Ontario’s proposed consent laws: 1. Consent and capacity, substitute decisions, advance directives and emergency treatment

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In the spring of 1991 the Ontario government introduced a legislative package that will fundamentally change the way health care is practised in Ontario and, if copied, elsewhere in Canada. The Consent to Treatment Act,1 the Substitute Decisions Act,2 the Consent and Capacity Statute Law Amendment Act3 and the Advocacy Act4 are the culmination of almost a decade of work by three provincial governments. The bills adopt the philosophy and borrow from the language and content of the present Mental Health Act.5 The Consent to Treatment Act defines treatment as anything “done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment.” It applies to a broad range of health practitioners, including physicians. The legislation received second reading in the provincial legislature on June 10, 1991, and during February and March 1992 the Standing Committee on Administration of Justice has been holding public hearings.

This article describes and evaluates the main provisions of the Consent to Treatment Act and the relevant sections of the other bills.

Consent and capacity

The Consent to Treatment Act codifies the requirement for and the elements of informed consent to treatment: consent must relate to the particular treatment, it must be informed, and it must be given voluntarily. Consent is informed only if, before giving it, the patient “received all the information about the treatment, alternative courses of action, and the material effects, risks, and side effects” that a “reasonable person” would need to make a decision. Although the requirement for consent to treatment has long been part of common law,6 at present there is no legislation that deals with the issue comprehensively.7

Both the Substitute Decisions Act and the Consent to Treatment Act hinge on a patient’s capacity to consent to treatment. People who are capable can consent to treatment for themselves, but those who are not require a substitute to act on their behalf. Capacity is defined as the ability 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 a lack of decision.”

Procedures for determining capacity will be set out in regulations that have not yet been made public. These may be based on the recommendations of the Enquiry on Mental Competency, chaired by Professor David N. Weisstub,8 which stated that capacity should “reflect the functional requirements of a particular decision [by] testing the individual in the decisional context.” As well, the enquiry suggested that the assessment of capacity should consist of

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four stages: (a) a basic threshold to determine if assessment is necessary, (b) a simple test to highlight problems with capacity, (c) a more thorough test and (d) the right of the patient to appeal a finding of incapacity to a review board. Under the proposed legislation the patient may appeal a finding of incapacity to the Consent and Capacity Review Board, a body created by the Consent to Treatment Act. Since the ultimate impact of the consent and capacity provisions will depend on the quality of the regulations it is premature to judge the provisions now.

Substitute decisions

In substitute decision making on behalf of an incapable patient two key questions arise: Who should make decisions for the patient and how should these decisions be made? With regard to the first, the Consent to Treatment Act establishes a hierarchy of substitute decision-makers. Guardians of the Person and Powers of Attorney for Personal Care (PAPCs) have the highest priority, then the patient’s spouse or partner, children, parents or legal guardian, brother or sister, and any other relative. The definition of partner includes a common-law spouse as well as a partner of the same sex. The substitute decision-maker must indicate that he or she has been in personal contact with the incapable person during the preceding 12 months and has no reason to believe that that person might object to his or her appointment. If there is conflict between substitute decision-makers with the same priority or if no one listed is available the public guardian and trustee may give or refuse consent. The appointment of the substitute decision-maker may be appealed to the Consent and Capacity Review Board.

These substitute decision-making provisions will assist clinicians. For instance, they will prevent the “daughter from California syndrome,” in which a distant relative who has had limited contact with the patient insists on a particular treatment direction. They will also help if the patient is without a substitute decision-maker.

The Consent to Treatment Act codifies the principles according to which the substitute should make the decisions. The recently expressed wishes of the patient, given in writing or orally, govern treatment decisions. Only in the absence of expressed wishes is the standard of best interests used. The Consent and Capacity Review Board is empowered to clarify a patient’s expressed wishes or to overrule a patient’s wish to forgo treatment in the event of unforeseen medical advances.

The Ontario Court of Appeal has recently decided that the Canadian Charter of Rights and Freedoms requires that a patient’s expressed wishes may not be overridden, even if it is in his or her best interests that they should be. The case of Fleming v. Reid, which was decided after the Consent to Treatment Act was introduced, involved the administration of neuroleptic medication for the treatment of schizophrenia to two patients at a mental health centre. Acting on instructions given by the patients when they were competent the official guardian, as their substitute decision-maker under the Mental Health Act, refused to consent to the treatment. Under a provision of the act, however, their psychiatrist was permitted to apply to a review board to override the patients’ refusal, which he successfully did. In its decision the court found that although the board’s order may have been in the patients’ best interests it violated their right to security of the person as guaranteed by section 7 of the charter.

By giving wishes priority over best interests the Consent to Treatment Act fulfills the requirements of section 7 of the charter. (The specific provision permitting a review board to overrule a patient’s wish in the event of unforeseen medical advances may not do so, but this is a matter for the courts.) It also enunciates the fundamental principle in our society that what people want for themselves takes precedence over what others think is best for them. This belief is the basis of the right of self-determination that underlies the doctrine of informed consent to medical treatment.

In addition to entrenching the priority of expressed wishes the Consent to Treatment Act defines the meaning of best interests so that if the patient’s wishes are unknown, substitute decision-makers will have clear guidance. The elements of best interests are (a) the values and beliefs the substitute decision-maker knows that the incapable person held when capable and believes that he or she would still act on, (b) the incapable person’s current wishes if known, (c) the possibility of improving the incapable person’s “condition or well-being” with and without treatment, (d) the balance between the benefits and the risks of treatment and (e) the possibility that a less intrusive or restrictive treatment would be as beneficial as the one proposed. “Best interests” has been an ill-defined and nebulous term. By defining it the act attempts to prevent its misuse, even by substitutes who are acting with the best of intentions.

