Health Care Directives

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Please see the Caveat included on the cover page of these Wills and Estates materials for qualifications to this material.

Reasons for this caution include but are not limited to:

- The Ministry of Justice and Attorney General has not yet developed its own form of Health Care Directives.
- The medical profession has raised concerns that lawyers may not have sufficient medical knowledge to advise their clients of the various treatments and conditions so as to make an informed advance health care decision.
Introduction

Instructions given by individuals to specify what should be done for their health in case they are no longer able to make decisions are known as health care directives.

The Health Care Directives and Substitute Health Care Decision Makers Act (1997) allows competent persons, who are at least 16 years of age, to make a health care directive or to give instructions for medical treatment they wish to receive if they become unable to make a health care decision.

There are three kinds of health care directives:

- general directives;
- specific directions to treatment providers as to the treatments that would be consented to or refused; and
- provisions for a proxy to make health care decisions.

A directive must be in writing, dated and signed by the person and one witness, who is not the proxy or the proxy’s spouse. A person may revoke a directive orally, in writing, by destroying the directive, or by making a new directive.

Health care directives are province specific. However, a directive may be valid in another jurisdiction if it meets all the requirements set out in the legislation and is in an acceptable form.
Background

On March 30, 1990, the Ontario Court of Appeal rendered its decision in Malette v. Shulman (1987), 43 C.C.L.T. 62 (Ont. HCJ) affirmed [1990] O.J. 450 (Ont. CA). In that case, the Plaintiff, a Jehovah’s Witness, was seriously injured in a motor vehicle accident. When she failed to respond to standard treatment for volume expansion, she was given a blood transfusion, despite the attending physician having been notified of the card that Mrs. Malette carried, which requested that “no blood or blood products be administered … under any circumstances.” On these facts, the Court stated:

A doctor is not free to disregard a patient’s advance instructions any more than he would be free to disregard instructions given at the time of the emergency.

Since this decision, advance directives have been used frequently and a number of provinces, including Saskatchewan, have enacted legislation governing their use. In our province, the Health Care Directives and Substitute Health Care Decision Makers Act, S.S. 1997, Chapter H-0.001 came into effect September 1, 1997. The enactment of this legislation, the media coverage surrounding it at the time, and a general increased awareness of end-of-life issues have all contributed to an increased frequency in inquiries from clients concerning the use of advance directives. Often such inquiries come while the client is providing you with instructions for the drafting of a Will.

Health Care Directives
(Living Wills)

A Health Care Directive, of course, speaks during the lifetime of the individual. The term frequently used for the provision of instructions regarding medical decisions was “living will.” However, “living will” is not a recognized legal term in Canada.

In the past, many considered living wills as pertaining primarily to patients who are suffering from terminal conditions and are no longer able to express their wishes concerning treatment. A health care directive, however, is not limited to situations of terminal illness and can take effect whenever an individual lacks capacity to make a health care decision. “Capacity” is
defined in section 2(1)(b) of the Act and includes not only the ability to understand information regarding treatment, but also the ability to communicate a health care decision.

Health care directives, therefore, assist in expressing the wishes of patients who are legally incompetent to consent to treatment or those who are temporarily unable to express their wishes due, for example, to the effects of anesthesia. This is reflected in the definition of capacity as well as the provision concerning the length of effectiveness of the directive.

By section 4(2) it is noted that “a directive remains in effect until the person making the directive recovers his or her capacity to make a health care decision respecting a proposed treatment.”

Thus, because the term “advance directive” is broader in scope than “living will” it is the preferred term and has been defined in the Report of the Special Senate Committee on Euthanasia and Assisted Suicide¹, released in June, 1995 as follows:

... a document executed by a competent individual concerning health care decisions to be made in the event that the individual becomes incompetent to make such decisions. Advance directives can be divided into two categories: instruction directives, and proxy directives, also known as durable powers of attorney for health care. In an instruction directive, an individual sets out what or how health care decisions are to be made in the event that he or she becomes incompetent. In a proxy directive, an individual sets out who is to make health care decisions in the event that he or she becomes incompetent. (p. 47)

In the Saskatchewan legislation, “directive” is defined as meaning “instructions given by a person pursuant to this Act that deal with the person’s health care decisions, with the appointment of a proxy or with both” (section 2(1)(C)). A “health care decision” is noted to be “a consent, refusal of consent or withdrawal of consent to treatment” (section 2(1)(d)). The Act, however, does not authorize the use of a directive to consent to active euthanasia or assisted suicide or the authorization of a proxy to do something that is prohibited by the Criminal Code.

