order of proximity to the patient; for example, spouse, then adult children, then parents, then siblings, etc. If the patient is mentally incapable of making a treatment decision, the relative highest on the list (the "nearest relative") has legal authority to provide or withhold consent on the patient's behalf. If that relative is unable or unwilling to make the decision, authority to do so then passes to the next person on the list.

The nearest relative approach has been adopted in several parts of the United States[61] and also in a few Canadian provinces.[62] In addition, it is a very common feature of mental health legislation in Canada, including Alberta. The *Mental Health Act*[63] of Alberta provides that, if a formal psychiatric patient[64] is mentally incapable of making treatment decisions and has no guardian, those decisions may be made by the patient's nearest relative, defined as the first adult person on the following list:[65]

spouse;
son or daughter;
father or mother;
brother or sister;

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[61] See Fowler, *supra*, note 37 at 993; B. Vignery, "Legislative Trends in Nonjudicial Surrogate Health Care Decision Making" (1989) 23 Clearinghouse Review 422 at 424.

[62] See e.g. *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 54(2); *Quebec Civil Code*, art. 15 [re-en. 1990, Bill No. 125]; Ont. Reg. 518/88, s. 25(1)(c) [made pursuant to the *Public Hospitals Act*, R.S.O. 1980, c. 410]; R.R.P.E.I. 1981, c. H-11, s. 48 [made pursuant to the *Hospitals Act*, R.S.P.E.I. 1988, c. H-11]; Sask. Reg. 331/79, s. 55(1) [made pursuant to the *Hospital Standards Act*, R.S.S. 1978, c. H-10]. The validity of the Regulations in Ontario, P.E.I. and Saskatchewan is questionable in light of dicta in *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388 at 406.

[63] S.A. 1988, c. M-13.1, s. 28(1) [proclaimed in force January 1, 1990].

[64] That is, a person who has been committed under the *Mental Health Act* to a psychiatric facility as an involuntary patient.

[65] *Mental Health Act*, s. (1)(h)(i).

grandfather or grandmother;
grandson or granddaughter;
uncle or aunt;
nephew or niece.

The *Mental Health Act* also stipulates certain conditions which must be satisfied before the nearest relative can exercise authority as a substitute decision-maker; the relative must be apparently mentally competent, must have been in personal contact with the patient during the preceding twelve months, and must be willing to assume responsibility for making treatment decisions on behalf of the patient.[66]

(2) Justification

A number of reasons have been advanced to justify empowering the nearest relative to make health care decisions on behalf of a mentally incompetent patient.[67] First, this usually reflects what the patient would have wanted. If they had to nominate someone to make the decision, most people would choose their nearest relative.

Another justification is that the nearest relative will usually know the patient well, and will be aware of the patient's values, beliefs, and preferences. Thus, the nearest relative will likely be in the best position to make the same decision which the patient would have made if competent.

Lastly, to a large extent this model reflects what is already done in practice. As we noted earlier,[68] physicians frequently consult with the patient's immediate family and view them as having authority to decide what is to be done.

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[66] *Ibid.*, ss 28(1), 28(2).

[67] See President's Commission, *supra*, note 40 at 182-83; Dickens, *supra*, note 11 at 50; Fowler, *supra*, note 37 at 1011; L. Gostin & R.F. Weir, "Life and Death Choices After *Cruzan*: Case Law and Standards of Professional Conduct" (1991) 69 Milbank Quarterly 143 at 155-56; M. Minow, "The Role of Families in Medical Decisions" [1991] Utah Law Review 1.

[68] *Supra*, Chapter 3.

(3) Possible Objections

When it considered this issue in 1982, in the context of discontinuing life-sustaining treatment, the Law Reform Commission of Canada concluded that the nearest relative model should not be adopted.[69] It did so for two reasons. First, it felt that family members might suffer immense feelings of guilt if they had to decide to withdraw life-sustaining treatment from the patient. Second, the Commission was concerned about a possible conflict of interest; for example, the relative might be a beneficiary under the patient's will or life insurance policy, and would therefore benefit financially from the patient's death. The Commission questioned whether a family member in this situation could make an objective decision whether to continue with life-sustaining treatment for the patient.[70]

In our view this potential conflict of interest cannot in itself justify a rejection of the nearest relative approach. The same potential exists with respect to proceedings under the *Dependent Adults Act*; in most cases it is the dependent adult's nearest relative who is appointed as trustee or guardian, because the Court considers that person to be the most suitable to act in the best interests of the dependent adult.[71] Indeed, the Act expressly provides that a person is not disqualified from being appointed as guardian or trustee by reason only of being a potential beneficiary or relative of the dependent adult.[72] Were it otherwise, those with the closest relationship with the dependent adult would likely be disqualified from acting. The same holds true of health care agents. A person's beneficiaries are likely to be those with whom he or she has the closest relationship, the very same people whom the person is likely to want to appoint as a health care agent.

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[69] See the Commission's Working Paper, *supra*, note 28 at 65, and its final Report, *supra*, note 58 at 26.

[70] The same point is made by Solnick, *supra*, note 59 at 23, and by Age Concern Institute of Gerontology, *supra*, note 27 at 63.

[71] Indeed, it is well established that, all other things being equal, preference should be given to family members in appointing a trustee or guardian: see G.B. Robertson, *Mental Disability and the Law in Canada* (1987, Toronto: Carswell) at 38-39.

[72] *Dependent Adults Act*, ss 7(1.1) [en. R.S.A. 1980, c. 6 (Supp.), s. 7], 26(1.1) [en. R.S.A. 1980, c. 6 (Supp.), s. 21]. See also *Re DeMontigny* (1982), 19 Alta. L.R. (2d) 118 (Q.B.).

We also do not accept that possible feelings of guilt, and the difficulty in remaining emotionally "objective", justify a rejection of the nearest relative model. Indeed, the lack of emotional distance and the intertwining of the patient's life with that of the family members are arguably the very factors which give the family the strongest moral claim to make decisions on the patient's behalf.[73]

As a sole model, however, the nearest relative approach is deficient. First, it provides no mechanism for patients who would prefer someone other than their nearest relative to make health care decisions for them. Second, it does not enable patients to exercise any control over the content of the decision, for example by leaving instructions or guidelines to be followed by the nearest relative when making health care decisions. We shall return to these issues in Chapter 6.

D. Living Wills

(1) Introduction

As we discussed earlier,[74] a living will[75] is an advance directive which expresses the writer's preferences and instructions with respect to future medical treatment. The following is an example of a living will,[76] taken from the prescribed form in the Northern Territory of Australia:[77]

> NOTICE OF DIRECTION PURSUANT TO
> *NATURAL DEATH ACT*
>
> To: The Medical Practitioner responsible for my treatment at such time when I am suffering from a terminal illness
>
> I,........................., declare that I am of sound mind and have attained the age of 18 years AND in the event that I may suffer from a terminal illness within the meaning of the *Natural Death Act* AND

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[73] See Gostin and Weir, *supra*, note 67 at 157.

[74] *Supra*, Chapter 2.

[75] The term "living will" was first suggested by Luis Kutner in "Due Process of Euthanasia: The Living Will, a Proposal" (1969) 44 Indiana Law Journal 539.

[76] For other examples see P. Williams, *The Living Will Source Book* (1986, Oak Park, Illinois: P. Gaines Co); Murray, *supra*, note 47.

[77] *Natural Death Act 1988*, No. 51. The form is prescribed in Reg. 1989/14.

> having the desire not to be subjected to extraordinary measures, namely medical or surgical measures that prolong life, or which are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation, or to particular extraordinary measures specified below, DO HEREBY make the direction that I not be subjected to—
>
> * extraordinary measures generally
>
> * extraordinary measures, being............
> (specify particular kind of measures)[78]

(2) Legislation in Other Jurisdictions

(a) United States

The first U.S. state to enact living will legislation was California, which passed its *Natural Death Act* in 1976.[79] Since then at least forty other states and the District of Columbia have enacted living will legislation.[80] In addition, the National Conference of Commissioners on Uniform State Laws approved a uniform living will statute in 1985.[81]

No two states have exactly the same living will legislation, but there are a number of common features. Most states permit a mentally competent adult

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[78] The form then provides for the date, and signature by the person making the direction and by two witnesses over the age of 18.

[79] For a discussion of the California Act see S. Schaeffer, "Death with Dignity: Proposed Amendments to the California Natural Death Act" (1988) 25 San Diego Law Review 781.

[80] For a comparative analysis of the legislation in each state see C.J. Condie, "Comparison of the Living Will Statutes of the Fifty States" (1988) 14 Journal of Contemporary Law 105; G. Gelfand, "Living Will Statutes: The First Decade" [1987] Wisconsin Law Review 737. See also L.P. Francis, "The Evanescence of Living Wills" (1988) 14 Journal of Contemporary Law 27; S.J. Nanovic, "The Living Will: Preservation of the Right-To-Die Demands Clarity and Consistency" (1990) 95 Dickinson Law Review 209; Vignery, *supra*, note 61; Gostin & Weir, *supra*, note 67.

[81] *Uniform Rights of the Terminally Ill Act.*

to execute a living will; only six states permit a minor to execute one.[82] Usually the legislation provides that the living will must be in writing and signed by (or on behalf of) the patient and by at least two witnesses. Many states disqualify certain "interested persons" from acting as a witness to a living will,[83] and a few states require the document to be notarized by a lawyer.[84] In California a living will is automatically revoked after five years. A few other states originally adopted this provision, but have since repealed it.[85]

One of the most important features of living will legislation in the United States is that it is usually restricted to patients who are terminally ill. Almost every state provides that a living will applies only if the patient has been diagnosed as suffering from a terminal illness.[86] The definition of "terminal illness" varies from state to state. The *Uniform Act,* section 1(9) defines "terminal condition" as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." Section 1(4) of the *Uniform Act* defines "life-sustaining treatment" as "any medical procedure or intervention that . . . will serve only to prolong the process of dying."

Most states do not require physicians to carry out the instructions contained in a living will. However, if the attending physician decides not to comply with the living will, he or she must arrange for the patient to be transferred into the care of a physician who will comply with it. The legislation in every state provides that a health care professional is not subject to criminal or civil liability for withholding or withdrawing life-sustaining procedures in

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[82] Some writers have argued that living will legislation should extend to all competent individuals, regardless of age: see e.g. Condie, *supra,* note 80 at 108; V. Cocotas & F. Storm, "The Florida Living Will: Alive and Well?" (1989) 19 Stetson Law Review 175 at 193.

[83] See Condie, *supra,* note 80 at 113; Gelfand, *supra,* note 80 at 755-63; A. Meisel, *The Right to Die* (1989, New York: John Wiley & Sons) at 362.

[84] Meisel, *supra,* note 83 at 364.

[85] Gelfand, *supra,* note 80 at 765-66.

[86] Condie, *supra,* note 80 at 111-12; Gelfand, *supra,* note 80 at 740; Meisel, *supra,* note 83 at 366. Only one state (New Mexico) extends the scope of living wills beyond terminal illness and applies them to patients who are irreversibly comatose: see Francis, *supra,* note 80 at 35.

compliance with a living will. The importance of this type of provision was emphasized by the Manitoba Law Reform Commission as follows:[87]

> Obviously, if fears of civil liability for honouring an advance directive or durable power of attorney for health care are large enough that physicians fail to honour these documents, their effectiveness will be seriously reduced.

Some statutes place additional restrictions on the scope of living wills. For example, in some states a living will cannot authorize the withdrawal of artificial hydration and nutrition.[88] It is also common in the United States for the legislation to provide that a living will has no effect during any period in which the patient is pregnant, although the constitutional validity of this limitation has been questioned by several writers.[89]

(b) Australia

Two Australian states have living will legislation, namely, South Australia[90] and the Northern Territory.[91] Both statutes are modeled on their U.S. counterparts, and contain most of the features which are typical of living will legislation in the United States.

Legislation in Victoria provides that medical treatment may be withheld from a person who has clearly expressed or indicated a decision to refuse treatment, either generally or of a particular kind.[92] However, the refusal of treatment applies only to the patient's "current condition", that is, the condition

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[87] Manitoba Discussion Paper, *supra,* note 5 at 25-26.

[88] See Condie, *supra,* note 80 at 121; Gelfand, *supra,* note 80 at 799-800; S.L. Thieman, "Missouri's Living Will Statute: All Dressed Up With No Place to Go?" (1989) 57 UMKC Law Review 531.

[89] See e.g. J. MacAvoy-Snitzer, "Pregnancy Clauses in Living Will Statutes" (1987) 87 Columbia Law Review 1280; Condie, *supra,* note 80 at 112; Schaeffer, *supra,* note 79 at 800-01; Gelfand, *supra,* note 80 at 779-80.

[90] *Natural Death Act 1983,* No. 121.

