A Paradox for Physicians with Patients of Marginal Capacity:
The Inner Workings of Ontario's
Heath Care and Consent Act* and *Substitute Decisions Act [*]

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Introduction

Hospitals and care facilities should stay as far away as possible from estate disputes and will challenges. Care providers and health practitioners should not be asked or expected to be witnesses to wills and indeed many care facilities have protocols preventing their staff from witnessing wills and other legal documents.

Testamentary capacity and capacity to manage property are not the business of health practitioners who should be encouraged to keep away from estate and property disputes.[1] Their role is to provide health care to the individual, not to manage family infighting, and their focus should be exclusively on that purpose. As a consequence, the note taking of health practitioners ought to be for the sole purpose of documenting treatment and other health related observations and decisions. As much as estate litigation lawyers may dream of hospital records containing a nurse's observation of testamentary incapacity or undue influence, it is not the job of the heath care provider to bear witness to or to document these uncomfortable scenarios except to the extent that the individual's health may affected by such situations. If families start to fight over property or money in the presence of a health practitioner, as long as the individual receiving the care is safe from emotional harm, the practitioner should leave the room and not become a witness to be subpoenaed later in a will challenge trial. Further, as a

[*] This paper is based on a paper I originally presented at the 2008 11th Annual Law Society of Upper Canada Estates and Trusts Summit. Many thanks to my articling student Joelle Briggs-Sears who provided invaluable assistance for this paper.

[1] Except to the extent that some care facilities or health practitioners will require a signature on a contract for accommodation or for a private treatment where a fee is involved and therefore may need to understand whether the individual is capable of making his or her own property decisions.

matter of general policy, a health practitioner ought to be insulated from learning of the financial particulars of the individual receiving care.

Unfortunately, may of these property / pre-estate disputes are played out in the setting of the hospital or nursing home – in mom's room – when the kids visit and bicker with each other over their forthcoming inheritance. In these disputes, family histories are acted out. Power dynamics, developed between siblings in childhood, escalate. Mistrust and suspicion magnify. For some, seeing mom in hospital is a traumatizing experience. For others, admitting mom to a nursing home begins a grieving process. In many cases, the adult children themselves have their own children and are exhausted by the double-bind[2] of caregiving for parent and child at the same time as well as trying to maintain a job.

If the family unit is founded on love, then although differences may be expressed between family members during these difficult periods, consensus is eventually achieved, and the stressful decisions that need to be made are made together and with mom's participation to the extent that she can express meaningful preferences. These are the ideal situations for care facilities and health practitioners; capacity and authority for decision making are moot issues because the family unit has joined together and made a unanimous decision in mom's best interest and based on her wishes.

In other families, the family's emotional bond is weakened by the stress of watching mom die slowly and the environment consequently becomes ripe for friction, miscommunication, and misunderstanding. Estate litigators could fill pages of examples of families primed for conflict, some examples of which include when there is a second spouse and children from a first marriage; when children are living in different cities with varying degrees of involvement with mom's care giving and where resentment is building over the unequal workload; when there is one child who has a history of coercive, intimidating, or domineering behaviour toward his siblings and he has taken presumptive control as head of the household; and when family members have differing religious or other value-based attitudes toward medical intervention, death, and dying.

What documents do the health practitioners rely on when making decisions when a patient's capacity is in question? Who can care providers turn to when needing a

[2] Sometimes described as the "sandwich generation."

substitute decision maker for an incapable patient? What is to be done in the face of family disagreement over a treatment decision? These are broad questions that need to be broken into component parts. The *Health Care and Consent Act, 1996*[3] ("HCCA") and the *Substitute Decisions Act 1992*[4] ("SDA") provide much direction.

Substitute Decisions Act, 1992

The SDA is a broad statute in that it provides the mechanism, direction, and principles for personal care substitute decision makers where there is a power of attorney for personal care or where there is a guardian or need for the appointment of a guardian for personal care.[5] The duties and responsibilities of an attorney or guardian of personal care apply in all settings where personal care decisions must be made. Personal care decision making is defined as decisions affecting a person's own health care, nutrition, shelter, clothing, hygiene or safety.[6]

Health Care and Consent Act, 1996

The HCCA is likewise a broad statute which covers the consenting process for making treatment decisions[7] and decisions relating to personal assistance services[8] in all settings,[9] as well as admission to long term care facilities[10] which are defined under the statute to include nursing homes but not retirement homes or group homes.