It should be emphasized to clients, however, that a health care directive is very different from a will. A will deals with property and matters after the death of a person. A health care directive, on the other hand, focuses solely on health decisions and, again, speaks during the lifetime of the individual.

If a person wants to ensure that his/her directives will be followed in an emergency, or while out of province, it is best to provide copies of health care

documents to several people, including a physician, the named health care proxy, and a trusted friend. In many instances directives can become part of a medical record when a person is admitted to a hospital or other health care facility.

**Who Can Make a Health Care Directive**

Pursuant to section 3 of the *Act*, anyone who is 16 years of age or over, and has the capacity to make a health care decision, may make a health care directive. This directive then takes effect when the person who made it does not have the capacity to make a health care decision respecting a proposed treatment. In s. 2(1)(b), “capacity” is defined as follows:

2(1)(b) “**capacity**” means the ability:

(i) to understand information relevant to a health care decision respecting a proposed treatment;

(ii) to appreciate the reasonably foreseeable consequences of making or not making a health care decision respecting a proposed treatment; and

(iii) to communicate a health care decision on a proposed treatment.

In many situations, advance directives have proven to be useful tools in assisting the health care professionals to assess the patient’s desire and to determine an appropriate course of treatment. Under the legislation, health care professionals will be called upon to consider the type of health care directive that the patient has made.

**Types of Directives**

Essentially, the *Act* contemplates three types of directives:

- general directives;
- specific health care directives; and
- appointment of a proxy.

**General Directives**

Here, the health care directive does not clearly anticipate and give direction relating to treatment for the specific circumstances that exist. The directive, according to the legislation, is then to be used for guidance as to the wishes of the person.
Specific Health Care Directives

This type of directive clearly anticipates and gives directions relating to the treatment for the specific circumstances that exist. The resulting health care decision in the directive has the same effect as a health care decision made by a person with full capacity to make and communicate such a decision concerning a specific proposed treatment.

Appointment of a Proxy

The health care directive may give instructions concerning the appointment of a proxy. This proxy is given the power to make health care decisions for the person making the directive.

Part III of the Act sets out some restrictions on who may be a proxy and also provides guidelines concerning the role of the proxy.

It is significant to note that, while an individual need only be 16 years of age to make a health care directive, one must be eighteen years of age or more to act as a proxy, unless the intended proxy is the spouse of the individual making the directive.

When a court is satisfied a proxy or nearest relative is not acting in good faith, the court may suspend or terminate the appointment of the proxy, rescind any decision made, or may substitute the court’s decision for the decision of the proxy.

Construction of a Health Care Directive

One of the desires of many health care professionals is that people provide very specific instructions. This approach is supported by the Saskatchewan Department of Justice as well, as was demonstrated in the pamphlet entitled “Living Wills/Health Care Directives,” in circulation following enactment of the legislation. It stated:

Be clear and as specific as possible. It is difficult for treatment providers to follow directions that are not clear. The Act does not require them to follow directions that are not specific enough.

Similar statements are found in the current publication materials accessible on the Saskatchewan Justice and Attorney General website.

In addition, although the bulk of the Regulations to the Act are not yet proclaimed, consideration has been given to including a sample health care directive in them.
Some samples considered by the Department were designed to address a number of specific medical procedures. This proved to be somewhat problematic, so consideration may be given to simply providing the public with an information booklet. One reason a form is problematic is that clients often do not have sufficient medical background to understand the very specific directions contemplated by this type of directive. Furthermore, the question arises as to whether lawyers are qualified to advise clients concerning these matters.

Given the variety in types of directives contemplated by the Act, there is considerable variation in the forms and wording in use. Some directives are more general, while others are very specific, given the background and needs of the clients. Often, if your client has education or work experience in health care, it is easier to draft a more specific health care directive as that individual client understands the progressions of various diseases and the repercussions and potential side effects of various proposed treatments. Other clients, who are unfamiliar with such matters, may well wish to have a more general form of health care directive.