[91] *Natural Death Act 1988,* No. 51.

[92] *Medical Treatment Act 1988,* No. 41, s. 5(1).

at the time of the refusal. Thus, the legislation's scope in permitting living wills, in the sense of an advance directive in respect of a future medical condition, is very limited.[93]

(3) Canadian Position

(a) Legislation

No Canadian province or territory presently has living will legislation, although legislation incorporating the living will model has recently been proposed by the Manitoba Law Reform Commission and is also currently before the Ontario legislature.[94] Previous attempts at introducing living will legislation in Ontario have proved unsuccessful.[95]

In Alberta, one member of the legislature (Dr. Walter Buck) tabled living will legislation, by way of a private member's Bill, on three occasions, in 1977, 1978, and 1979. The Bill, which was never passed, was modeled on the *Natural Death Act* of California; for example, it applied only to patients who were terminally ill, and it required the living will to be re-executed every five years.

In 1990 the Alberta Healthcare Association passed a resolution calling for the introduction of living will legislation in Alberta.[96] The Premier's

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[93] See the discussion of the Act in Law Reform Commission of Western Australia, *Report on Medical Treatment for the Dying* (Project No. 84, 1991) at 22-23 ("Western Australia Report").

[94] See *infra*, Chapter 5.

[95] A private member's Bill, modeled on the California Act, was introduced in the Ontario legislature in 1977 and received second reading, but a provincial election intervened and the Bill died: see Dickens, *supra* note 47, at 873-879. In November 1990 another private member's Bill (Bill No. 8, the *Natural Death Act*) was introduced, once again modelled on U.S. legislation. The Bill received second reading on April 11, 1991, but the Government intervened with its own proposed legislation on May 27, 1991, and the sponsor of Bill No. 8 agreed to defer further debate on the Bill: see Ontario Hansard, June 20, 1991, at 2195.

[96] See *HospitAlta*, April 1991.

Commission on Future Health Care for Albertans, in its report published in 1989, also recommended that living will legislation be introduced.[97]

(b) Current practice

Despite the absence of enabling legislation, a number of initiatives have been taken in Canada in recent years to develop the use of living wills, particularly in the context of long term care facilities. Notable examples include the "Health-Care Directive" developed at McMaster University Medical School,[98] and the "Management of Serious Worsening of Condition Form", developed by Dr. Mark Addison at the Bethany Care Centre in Calgary. Both forms focus on the "level of care" which the patient wishes to receive in a given situation.[99] For example, the Bethany form describes the following four levels of care, in the event of a serious worsening in the patient's condition:

1. **Comfort Measures Only**. This includes nursing care, relief of pain, oral fluids, and controlling fever if present.
2. **Comfort Measures with Additional Treatment Available at Bethany Care Centre**. This consists of "comfort measures" as described above, plus oral medications (most frequently, antibiotics).
3. **Transfer to an Acute Care Hospital Without CPR**. Transfer to an acute hospital is requested, and the emergency department of the hospital assesses the patient and decides whether to admit. Neither cardiopulmonary resuscitation, nor admission to an intensive care unit, is requested.
4. **Transfer to an Acute Care Hospital With CPR**. Transfer to an acute care hospital is requested with intensive care unit and CPR, if necessary.

All residents at the Bethany Care Centre are required to complete this form within approximately six weeks of their admission to the Centre. For those

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[97] Premier's Commission on Future Health Care for Albertans, *Rainbow Report* (1989) at 34.

[98] See "Doctor Recommends Wider Use of 'Living Wills'" *National (Canadian Bar Association)* (February 1991) at 4.

[99] For a similar approach in the United States see L.L. Emanuel & E.J. Emanuel, "The Medical Directive: A New Comprehensive Advance Care Document" (1990) 10 Estates & Trusts Journal 134.

residents who are mentally incompetent, the form is completed by their guardian, or family members if there is no guardian.

(4) Problems With Living Wills

(a) Interpretation

The living will concept has a number of inherent problems, the most significant of which is that it involves the individual having to anticipate what medical condition he or she may be faced with in the future, and what treatment options may be available at that time. This inevitably leads to difficulties of interpretation. One writer sums up the problem as follows:[100]

> [N]o living will—no matter how broadly or how specifically worded—can possibly anticipate the full range of difficult medical decisions to be made. Inevitably, questions of interpretation arise concerning whether an incompetent patient's actual situation conforms to the situation described in the living will.

Most standardized or prescribed forms of living will attempt to overcome the problem of anticipation by resorting to generalized and imprecise language, employing such terms as "heroic measures" and "extraordinary treatment". However, this merely exacerbates the problem, because these terms are capable of a wide range of interpretations. In the end, the attending physician may find that the living will is simply too vague and ambiguous to provide any useful guidance as to the patient's wishes.[101] Indeed, this is one of the reasons why

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[100] Fowler, *supra*, note 37 at 999. See also Solnick, *supra*, note 59 at 29-30; President's Commission, *supra*, note 40 at 157; Age Concern Institute of Gerontology, *supra*, note 27 at 61-62; C. Hackler, "Advance Directives and the Refusal of Treatment" (1989) 7 Medicine and Law 457 at 458; D.A. Peters, "Advance Medical Directives: The Case for the Durable Power of Attorney for Health Care" (1987) 8 Journal of Legal Medicine 437 at 444-46; Manitoba Discussion Paper, *supra*, note 5 at 14; Western Australia Report, *supra*, note 93 at 12.

[101] See Nanovic, *supra*, note 80 at 216-24; Manitoba Discussion Paper, *supra*, note 5 at 14.

empirical studies indicate that living wills in the United States have had only a marginal impact on clinical practice.[102]

(b) Statutory restrictions

It is important to emphasize that the scope of most living will statutes is extremely limited. They are not the panacea that some people believe them to be. Living will legislation tends to focus exclusively on the issue of withholding or withdrawing life-sustaining treatment; it does not deal with advance health care directives in general, which would enable individuals to express their preferences with respect to all forms of health care. Furthermore, as we have already noted, living will legislation in the United States is limited to cases of terminal illness.[103] In particular, the legislation does not apply to a person who is in a persistent vegetative state, as in the well known case of Karen Quinlan.[104] Ironically, this is probably the one situation which is most commonly contemplated by people who want to draw up a living will, namely, a direction to switch off the "life-support machine" in the event of their being in a persistent vegetative state.

These restrictions are not, of course, inherent in the concept of a living will. Rather, they have been imposed by the legislation in the United States, usually to achieve a political compromise,[105] and they would not have to be included in any proposed legislation in Alberta. However, it is important to understand how restrictive the U.S. living will legislation truly is when we are considering the extent to which we should view that legislation as a model which ought to be adopted in Alberta.

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[102] See J.M. Zinberg, "Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives" (1989) 13 Vermont Law Review 445. Fowler, *supra*, note 37 at 999 states that "living will legislation has been notoriously ineffective in guaranteeing patients' rights".

[103] This also has the effect of making physicians the "gate-keepers of their patients' autonomy in that they diagnose patients to be outside or within a terminal condition"—B.M. Dickens, "Decision-Making in Terminal Care: The Days of One's Life and the Life of One's Days" (1986) 51 Saskatchewan Law Review 1 at 10.

[104] *Re Quinlan*, 355 A. 2d 647 (N.J., 1976).

[105] See Gelfand, *supra*, note 80 at 746-47.

(c) Presumption in favour of treatment

Studies in the United States indicate that only a small minority (at most, 15%) of the population actually have a living will.[106] Just as many people do not have a testamentary will, because they do not like to contemplate their own death, so too the fear of mental incapacity, terminal illness and death prevents most people from preparing a living will.[107] Thus, even if living will legislation were to be introduced in Alberta, it is likely that most people would not use it.

This creates a risk that individuals who do not execute a living will may be presumed by their physician to want all available life-sustaining procedures to be initiated and maintained, even if they are therapeutically useless. This concern led the Law Reform Commission of Canada to recommend against the introduction of living will legislation in Canada.[108] Indeed, some commentators suggest that because of this problem, living will legislation in the United States has actually restricted rather than protected patients' rights, and has resulted in the provision of more rather than less health care.[109] In an attempt to address this problem, legislation in some jurisdictions expressly provides that no presumption arises from the fact that the patient has not executed a living will.

E. Attorney for Health Care

(1) Existing Legislation

This model transplants the power of attorney concept from its traditional financial context into the health care context. It enables an individual, while

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[106] W.L. Leschensky, "Constitutional Protection of the Refusal-of-Treatment" (1991) 14 Harvard Journal of Law & Public Policy 248 at 257; J.C. Fletcher & M.L. White, "Patient Self-Determination Act to Become Law: How Should Institutions Prepare?" BioLaw (January 1991) S:509.

[107] This is discussed in detail by Vance, *supra*, note 47. It is also referred to by Justice Brennan in *Cruzan v. Director, Missouri Department of Health*, 110 S. Ct. 2841 at 2875 (1990).

[108] Law Reform Commission of Canada, *supra*, note 28 at 69. The same concern is expressed by Hackler, *supra*, note 100 at 461, and by Fisher & Meslin, *supra*, note 4.

[109] See e.g. Hackler, *supra*, note 100 at 461; Fowler, *supra*, note 37 at 1000; Francis, *supra*, note 80 at 43.

competent, to appoint an attorney who will have authority to make health care decisions on the donor's behalf once the donor becomes mentally incapable of making these decisions personally. As we discussed earlier,[110] such an appointment is ineffective under current Alberta law.

Legislation providing for the appointment of a health care attorney exists in two Canadian provinces, namely, Nova Scotia and Quebec.[111] The Nova Scotia statute was enacted in 1988,[112] and it provides that a person who has attained the age of majority may authorize another adult person to give consent or directions respecting medical treatment.[113] The authorization must be in writing, signed by the person giving it, and witnessed by someone other than the attorney or his or his spouse.[114] In Quebec, the authority of the attorney is not limited to health care; it extends to "the performance of acts intended to ensure the personal protection of the [donor] as well as his physical and moral well-being".[115]

The power of attorney model, either limited to health care or extended to all personal care decisions, has also been adopted in New Zealand[116] and in two Australian states, namely, Victoria[117] and the Australian Capital Territory.[118]

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[110] *Supra*, Chapter 2.

[111] It is also an integral part of the proposed legislation in Ontario and Manitoba, discussed *infra*, Chapter 5.

[112] *Medical Consent Act*, S.N.S. 1988, c. 14 [now R.S.N.S. 1989, c. 279].

[113] *Ibid.*, s. 3(1).

[114] *Ibid.*, s. 3(2). On third reading of the Bill in the Nova Scotia legislature the official opposition indicated that it would not support the Bill, because though well intentioned it was "poorly drafted" and would probably be challenged successfully in the courts: see Nova Scotia Hansard, May 24, 1988, at 3948.

[115] *Quebec Civil Code*, art. 2118 [en. Bill 125, 1990].

[116] *Protection of Personal and Property Rights Act 1988*, No. 4. For a discussion of the New Zealand Act see W.R. Atkin, "Enduring Powers of Attorney in New Zealand" [1988] New Zealand Law Journal 368.

[117] *Medical Treatment (Enduring Power of Attorney) Act 1990*, No. 7.

[118] *Powers of Attorney (Amendment) Act 1989*, No. 15. This statute was based upon the recommendations of the Australian Law Reform Commission,

(continued...)

It is also becoming increasingly common in the United States.[119] As one American writer notes:[120]

> Beginning in the 1970s, the first wave of legislative activity focused on living will laws. In recent years, durable power of attorney or proxy laws have emerged as a second generation of laws, along with statutes that authorize surrogate decisions in the absence of a prior designation. In 1990 alone, fifteen states passed laws allowing individuals to delegate authority for treatment decisions.

Although the concept of a power of attorney for health care is attracting growing support among U.S. legislatures, there is no overall consensus as to the specific provisions which legislation in this area ought to be contain. In particular, the procedure for appointment, the formalities of execution, and the scope of the attorney's authority vary considerably from state to state, reflecting what has been described as a "haphazard approach" to the problem.[121]

(2) Advantages and Problems

This model has the same advantages which are associated with the enduring power of attorney for financial matters. In particular, it promotes individual autonomy and dignity by giving people control over their life after

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[118](...continued)
Enduring Powers of Attorney (Report No. 47, 1988). The Law Reform Commission of Western Australia has also recommended the introduction of enduring powers of attorney for health care: see Western Australia Report, *supra*, note 93.

[119] For a detailed discussion of the U.S. legislation see American College of Probate Counsel, "Report of the State Laws Committee on the Use of Durable Powers of Attorney for Health Care Decisions" (1989) 15 Probate Notes 89. See also Fowler, *supra*, note 37; Vignery, *supra*, note 61.

[120] T.E. Miller, "Public Policy in the Wake of *Cruzan*: A Case Study of New York's Health Care Proxy Law" (1990) 18 Law, Medicine & Health Care 360 at 361.