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[3] S.O. 1996, c.2, as amended.

[4] S.O. 1992, c.30, as amended.

[5] SDA Part II, subsections 43-68.

[6] SDA section 45.

[7] HCCA Part II, sections 8-37.1 and defined under section 2 "treatment" to include very broadly anything done for therapeutic or other health related purposes.

[8] HCCA Part IV, sections 55-69.1 and defined under section 2 "personal services assistance" to include very broadly assistance with routine daily health related activities including grooming and eating.

[9] HCCA subsection 1(a).

[10] HCCA Part III, sections 38-54.2 and defined under section 2 "care facilities." Admission to a hospital or psychiatric facility for the purposes of a treatment is dealt with under section 24 of the HCCA.

Consent To Treatment

Health practitioners[11] who propose treatment for a patient shall not administer the treatment unless they are of the opinion that (1) the patient is capable to decide whether to accept the course of treatment and (2) that the patient consents to the treatment.[12] Consent must, among other things, be informed consent and must be given voluntarily.[13]

Treatment has a very broad definition under the HCCA under section 2 to cover anything done for a therapeutic or health-related purpose and includes isolated treatment decisions as well as plans of treatment. Treatment decisions may also include end of life decision making given that the definition of "plan of treatment" under section 2 includes "withholding or withdrawal of treatment in light of the person's current health condition." Emergency treatment is covered separately in sections 25-28 of the HCCA and does not require consent where there is severe suffering or a risk of bodily harm if the treatment is not administered immediately.

Ranking of Substitute Decision Makers

If the patient is incapable of consenting to treatment, then the health practitioner must turn to a ranked hierarchy of substitute decision makers to seek consent to the treatment.[14] In ranked order, these people are:

1. the patient's guardian for personal care.
2. the patient's attorney by power of attorney for personal care.
3. the patient's representative as appointed by the Consent and Capacity Board.
4. the patient's spouse or partner.[15]

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[11] HCCA section 2 "health practitioner" is a very broad category which includes almost all health care providers who are licenced under a College.

[12] HCCA subsection 10(1)(a).

[13] HCCA section 11.

[14] HCCA subsection 20(1) with the hierarchical ranking identified under subsection 20(3).

[15] HCCA subsection 20(7)–(9), a spouse includes a married spouse, cohabiting spouses, partners of at least one year living together, or partners living together who have a child in common, but does not include separated spouses whose relationship has broken down but who may not yet be divorced.

5. the patient's child (at least 16 years old) or parent.
6. the patient's brother or sister.
7. any other relative of the patient.

For a person to qualify within the ranking as a substitute decision maker for a proposed treatment, the person must himself be capable of consenting to the treatment, be available to make the decision,[16] and be willing to assume the responsibility of giving or refusing consent.[17] For this reason, health practitioners cannot blindly file and follow a guardianship order or power of attorney for personal care and never return to this ranking if the health practitioner becomes of the opinion that the substitute decision maker, despite apparent authority, is not capable of consenting to the treatment, is unavailable, or is unprepared to assume the responsibility of the consequences of the treatment. In such cases, the health practitioner ought to elicit the involvement of the next ranked person.

If no person is available or qualified to make the decision, then the Public Guardian and Trustee ("PGT") shall make the decision to give or refuse consent to the proposed treatment.[18] Further, if two or more persons who rank equally disagree about whether to consent to treatment, then that health practitioner again must turn to the PGT rather than continuing to move down the list to a lesser ranked person.[19]

If a health practitioner has a lesser ranked supportive family member present and available to make a treatment decision for an incapable patient, that person may make the treatment decision only if (1) there is no guardian, power of attorney for personal care, or representative (as appointed by the Consent and Capacity Board), and (2) if the

[16] HCCA subsection 20(11). A person is considered available if "it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal."

[17] HCCA subsection 20(2).

[18] HCCA subsection 20(5).

[19] HCCA subsection 20(6).

family member believes that no other person ranking higher would object to the decision.[20]

One of the stated purposes of the HCCA is "to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment."[21] This articulation is all well and good for an ideal society but sometimes becomes burdensome for the health care provider who now must make a family tree, may need to learn of the cohabitation particulars and spousal status of their incapable patients, and make summary determinations of the capacity and responsibility of the supportive family members before treatment decisions are made for an incapable patient.

