Sinai Health

FAQs on Advance Care Planning (ACP)

Information for Patients, Caregivers, and the Sinai Health Community

The following information is for patients cared for in Ontario.

Prepared by the Department of Bioethics

What is Advance Care Planning?

ACP means considering what is important to you, and what makes your life meaningful in relation to your health. If you lose decision-making capacity, your values, wishes and beliefs expressed during advance care planning can guide your substitute decision maker to make more appropriate treatment decisions for you.

Why do Advance Care Planning?

There may come a time when you cannot make decisions for yourself. This condition could be temporary (e.g., infection) or permanent (e.g., acquired brain injury), sudden (e.g. a stroke), or slow to develop (e.g., dementia).

When this happens, Canadian law requires a substitute decision maker to make decisions on your behalf. Advance care planning can help your substitute decision maker make better decisions in support of the kind of care you may want.

Why is Advance Care Planning important?

Even within a loving family, people often have different values, beliefs, and healthcare goals.

If you want your values, wishes, and beliefs respected, you need to express them while you are capable. To give or refuse consent to a particular decision, you must have decision-making capacity for that decision.

You must be able to understand the information relevant to making a decision, and to appreciate the reasonable and foreseeable consequences of that decision. Unfortunately, many people eventually lose decision-making capacity fromdisease, injury, or age-related deterioration. Such losses may be temporary or permanent.

What Advance Care Planning is NOT

ACP is an expression of your wishes, values, and beliefs in relation to your health and well-being. ACP is not advance consent and not an Advance Directive.

Who should do Advance Care Planning?

All of us, especially as we get older. If you have a chronic condition, a progressive condition, or a terminal illness, it's extremely important to make your wishes known to your substitute decision maker.

Is Advance Care Planning difficult?

No. ACP is not difficult, but it may raise emotional issues — in particular, wishes for care at the end of life. Although many people find it difficult to talk about these things with friends and family, it's usually easier to start the conversation before the need becomes urgent and while you have capacity.

What decisions are needed?

1. Who do you want to make decisions on your behalf if you become incapable (i.e. choosing your substitute decision maker(s))?
2. What do you want your substitute decision maker to know about your wishes, values, and beliefs in relation to your health and well-being? What would you like them to know about your life goals, end of life goals, quality of life or other care wishes?

What is a substitute decision maker?

If you are not able to make decisions for yourself, a substitute decision maker (SDM) will do it for you.

A SDM is a person with the legal authority to make decisions about treatment, admission to care facilities, or personal assistance services on behalf of someone who has been found incapable.

Who might be my substitute decision-maker?

The Health Care Consent Act lists substitute decision makers in the order that health-care professionals must follow:

1. A guardian with the authority to give or refuse consent to treatment
2. An attorney for personal care with the authority to give or refuse consent to treatment
3. A representative appointed by the Consent & Capacity Board
4. A spouse or partner
5. A child or parent
6. A parent who has only a right of access
7. A brother or sister
8. Any other relative (related by blood, marriage or adoption)
9. Public Guardian and Trustee

What is the difference between SDM and POA?

An attorney for personal care or an attorney for property is a specially appointed substitute decision maker (appointed by the patient) by completing a Power of Attorney for Personal Care (POA-PC) or Power of Attorney for Property (PAO –P) document or following the criteria outlined by the law. This is the person you chose,above all others, to make decisions for you. All attorneys for personal care are substitute decision makers, but not all substitute decision makers hold a power of attorney for personal care document. In Ontario there are two main types of POA.

1. **Power of Attorney for Personal Care (POA-PC)** is the person(s) you choose to make health care and related decisions if you lose decision-making capacity. This is the most common type of POA.
2. **Continuing Power of Attorney for Property (POA-P)** is the person(s) you choose to make financial and other property decisions now; the appointment continues if you later become incapable. For example, this person may hire care providers, buy equipment,and pay your bills using your money.

Do I need a lawyer?