[121] American College of Probate Counsel, *supra*, note 119 at 89.

incapacity,[122] in the sense of being able to choose who will make health care decisions on their behalf once they are no longer capable of doing so themselves. In addition, it provides a real alternative to guardianship, and thus gives meaning to the underlying philosophy of the *Dependent Adults Act*, namely, guardianship as a last resort.

The health care attorney model also has several advantages over the statutory nearest relative approach. First, it promotes discussion of life and death issues among family members, since the donor is likely to discuss these matters with the attorney at the time of the appointment. As a result, when the time comes to make a health care decision on the donor's behalf, the attorney may well be a strong position to know what the donor would have wanted in this particular situation.[123] Second, the attorney model offers the individual greater freedom of choice. As we have noted already, the nearest relative approach approximates the wishes of most people; however, it does not accommodate those who would prefer someone other than their nearest relative to make health care decisions on their behalf.[124] By enabling the individual to appoint whomever he or she chooses to make these decisions, the power of attorney approach secures the greatest degree of autonomy and flexibility.

The appointment of a health care attorney also avoids many of the difficulties inherent in the living will approach, especially the problem of anticipation and interpretation.[125] Rather than trying to make health care decisions in advance, based on insufficient information and (to a large extent) speculation, the individual decides whom he or she trusts sufficiently to act as a proxy in relation to future health care decisions. Thus, unlike the living will situation, when the time arrives to make treatment decisions there is someone with whom the attending physician can discuss the patient's condition and prognosis, as well as the treatment options available, with a view to obtaining informed consent. As Fowler states:[126]

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[122] See our Report for Discussion, *supra*, note 1 especially at 21.

[123] See Fowler, *supra*, note 37 at 1002.

[124] See Solnick, *supra*, note 59 at 22.

[125] See Fowler, *supra*, note 37 at 1001; Peters, *supra*, note 100 at 451; Miller, *supra*, note 120 at 362; Manitoba Discussion Paper, *supra*, note 5 at 17.

[126] *Supra*, note 37 at 1005. See also Miller, *supra*, note 120 at 362.

> Although an agent's informed consent is an imperfect substitute for the patient's own informed consent, at least the resulting decision is based on factual information about a specific, known medical condition, rather than a layman's abstract speculation about the treatment of future ailments.

The main drawback to the health care attorney approach stems from the fact that it will be underused. We have already noted that most people do not have a living will, even in those parts of the United States which have living will legislation. This is also true of the power of attorney for health care.[127] A reluctance to contemplate one's own loss of capacity and ultimately one's own death, combined with apathy and in some cases denial,[128] results in the power of attorney for health care being used by only a minority of the population. Thus, there is a need for a statutory default provision, to provide for substitute decision-making on behalf of patients who have no guardian or health care attorney.

(3) Attorney for Personal Care

Legislation in some jurisdictions permits the appointment of an attorney whose authority extends not only to matters of health care but also to personal care decisions affecting the donor. For example, in the Australian Capital Territory an enduring power of attorney may authorize the attorney to make decisions on behalf of the donor "in relation to the donor's day-to-day affairs other than those relating to the management of the donor's property and money".[129] Likewise, in New Zealand an attorney has authority to act in relation to the donor's personal care and welfare, either generally or in relation to specific matters.[130]

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[127] See in particular Vance, *supra*, note 47.

[128] Denial is often a feature of the early stages of intellectual impairment associated with conditions such as dementia of the Alzheimer's type: see A.J. Rosoff & G.L. Gottlieb, "Preserving Personal Autonomy for the Elderly: Competency, Guardianship, and Alzheimer's Disease" (1987) 8 Journal of Legal Medicine 1 at 40-41.

[129] *Powers of Attorney (Amendment) Act 1989*, No. 15, s. 5.

[130] *Protection of Personal and Property Rights Act 1988*, No. 4, s. 98. Ss 18(1) and 98(4) of the Act expressly withhold certain powers from the personal attorney, including the power to make decisions relating to

(continued...)

In Canada, the Quebec *Civil Code* makes provision for the appointment of an attorney for personal care,[131] as does the legislation presently before the Ontario legislature.[132] The latter was based on the report of the Fram Committee, which recommended the introduction of powers of attorney for personal care to enable individuals to "make total preparations for their incapacity".[133]

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[130] (...continued)
marriage, divorce, and adoption, as well as certain medical treatment decisions.

[131] *Quebec Civil Code*, art. 2118 [en. Bill 125, 1990]. See also arts 2154-2162.

[132] *Substitute Decisions Act 1991* (Bill 108). This is discussed *infra*, Chapter 5.

[133] Ontario Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (Fram Committee), *Final Report* (1987) at 137.

CHAPTER 5 — THE PROPOSALS IN ONTARIO AND MANITOBA

A. Introduction

As we have already noted, legislation in this area is currently before the Ontario legislature and has recently been proposed by the Manitoba Law Reform Commission. The importance of these two initiatives justifies examining them in some detail. As will become apparent, the two proposals share many key features, and their basic approach to the issue of mental incapacity and substitute health care decision-making is the same.

B. Ontario

(1) Attorney for Personal Care

The *Substitute Decisions Act 1991* (Bill 108) represents a complete revamping of Ontario's legislation relating to substitute decision-making and vulnerable adults. The Bill, which is based on the recommendations of the Fram Committee in 1987,[134] repeals the *Mental Incompetency Act*[135] and provides an entirely new system of guardianship of property and the person. The Bill received second reading on June 20, 1991, and is presently at the committee stage.

One of the most significant aspects of Bill 108 relates to the appointment of an attorney for personal care. The Bill provides that a person aged sixteen or older may grant a power of attorney for personal care.[136] The attorney must also be at least sixteen years old.[137] The power of attorney must be executed in the presence of two witnesses, neither of whom must be related to the donor or to the attorney, and must be accompanied by a written statement

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[134] *Supra*, note 133.

[135] R.S.O. 1980, c. 264.

[136] Bill 108, ss 44, 47(1). A private member's Bill authorizing the appointment of an attorney for health care was introduced on November 29, 1990 (Private Member's Bill No. 7) but the sponsor of the Bill agreed to defer further debate when the Government introduced Bill 108: see *Ontario Hansard* (20 June 1991) at 2195.

[137] Bill 108, s. 45.

from the witnesses that they have no reason to believe that the donor is incapable of giving a power of attorney for personal care.[138]

The power of attorney for personal care has no effect unless it is validated in accordance with the Act.[139] Validation requires an application by the attorney to the Public Guardian and Trustee, accompanied by a guardianship plan. The Public Guardian and Trustee can request an advocate to meet with the grantor.[140] The grantor is then assessed by the persons named in the power of attorney as assessors (or failing them, by a physician and an assessor) to determine if the grantor is "incapable of personal care".[141] If the Public Guardian and Trustee refuses to validate the power, the matter must be referred to the court for determination.

(2) Substitute Decision-Making

In conjunction with Bill 108, the *Consent to Treatment Act 1991* (Bill 109) provides a system of substitute health care decision-making on behalf of patients who lack the mental capacity to make these decisions personally.[142] Bill 109 defines "capacity" with respect to treatment as being the capacity to understand the information that is relevant to making a decision concerning the treatment and to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[143]

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[138] *Ibid.*, ss 10(2), 48.

[139] *Ibid.*, s. 47(9). For criticism of this see *Ontario Hansard* (20 June 1991) at 2199.

[140] The "advocate" is part of the system of advocacy services for vulnerable persons established by the *Advocacy Act 1991* (Bill 74), which received second reading on June 10, 1991.

[141] S. 46 of Bill 108 provides that a person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

[142] Bill 109 received second reading on June 20, 1991 and is presently at the committee stage.

[143] Bill 109, s. 6(1). This is consistent with the accepted test of capacity to consent to health care: see S.A. Kline, "Mental Competency to Make (continued...)

Bill 109 contains a list of substitute decision-makers[144] and provides that, if the patient lacks capacity, the first person on the list who meets certain requirements[145] has authority to make health care decisions on the patient's behalf. If that person is unavailable or is unwilling to assume responsibility for making the decision, proxy authority then passes to the next person on the list.[146] The prescribed list is as follows:

Guardian
Attorney for personal care
Representative appointed by the Board
Spouse or partner[147]
Child
Parent
Brother or sister
Any other relative
Public Guardian and Trustee

The "representative appointed by the Board" refers to the procedure contained in Bill 109[148] which provides that a person who is incapable with respect to treatment may apply to the Consent and Capacity Review Board to have a representative appointed to make treatment decision on his or her behalf. The proposed representative may also make the application.

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[143](...continued)
Medical Decisions" (1991) 11 Health Law in Canada 70; M. Silberfeld, "The Mentally Incompetent Patient: A Perspective from the Competency Clinic" (1990) 11 Health Law in Canada 33; Robertson, *supra*, note 71 at 408; *Institut Philippe Pinel De Montreal v. Dion* (1983), 2 D.L.R. (4th) 234 (Que. Super. Ct.); *Mental Health Act*, S.A. 1988, c. M-13.1, s. 26 [proclaimed in force January 1, 1990].

[144] Bill 109, s. 16.

[145] The proxy must be at least 16 years of age, must be mentally capable of making treatment decisions, and must have been in personal contact with the patient over the preceding 12 months: Bill 109, ss 16(3), 17.

[146] *Ibid.*, s. 16(5). S. 16(7) defines "available" as meaning that it is possible for the health care practitioner, within a time that is reasonable in the circumstances, to communicate with the person to obtain a consent or refusal of consent.

[147] "Partner" is defined in s. 1(2) in such a way as to include persons of the same sex.

[148] S. 27.

If two or more persons referred to in the same paragraph of the above list (for example, two parents) disagree on a particular treatment decision, the decision is made by the Public Guardian and Trustee.[149]

It can be seen from the above list that Bill 109 combines both the nearest relative approach and the attorney for health care approach; the nearest relative becomes the proxy, unless the patient has appointed an attorney or has a guardian. However, Bill 109 also incorporates the "living will" model by enabling the patient, while competent, to exercise control over the content of a decision taken by the proxy. The Bill provides that a proxy (whether it be a guardian, an attorney, a relative, or the Public Guardian and Trustee) must comply with the following criteria when making a health care decision on behalf of the patient:[150]

1. If the patient has a power of attorney for personal care which contains instructions as to treatment, these instructions *must* be followed, except as set out in paragraph (3) below.

2. If the proxy does not know of any such instructions, he or she must act in accordance with any wishes applicable to the circumstances that the proxy knows the patient expressed (orally or in writing) when mentally capable and which the proxy believes the patient would still act on if capable.

3. If these expressed wishes are more recent than the instructions contained in a power of attorney for personal care, these wishes must be followed.[151]

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[149] *Ibid.*, s. 16(8). This contrasts with Alberta's *Mental Health Act*, s. 1(h)(i), which prefers the elder over the younger.

[150] Bill 109, s. 14.

[151] The requirement that the proxy follow any instructions or wishes expressed by the patient while mentally capable is subject to one exception. S. 29 provides that the proxy can apply to the Consent and Capacity Review Board for permission to depart from instructions or wishes expressed by the patient. Before it can grant such an order, the Board must be satisfied that the patient would probably, if capable, consent to the treatment because the likely result of the treatment is significantly better than would have been the result of treatment that was available in comparable circumstances at the time the instructions or wishes were expressed by the patient.

4. If the proxy does not know of any instructions or wishes, he or she must act in the patient's best interests, having regard to:

a. the values and beliefs that the proxy knows the patient held when capable and believes would still act on if capable;

b. the patient's current wishes, if they can be ascertained; and

c. a list of factors relating to the proposed treatment,[152] specifically, whether the patient's condition or well-being is likely to improve with or without the treatment, whether the benefits outweigh the risk of harm, and whether the treatment is the least restrictive beneficial alternative.

(3) Procedural Safeguards

Bill 109 contains a wide range of procedural safeguards aimed at protecting the patient from an incorrect assessment of incapacity. In triggering the substitute decision-making provisions, a finding of incapacity has the effect of depriving the patient of the fundamental legal right to make his or her own health care decisions. Thus, Bill 109 seeks to ensure that the patient not only has the right to challenge an assessment of incapacity but also is made aware of the existence of that right.

The Bill establishes the Consent and Capacity Review Board, to which the patient may appeal a finding of incapacity.[153] The Board must give written reasons for its decision, and a further appeal lies from the Board to the courts.[154]

If a health practitioner determines that a patient is not capable of making treatment decisions, the practitioner must (1) advise the patient of this determination, unless the patient is unconscious, (2) inform the patient in writing of the right to apply to the Board to have the determination of incapacity reviewed, and (3) notify an advocate.[155]

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[152] For a similar list of factors see Alberta's *Mental Health Act*, s. 29(3).

