

Health Care Directives Legislation

Discussion Paper for the Standing Committee on Law Amendments

September 2008

Introduction

New Brunswickers place a high value on personal autonomy, and the ability to make life choices which reflect our own preferences, values and beliefs. This is no truer than when the decisions in question relate to highly personal choices about health care.

For many, situations will eventually arise in which individuals lose their capacity to make or communicate these choices directly; a health care directive (sometimes called a living will) can provide a means to ensure that individuals wishes are known and respected, guiding the actions to be taken by family and health care providers.

New Brunswick is the only province in Canada without legislation giving legal force to health care directives, and describing the circumstances in which they can take effect. The 2007-2008 Speech from the Throne signaled New Brunswick's intention to remedy this, committing the government to introduce enabling legislation both for written health care directives, and/or the designation of substitute decision makers.

This paper highlights specific components proposed to be included in the new legislation. While it is not all inclusive and while legislative drafters always have the final say regarding the specific wording in any legislation, this discussion paper addresses the major elements expected to be in the legislative proposal, including:

1. Purpose of health care directive legislation: General
2. Who can make a health care directive
3. Elements of a valid health care directive
4. When a health care directive becomes or ceases to be effective
5. Instances when a health care directive loses effect
6. Health care providers
7. Proxies
8. General Provisions

The Department of Health recommends that a public consultation process occur in the near future, using this paper as the primary documentation. Public and stakeholder input would then be used to help craft the legislative proposal.

1. Purpose of the health care directive legislation: General

The occasions when persons lose their capacity to make their own medical care choices are often very difficult, both for the individuals themselves and for their family and caregivers.

While New Brunswick's *Infirm Persons Act* enables a person to appoint a person to hold power of attorney to make "personal care" decisions, "personal care" itself has not been defined in legislation or interpreted by the courts. It is unclear whether the definition of personal care includes medical treatments, and other aspects of a person's care, or if it is more limited. Also, there is no process under the *Infirm Persons Act* to swiftly appoint a substitute decision maker if one has not been named by the individual themselves. One effect is that people who lose competence may have treatment (or placement) delays, while the process of appointing a substitute decision maker goes through the courts. Across Canada, the mechanism used to ensure that an individual's health care wishes are known and respected is a health care directive, as defined in legislation.

A health care directive is a document in which an individual:

- describes their instructions, principles, or wishes relating to their health care; or
- appoints someone to be a "proxy," making health care decisions on their behalf if the individual becomes unable to make or communicate their choices; or
- both.

Legislative approaches vary by jurisdiction on the provisions included in health care directives legislation, although most provinces adopt a “mixed” model which recognizes both written directives and proxies.

It is proposed that a health care directive under New Brunswick’s legislation will deal with health care decisions – such as providing/withdrawing consent for any care, treatment, service, medication, etc., for an individual’s physical health, mental health, or personal care. It would not apply to the treatment of involuntary psychiatric patients under the *Mental Health Act*.

To this end, it is proposed that new health care directives legislation for New Brunswick would enable individuals to create written health care directives, or assign a proxy (substitute decision maker) to make health care decisions on their behalf.

If a person does not create a written directive or name a proxy, the legislation would also include a default list of persons to act as a proxy, similar to lists in the *Devolution of Estates Act*, or *Mental Health Act*.

Questions for consideration:

Should New Brunswick adopt a mixed model for health care directive legislation? Should it provide a process to determine a proxy decision maker, if none has been named and there is no written directive?

Should the legislation provide for other purposes? If so, what purposes?

2. Who can make a health care directive?

Given that a health care directive is a binding expression of the wishes of the individual, it is important that the individual is both eligible and competent to make decisions which may influence their own life or death.

Legislation across Canada generally states individuals are deemed eligible to make health care decisions when they are age 16 or older. New Brunswick’s *Medical Consent of Minors Act* provides that younger

people can make medical decisions when they are judged competent to do so (i.e. are deemed a “mature minor”) by a health care professional.

In New Brunswick, we propose that the new legislation indicates that competent individuals 16 years of age or older, or “mature minors,” are eligible to make health care directives.

Whether an individual is competent to make the decision can be difficult to clearly assess. For example, one may be competent to make decisions in some health or personal care domains (e.g. would you like lunch now?) while incompetent in others (e.g. do you want this medical treatment, or that medical treatment?). One may be competent to make a decision today which one could not have made yesterday, or could make tomorrow. The effectiveness of a health care directive should reflect this understanding, and allow for flexibility.

In New Brunswick’s proposed legislation, “competence” would mean that an individual:

- understands the information relevant to making a health care decision;
- understands the reasonably foreseeable consequences both of their decision ... or of not making a decision;
- can communicate their decision.