It's up to you; some people prefer to consult a lawyer. Forms, booklets and internet resources can help you choose an attorney for personal care or property and complete a Power of Attorney without a lawyer. Be sure to read the information carefully. https://www.ontario.ca/page/make-power-attorney

What directions do I want to give?

It is impossible to know what the future will bring and how you may feel in those moments. However, we all hold certain values, beliefs and wishes about quality of life, end of life, and overall health care. It is important you share those with your substitute decision maker to help inform their decisions about what you may want or not want. Writing down or speaking about your values, wishes, and beliefs aloud now may make health care and end-of-life decisions a little easier when the time comes.

Is there a form for expressing wishes?

No, it's a matter of personal choice. In Ontario, you can share values, wishes, and beliefsin anyway you wish. There is no mandatory form. You can use a pre-printed form, write your wishes in a letter, make an audio or videotape record, or use Braille. You may express your wishes in writing or simply by telling your SDM. The amount of detail is up to you.

Can I change my mind?

Yes. If you change your mind about health care decisions, you should:

- Discuss your current wishes, beliefs and health care goals with your substitute decision maker
- Consider writing down your current wishes, beliefs and health care goals.

If you change your mind about the person you wish to be your attorney of personal care,

- Complete a new Power of Attorney form
- Discuss your current wishes, beliefs and health care goals with your new attorney for personal care.

ACP and Consent

Consent for treatment will be obtained at the time from the appropriate substitute decision maker in accordance with the following principles:

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

When does Advance Care Planning take effect?

As long as you are capable, you are the decision maker. Health care professionals will ask you for consent. Your ACP takes effect when you lose decision making capacity (see "Decision Making Capacity" FAQ).

Is Advance Care Planning required?

No, but it is recommended. If you do not make your wishes known, your health care team will work with the highest-ranking substitute decision maker to make decisions in accordance with your best interests.

Is my substitute decision maker required to follow my wishes?

Yes. Your SDM must give consent to treatments proposed by a health care professional on the basis of your previously expressed capable wishes that fit the situation.

Glossary

Consent and Capacity Board: An independent body that ensures fair access to consent and capacity issues.

Continuing Power of Attorney for Property (POA-P): A person(s) you choose to make financial and other property decisions now; the appointment continues if you later become incapable. For example, this person may hire care providers, purchase equipment, and pay your bills using your money.

Decision-making capacity: The ability to make an informed choice regarding a decision.

Guardian of the Person: A person appointed by a court to make health and financial decisions for you if you are not capable.

Power of Attorney for Personal Care (POA-PC): A substitute decision maker you have specially appointed to give/refuse consent if you become incapable. Because POA-PCs are specially appointed, you must complete a legal document.

Substitute decision maker: A person with the legal authority to make decisions about treatment on behalf of someone who has been found incapable.

Treatment: Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

Resources

Speak Up Ontario
www.speakupontario.ca

Consent and Capacity Board
www.ccboard.on.ca/

Health Care Consent Act
ontario.ca/laws/statute/96h02

Substitute Decisions Act
ontario.ca/laws/statute/92s30

Ontario Ministry of the Attorney General
www.attorneygeneral.jus.gov.on.ca/english

References

Hospice Palliative Care Ontario. Health Care Consent Advance Care Planning Community (HCC ACP CoP) of Practice(HCC ACP CoP) HCC ACP in Ontario –Summary of Key Themes and Common Errors. April 1, 2016. http://acpww.ca/wp-content/uploads/2016/01/Summary-of-Key-Review-Themes-Final-April-1-2016.pdf

Health Care Consent Act 1996, c. 2, Sched. A, s. 21(1). https://www.ontario.ca/laws/statute/96h02#BK24

Adapted from Hospice Palliative Care Ontario. Health Care Consent Advance Care Planning Community (HCC ACP CoP)of Practice (HCC ACP CoP) HCCACP in Ontario – Summary of Key Themes and Common Errors. April 1, 2016.
http://acpww.ca/wp-content/uploads/2016/01/Summary-of-Key-Review-Themes-Final-April-1-2016.pdf

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