**Formal Requirements**

As to the formal requirements of a health care directive, it must be in writing and dated and signed by the person making it or by another person (other than a proxy or a proxy’s spouse) “at the direction and in the presence of the person making the directive.” Where the person making the directive does not sign it, but rather directs another to do so, there must be a witness to the making of the directive and this witness must also sign the directive [section 6(2)].

The witness is an individual “who is not a proxy appointed in the directive or the proxy’s spouse.” It is, however, always good practice to have a qualified witness to the directive, even where the person making it is able to sign the directive.

Section 6, which sets out the above requirements concerning the making of a directive, also indicates that “a person may make a directive by any method prescribed in the regulations.” Again, these regulations have not yet been proclaimed. Sections 8 and 9 also deal with transitional provisions and confirm that a directive made outside Saskatchewan that complies with requirements of this Act is deemed to be a directive made according to the Act, as is a similar directive that was made before the Act came into force.
**Revocation**

A directive may be revoked by the person who made it or by any other person at the direction and in the presence of the person who made the directive. Revocation may be effected in writing, orally, by destroying the directive, or by making a new directive (section 7(1)). The Act also provides that unless the directive indicates otherwise, the appointment of a spouse as a proxy is revoked if the marriage is terminated by divorce.

**When There Is No Directive: Substitute Decision-Maker**

Clients may also have questions about what occurs if no directive is in place or no proxy appointed. Section 15 of the Act sets out, in descending order, those individuals who are considered to be “nearest relatives” and who, if willing, available and with capacity, can make a health care decision for the individual.

The priority of a substitute decision-maker is as follows:

1. a spouse or common law equivalent if a relationship of some permanence;
2. an adult son or daughter;
3. a parent or legal custodian;
4. an adult brother or sister;
5. a grandparent;
6. an adult grandchild;
7. an adult uncle or aunt; or
8. an adult nephew or niece.

The first nearest relative indicated is “the spouse or person with whom the person requiring treatment co-habits and has co-habited as a spouse in a relationship of some permanence.” If health care providers are called upon to determine who the nearest relative is and the patient is in a common-law relationship, the health care providers must then determine, upon the information available to them, whether or not the relationship is of sufficient permanence.

The degree of permanence required is not addressed in the legislation. Thus, if your client is separating, he or she may wish to consider appointing a proxy to ensure that the estranged partner will not be making health care decisions for your client.
Whether a proxy or a nearest relative, the decision-maker must act in accordance with the patient’s wishes. If the substitute decision-maker has no knowledge of the patient’s wishes, the proxy or relative must act in what he or she believes to be the patient’s best interests.

As was noted in the case of proxies, where a nearest relative is not acting in good faith, the court may intervene. Pursuant to section 20(2), the authority of the nearest relative may be suspended or terminated, any health care decision made by the nearest relative rescinded, another relative from the list in section 15(1) appointed to make decisions, and/or the court’s health care decision substituted for that of the nearest relative.

Section 16 and 17 of the Act also contemplate other aspects of substitute health care decision making. For example, in section 16(4) the Act provides that where there is no nearest relative available the following may occur:

16(4) Where there is no nearest relative or where a reasonable attempt to find the nearest relative has been made but the nearest relative cannot be found, and a person requiring treatment lacks the capacity to make a health care decision, a treatment provider may provide treatment in a manner and to the extent that is reasonably necessary and in the best interests of the person without receiving a health care decision from the nearest relative if:

(a) the treatment provider believes that the proposed treatment is needed; and

(b) another treatment provider agrees in writing that the proposed treatment is needed.

Section 17 allows for the ecclesiastical authority designated by the religious order to whom the patient belongs to make certain decisions.

Section 22 of the Act provides a limitation on actions where proxies and health care providers act in good faith, or where they proceed with a treatment that is contrary to a directive in circumstances where they were unaware of the existence of the directive.

For many people, particularly those strong proponents of “living wills” and groups upholding the right to die with dignity, the enactment of this legislation was seen as a very positive move.

However, the Act does not address all questions and, as is apparent from the foregoing, health care providers may be called upon to interpret directives and make judgment calls concerning who is a “nearest relative.”

These types of uncertainties should be discussed with the client who is seeking assistance from you concerning the drafting of a health care directive.
Forms

Please note, “if you are looking for a form for a health care directive under the regulations, please be advised that the Act does not require that a form be prescribed (the relevant provision [section 10] says that certain things ‘may’ be prescribed), and the decision has been made not to include a form” (Public Law Division, Ministry of Justice and Attorney General).