The Substitute Decisions Act contains extensive provisions regarding guardianship that will be highly relevant to physicians practising in long-term care facilities. These provisions are beyond the scope of this article.

Advance directives

Since the preferred type of substitute decision
making is that done in advance, when the person is still capable, an essential feature of the proposed laws is the legalization of advance directives.

There are two types of advance directives: proxy and instruction. In a proxy directive, also called a durable power of attorney for health care in many US jurisdictions, a person states who is to make decisions on his or her behalf. In an instruction directive, also called a living will, a person states what is to be done with regard to specific life-sustaining treatments in particular clinical situations. In the United States 49 states and the District of Columbia have legalized the use of advance directives, and two Canadian provinces, Nova Scotia and Quebec, have legalized the use of proxy directives. In Manitoba the Law Reform Commission has recently issued a report and draft legislation on advance directives. For further information on advance directives we refer readers to the CMA policy statement and a recent article on this topic.

The Substitute Decisions Act creates PAPCs, in which proxies may be named and conditions and restrictions set on their decision-making authority; those named in PAPCs are the substitute decision-makers of highest priority. As well, PAPCs may contain instructions. Thus, they combine the essential features of proxy and combined proxy-instruction directives.

The legalization of advance directives should be welcomed by physicians, because it addresses the central clinical paradox in the care of incapable patients: physicians want to follow their patients' wishes regarding life-sustaining treatment, but these wishes are often unknown. Moreover, by incorporating proxy and instruction components in a PAPC the legislation permits a proxy to apply wishes to clinical situations that may not have been anticipated by the patient. However, although the Substitute Decisions Act permits patients to express their wishes in a PAPC it does not encourage them to do so. Research studies show that if people have not discussed their wishes in advance their loved ones often do not know what the wishes are. Since the regulations will set out a “prescribed form” that may be used for the PAPC this difficulty could be addressed if the form contained a combined proxy-instruction directive. This could be based on currently available formats.

Emergency treatment

In emergencies health care practitioners may treat incapable patients without obtaining consent. However, this exemption may only be invoked if the patient is “likely to suffer” serious bodily harm within 12 hours unless treatment is administered promptly or if it is not possible to obtain a substitute decision-maker's consent or refusal (or the delay required to do so would likely result in serious bodily harm to the patient). Emergency treatment may be administered for a maximum of 72 hours. Moreover, the health practitioner must notify the public guardian and trustee, and efforts to find the substitute decision-maker must continue.

One of the problems with this definition of emergency is that, strictly interpreted, it may not include most medical emergencies. For example, a patient with an acute myocardial infarction is not likely to suffer serious bodily harm within 12 hours if treatment is not administered promptly. Such a patient will suffer serious bodily harm (i.e., myocardial damage) whether or not thrombolytic therapy is administered, but the harm will be reduced by the therapy. Moreover, if bodily harm is understood to include death the patient is not “likely” to die within 12 hours but may die whether or not thrombolytic therapy is administered. In absolute terms, the benefit of thrombolytic therapy is that it reduces the chance of death by only a few percent (e.g., from 12.8% in patients treated with placebo to 10.0% in those treated intravenously with streptokinase). Would thrombolytic therapy for acute myocardial infarction — widely hailed as the most significant medical advance in the treatment of coronary artery disease in the past decade — count as an emergency treatment under the proposed Ontario legislation? We are not sure. Because many medical treatments in “emergency” situations provide similar margins of benefit we believe that the definition of emergency should be clarified to include them.

Despite authorizing health care practitioners to treat without consent in emergencies the Consent to Treatment Act obliges health care practitioners to refrain from administering treatment if there are reasonable grounds to believe that the patient has completed a PAPC containing instructions or has previously expressed a wish to refuse consent to the proposed treatment. The act protects health care practitioners from legal liability for withholding treatments in accordance with the provisions of the act.

The emergency provisions are based on the case of Malette v. Shulman, in which a physician administered a blood transfusion to an unconscious woman who carried on her person a signed but undated and unwitnessed Jehovah's Witness card stating her refusal of such treatment. The patient ultimately sued the doctor for battery. At the trial the physician was found to be liable, despite having acted with good intentions to save the patient's life. The Ontario Court of Appeal affirmed the decision.

One of us has criticized the Malette decision elsewhere. In brief, we argued that if uncertain about the wishes of an incompetent patient in a
medical emergency physicians may make one of two
types of error: providing unwanted treatment or
withholding wanted treatment. We believe that the
latter error, which may result in death, is more
serious than the former error, which may result in
life. For physicians the critical question is how much
information about the prior wishes of an incompe-
tent patient is sufficient to decide to withhold a
simple and possibly life-saving treatment in an
emergency. For example, it might be reasonable for
physicians to withhold life-sustaining treatment on
the strength of a properly executed PAPC or if a
substitute decision-maker and the patient’s written
wishes are available; however, written wishes alone
(as in the first few hours of the Malette case) or
wishes expressed orally may not be enough.

Conclusions

The provisions of Ontario’s proposed new con-
sent laws reviewed here generally follow what phy-
sicians currently do or say they should do. In some
respects they will assist physicians to provide high-
quality, ethical care to their patients. In other
respects there is room for fine-tuning, and we have
made some specific recommendations.

By contrast, the provisions of Ontario’s pro-
posed laws on advocacy represent a dramatic depart-
ure from current medical practice. We will review
these in the next issue of CMAJ.

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