Jurisdictions take different approaches on who should assess an individual’s competency to make health care decisions, and on what basis. Some restrict this to medical professionals (i.e. physicians), others include a broader range of regulated health professionals; all include the courts.

In New Brunswick’s proposed legislation, health professionals (and the courts) would have this role, using criteria and processes to determine an individual’s competence to make health decisions in a given domain as prescribed by regulation. In addition,

- an individual would be informed by their health care provider upon being deemed incompetent, could request a reassessment, and would be considered competent to instruct counsel in such a proceeding;

- a person assessing or re-assessing an individual's competence would have the right to all of the individual's relevant health care information and documents to assist in the assessment.

Questions for consideration:

Is it appropriate that a health care provider determines an individual's competence to make health care decisions, and so the coming-into-force of a health care directive?

Should this be limited to certain types of health care providers? What processes or procedures should be prescribed to determine competence? How should competence be defined?

3. Elements of a health care directive

Mandatory Elements

While the elements of a health care directive can vary slightly from jurisdiction to jurisdiction, Canadian legislation consistently requires that directives be both written and witnessed. The document must be signed by the individual and any witness(es). If the document names someone as a "proxy" (substitute decision maker), that person must also sign the directive.

Signing the document is important because it legitimizes the contents of the health care directive as the wishes of the individuals themselves. Decisions made on the basis of the health care directive have the same legal force as if the individual had made the decision autonomously.

Some jurisdictions have developed forms to assist individuals who wish to prepare a health care directive. The forms typically include each of the required elements, but their use is not mandatory.

In New Brunswick, it is proposed that any legislation requires that health care directives be:

- written;
- witnessed, dated and signed by the maker,

- or on behalf of and in the presence of the maker by someone other than the individual's spouse or proxy; and
- signed by the witness, and by any proxy named in the document.

It is also proposed that once the health care directive is created, an individual has a responsibility to inform their health provider of that directive, and a copy of the directive be kept in the individual's medical file.

Questions for consideration:

Are these mandatory elements for health care directives appropriate? Are there elements which should be included or excluded?

Limitations

While health care directives are intended to ensure that the preferences of an individual are known and respected, there may be some instances where these wishes cannot be addressed (limitations). For example, an instruction which is contrary to a law of New Brunswick or of Canada, for instance, would be void. A health care directive – whether written or expressed by a proxy – would have no greater force than the decision of the individual, had the individual been competent.

In some jurisdictions' health care directives legislation, a broader range of issues can be addressed in written directives than by an individual named as a proxy. Often, these issues are among the most personal, and potentially ethically challenging (e.g. sterilization, donating organs or tissue from a living donor). Without clear written direction, some jurisdictions reserve decisions on such personal and irreversible actions to the individual themselves.

In New Brunswick it is proposed the new health care directives legislation would address these issues by stating that an instruction in a health directive which is contrary to a law of New Brunswick or Canada is void.

The legislation would further state that unless expressly authorized in a written health directive, a proxy may not make decisions relating to:

- medical treatment for the primary purpose of research;
- sterilization which is not medically necessary for the protection of the health of the individual;
- the removal of living tissue for transplantation, medical education, or medical research;
- other types of health care, as described in regulation.

Questions for consideration:

What limitations should be in place regarding the scope of health care directives? Is a distinction between the scope for written directives and decision making by a proxy appropriate?

4. Treatment of health care directives made outside New Brunswick

As one would expect, it will be proposed that new health care directives legislation for New Brunswick will state a health care directive made in New Brunswick by a competent individual would become a valid document as soon as it is signed, dated and witnessed in accordance with the provisions to be laid out through legislation (see section 3, above). But what of directives made outside New Brunswick? Would such a directive be valid, if the health care decisions need to be made within New Brunswick? What if there is such a directive, but it does not meet the criteria described in the New Brunswick legislation?

Moreover, many jurisdictions choose to honour health directives which are valid in the jurisdiction in which they were made, whether or not in all respects the directive meets the requirements of the jurisdiction in which they need to be used.

New Brunswick proposes to treat health care directives made outside New Brunswick with the same force as those made within New Brunswick if:

- the directive meets the formal requirements of the NB Act; or
- the directive meets the formal requirements of the legislation in the jurisdiction in which it was made.

Questions for consideration:

Is this an appropriate way to treat health care directives made in other jurisdictions? What other provisions should be considered?

5. Instances when a health care directive loses effect

In most jurisdictions, a valid health care directive, whether made within or outside that province, can be rendered invalid if the individual formally revokes it, or formally invokes a new directive to supersede it. In some circumstances, a Court may determine that the directive ceases to have effect.

New Brunswick proposes that if an individual is competent to make health care decisions, he or she may also revoke a health care directive by:

- making a new directive, in accordance with the legislation; or
- revoking the directive in writing (signed, dated and witnessed); or
- the destruction (with the intent to revoke) of all original signed copies of a directive – either by the individual, or by another person in their presence and at their direction.