As well, the following forms can be found in *The Adult Guardianship and Co-decision-making Regulations*:

<table>
<thead>
<tr>
<th>Form</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A</td>
<td>Application for Appointment of a Decision-maker other than a Temporary Personal Guardian or Temporary Property Guardian</td>
</tr>
<tr>
<td>Form B</td>
<td>Affidavit in Support of an Application for Appointment of a Decision-maker other than a Temporary Personal Guardian or Temporary Property Guardian</td>
</tr>
<tr>
<td>Form C</td>
<td>Application for Confirmation of a Testamentary Nomination (Appointment by Will)</td>
</tr>
<tr>
<td>Form D</td>
<td>Affidavit in Support of an Application for Confirmation of a Testamentary Nomination (Appointment by Will)</td>
</tr>
<tr>
<td>Form E</td>
<td>Consent to Appointment of a Co-decision-maker or Guardian or to Confirmation of a Testamentary Nomination (Appointment by Will)</td>
</tr>
<tr>
<td>Form F</td>
<td>Affidavit of Execution</td>
</tr>
<tr>
<td>Form G</td>
<td>Statement of Objection</td>
</tr>
<tr>
<td>Form H</td>
<td>Application for Appointment of a Temporary Personal Guardian or Temporary Property Guardian</td>
</tr>
<tr>
<td>Form I</td>
<td>Affidavit in Support of an Application for the Appointment of a Temporary Personal Guardian or Temporary Property Guardian</td>
</tr>
<tr>
<td>Form J</td>
<td>Affidavit re Assessment of Adult’s Capacity</td>
</tr>
<tr>
<td>Form K</td>
<td>Statement of Inventory re Application for Appointment of a Property Co-decision-maker or Property Guardian</td>
</tr>
<tr>
<td>Form L</td>
<td>Annual Accounting by Property Co-decision-maker or Property Guardian</td>
</tr>
<tr>
<td>Form M</td>
<td>Bond</td>
</tr>
<tr>
<td>Form N</td>
<td>Order Appointing a Decision-maker</td>
</tr>
<tr>
<td>Form O</td>
<td>Notice of Authority of Property Decision-Maker</td>
</tr>
<tr>
<td>Form P</td>
<td>Withdrawal of Notice</td>
</tr>
<tr>
<td>Form Q</td>
<td>Amended Notice</td>
</tr>
<tr>
<td>Form R</td>
<td>Application for Review</td>
</tr>
</tbody>
</table>

The materials assembled in this appendix deal with scenarios that commonly arise and proceedings that commonly take place in legal practice. It is hoped that they will provide a useful reference point for the practitioner; however, it is not intended that the precedents be regarded as a comprehensive set of material and should be looked to for guidance only.
Considerations When Drafting a Health Care Directive

Encourage your client to sit down with their health care team and discuss what might happen as an illness progresses or what kinds of tests or treatments might be offered during an emergency.

Directives do not need to cover every medical possibility, but if specific concerns about receiving certain tests or treatments exist, these should be written down. Measures should also be taken to ensure the health care directive is available to health care personnel providing treatment.

Throughout the course of an illness or emergency, health care providers will want to make patients as comfortable as possible, while considering physical, emotional, and spiritual needs, along with the wishes of the patient.

When drafting health care directive, familiarize yourself with medical procedures that are commonly administered to patients. The most common procedures include the following:

- respirators or ventilators;
- blood and blood products;
- cardio-pulmonary resuscitation (CPR);
- diagnostic tests;
- dialysis;
- drugs/medication;
- nutrients or hydration by tube;
- surgery; and
- pain management.

Many people worry about pain and discomfort during an illness or procedure. In many instances, relief from pain and discomfort can be provided and even pain-relieving procedures undertaken which are not regarded as life-prolonging treatments.

Some jurisdictions also exclude food and water (nutrition and hydration) from their definitions of life-prolonging treatments. There is some controversy about whether providing food and water or drugs to make a person comfortable will also have the effect of prolonging life. Some people feel so strongly about not having their lives prolonged if they are comatose or likely to die that they choose to direct that all food, water and pain relief be withheld, even if the doctor thinks those procedures are necessary.