Where there is Disagreement Between Substitute Decision Makers

The HCCA provides no mechanism for equally ranked but disagreeing substitute decision makers to apply to the Consent and Capacity Board ("Board") for guidance in making treatment decisions. This is unfortunate especially because it has been recognized by the Court of Appeal that the Board is "likely better placed … to decide what is in the incapable person's best interests"[22] once all the facts are before it. Instead, the health practitioner must turn to the PGT for a treatment decision where equally ranked substitute decision makers cannot agree on treatment for the incapable person.[23] This is also unfortunate given that there may be a lesser ranked supportive family member in the family unit willing and available to make a treatment decision in the incapable person's best interest.

Joint guardians of the person or joint powers of attorney for personal care who disagree on a treatment decision for an incapable person may be able apply under the SDA to the

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[20] HCCA subsection 20(4).

[21] HCCA subsection 1(e).

[22] *M (A) v. Benes*, 1999 CarswellOnt 3529 at para. 46 (Ont. C.A.); cited with approval in *Scardoni v. Hawryluck*, 2004 CarswellOnt 424 at para. 36 (Ont. Sup. Ct.).

[23] HCCA subsection 20(6).

Superior Court of Justice for directions.[24] For this section to be activated, the person's incapacity must already be established and cannot be used as a "back door" for a declaration of incapacity or for an order to have the person assessed.[25] However, the court has already warned applicants that "the court is not to micromanage the day to day decisions of the substitute decision-maker. An application for directions is designed to provide an avenue for guidance and direction by the court in how to approach decision making, not to have the court make the decision for the substitute except for certain exceptional circumstances."[26]

As a practical matter, this means that ongoing disputes between joint guardians or joint powers of attorney may be best addressed on a more permanent basis with an application by one of them to remove the other by way of a single guardianship order under section 55 of the SDA (or on a motion under section 61 of the SDA if there already is a guardianship order in place).

The only time a substitute decision maker may apply to the Board for assistance is a situation where the incapable person expressed a wish while capable and that wish requires interpretation or needs to be departed from.[27] This recourse is also available to a health practitioner.

Because of the limited recourse available to disagreeing substitute decision makers, hospitals and care facilities which have staff social workers who can assist conflicted families in making treatment decisions for an incapable person are serving their patients well. Disputes over treatment decisions are usually fact based and do not require lawyers or courts, except in rare situations. Both the SDA and HCCA speak of fostering the involvement of supportive family members[28] and some families need a neutral and qualified professional to guide them and help them communicate through the various

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[24] SDA section 68.

[25] *Neill v. Pellolio*, 2001 CarswellOnt 4158 (Ont. C.A.).

[26] *Sly v. Curran*, 2008 CarswellOnt 4301 (Ont. Sup. Ct.).

[27] HCCA sections 35 and 36.

[28] SDA subsections 66(6) and (7) and HCCA subsection 1(e).

and sometimes difficult components of substitute decision making. Avoiding lengthy and expensive guardianship proceedings in favour of summary alternative dispute resolution mechanisms is almost always preferable. Early family mediations, where there are growing disputes over treatment decisions among family members, may serve a family and the incapable person much better than the adversarial process of a court application.

Criteria for Making Substitute Decisions

Both the SDA and HCCA articulate mirrored principles for making substitute treatment decisions for incapable persons which involves following the wishes of the incapable person but, in the absence of expressed wishes, operating in the best interests of the incapable person.[29] In determining what is in the incapable person's best interest, the substitute decision maker must consider the values and beliefs of the incapable person, current wishes, and whether the treatment decision is likely to improve the quality of the incapable person's life.[30]

These are carefully worded and important statutory articulations repeated throughout the HCCA with slight wording changes depending on which Part (treatment, admission to care facilities, etc) is applicable.[31] The SDA wording is more general and designed for settings where the HCCA does not apply (such as in a person's home) and provides guidance for both guardians and powers of attorney for personal care.[32]

Despite their length, these subsections are important reference points to read because violating these sections may expose a substitute decision maker to a $10,000 fine.[33] Subsections 21(1) and (2) of the HCCA read as follows for consent to treatment:

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[29] HCCA subsection 21(1) and SDA subsection 66(3).

[30] HCCA subsection 21(2) and SDA subsection 66(4).

[31] HCCA sections 21, 42, and 59.

[32] SDA section 67.

[33] HCCA section 84.