[153] Bill 109, s. 36(3).

[154] *Ibid.*, s. 41.

[155] *Ibid.*, s. 10(1). For the meaning of "advocate" see *supra*, note 140.

Unless the patient is unconscious, an advocate must meet with the patient promptly after the finding of incapacity, and explain to the patient the effect of that finding and the right to apply to the Board to have the finding reviewed.[156] If so requested, the advocate must assist the patient in applying to the Board and in obtaining legal services.[157]

No medical treatment can be given (except in an emergency) until the health care practitioner is advised by the advocate that the patient has been informed of the right of appeal and has not indicated a desire to exercise that right, or (if the patient does appeal) until the Board makes its decision.[158]

These procedural safeguards were the subject of criticism during the Bill's second reading in the Ontario legislature. Referring to the Bill as a "nightmare to implement", one member criticized it as having "gone too far in terms of trying to protect the incompetent patient".[159]

C. Manitoba

In many respects the recommendations of the Manitoba Law Reform Commission[160] are similar to the proposed legislation in Ontario. The Manitoba Report recommended the creation of a "health care directive", in which individuals would be able to express their wishes with respect to future health care and to appoint a proxy to make health care decisions on their behalf. The health care directive would take effect when the person lost the capacity to make and communicate health care decisions, and would remain effective for the duration of that incapacity.

With respect to the formalities of a health care directive, the Manitoba Report recommended that these be kept as simple as possible, with a requirement that the directive be in writing and be signed by or on behalf of the maker. There

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[156] Bill 109, s. 10(2).

[157] *Ibid.*, s. 10(5).

[158] *Ibid.*, ss 10(6), 22. These provisions do not apply if the patient has a guardian or an attorney for personal care under a power of attorney that has been validated under Bill 108: Bill 109, s. 12.

[159] See *Ontario Hansard* (20 June 1991) at 2198.

[160] Manitoba Report, *supra*, note 5.

would be no requirement that it be witnessed. The person executing a health care directive would have to be mentally capable of making health care decisions. The Report recommended that there be a rebuttable presumption that a person aged sixteen or older has the capacity to execute a health care directive and that a person under that age lacks this capacity. If the directive were to appoint a proxy decision-maker, the proxy would have to be an adult and would have to consent in writing to being appointed.

If the health care directive expressed a wish which was both unambiguous and relevant to the health care decision in question, it would be binding. The proxy would not be called upon to make a decision in these circumstances: the physician would simply follow the instructions contained in the directive. If there were no instructions, or if the instructions were irrelevant or unclear, the proxy would have sole authority to make the decision. The proxy would have to make the decision in accordance with his or her interpretation of the patient's wishes. If the proxy did not know of any such wishes, the decision would be made in accordance with what the proxy believed to be in the patient's best interests.

The Manitoba Report also recommended that the proxy's decision be reviewable by the court only if the proxy is shown to have acted in bad faith or contrary to the known wishes of the patient. If this were established, the court could rescind the proxy's decision and revoke the proxy's appointment.

According to the Report, the instructions in the health care directive (if relevant and unambiguous, failing which the proxy's decision) should be as effective as the patient's own decision would have been if the patient had been mentally competent. This has two consequences. First, it means that the health care directive cannot authorize anything which the patient could not lawfully consent to if competent (for example, active euthanasia). Second, if the health care directive or the proxy's decision is ignored, the legal result is the same as if a competent patient's decision had been ignored. Thus, treatment performed against the proxy's wishes or contrary to the unambiguous wishes expressed in the health care directive would constitute a battery.

The Manitoba Law Reform Commission did not deal with the question of whether there should be a statutory list of proxy decision-makers (including nearest relatives), but the Commission indicated that it may consider this issue at a later date.[161] However, in recommending that individuals should be free to appoint their own health care proxy, and that any unambiguous and relevant instructions given by the patient while competent with respect to future treatment should be binding on the attending physician, the Manitoba Report adopts a position very similar to that taken in the proposed Ontario legislation.

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[161] *Ibid.* at 1.

CHAPTER 6 — THE INSTITUTE'S RECOMMENDATIONS

A. Our Basic Position

In Chapter 4 we examined four possible models for reform. None of these offers a sufficient response to the problem. In our view the best approach is to combine various aspects of each model, in a way which is similar (though not identical) to the proposed legislation in Ontario and Manitoba.

The scheme which we propose will enable individuals to appoint someone as their health care agent, to make health care decisions on their behalf in the event of their becoming mentally incapable of making these decisions personally. In addition, we propose that if a health care agent has not been appointed, the patient's nearest relative should have authority to make health care decisions. Proxies (whether they be an appointed agent or a nearest relative) should be required to make health care decisions according to what they believe the patient would have decided if competent, or if this is not possible, according to what they believe to be in the patient's best interests. We also recommend that, if the patient has left written instructions which are unambiguous and relevant to the health care decision being considered, the proxy should be required to carry out these instructions.

B. Health Care Directive

(1) Appointment of a Health Care Agent

We agree with the recommendation of the Manitoba Law Reform Commission that individuals should be able to execute a health care directive. One purpose of such a directive would be to appoint an agent to make health care decisions on behalf of the principal in the event of the latter becoming incapable of making these decisions personally. We believe that the reasons which justify using the enduring power of attorney concept in a financial context apply with equal force in the health care context: it promotes individual autonomy and dignity, and provides a meaningful alternative to proceedings under the *Dependent Adults Act*.

(2) Disqualifying a Proxy

Later we recommend that there be a statutory list of health care proxies, in order to address the situation where the patient has not appointed a health care agent or where the agent is unavailable to make a decision. Thus, for example, if there is no agent, the patient's spouse or partner (failing which, the patient's children) would have authority to act as proxy. However, what if the patient has a strong objection to a particular person acting as proxy? In our view individuals should be able to name in their health care directive anyone whom they do *not* want to act as their health care proxy, and this should have the effect of disqualifying the named person from so acting.

(3) Instructions as to Future Health Care

The other purpose of a health care directive is to afford individuals an opportunity to provide instructions and information concerning their future health care. Not only will people be able to determine who will make health care decisions on their behalf (by appointing a health care agent), they will also be able to exercise some control over the content of these decisions. In this way, the autonomy of the individual is respected and protected to the greatest possible extent.

We agree with the view expressed by the Manitoba Law Reform Commission that what is needed is "an approach which is broader than that typically found in the American and Australian models."[162] We see no justification for confining advance directives to cases of terminal illness and the withdrawal or withholding of life-sustaining treatment. Just as the law now permits a Jehovah's Witness to refuse consent to a blood transfusion in advance, by means of a written "no blood" card,[163] so too it should enable individuals to exercise control over all health decisions taken on their behalf after they become incapable of making decisions personally. This is consistent with the common law position as enunciated by the Ontario Court of Appeal in *Fleming v. Reid*,[164] and we believe that this should be codified in legislation.

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[162] Manitoba Report, *supra*, note 5 at 4.

[163] *Malette v. Shulman*, *supra*, note 8 discussed *supra*, Chapter 2.

[164] *Supra*, note 8. See *supra*, notes 33-36 and accompanying text.

We prefer to offer no guidelines as to the type of instructions and information that may be contained in a health care directive. This should be left entirely to the judgment of the individual in drafting a directive. On the one hand, the directive can be used in the traditional sense of a "living will", specifying certain treatment or procedures which the individual does not wish to receive if he or she is faced with a particular condition such as terminal illness or a persistent vegetative state. We have already noted that advance directives of this nature tend to be of little use because of problems of anticipation and interpretation.[165] However, we believe that individuals should be given the opportunity to leave advance instructions of this type if they so wish. Moreover, as we discuss below, we agree with the position reflected in the Ontario and Manitoba proposals, that if the individual's advance instructions are unambiguous and relevant to the health care decision being considered, they should be legally binding and should be followed.

We anticipate that the health care directive will be used not simply as a means of giving binding instructions, but also as a source of information about the individual and his or her values and preferences, which the health care agent (or other proxy) will take into consideration when the time comes to make substitute decisions. Many writers have emphasized the value of advance directives as a source of guidance to proxy decision-makers.[166] We view this as one of the principal functions of an advance health care directive.

RECOMMENDATION 1

We recommend that legislation be introduced to enable individuals to execute a health care directive, in which they can

(1) appoint someone as their health care agent, who will have authority to make health care decisions on their behalf in the event of their becoming incapable of making these decisions personally; and/or

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[165] *Supra*, notes 100-102 and accompanying text.

[166] See e.g. N.L. Cantor, "My Annotated Living Will" (1990) 18 Law, Medicine & Health Care 114; Silberfeld, *supra*, note 143; Emanuel & Emanuel, *supra*, note 99; P. Lambert *et al.*, "The Values History: An Innovation in Surrogate Medical Decision-Making" (1990) 18 Law, Medicine & Health Care 202.

(2) identify anyone whom they do not wish to act as their health care proxy, as provided in Recommendation 8; and/or

(3) provide instructions and information concerning future health care decisions.

(4) Formalities of Execution

In our Report for Discussion on enduring powers of attorney we took the view that the formalities of execution should be kept as simple as possible.[167] In the end we recommended that an EPA be signed by (or on behalf of) the donor, incorporate a series of explanatory notes, and be accompanied by a certificate of legal advice.

In our view the formalities of execution for a health care directive should also be kept to a minimum. Indeed, we believe that they should be simpler than those we proposed for EPAs. In particular, our recommendation that EPAs contain explanatory notes and be accompanied by a certificate of legal advice was prompted by evidence from other provinces that many people sign an EPA without fully understanding what they are doing. Hence, our recommendation was aimed at ensuring that people are informed about the basic nature and effect of an EPA before signing one.[168]

We do not have the same concern about the health care directive. Its purpose and effect are much simpler and much different than those of an EPA for financial matters. We think it unlikely that any mentally competent individual who signs a health care directive, appointing a health care agent and/or providing instructions and guidance as to future health care decisions, will fail to understand the basic purpose and effect of the document. Accordingly, we do not consider it necessary or justifiable to require that a health care directive be accompanied by a certificate of legal advice or contain a series of explanatory notes. Some may take the view that it would be appropriate, at least in certain circumstances, to require a certificate from a physician stating that the person is capable of understanding the nature and effect of the directive. Our present view is that such a requirement should not be imposed, but we welcome input on this issue.

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[167] *Supra*, note 1 at 35.

[168] See in particular our Report for Discussion, *supra*, note 1 at 45-50.

In our opinion the proposed legislation should require that a health care directive be signed by its maker, or on the maker's behalf if he or she is physically incapable of signing it.[169] Unlike the Manitoba Law Reform Commission,[170] we believe that the document should be witnessed, in order to provide evidence of authenticity to third parties who rely on it, and also to minimize the risk of forgery and duress. As is discussed in our Report for Discussion on EPAs,[171] the case for two witnesses rather than one is not strong. The legislation in Nova Scotia requires that the appointment of a health care agent be witnessed by one person other than the agent and the agent's spouse.[172] We believe that the proposed legislation should do likewise.

RECOMMENDATION 2

We recommend that the proposed legislation require that, subject to Recommendation 3, a health care directive be in writing, be signed by the person making it, and be witnessed by one person other than the health care agent or the spouse of that agent.

RECOMMENDATION 3

We recommend that the proposed legislation provide that a health care directive may be signed on the maker's behalf, in the presence and under the direction of the maker, by a person other than the health care agent, a witness, or the spouse of the health care agent or witness, if the maker is physically incapable of signing it.

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[169] In our Report for Discussion, *supra*, note 1 at 37-38, we made a similar recommendation with respect to individuals who are physically incapable of signing an EPA, and this was implemented in the legislation: see *Powers of Attorney Act*, S.A. 1991, c. P-13.5, s. 2(3).

[170] Manitoba Report, *supra*, note 5 at 12-13.

[171] *Supra*, note 1 at 41.

[172] *Medical Consent Act*, R.S.N.S. 1989, c. 279, s. 3(2).

(5) Capacity and Age

(a) Mental capacity

What mental capacity should a person have in order to execute a health care directive? One option is to require that the person have the capacity to make health care decisions. That option is favoured by the Manitoba Law Reform Commission.[173] However, there are two problems with this. First, a person may have capacity to make some health care decisions but not others.[174] Capacity is a functional, task-specific concept, and it must be assessed with reference to the particular health care decision in issue rather than to health care decisions in general. Second, in order to have capacity to execute an enduring power of attorney, the donor need only be able to understand the nature and effect of the document; the donor does not have to able to understand the nature and effect of the acts which the attorney is authorized to perform.[175] In our view it would be inconsistent with this principle to require individuals to be capable of making health care decisions in order to appoint a health care agent. So long as they are capable of understanding that they are authorizing someone else to make these decisions for them, they have sufficient capacity to appoint an agent.