A valid health care directive may also cease to have effect for other reasons, even if not formally revoked by its maker. It is proposed that the new legislation address this issue, by stating that a health care directive would have no further effect if:

- the individual is competent (or regains competence);
- the individual dies;

- a court determines that the directive should have no further effect.

Questions for consideration:

Are these appropriate provisions for a health care directive to lose effect?

6. Health Care Providers

As described above in section 2, “Who can make a health care directive” New Brunswick’s proposed legislation would name health care providers responsible to determine an individual’s competence to make health care decisions. However, not only are health care providers responsible to determine an individual’s competence, the very nature of their work lays further responsibilities upon them, and exposes them to certain liabilities.

While it is proposed the legislation will direct that a copy of an individual’s health directive should be placed in their medical file, these may not always either be present, or be current. Individuals from other jurisdictions visiting New Brunswick will be unlikely to have a copy of any health directive with them.

To address these issues, it is proposed that upon determining that an individual is not competent to make a health care decision, New Brunswick’s proposed legislation will oblige a health care provider to ask:

- if the individual has a health care directive; or
- to clarify the individual’s wishes if the directive is unclear.

Moreover, it is proposed that new health care directives legislation for New Brunswick will state the provider also has an obligation to include a copy of the current health care directive in the individual’s medical file, if one exists.

If it also presumed that the health care directive is valid and its instructions legal, a health care provider must follow any clear directions and instructions written in the directive, or provided by a proxy decision maker.

In an emergency, however, there may be no time to determine if there is a health care directive, or a named proxy. In addition, there may be a question of whether a health care provider has made enough effort to determine whether there was a health care directive. In these situations, it is proposed that new health care directives legislation for New Brunswick would state:

- A health care provider is not required to obtain a proxy’s consent or locate a written health care directive in the case of a life threatening emergency, or where the delay may pose a significant risk to the individual’s life.

It is important that health care providers are protected from legal action when providing or withdrawing health care in good faith. In this regard, it is proposed that new health care directives legislation for New Brunswick would prohibit legal action against a health care provider who:

- acts in good faith according to a decision by a proxy or a statement in a written health care directive;
- asked about the existence of a health care directive or proxy, but did not learn that one existed;
- provided emergency care without first learning of a health care directive or proxy, because the delay could have had serious consequences to the patient.

Questions for consideration:

Are these appropriate obligations and protections to place on health care providers respecting health care directives?

7. Proxies

New Brunswick’s proposed legislation would allow for individuals to name one or more proxies, to make health care decisions on their behalf. A person is eligible to be a proxy if they are 19 or over, and deemed competent themselves to make a health care decision.

A proxy model can be more flexible than a written directive; while a proxy can make decisions based on the values, wishes, and beliefs of the individual, a written directive can become dated as an individual's mind is changed, or as technology advances. In the "mixed" model being proposed, an individual may have both a written directive and name one or more proxies. The written directive can set out specific provisions and/or provide instructions – and may expand or restrict what would otherwise be the scope of a proxy's authority.

Duties and Obligations of Proxies:

New Brunswick's proposed legislation would have a mixed proxy mode, obliging the proxy to follow any clear instructions provided in a written health care directive, except if:

- the individual later clearly expressed a contrary wish to the proxy;
- technological or medical changes would have made the instruction inappropriate to the individual's values, wishes, beliefs or intentions;
- circumstances exist which would have made the instruction inappropriate to the individual's values, wishes, beliefs or intentions;
- the instructions in the health care directive are contrary to legislation

It is proposed that health care directives legislation for New Brunswick would further state that when a proxy has no knowledge of an individual's values, wishes, beliefs or intentions, a proxy will act in what s/he believes to be the best interests of the individual.

Health care directive legislation usually indicates that a proxy's authority in health care decisions ceases:

- when s/he declines to act, resigns, dies, or lacks capacity to make health care decisions;
- when an individual revokes a proxy's authority (in writing, signed, dated, and witnessed);
- if a court so determines;
- if the proxy is a spouse, and the marriage ends – unless the health care directive expressly provides otherwise.

It is proposed that New Brunswick's legislation would mirror this pattern.

And finally, it is proposed that new health care directives legislation for New Brunswick should protect a proxy from legal action by stating a proxy will not be liable to legal action only for the reason of having acted in accordance with the legislation, or of failing to make a health care decision on behalf of the individual.

Questions for consideration:

Are these appropriate criteria to guide proxy decision making?

Number of Proxies:

Some jurisdictions allow the naming of more than one proxy, to share responsibility in the event that health care decisions become necessary – such proxies can be named jointly (with equal authority), or successively (if the first cannot assume the role, a second may step in).