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

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

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

21(2) – In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

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

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

(c) the following factors:

1. whether the treatment is likely to,

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

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

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

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

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

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

Where the Substitute Decision Maker is not Acting in the Person's Best Interest

If a health practitioner is concerned that the substitute decision maker is not acting in an incapable person's best interest or based on the incapable person's wishes stated while capable, then the health practitioner may apply to the Consent and Capacity Board for a determination as to whether the substitute decision maker is complying with the circumscribed rules for making treatment decisions.[34] Surprisingly, this recourse is only available to the health practitioner, not the incapable person or other supportive family members.

Lesser ranked supportive family members who object to a treatment decision out of concern that the incapable person's wishes or best interests are not being followed by a higher ranked substitute decision maker can apply to the Consent and Capacity Board as can the incapable person apply to the Board to have this lesser ranked supportive family member become the incapable person's substitute decision maker for the treatment decision only if the incapable person does not already have a guardian of the person or has not previously granted a power of attorney for personal care.[35] Otherwise, the lesser ranked supportive family member must apply to the Superior Court of Justice under section 55 of the SDA for a guardianship of the person. This is an expensive and slow undertaking which provides a host of problems including a statutory restriction that a court shall not make a guardianship order if there is a course of action that is "less restrictive of the person's decision making rights than the appointment of a guardian."[36] Further, the courts have indicated their reluctance in becoming involved in micro-managing decision making[37] and so a guardianship of the person ought to be sought only when broad and permanent issues arise.

An incapable person whose incapacity has been established but who objects to a treatment decision made by the substitute decision maker has surprisingly little recourse

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[34] HCCA sections 35 and 37. See *Scardoni, supra*, note 22 for an excellent review by Cullity J. of the role of section 37 and a detailed analysis of how to make a decision in an incapable person's best interest.

[35] HCCA section 33(1)&(2).

[36] SDA subsection 55(2)(b).

[37] *Sly, supra*, at note 26.

under either the HCCA or the SDA. Under the HCCA, a person who is the subject of a treatment may apply to the Consent and Capacity Board for a review of the finding of incapacity,[38] may apply to the Board for the appointment of a substitute decision maker,[39] and may apply to the Board for a review of a decision to be admitted to a care facility for the purposes of treatment[40] but does not appear to be able to apply to the Board for a review of the actual treatment decision. In such a case, the incapable person may need to elicit the support of the health practitioner who can access the Board under sections 35, 36, or 37 of the HCCA for a review of the treatment decision if the health practitioner shares the view that the decision was not made in the incapable person's best interests or in accordance with his or her wishes. Whenever there is a review of a treatment decision before the Board, the incapable person's capacity is automatically reviewed at the same time.[41]

Neither does the SDA provide an obvious avenue for an incapable person to review a treatment decision of a guardian of the person or power of attorney for personal care. Presumably, although I have never seen it done, an incapable person could elicit a litigation guardian to bring directions under section 68 of the SDA but the litigation guardian would first need leave of the court to be able to bring such application.[42]

Interestingly, where the Board thinks it is necessary, it can appoint *amicus* counsel to assist the incapable person in these types of hearings.[43]

Under the SDA, a person is capable of granting a power of attorney for personal care if the person "has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare and appreciates that the proposed attorney may have

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[38] HCCA section 32.

[39] HCCA section 33 but only where the incapable person does not have a guardian of the person or has not granted a power of attorney for personal care.

[40] HCCA section 34.

[41] HCCA section 37.1 except where the person's capacity to consent to such treatment has been reviewed by the Board within the previous six months.

[42] SDA subsection 68(3).

[43] *Hillier v. Milojevic*, 2010 CarswellOnt 5907 (Ont. Sup. Ct.).

to make decisions for the person."[44] Further, a person is capable of revoking a power of attorney for personal care if he or she is capable of granting it.[45] This one of the lowest thresholds in the SDA and so, as a practical matter, an incapable person may nevertheless be capable of revoking a power of attorney for personal care if the person, although incapable of making a treatment decision, is capable of understanding that their attorney for personal care is no longer making decisions out of genuine concern for them. In such a case, the person ought to be seen by a lawyer right away to execute a revocation of the power of attorney for personal care and then the health practitioner must return to the ranking in the HCCA to seek out the next highest ranking decision maker.

Where Capacity is Questionable or Fluctuating

The easiest situations for health practitioners are the ones where the patient is either clearly capable or incapable. In the former, the health practitioner will obtain consent to treatment from the patient herself or, in the latter, find the highest ranked substitute decision maker in order to seek out consent to the proposed treatment.