Capacity for the present purposes should be defined as the capacity to understand the nature and effect of the advance directive. We view this are more consistent with established legal principles and easier to apply in practice.

(b) Age

What should be the minimum age at which a person may appoint a health care agent? The proposed legislation in Ontario, adopting the recommendation of the Fram Committee,[176] sets the minimum age at sixteen.[177] The Manitoba

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[173] Manitoba Report, *supra,* note 5 at 13-14.

[174] See Robertson, *supra,* note 71 at 407-08.

[175] *Re K.,* [1988] 2 W.L.R. 781 (Ct. of Protection); *Godelie v. Public Trustee* (1990), 39 E.T.R. 40 (Ont. Dist. Ct.); *McCardell's Estate v. Cushman (No. 2)* (1989), 107 A.R. 161 at 175 (Q.B.); *Powers of Attorney Act,* S.A. 1991, c. P-13.5, s. 3.

[176] *Supra,* note 133 at 134.

Law Reform Commission recommended that there be a rebuttable presumption that a person aged sixteen or older has the capacity, and those under that age lack the capacity, to execute a health care directive.[178] The Commission pointed out that a minimum age of eighteen would exclude minors even if they were capable of consenting to health care.[179] Eighteen is the minimum age prescribed in the legislation in Nova Scotia,[180] as well as in Alberta's legislation governing enduring powers of attorney for financial matters.[181]

We agree that a minimum age of eighteen would mean that some minors who were capable of consenting to health care would nevertheless be unable to appoint a health care agent. Under present Alberta law there is no set age at which a person becomes capable of consenting to health care; the test is whether the individual can understand the nature and effect of the proposed treatment.[182] However, we believe that the Manitoba Law Reform Commission's suggestion of a rebuttable presumption, focusing on the age of sixteen, would create too much uncertainty. In our view the proposed legislation should adopt the same position as that governing EPAs and provide that the minimum age for executing a health care directive is eighteen.

RECOMMENDATION 4

We recommend that the proposed legislation provide that, in order to execute a health care directive, a person must be at least eighteen years of age and must be capable of understanding the nature and effect of the directive.

(6) Qualifications of the Agent

Under our proposals for substitute decision-making discussed below, a health care agent would be part of a statutory list of proxy decision-makers

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[177](...continued)

[177] Bill 108, ss 44, 47(1).

[178] Manitoba Report, *supra,* note 5 at 14.

[179] *Ibid.* at 13. See also Manitoba Discussion Paper, *supra,* note 5 at 27.

[180] *Medical Consent Act,* R.S.N.S. 1989, c. 279, s. 3(1).

[181] *Powers of Attorney Act,* S.A. 1991, c. P-13.5, s. 2(1)(a).

[182] See *supra,* note 10.

(second only to a guardian appointed under the *Dependent Adults Act*). Certain conditions would have to be satisfied before a person on that list could act as a health care proxy. For example, the proxy would have to be an adult and be apparently mentally capable of making the health care decision in question.

Because of these conditions, it is unnecessary to prescribe specific requirements which a person must meet (for example, age, mental capacity, etc.) in order to be appointed as a health care agent. Thus, for example, the appointment of a sixteen year old would not *per se* be invalid, but that person would not have authority to act as a health care proxy until he or she reached the age of majority.

Some jurisdictions in the United States disqualify certain individuals from being appointed as a health care agent; for example, the attending physician or the operator and employees of a community care facility.[183] We discussed the question of disqualification in the context of enduring powers of attorney and concluded that individuals or groups ought not to be singled out as being unsuitable to act as an attorney.[184] Ultimately that is a matter for the donor to decide. We tend to the same view with respect to the appointment of a health care agent, but once again this is an issue on which we seek input.

RECOMMENDATION 5

We recommend that the proposed legislation should not disqualify any particular individual or group from being appointed as a health care agent.

(7) Relationship with Existing EPA Legislation

In many respects the appointment of a health care agent under our proposed health care directive is similar to the appointment of an attorney for financial matters under an enduring power of attorney. In each case an agent is authorized to make certain decisions in the event of the principal's incapacity. However, although the two situations are similar, we do not believe that the

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[183] See S.R. Martyn & L.B. Jacobs, "Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney" (1984) 63 Nebraska Law Review 779 at 798; American College of Probate Counsel, *supra*, note 119 at 91.

[184] See Report for Discussion, *supra*, note 1 at 60-62.

proposed legislation should seek to create a perfect identity between the two. Thus, for example, we have already recommended that the formalities of execution which apply to EPAs (in particular, the certificate of legal advice) should not apply to health care directives.

We do not foresee any significant problems or inconvenience arising in practice from our decision to treat the two documents differently. Under our proposals it will be possible for individuals, if they so choose, to execute an EPA for financial matters and appoint a health care agent in the same document. However, we think that this will be uncommon. Most people will probably want to have separate documents, particularly since they may wish to have the health care directive, but not the EPA, placed on their medical chart (for example, if they are admitted to a nursing home). Thus, although the EPA for financial matters and the health care directive can be viewed as part of the same overall "scheme", that is, planning for one's own incapacity, in our opinion it is preferable to regard the two documents as separate entities.

(8) Termination

(a) Revocation

When should the appointment of a health care agent terminate? Perhaps the most obvious answer is when it is revoked by the principal. However, this leads to the difficult question of whether revocation should be effective if the principal lacks the capacity to understand its nature and effect. For example, Alberta's enduring power of attorney legislation provides that an EPA terminates if it is revoked in writing by the donor "at a time when the donor is mentally capable of understanding the nature and effect of the revocation".[185] The proposed legislation in both Ontario[186] and Manitoba[187] also provides that the principal must have mental capacity in order to revoke the appointment.

However, some writers and law reform agencies have taken the view that the revocation of a health care agent's appointment should be effective even if the

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[185] *Powers of Attorney Act*, S.A. 1991, c. P-13.5, s. 13(1)(a).

[186] Bill 108, ss 48(3), 51(2).

[187] Manitoba Report, *supra*, note 5 at 16.

principal is mentally incompetent at the date of the revocation,[188] and legislation in many U.S. states provides for this.[189] We disagree. We find compelling the view expressed in the report of the U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,[190] that "allowing revocations by an incompetent patient could wreak havoc on a course of treatment authorized by the proxy". For that reason we recommend that revocation be valid only if the principal is mentally capable of understanding its nature and effect. However, we believe that there should not be any required formalities for revocation; the individual should be able to revoke the appointment verbally, or in writing, or by destroying the health care directive.

Some jurisdictions provide for automatic revocation after a specified period of time. For example, the legislation in California provides that a power of attorney for health care automatically terminates after seven years.[191] We rejected this type of limitation in the context of EPAs for financial matters,[192] and for the same reasons we do so again in the present context.

(b) Divorce

If a person appoints his or her spouse as a health care agent and the couple is subsequently divorced, should the divorce terminate the agent's appointment? Some law reform agencies have taken the view that it should,[193] and we agree. It is quite possible that the individual will forget to change the health care directive after the divorce, and in these circumstances we consider that it would be inappropriate for the former spouse to act as health care agent. Thus, we

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[188] See e.g. Western Australia Report, *supra,* note 93; Fowler, *supra,* note 37 at 1023-24.

[189] See American College of Probate Counsel, *supra,* note 119 at 92.

[190] *Supra,* note 40 at 165.

[191] See American College of Probate Counsel, *supra,* note 119 at 92. The California Law Revision Commission, *Recommendations Relating to Powers of Attorney* (November 1990) recommended that this provision be repealed.

[192] See our Report for Discussion, *supra,* note 1 at 64.

[193] See e.g. Manitoba Report, *supra,* note 5 at 17; Age Concern Institute of Gerontology, *supra,* note 27 at 72.

recommend that the appointment of a health care agent should terminate on divorce, if the health care agent is the spouse of the principal.

(c) Court order

In our Report for Discussion on EPAs we expressed the view that "revocation by the court is one of the most fundamental and necessary safeguards which ought to be included in EPA legislation".[194] The same is true with respect to health care agents. It is essential that there be a mechanism for interested persons to have the court review the decisions of a health care agent and, if necessary, rescind the appointment. We recommend, therefore, that the authority of a health care agent should come to an end if a court issues an order terminating the appointment. Later we discuss what standard the court should apply in reviewing an agent's decision, and in what circumstances it should rescind the appointment.

(d) Other grounds

Earlier in this Chapter we noted that, because of the requirements which we will be recommending with respect to all health care proxies, there is no need to disqualify a person on grounds such age and mental incapacity from being appointed as a health care agent.[195] The same holds true with respect to termination of a health care agent's appointment. It is unnecessary, for example, to provide that the appointment terminates if the agent becomes mentally incompetent, since a mentally incompetent agent will not have authority under our later recommendations to make health care decisions on behalf of the principal. Accordingly, we do not propose that there be any other grounds for termination of a health care agent's appointment.

RECOMMENDATION 6

We recommend that the proposed legislation provide that the appointment of a health care agent terminates

(1) if it is revoked by the principal at a time when the principal is mentally capable of understanding the nature and effect of the revocation;

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[194] *Supra*, note 1 at 92.

[195] See *supra*, "Qualifications of the Agent".

(2) on divorce, if the health care agent is the spouse of the principal; and

(3) if a court issues an order terminating the appointment.

(9) Health Care or Personal Care?

We noted in Chapter 4 that in some jurisdictions (such as Quebec and New Zealand) the agent's authority is not limited to health care decisions but rather extends to all matters affecting the principal's personal care and well-being. Such an agent has powers which are similar to those which a court can confer on a guardian under the *Dependent Adults Act*; for example, the power to decide where and with whom the dependent adult is to live, and the power to make normal day to day decisions on behalf of the dependent adult including matters of diet and dress.[196]

Our initial view was that the proposed legislation should be similarly extended, enabling individuals to appoint an agent for personal care. This initial view was based on two main factors. First, if the Institute considers that "the case on behalf of EPAs is compelling",[197] why limit their scope to financial and health related matters? Second, decisions concerning health care may overlap with other personal care issues; for example, a health care decision may affect where the individual will reside. Thus, it may be artificial and overly restrictive to limit the agent's authority to health care decisions.

On reflection, however, we have decided for a number of reasons not to recommend that the agent's authority be extended to all personal care decisions. We have seen no evidence or indication that the absence of personal care authority is a problem in practice. By contrast, it is clear that the absence of health care decision-making authority *is* a significant problem. We believe that our proposals should focus on what we perceive to be the real problem and the real need for reform, namely, a system of substitute decision-making *for health care*.

We are not persuaded that the potential overlap between health care and other personal care decisions is so significant as to require the health care agent

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[196] *Dependent Adults Act*, R.S.A. 1980, c. D-32, s. 10(2) [am. 1985, c. 21, s. 11].

[197] Report for Discussion, *supra*, note 1 at 25.

to have greater authority. For example, in our view health care agents (or other proxies) would have authority to consent to the individual being admitted to a hospital, or a nursing home, or an extended care facility. This would be part of their authority to make health care decisions, and although it would also involve deciding where the individual would live, we do not believe that a health care agent would lack the authority to make this decision. Nor do we think it likely that others would view the health care agent as lacking this authority.

We also foresee a risk that the proposed legislation could become overly complex if we were to recommend extending its scope to include personal care decisions. Indeed, this is one of the criticisms which can be made of Ontario's Bill 108 and its "omnibus" approach to mental incapacity and substitute decision-making. If we were to propose the creation of an agent for personal care, a whole range of additional issues would arise; for example, its relationship with existing EPA legislation, the formalities of execution, the standard of decision-making, termination, etc. In our view it is possible to deal with these issue in a meaningful way if we restrict the focus of the reform to health care and health care directives. Once the focus is extended to all personal care decisions, the issues become much more complex. Given that we are not persuaded that there would be any practical benefit in doing this, we conclude that the proposed legislation should be confined to health care decision-making.

RECOMMENDATION 7

We recommend that the proposed legislation should not make provision for advance directives for personal care.

C. Substitute Decision-Making

(1) Statutory List

As we discussed in Chapter 4, many people will not execute a health care directive.[198] Thus, there is a need to create a system of substitute decision-making for those patients who have no guardian and who have not appointed a health care agent. For the reasons which we gave in Chapter 4, we believe that this system should be based on the premise that the patient's nearest relative should have authority to make health care decisions on the patient's behalf.

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[198] See *supra*, notes 106-107 and 127-128, and accompanying text.

We propose, therefore, that there be a statutory list of proxy decision-makers, the person highest on the list being authorized to act as proxy. If the first person is unavailable, or is unable or unwilling to make a decision, proxy authority passes to the next person on the list. In our view the first person on the list should be the patient's guardian, that is, a guardian appointed under the *Dependent Adults Act* with authority to make health care decisions on behalf of the dependent adult. If the court has seen fit to appoint a guardian, and to invest that guardian with the power to make health care decisions, that should supersede the authority of all others to make health care decisions on the patient's behalf.