Conflicts have arisen between proxies, leading some jurisdictions to allow an individual to assign only one. New Brunswick is considering enabling multiple proxies, but to help define the framework within which they interact.

For example, it is proposed that when more than one proxy is named, and the health care directive does not indicate they are to act jointly, they will be considered to have been appointed to act successively – in the order they are named in the directive.

As well, New Brunswick proposes that when proxies are directed to act jointly, unless the directive provides otherwise:

- a majority decision will be deemed to be the decision of all;
- if one or more has died, is unwilling, or is unavailable, a majority decision of the remainder will be deemed to be the decision of all;

- if there is no majority decision, the proxy first named in the directive may make the health care decision on behalf of the individual.

Questions for consideration:

Should the legislation allow for multiple proxies? If so, does this provide an appropriate framework within which multiple proxies can make a health care decision?

Naming a Proxy:

As described in the “Purpose” section above (section 1), it may be that an individual neither makes a written health care directive, nor assigns anyone to be a proxy. Other jurisdictions recognize that situations may occur in which a substitute decision maker is required, and have developed processes to name one if needed.

Health care decisions are no different. If an individual is not competent to make autonomous decisions about their own care, has left no instructions, and has either not named a proxy or the proxy refuses to make a decision, it is important that a process is put in place where decisions can be made in the best interest of the individual.

In this regard, it is proposed that New Brunswick’s health care directives legislation states that if an individual is not competent to make a health care decision, has no health care directive, has named no proxy, and has neither a person with Power of Attorney for Personal Care under the *Infirm Persons Act* nor a court appointed guardian with the authority to make a health care decision, a proxy may be:

- the individual’s spouse;
- the individual’s children;
- the individual’s parents or legal custodian;
- the individual’s siblings;
- a person whom the individual’s health care provider considers to be the individual’s trusted friend, with close knowledge of the individual’s wishes;

- another relative, including the individual’s grandchildren, grandparents, uncles or aunts, nieces or nephews;
- the individual’s health care provider who is responsible for the proposed health care; or
- as a last resort, the Public Trustee.

It is further proposed that the proxy will be the first named person or member of a category of persons from this list who is at least 19 years of age, competent to make a health care decision, and willing to make one.

Questions for consideration:

Are these appropriate provisions for naming a proxy, when one has not otherwise been designated?

8. General Provisions

Jurisdictions across Canada provide a variety of general provisions in their health care directives legislation – ranging from discussions of how to prevent a conflict of interest if a proxy is also a beneficiary of an individual’s will, to processes for making an application to the Court of Queen’s Bench, to offences and penalties. General provisions can also indicate the relationship between health care directives legislation and other pieces of legislation, and provide regulation making authority.

Some of the general provisions New Brunswick is considering introducing in its new legislation include:

- If a health care directive has been acted upon in good faith by a health care provider or proxy, but the directive itself was invalid (i.e. not made according to the Act, or had been revoked, or was not made by a competent individual), the directive will be treated as valid if the proxy or health care provider had no reason to believe it was not so;
- The agreement of a person to act as a proxy for health care decisions does not affect their entitlement to any bequests, dispositions of property, proceeds of insurance policies etc.

relating to the individual for whom they will act;

- Offences under the Act would include:
 - Willfully concealing, altering, cancelling, or otherwise falsifying or forging an advance care directive, or the revocation of one;
 - Willfully misrepresenting either him/herself in relation to a health care directive, or the individual's wishes in one;
 - Coercing or exerting undue influence on an individual to make a health care directive.

These offences would be considered Category E offences under the *Provincial Offences Procedures Act*, subject to a penalty of not less than \$240, and not more than \$2620;

- Persons may apply to the Court of Queen's Bench regarding a range of issues, including:
 - Whether a written document which does not meet the requirements of the legislation should be treated as an effective health care directive;
 - Determining the competence of an individual or of a proxy to make health care decisions – or health care directives;
 - Determining the validity of part or all of a health care directive;
 - Determine the authority of a proxy, and confirm/alter/rescind a proxy's decision based on evidence of an individual's wishes or intentions;
 - Designate another person as a proxy;
 - Order that costs of a proceeding be paid from an individual's estate;
 - Other orders as the court deems appropriate.
- If the health care directives legislation was to come into conflict with the *Mental Health Act*, the latter would take precedence
- Provisions of the new health care directives legislation or regulation would apply to a power of attorney for personal care, in the *Infirm Persons Act*;
- The Lieutenant-Governor in Council would have broad authority to make regulations respecting any aspect of the Act, including those regarding:

- Criteria/standards/processes to assess or reassess an individual's competence;
- Decisions which a proxy may not make on another's behalf, absent a clear instruction in a health care directive or other clear expression of an individual's wish;
- Prescribing a form for a health care directive.

Questions for consideration:

Are you comfortable with the general provisions described above? Are there other provisions which should be included in the legislation?