It is important for health practitioners proposing treatment for persons with questionable or fluctuating capacity to know the legal test for capacity and to document their observations and conclusions of capacity for each proposed treatment. D'Arcy Hiltz and Anita Szigeti, in their introduction to *A Guide to Consent and Capacity Law in Ontario,*[46] discuss how some applications to the Consent and Capacity Board arise from situations where a patient does not agree with the proposed treatment by a health practitioner and the health practitioner, out of a concern that the patient is not operating in his own best interest, concludes that the disagreeing patient is incapable with respect to the

[44] SDA subsection 47(1).

[45] SDA subsection 47(3).

[46] D'Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario, 2009 Edition* (Toronto: Lexis Nexis, 2009) at 165-194. This is highly recommended reading for a detailed understanding of the *Health Care and Consent Act* and how the Consent and Capacity Board operates.

treatment. In such cases, if there has not been a valid assessment of capacity with respect to the proposed treatment, then the patient is deemed to be capable.[47]

Capacity is a question of mixed law and fact based on the evidence as applied to the statutory tests for capacity.[48] This becomes a tricky venture especially given the paucity of joint medical-legal conferences where the two professions can explore the subject from legal and medical perspectives together.

Under the HCCA, a person is capable of making a treatment decision if the person is "able to understand the information that is relevant to making a decision about the treatment…and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[49] Such capacity is presumed unless there are reasonable grounds to believe that the person is incapable of making the treatment decision.[50]

Under the SDA, a person is capable of personal care if the person is able "to understand the information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety" and is able "to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[51]

The ability to understand the information that is relevant to making a decision either under the HCCA or SDA requires the "cognitive ability to process, retain and understand the relevant information."[52] A person may be capable with respect to some treatments but incapable with respect to others.[53] Further, a person may be capable with respect to

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[47] *Ibid*, at 172 and 176.

[48] *Starson v. Swayze*, 2003 CarswellOnt 2079 (SCC).

[49] HCCA subsection 4(1).

[50] HCCA subsection 4(2).

[51] SDA section 45.

[52] *Starson, supra* note 47 at para. 78. Interestingly, this exact paragraph of *Starson* has been cited over 200 times in other cases.

[53] HCCA subsection 15(1).

treatment at one time but incapable at another.[54] These statutory articulations of capacity match current geriatric medicine's recognition that capacity may be task and situation specific in borderline cases and that the previous model of a globalized "on/off" switch for capacity is outdated.[55]

This means that, for persons of questionable or fluctuating capacity, the health practitioner may need to test for capacity each time a treatment decision needs to be made. The health practitioner ought to document clearly in the patient's record his or her assessment of capacity when seeking consent to treatment where capacity is fluctuating or questionable. If necessary, the health practitioner may wish to seek a formal capacity assessment of the patient's capacity to consent to the treatment for these questionable situations especially if the treatment decision is one with serious consequences, such as end of life decisions.

The process of operating on a person's wishes and in that person's best interests, only relate to substitute decision making for an incapable person. A capable person has no obligation to make treatment decisions in his or her own best interest. Medical self-determination is protected by the courts and it is clear that a capable person may be unwise and unreasonable regarding his or her own treatment decisions. Further a capable person has no obligation to follow his or her own previously stated wishes. The Supreme Court of Canada has confirmed that, "The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy…. Unwarranted findings of incapacity severely infringe upon a person's right to self-determination."[56]

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[54] HCCA subsection 15(2).

[55] See Dr. Michel Silberfeld, "Capacity Assessments" (1991) 11 E.T.P.S. 165 at 167. See also Dr. Kenneth Shulman "Mental Capacity and Undue Influence: A Psychiatric Perspective" (Paper presented to the Law Society of Upper Canada's *Elder Law – Your Growing Clientele* conference, Toronto, May 2006) [unpublished] for a very good discussion of mental capacity and brain functioning.

[56] *Starson*, *supra* note 48, at para. 75.

What Documents Can Be Relied On In Taking Instructions?

When a health practitioner needs a treatment decision to be made by a substitute decision maker for an incapable patient, there are many documents which may provide guidance. These documents need to be read for both learning of the highest ranking substitute decision maker and also for possible expressions of the incapable person's wishes.