The second person on the statutory list would be the health care agent appointed pursuant to a health care directive. Thereafter, the list should authorize the patient's relatives in descending order of proximity to the patient, as follows: spouse or partner, children, parents, siblings, grandchildren, grandparents, uncle and aunt, nephew and niece, and then any other relative.

This statutory scheme of substitute decision-making would apply only in the case of an *adult* patient who was mentally incapable of making health care decisions. We do not propose extending the scheme to include decisions taken on behalf of minors. The common law is clear that parents have legal authority to make health care decisions on behalf of their minor child if the child lacks the mental capacity to make the decision personally.[199] We see no reason to incorporate this into the legislation, and accordingly our proposals are confined to adult patients.

(2) Default Proxy

Some patients will have no guardian, no health care agent, and no relatives. Who should have authority to make health care decisions on their behalf? One answer is the Public Guardian, an option favoured by the proposed legislation in Ontario.[200] On balance we feel that it would be more appropriate, and involve less inconvenience and delay, if the decision were left to the patient's

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[199] See *supra*, note 10.

[200] Bill 109, s. 16.

health care practitioner.[201] This approach is adopted in some U.S. states,[202] and is also consistent with existing provisions in the *Dependent Adults Act*.[203]

We do not propose, however, that the professional judgment standard favoured by the House of Lords in *Re F.*[204] be applied here. In other words, the health care practitioner should not be free to perform whatever treatment he or she believes to be in the patient's best interests. Rather, the practitioner should act as a proxy decision-maker and thus be required to follow the criteria for substitute decision-making which we discuss later in this Chapter. This would mean, for example, that the practitioner would be required to make health care decisions according to what he or she believed the patient would have decided if competent, and would be required to implement any unambiguous and relevant instructions which the patient had given while competent.

RECOMMENDATION 8

We recommend that the proposed legislation provide that if an adult person (the "patient") lacks the capacity to make a health care decision, that decision may be made on the patient's behalf by his or her health care proxy, defined as the first named person or group of persons on the following list:

(a) a guardian appointed under the *Dependent Adults Act* (or the equivalent legislation in another jurisdiction) with authority to make health care decisions on behalf of the patient;

(b) a health care agent appointed by the patient pursuant to a health care directive;

(c) the patient's spouse or partner;

(d) the patient's children;

(e) the patient's parents;

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[201] We use this term rather than "attending physician" because our proposals are intended to apply to all types of health care (including, for example, dental treatment) and not merely medical treatment.

[202] See Gelfand, *supra*, note 80 at 790.

[203] R.S.A. 1980, c. D-32, s. 20.1, discussed *supra*, Chapter 2.

[204] *Supra*, note 21, discussed *supra*, Chapter 2.

(f) the patient's siblings;

(g) the patient's grandchildren;

(h) the patient's grandparents;

(i) the patient's uncle and aunt;

(j) the patient's nephew and niece;

(k) any other relative of the patient;

(l) the patient's health care practitioner,

and that if a health care proxy is unavailable, or is unable or unwilling to make a decision, proxy authority passes to the next person or category of persons on the list.

(3) Triggering Event

We have emphasized already that a person may have capacity in one area but not in another, and may have capacity to make some health care decisions but not others. Thus, with respect to defining when the substitute decision-making provisions will be triggered, we have avoided phrases such as "mental incompetence" or even "mentally incompetent to make treatment decisions".[205] Instead, we have suggested that if a patient is mentally incapable of making a health decision, *that decision* may be taken on the patient's behalf by the health care proxy. This will accommodate patients who are capable of making some health care decisions but not others, and also patients whose mental capacity may fluctuate.

In addition, we recommend that the legislation define capacity in the same way as the proposed Ontario legislation:[206] capacity to make a health care decision means the capacity to understand the information that is relevant to making the decision and to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

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[205] This is the phrase used in the *Mental Health Act*, S.A. 1988, c. M-13.1, s. 26.

[206] Bill 109, s. 6(1). See *supra*, note 143.

RECOMMENDATION 9

We recommend that the proposed legislation provide that a person has capacity to make a health care decision if that person is capable of understanding the information that is relevant to making the decision and is capable of appreciating the reasonably foreseeable consequences of a decision or lack of decision.

(4) Qualifications of the Proxy

As we discussed in Chapter 4, Alberta's *Mental Health Act* prescribes certain conditions which must be satisfied before the nearest relative can make health care decisions on behalf of a mentally incompetent psychiatric patient. In particular, the relative must be apparently mentally competent to make treatment decisions, and must have been in personal contact with the patient during the preceding twelve months.[207] Comparable provisions are contained in the proposed Ontario legislation.[208]

In our view similar requirements should apply to health care proxies under our proposed legislation, except that the requirement of personal contact should be rephrased as personal "involvement"[209] and should not apply to a guardian, health care agent or health care practitioner acting as proxy. In addition, we believe that a proxy should be of the age of majority. While it is true that at common law a minor may have capacity to give a valid consent to treatment, this depends on the maturity of the individual involved and the complexity of the treatment which is proposed.[210] Thus, a minor may have capacity to consent to some forms of treatment but not others. In our view this would cause too much uncertainty if minors were permitted to act as proxies. The legislation in a number of jurisdictions requires health care proxies to be of the age of

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[207] *Mental Health Act*, S.A. 1988, c. M-13.1, ss 28(1), 28(2).

[208] Bill 109, ss 16, 17.

[209] Personal "contact" may imply physical contact, and thus would not include, for example, someone with whom the patient kept in close touch (regular telephone calls, letters, etc) but had not seen for 12 months.

[210] See *supra*, note 10.

majority,[211] as does Alberta's legislation with respect to attorneys under an EPA.[212] In our view the proposed legislation should do likewise.

RECOMMENDATION 10

We recommend that the proposed legislation provide that an individual cannot act as a health care proxy

(1) unless that individual

  (a) is an adult who apparently has capacity to make the health care decision in question, and

  (b) with the exception of a proxy mentioned in paragraphs (a), (b), or (l) of Recommendation 8, has had personal involvement with the patient at some time during the preceding twelve months; or

(2) if the patient has indicated in a health care directive that he or she does not wish that individual to act as health care proxy.

(5) Disagreement

Under our proposals, in some situations there may be more than one health care proxy. For example, if a widow has no guardian and has not appointed a health care agent, her adult children would act as health care proxy. What if they disagree? Ontario's solution is to have the Public Guardian make the decision.[213] Alberta's *Mental Health Act* avoids the problem of disagreement by preferring the eldest relative in any particular category.[214] We question the wisdom (and constitutional validity) of this solution.

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[211] See e.g. *Medical Consent Act,* R.S.N.S. 1989, c. 279, s. 3(1); *Powers of Attorney (Amendment) Act 1989,* No. 15, s. 5 (Australian Capital Territory). See also Manitoba Report, *supra,* note 5 at 14.

[212] *Powers of Attorney Act,* S.A. 1991, c. P-13.5, s. 2(2).

[213] Bill 109, s. 16(8).

[214] *Mental Health Act,* S.A. 1988, c. M-13.1, s. 1(h)(i).

In our opinion, if more than one person is acting as proxy, the majority should prevail.[215] If there is an even number and no majority, we see two possible options, each having some merit. The first is to provide that decision-making authority passes to the next person or category of persons on the list; thus, for example, if the parents could not agree, the siblings would decide. The second option is for the patient's health care practitioner to make the decision. On balance we prefer the former approach, as being the one which is more likely to produce the decision which the patient would have made if competent.

RECOMMENDATION 11

We recommend that the proposed legislation provide that, if more than one person is acting as health care proxy, the decision of the majority prevails, and that in the absence of a majority decision, proxy authority passes to the next person or category of persons on the list.

(6) Health Care Practitioner's Duty

In Recommendation 8 we stated that if the first person on the list is "unavailable", proxy authority passes to the next category of persons on the list. What does "unavailable" mean, and what is the responsibility of the health care practitioner to determine whether a person is available?

We favour the approach adopted in the proposed Ontario legislation. A proxy is "available" if it is possible for the health care practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a consent or refusal of consent.[216] In addition, the health care practitioner is required to make "reasonable inquiry" to determine who has proxy authority, and so long as this is done, the practitioner is not liable for failing to find the correct proxy.[217]

This approach also has the advantage of accommodating the common law emergency principle. We have already noted that, if a patient is mentally incapable of consenting to treatment which is immediately necessary to preserve

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[215] This solution is adopted in some U.S. states: see Gelfand, *supra*, note 80 at 789.

[216] Bill 109, s. 16(7).

[217] *Ibid.*, ss 16(2), 24(4).

the patient's life or health, the treatment can be performed without consent.[218] Under our proposals, the health care practitioner would not have to delay emergency treatment so as to obtain consent from the health care proxy, because the definition of whether a proxy is "available" refers to whether that proxy's consent can be obtained within a time that is reasonable *in the circumstances*. If no proxy were immediately available, and it would be unreasonable to delay the treatment so as to wait for one to become available, proxy authority would pass to the last person on the statutory list, that is, the health care practitioner.

RECOMMENDATION 12

We recommend that, for the purposes of Recommendation 8, the proposed legislation provide that

(1) a health care proxy is "unavailable" if it is not possible for the health care practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a consent or refusal of consent; and

(2) the health care practitioner is required to make reasonable inquiry to determine who has proxy authority, and so long as this is done, the practitioner is not liable for failing to find the correct proxy.

D. Criteria for Substitute Decision-Making

(1) Unambiguous and Relevant Instructions

As noted above,[219] we strongly agree that an individual should be free to provide advance written instructions as to future health care and that these instructions, if unambiguous and relevant, should be legally binding. This is consistent with both the common law[220] and the proposals in Ontario and Manitoba.[221] Indeed, it is difficult to see how one could argue for a different

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[218] See *supra*, note 20.

[219] *Supra*, notes 162-165 and accompanying text.

[220] *Fleming v. Reid*, *supra*, note 8; *Malette v. Shulman*, *supra*, note 8. See *supra*, notes 29-36 and accompanying text.

[221] See *supra*, Chapter 5. This is also true of legislation in several other jurisdictions: see e.g. *Natural Death Act 1988*, No. 51, s. 4(1) (Northern (continued...)

position, given that legislation in Ontario empowering a review board to override the advance instructions of a competent patient has been held to be contrary to the *Charter*.[222]

In one respect, however, we differ from the Manitoba proposals on this issue. The Manitoba Law Reform Commission recommended that, if the patient's written instructions are unambiguous and relevant, the proxy is not called upon to make a decision; the health care practitioner simply follows the instructions.[223] In our view this approach begs the question of whether the instructions are unambiguous and relevant; in effect, it leaves the question to the health care practitioner to decide. We believe that the health care proxy should be the one who ultimately decides whether the patient's instructions are unambiguous and relevant.

Accordingly, we recommend that the health care proxy should be required to follow any written instructions which the patient has given while mentally competent and has not revoked, if these instructions are unambiguous and relevant to the health care decision in question.

(2) Substituted Judgment

If there are no unambiguous and relevant advance instructions from the patient, how should the health care proxy arrive at a decision? We propose that, where possible, proxies should apply a substituted judgment test; that is, they should decide according to what they believe the patient would have decided if competent. We view this as essential to our goal of protecting the patient's interest in self-determination.

The substituted judgment test involves consideration of a number of factors, including what the proxy knows about the patient (in particular, the patient's values and preferences), and any instructions and information (whether

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[221](...continued)
Territory of Australia); *Powers of Attorney (Amendment) Act 1989*, No. 15, schedule (Australian Capital Territory). See also American College of Probate Counsel, *supra*, note 119 at 91.

[222] *Fleming v. Reid*, *supra*, note 8. See *supra*, notes 8-9 and accompanying text.

[223] See Manitoba Report, *supra*, note 5 at 6-7.

written or verbal) provided by the patient while competent. As one recent article notes:[224]

> The over-arching goal of all surrogate decision-making, informed or informal, ought to be the making of principled choices that reflect, as far as possible, the incapacitated person's values and preferences.

The substituted judgment test is the usual standard adopted in the United States,[225] even in those states which do not have living will legislation.[226] It is used in recent Australian legislation,[227] it figures prominently in the Ontario[228] and Manitoba[229] proposals,[230] and it has also been applied in a recent decision of the English Court of Appeal.[231]

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[224] Lambert *et al., supra,* note 166 at 202.

[225] See Fowler, *supra,* note 37 at 1003-04; Solnick, *supra,* note 59 at 15; Meisel, *supra,* note 83 at 267 *et seq.;* President's Commission, *supra,* note 40 at 178 *et seq.;* S.M. Weiner, "Privacy, Family and Medical Decision Making for Persistent Vegetative Patients" (1990) 11 Cardozo Law Review 713.

[226] In a number of cases in the United States involving a living will executed in a jurisdiction which does not have living will legislation, the court has referred to the document as being important evidence of the patient's intention, for the purposes of a substituted judgment decision by a proxy: see e.g. *John F. Kennedy Memorial Hospital, Inc. v. Bludworth,* 452 So. 2d 921 (Fla., 1984); *Re Conroy,* 486 A. 2d 1209 (N.J., 1985); *Bartling v. Superior Court,* 163 Cal. App. 3d 186 (1984); *Saunders v. State,* 492 N.Y.S. 2d 510 (1985); see also Annotation, 49 A.L.R. 4th 812. In some cases the court has placed reliance on the patient's oral expression of treatment preference, made prior to incapacity: see Meisel, *supra,* note 83 at 327-31; Fowler, *supra,* note 37 at 996-97.

[227] *Powers of Attorney (Amendment) Act 1989,* No. 15, s. 5 (Australian Capital Territory); *Medical Treatment (Enduring Power of Attorney) Act 1990,* No. 7, s. 7 (Victoria). The Law Reform Commission of Western Australia also favoured the substituted judgment test: see Western Australia Report, *supra,* note 93.

[228] Bill 109, s. 14.

[229] Manitoba Report, *supra,* note 5 at 6-7.

[230] See also *Quebec Civil Code,* art. 12 [en. Bill 125, 1990].

[231] *Re J.,* [1990] 3 All E.R. 930 (C.A.).

The difference between the substituted judgment test and the best interests test is summed up by Professor Meisel as follows:[232]

> The essential distinction between the two is that under the best interests standard the surrogate is to do what is best for the patient in the surrogate's own judgment, whereas under the substituted judgment standard the surrogate is to attempt to replicate what the patient would have decided if competent to do so.

Often the two tests will produce the same result.[233] Even in that situation, however, symbolism is important. As the English Law Commission points out:[234]

> The distinction is, perhaps, likely to be more important as an indication of ethos and emphasis: thinking oneself into the shoes of the persons concerned and recognising the value we all place on personal preferences (not all decisions are, or should be, taken on reasonable grounds) is a mark of respect for human individuality which may have a value greater than its practical effect.

Although in the past both the Institute[235] and the Supreme Court of Canada[236] have been critical of the substituted judgment test and have rejected it in favour of the best interests test, this has been in the context of individuals who have never been mentally competent. Even the most ardent supporters of the substituted judgment test accept that it is sometimes impossible or

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[232] *Supra*, note 83 at 270.

[233] See e.g. Solnick, *supra*, note 59 at 13.

[234] *Supra*, note 60 at 108.

[235] *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion No. 6, 1988) at 113-14; *Competence and Human Reproduction* (Report No. 52, 1989) at 61-63.

[236] *E. (Mrs.) v. Eve, supra*, note 62 at 434-35.

inappropriate to apply, particularly in the context of never-competent individuals.[237]

We propose, therefore, that health care proxies should make decisions according to what they believe the patient would have decided if competent, and if this is not possible, according to what they believe to be in the patient's best interests.

RECOMMENDATION 13

We recommend that the proposed legislation provide that, when making a health care decision on behalf of a patient, a health care proxy

(1) shall follow any written instructions which the patient has given while mentally competent and has not revoked, if these instructions are unambiguous and relevant to the health care decision in question, and in the absence of unambiguous and relevant instructions

(2) shall make the decision according to what he or she believes the patient would have decided if competent, and if this is not possible

(3) shall make the decision according to what he or she believes to be in the patient's best interests.

The *Dependent Adults Act*[238] provides that a court may authorize a guardian to consent to health care that is in the "best interests" of the dependent adult, and that the guardian must exercise his or her power and authority in the "best interests" of the dependent adult. This will have to be amended to give effect to Recommendation 13 in respect of a guardian acting as a health care proxy.

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[237] See e.g. President's Commission, *supra*, note 40 at 180; Solnick, *supra*, note 59 at 15; L. Harmon, "Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment" (1990) 100 Yale Law Journal 1 at 63-64; Meisel, *supra*, note 83 at 275-76. See also Fram Committee, *supra*, note 133 at 48-49; Dickens, *supra*, note 103 at 14-15; Age Concern Institute of Gerontology, *supra*, note 27 at 70-71.

[238] R.S.A. 1980, c. D-32, ss 10(2)(h), 11(a).

RECOMMENDATION 14

We recommend that consequential amendments be made to the *Dependent Adults Act* to give effect to Recommendation 13 in respect of a guardian acting as a health care proxy.

E. Restrictions on the Proxy's Authority

(1) Types of Procedure

Legislation (or proposed legislation) in a number of jurisdictions expressly prohibits health care proxies from consenting to certain types of medical procedures. In some jurisdictions this prohibition is subject to the proviso that the patient, while competent, may expressly confer authority on the proxy to consent to these procedures. The most common examples are non-therapeutic sterilization,[239] non-therapeutic research,[240] psychosurgery,[241] electro-convulsive therapy (ECT),[242] and *inter vivos* tissue donation.[243]

In our report on Competence and Human Reproduction[244] we recommended a procedure for obtaining court authorization for non-therapeutic sterilization of a mentally incompetent person. In our view this procedure should apply notwithstanding the existence of a health care proxy. Accordingly we recommend that health care proxies should not have authority to consent to non-therapeutic sterilization.

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[239] See e.g. Ontario Bill 109, s. 15; Ontario Bill 108, s. 47(7); Manitoba Report, *supra,* note 5 at 6-7; Vignery, *supra,* note 61 at 423; American College of Probate Counsel, *supra,* note 119 at 94.

[240] See e.g. Ontario Bill 109, s. 15; Ontario Bill 108, s. 47(6); Manitoba Report, *supra,* note 5 at 6-7; *Quebec Civil Code,* art. 18 [en. Bill 125, 1990]; *Protection of Personal and Property Rights Act 1988,* No. 4, ss 18(1), 98(4) (New Zealand).

[241] See e.g. Ontario Bill 108, s. 47(7); *Protection of Personal and Property Rights Act 1988,* No. 4, ss 18(1), 98(4) (New Zealand).

[242] See e.g. *Protection of Personal and Property Rights Act 1988,* No. 4, ss 18(1), 98(4) (New Zealand); Vignery, *supra,* note 61 at 423; American College of Probate Counsel, *supra,* note 119 at 94.

[243] See e.g. Ontario Bill 109, s. 15; Manitoba Report, *supra,* note 5 at 6-7.

[244] *Supra,* note 235.

Alberta's *Mental Health Act* provides that psychosurgery[245] may not be performed on a formal patient without, *inter alia,* the patient's consent; the consent of the patient's nearest relative is not sufficient.[246] In our view the proposed legislation should contain the same restriction. However, we do not favour including a similar restriction in relation to ECT. ECT does not come within the definition of psychosurgery,[247] and it is a well recognized therapeutic treatment for certain types of mental illness. We see no reason to restrict the proxy's authority to consent to it on the patient's behalf.

With respect to non-therapeutic research, the present law appears to be that no-one may consent to such research on a mentally incompetent person, since by definition the research is not of any benefit to that person and thus cannot be in his or her best interests.[248] Likewise, the *Human Tissue Gift Act*[249] prohibits *inter vivos* tissue donation unless the donor is a mentally competent adult who gives free and informed consent to the donation. We believe that these restrictions should also be reflected in the proposed legislation. In addition, our tentative view is that the patient should be able to waive these restrictions in a health care directive, although we have some reservations about the wisdom of such a proposal.

RECOMMENDATION 15

We recommend that the proposed legislation provide that, unless the patient provides otherwise in a health care directive, a health care proxy does not have authority to consent to non-therapeutic sterilization, psychosurgery, non-therapeutic research, or *inter vivos* tissue donation.

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[245] Defined in the *Mental Health Act,* S.A. 1988, c. M-13.1, s. 1(k).

[246] *Ibid.,* s. 29(5).

[247] See *Re T and Board of Review* (1983), 3 D.L.R. (4th) 442 (Ont. H.C.).

[248] See e.g. W.F. Bowker, "Minors and Mental Incompetents: Consent to Experimentation, Gifts of Tissue and Sterilization" (1981) 26 McGill Law Journal 951; Robertson, *supra,* note 71 at 139-40; but *contra* Dickens, *supra,* note 11 at 52.

[249] R.S.A. 1980, c. H-12, ss 2, 3(1).

(2) Unlawful Acts

Some concern has been raised that a system of substitute decision-making for mentally incapable patients, especially one which incorporates the living will model, may lead to the perpetration of criminal acts, in particular active euthanasia.[250] While not offering any comment on whether such a view is realistic, we believe that the proposed legislation should make it clear that health care proxies cannot authorize anything which the patient, if competent, could not lawfully have authorized.[251]

RECOMMENDATION 16

We recommend that the proposed legislation provide that a health care proxy cannot authorize anything which the patient, if competent, could not lawfully have authorized.

F. Review Procedures

(1) Appeal by the Patient

In Chapter 5 we outlined the provisions of the proposed Ontario legislation which are aimed at protecting patients from an incorrect assessment of incapacity.[252] The patient is given a right of appeal to a special Board; the health care practitioner must notify the patient of the assessment of incapacity, and must also inform the patient in writing of the right of appeal; the patient must then be visited by an advocate, who again explains the right of appeal and offers assistance in exercising that right. Only after all of this is completed, and the patient has not indicated an intention to appeal, may treatment be given (unless the situation is one of emergency).

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[250] See e.g. "Living Wills Becoming Thorny Issue" *Toronto Globe and Mail* (24 April 1991) at A1, which states that the issue of living wills "is just a heartbeat away from euthanasia".

[251] The legislation in New York contains a similar provision: see Miller, *supra,* note 120 at 365. A private member's Bill presently before Parliament (Bill C-351) is an attempt to clarify the *Criminal Code* as to the patient's right to refuse medical treatment. This is a matter of federal jurisdiction and falls outside the scope of this Report.

[252] See *supra,* notes 153-159 and accompanying text.

We noted that these provisions have been described as a "nightmare".[253] We agree. In our opinion the safeguards are far too complex, and could represent a serious obstacle to the patient receiving timely medical care. We do not believe that a special Board needs to be created. In the unlikely event of the patient wishing to challenge the assessment of incapacity, this can be done in the courts. We do feel, however, that the health care practitioner should have a duty to inform the patient that decision-making authority has passed to a proxy. We also propose that the legislation incorporate the provision contained in the *Mental Health Act*,[254] that if, following an assessment of incapacity, the patient objects to treatment, that treatment shall not be performed (notwithstanding consent from the health care proxy) until the patient's incapacity has been confirmed by a second health care practitioner.

RECOMMENDATION 17

We recommend that the proposed legislation provide that if a health care practitioner determines that a patient lacks the capacity to make a health care decision, the practitioner shall advise the patient that this decision will be taken on the patient's behalf by his or her health care proxy.

RECOMMENDATION 18

We recommend that the proposed legislation provide that if a health care practitioner determines that a patient lacks the capacity to make a health care decision, but the patient objects to the proposed treatment, that treatment shall not be performed on the basis of consent obtained from the patient's health care proxy unless a second health care practitioner confirms that the patient lacks the capacity to make the health care decision.

(2) Review of the Proxy's Decision

We noted earlier that provision should be made for interested persons to have the court review decisions taken by a health care agent appointed under a health care directive.[255] In our view this should extend to all health care proxies. The court, on the application of any interested person, should have

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[253] See *supra*, note 159.

[254] S.A. 1988, c. M-13.1, s. 28(5).

[255] *Supra*, note 194 and accompanying text.

jurisdiction to review (and rescind) any decision taken by a health care proxy. Indeed, such jurisdiction probably already exists, pursuant to the court's inherent *parens patriae* jurisdiction in respect of mentally incompetent persons.[256]

What criteria should the court apply in reviewing the proxy's decision? Traditionally courts have applied a "best interests" standard in exercising their *parens patriae* jurisdiction; the best interests of the incompetent person are paramount. Thus, the court will authorize medical treatment if it considers this to be in the patient's best interests.[257] However, we do not propose that this criteria be applied in the present context. If the court were to use the best interests standard in reviewing the proxy's decision, this would undermine the importance of the substituted judgment test as a means of promoting the patient's interest in autonomy and self-determination.[258] A key feature of our proposed scheme is that health care proxies should attempt to arrive at the decision which the patient would have made if competent, regardless of whether this appears to be in the objective best interests of the patient.