Guardianship of the Person Order: If an incapable person has a guardian of personal care, the order appointing the guardian must contain at its outset a declaration that the person is incapable of either all or some of the functions listed in the SDA (health care, nutrition, shelter, clothing, hygiene or safety)[57] and may appoint a guardian for a limited time or limited purpose.[58] For this reason, the whole of the guardianship order ought to be read by the health practitioner in order to ensure it applies to the proposed treatment. If there is a guardianship of the person order, it supercedes a power of attorney for personal care.

Power of Attorney for Personal Care: If an incapable person has granted a power of attorney for personal care, the document will appoint one or more persons to make personal care decisions if the grantor becomes incapable. A power of attorney for personal care may also contain health care directives or other wishes regarding personal care decision making[59] or may contain restrictions to the attorney's power (otherwise the power applies to all functions of personal care including health care).[60] Therefore, these documents need to be read in full, not just for the names of the attorneys.

Powers of attorney for personal care which appoint two or more persons may be joint or several.[61] If the document is silent, then the power is deemed to be jointly held. A *joint* power of attorney for personal care requires the consent of both attorneys, not just one

[57] SDA subsection 58(1).

[58] SDA subsection 58(2).

[59] SDA subsection 46(7).

[60] SDA subsection 46(6).

[61] SDA subsection 46(4).

of them for a treatment decision. Powers of attorney for personal care that convey *several* powers (or *joint and several* as it is commonly phrased*)* allow one of the attorneys alone to make the treatment decision. Powers of attorney for personal care that appoint multiple persons may contain a majority rule clause; otherwise, the entire group must unanimously consent to the treatment decision on behalf of the incapable person. These documents need to be read in their entirety to understand how they are to operate.

Advance Care Plans: Sometimes referred to as "living wills" or "advance care directives," advance care plans may contain a person's wishes regarding treatment decisions or principles on which decisions ought to be made for the person in the event of incapacity. These may be specific or general directions. There is no prescribed form for advance care plans. They may be set out in the power of attorney for personal care.[62] Advance care plans, if available, must be read and followed. Any departure from a documented advance care plan for a treatment decision will require an application to the Consent and Capacity Board.[63]

Wishes: Wishes may be expressed in writing or orally[64] and may be documented in the power of attorney for personal care or in any other form.[65] Only wishes expressed while capable have binding effect on a substitute decision maker under the HCCA and the SDA. The effect of wishes expressed while incapable is less clear but it appears that, although not binding, they may be relevant to the issue of the person's best interests.[66]

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[62] See Judith A. Wahl, "Advance Care Planning in Ontario" (Paper presented to the Law Society of Upper Canada's *Elder Law – Your Growing Clientele* conference, Toronto, May 2006) [unpublished] for a very good review of advanced care plans.

[63] HCCA section 36.

[64] HCCA subsection 5(2).

[65] HCCA subsection 5(2).

[66] See *Scardoni, supra* note 22, at para. 55 for a discussion of the role of incapable wishes.

It should be noted that even where prior wishes have been expressed, they cannot "be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed."[67]

Even if there is a guardianship order, a prior power of attorney for personal care document may contain stated wishes and so it still ought to be read thoroughly despite the fact that the guardianship order supercedes the determination of who is the highest ranking substitute decision maker. Because there are no requirements of formality for these wishes to be expressed, they may be found in an advance care plan or even in a person's diary or written on a scrap of paper while sitting in the hospital waiting for test results. Oral wishes expressed while capable appear to have the same value as written wishes and so inquiries ought to be made of the supportive family members to learn of any oral expressions of wishes. Later wishes prevail over earlier wishes.[68]

It is fundamentally the job of the substitute decision maker to learn of these wishes. However, a health practitioner who is seeking consent for a serious treatment issue would be serving the incapable patient well to make a documentary inquiry and an inquiry of available supportive family members to learn of any prior capable wishes that may affect the treatment decision.

Irrelevant Documents - Will: A will takes effect only on the death of the person and therefore should not contain any instructions or guidance for personal care decision making while alive but incapable. There should be exceptionally few reasons for a health practitioner to read the will of a living person.

Irrelevant Documents – Power of Attorney for Property: A power of attorney for property confers property management powers and may contain property related instructions. Because they are creatures for property management only, the power of

[67] *Conway v. Jacques*, 2002 CarswellOnt 1920 at para. 31 (Ont. C.A.); cited with approval in *Scardoni, supra*, note 22 at para 54.

[68] HCCA subsection 5(3).

attorney for property will not contain any health care directives. There is no reason for a health practitioner to review a power of attorney for property, except perhaps for the contract for admission to a facility or for treatment where there is a fee involved.

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