In our view it does not make any sense to have proxies applying one standard (substituted judgment) and the courts, in reviewing their decisions, applying another (best interests). The Manitoba Law Reform Commission recommended that a health care agent's decision should be reviewable only if the agent is shown to have acted in bad faith or contrary to the known wishes of the patient.[259] We prefer a slightly different approach. The court should have the power to rescind the proxy's decision only if it considers that the decision is unreasonable *having regard to the criteria which the proxy was required to apply in making the decision,*[260] that is, the criteria set out in Recommendation 13.

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[256] See *E. (Mrs.) v. Eve, supra,* note 62; *Institut Philippe Pinel De Montreal v. Dion, supra,* note 143; Robertson, *supra,* note 71 at 397.

[257] See e.g. *Institut Philippe Pinel De Montreal v. Dion, supra,* note 143; *Re S.D.,* [1983] 3 W.W.R. 618 (B.C.S.C.).

[258] See Peters, *supra,* note 100 at 454. It would also be of questionable validity under the *Charter,* in light of *Fleming v. Reid, supra,* note 8.

[259] Manitoba Report, *supra,* note 5 at 10.

[260] See Moore, *supra,* note 37 at 670-71, adopting the suggestion made (in the context of guardianship) by R.M. Veatch, "Limits of Guardian Treatment Refusal: A Reasonableness Standard" (1984) 9 American Journal of Law & Medicine 427. See also Western Australia Report, *supra,* note 93.

Thus, for example, if the health care proxy applied a substituted judgment test in arriving at a decision, and the court took the view that in all the circumstances there were no reasonable grounds for concluding that the patient, if competent, would have made that decision, the court could rescind the proxy's decision. It would then substitute its own decision, applying the same criteria set out in Recommendation 13.

We also propose that the court be empowered to issue an order terminating the health care proxy's authority if it considers that the proxy is likely to continue to make unreasonable decisions. The termination order would have the effect of transferring proxy authority to the next person on the list as set out in Recommendation 8.

RECOMMENDATION 19

We recommend that the proposed legislation provide that

(1) any interested person may apply to the court to have the decision of a health care proxy reviewed;

(2) if the court considers that the proxy's decision is unreasonable having regard to the criteria set out in Recommendation 13, it may rescind the proxy's decision and substitute its own decision based on the criteria set out in Recommendation 13; and

(3) the court may issue an order terminating the authority of a health care proxy if it considers that the proxy is likely to continue to make unreasonable decisions.

RECOMMENDATION 20

We recommend that consequential amendments be made to the *Dependent Adults Act* to give effect to Recommendation 19 in respect of a guardian acting as a health care proxy.

G. Other Issues

(1) Protection from Liability

We consider it important to ensure that health care professionals and others do not incur liability arising out of their *bona fide* reliance on a decision taken by a health care proxy. In addition, we believe that health care proxies should have protection from liability so long as they act in good faith. The proposed legislation in Ontario[261] and Manitoba[262] affords this protection, and in our view Alberta should do likewise.

RECOMMENDATION 21

We recommend that the proposed legislation confer protection from liability on

(1) persons acting in good faith in accordance with a decision made by a health care proxy; and

(2) health care proxies, in respect of a decision made by them in good faith.

(2) Access to Information

A health care proxy stands in the shoes of the patient, and it is essential that the proxy have the same rights of access to health care information, and to health care records, that the patient would have had if competent.[263] This ensures that the proxy has an opportunity to make an informed decision concerning the patient's health care.

RECOMMENDATION 22

We recommend that the proposed legislation provide that a health care proxy has the same rights of access to health care information, and to health care records, that the patient would have had if competent.

(3) The Effect of No Directive

In Chapter 4 we referred to the possible risk that people who do not execute a living will may be presumed to want all available life-sustaining procedures to be initiated and maintained, even if these are therapeutically useless.[264] We recommend that the proposed legislation make it clear that no

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[261] Bill 109, s. 25.

[262] Manitoba Report, *supra*, note 5 at 9.

[263] See *ibid*. at 18.

[264] See *supra*, notes 106-109 and accompanying text.

presumption arises from the fact that a person has not executed a health care directive.[265]

RECOMMENDATION 23

We recommend that the proposed legislation provide that no presumption as to a person's health care wishes arises from the fact that the person has not executed a health care directive.

(4) Section 20.1 Certificate

We noted in Chapter 2 that the *Dependent Adults Act,* s. 20.1 provides for treatment to be given without consent, on the authority of a certificate from two physicians (or in the case of dental treatment, two dentists), if the patient is incapable of consenting to the treatment.[266] This procedure is redundant in light of our proposals, and we recommend that it be repealed.

RECOMMENDATION 24

We recommend that section 20.1 of the *Dependent Adults Act* be repealed.

(5) *Mental Health Act* Implications

Alberta's *Mental Health Act*[267] has detailed provisions dealing with substitute decision-making on behalf of formal (involuntary) psychiatric patients who have been certified as mentally incompetent to make treatment decisions. The Act defines competence, provides for proxy decision-makers, sets out the criteria which the proxy must apply in making a decision, and provides a number of procedural safeguards including a right to appeal the assessment of incapacity to a special tribunal.

We do not intend that our proposals should affect these provisions, and we recommend that the proposed legislation make this clear. At the same time, however, we recognize that this will create two systems of substitute decision-making, one for formal psychiatric patients and one for other patients, with some

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[265] For a similar proposal see Manitoba Report, *supra,* note 5, at 19.

[266] See *supra,* note 19 and accompanying text.

[267] S.A. 1988, c. M-13.1 [proclaimed in force January 1, 1990].

very significant differences between the two. At the present time we are not in a position to decide whether this differentiation is justified. A great deal of consultation will be required on this issue. We do, however, recommend that the *Mental Health Act* be reviewed to determine whether it should be amended to incorporate the principles contained in our proposed legislation.

RECOMMENDATION 25

We recommend that

(1) the proposed legislation provide that it does not apply to a formal patient as defined in the *Mental Health Act*; and

(2) the *Mental Health Act* be reviewed to determine whether it should be amended to incorporate the principles contained in the proposed legislation.

(6) Education

In 1990 the U.S. Congress passed the *Patient Self-Determination Act*, which comes into force on December 1, 1991.[268] The Act requires hospitals and other health care institutions to ensure compliance with state laws on advance health care directives and to inform patients of their rights with respect to these directives. The Act also requires health care institutions to provide education for staff and the community on issues relating to advance health care directives.

The Manitoba Law Reform Commission also recommended that there be an extensive program of public education to make people aware of the availability and use of health care directives.[269] We share the Commission's view of the importance of such a program.

RECOMMENDATION 26

We recommend that appropriate education programs be established to ensure that the general public, and health care professions and institutions, are made fully aware of the legislation governing health care directives and proxy decision-making.

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[268] For a detailed discussion of the Act see Fletcher & White, *supra*, note 106.

[269] Manitoba Report, *supra*, note 5 at 24.

H. Conclusion

We believe that our recommendations go a long way to achieve what we identified in Chapter 3 as being the fundamental goals of reform in this area. First, they provide certainty for health care professionals as to who has authority to make health care decisions on behalf of an incapable patient. Second, our recommendations promote autonomy and self-determination for those who are no longer capable of making health care decisions personally, by enabling individuals to execute a health care directive which appoints a health care agent and which provides instructions and information concerning future health care decisions. Third, our proposals provide a meaningful alternative to guardianship proceedings under the *Dependent Adults Act*, and will likely result in a significant reduction in the number of applications under that Act.

We stress once again, however, that this is a report for discussion, and we invite those with views and comments (whether for or against our recommendations) to communicate these to us.

PART III — LIST OF RECOMMENDATIONS

RECOMMENDATION 1

We recommend that legislation be introduced to enable individuals to execute a health care directive, in which they can

(1) appoint someone as their health care agent, who will have authority to make health care decisions on their behalf in the event of their becoming incapable of making these decisions personally; and/or

(2) identify anyone whom they do not wish to act as their health care proxy, as provided in Recommendation 8; and/or

(3) provide instructions and information concerning future health care decisions.

RECOMMENDATION 2

We recommend that the proposed legislation require that, subject to Recommendation 3, a health care directive be in writing, be signed by the person making it, and be witnessed by one person other than the health care agent or the spouse of that agent.

RECOMMENDATION 3

We recommend that the proposed legislation provide that a health care directive may be signed on the maker's behalf, in the presence and under the direction of the maker, by a person other than the health care agent, a witness, or the spouse of the health care agent or witness, if the maker is physically incapable of signing it.

RECOMMENDATION 4

We recommend that the proposed legislation provide that, in order to execute a health care directive, a person must be at least eighteen years of age and must be capable of understanding the nature and effect of the directive.

RECOMMENDATION 5

We recommend that the proposed legislation should not disqualify any particular individual or group from being appointed as a health care agent.

RECOMMENDATION 6

We recommend that the proposed legislation provide that the appointment of a health care agent terminates

(1) if it is revoked by the principal at a time when the principal is mentally capable of understanding the nature and effect of the revocation;

(2) on divorce, if the health care agent is the spouse of the principal; and

(3) if a court issues an order terminating the appointment.

RECOMMENDATION 7

We recommend that the proposed legislation should not make provision for advance directives for personal care.

RECOMMENDATION 8

We recommend that the proposed legislation provide that if an adult person (the "patient") lacks the capacity to make a health care decision, that decision may be made on the patient's behalf by his or her health care proxy, defined as the first named person or group of persons on the following list:

(a) a guardian appointed under the *Dependent Adults Act* (or the equivalent legislation in another jurisdiction) with authority to make health care decisions on behalf of the patient;

(b) a health care agent appointed by the patient pursuant to a health care directive;

(c) the patient's spouse or partner;

(d) the patient's children;

(e) the patient's parents;

(f) the patient's siblings;

(g) the patient's grandchildren;

(h) the patient's grandparents;

(i) the patient's uncle and aunt;

(j) the patient's nephew and niece;

(k) any other relative of the patient;

(l) the patient's health care practitioner,

and that if a health care proxy is unavailable, or is unable or unwilling to make a decision, proxy authority passes to the next person or category of persons on the list.

RECOMMENDATION 9

We recommend that the proposed legislation provide that a person has capacity to make a health care decision if that person is capable of understanding the information that is relevant to making the decision and is capable of appreciating the reasonably foreseeable consequences of a decision or lack of decision.

RECOMMENDATION 10

We recommend that the proposed legislation provide that an individual cannot act as a health care proxy

(1) unless that individual

  (a) is an adult who apparently has capacity to make the health care decision in question, and

  (b) with the exception of a proxy mentioned in paragraphs (a), (b), or (l) of Recommendation 8, has had personal involvement with the patient at some time during the preceding twelve months; or

(2) if the patient has indicated in a health care directive that he or she does not wish that individual to act as health care proxy.

RECOMMENDATION 11

We recommend that the proposed legislation provide that, if more than one person is acting as health care proxy, the decision of the majority prevails, and that in the absence of a majority decision, proxy authority passes to the next person or category of persons on the list.

RECOMMENDATION 12

We recommend that, for the purposes of Recommendation 8, the proposed legislation provide that

(1) a health care proxy is "unavailable" if it is not possible for the health care practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a consent or refusal of consent; and

(2) the health care practitioner is required to make reasonable inquiry to determine who has proxy authority, and so long as this is done, the practitioner is not liable for failing to find the correct proxy.

RECOMMENDATION 13

We recommend that the proposed legislation provide that, when making a health care decision on behalf of a patient, a health care proxy

(1) shall follow any written instructions which the patient has given while mentally competent and has not revoked, if these instructions are unambiguous and relevant to the health care decision in question, and in the absence of unambiguous and relevant instructions

(2) shall make the decision according to what he or she believes the patient would have decided if competent, and if this is not possible

(3) shall make the decision according to what he or she believes to be in the patient's best interests.

RECOMMENDATION 14

We recommend that consequential amendments be made to the *Dependent Adults Act* to give effect to Recommendation 13 in respect of a guardian acting as a health care proxy.

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We recommend that the proposed legislation provide that, unless the patient provides otherwise in a health care directive, a health care proxy does not have authority to consent to non-therapeutic sterilization, psychosurgery, non-therapeutic research, or *inter vivos* tissue donation.

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RECOMMENDATION 19

We recommend that the proposed legislation provide that

(1) any interested person may apply to the court to have the decision of a health care proxy reviewed;

(2) if the court considers that the proxy's decision is unreasonable having regard to the criteria set out in Recommendation 13, it may rescind the proxy's decision and substitute its own decision based on the criteria set out in Recommendation 13; and

(3) the court may issue an order terminating the authority of a health care proxy if it considers that the proxy is likely to continue to make unreasonable decisions.

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(2) the *Mental Health Act* be reviewed to determine whether it should be amended to incorporate the principles contained in the proposed legislation.

RECOMMENDATION 26

We recommend that appropriate education programs be established to ensure that the general public, and health care professions and institutions, are made fully aware of the legislation governing health care directives and proxy decision-making.

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