

When does an advance care choice come into effect?

Choices expressed through advance care planning come into effect only at the time when an individual does not have the capacity to make a treatment decision. Capacity is the ability to understand the nature of a treatment decision and appreciate the consequences of making the decision. The healthcare provider proposing the treatment determines the person's capacity. When an individual is found incapable, he or she should be informed of the finding. If the person disagrees with the finding, it can be challenged through the Consent and Capacity Board.

Are substitute decision makers (SDMs) required to follow the expressed wishes of the individual?

Yes, SDMs are required to provide or refuse consent to treatment proposed by a healthcare provider based on an individual's previously expressed capable wishes that are applicable to the situation. If the individual has not previously expressed any applicable wishes, SDMs are required to make decisions based on the individual's best interests.

Is everyone required to do ACP?

No. There is no legal requirement for individuals to do advance care planning (either to express their choices or to appoint a substitute decision-maker). Admission to a facility or access to health care cannot be denied based on the absence of advance care planning.

For more information:

For more information about advance care planning, speak to a member of your healthcare team or refer to one of the following on-line resources.

Speak Up: Advance Care Planning in Canada
<http://www.advancecareplanning.ca>

Advocacy Centre for the Elderly
http://www.advocacycentreelderly.org/advance_care_planning_-_publications.php

Consent and Capacity Board
<http://www.ccboard.on.ca>

Ministry of the Attorney General – Powers of Attorney Booklet
<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf>

Ontario Seniors' Secretariat – A Guide to Advance Care Planning
<http://www.seniors.gov.on.ca/en/advancedcare/docs/AdvancedCare.Guide.pdf>

Regional Ethics Program

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A Guide to Advance Care Planning

There is a history of strokes in a 60 year-old woman's family. She has strong opinions about how she would like to be cared for if she experiences a serious stroke. She does not want to be "hooked up to machines" if she is unlikely to regain the ability to talk or eat or move about.

A 90 year-old man has recently been diagnosed with Alzheimer's disease, he lives in his own home and wants to continue to do so, despite concerns raised by his children about his safety.

A 70 year-old woman with strong religious convictions believes that "where there is life, there is hope." If she becomes comatose, she wishes to continue receiving life-sustaining treatments.

In each of the above scenarios, an individual has expressed wishes about the kind of health care they want to receive in a future medical situation when they are unable to tell us their wishes. This expression of wishes is often referred to as advance care planning.

This guide outlines some key information for individuals to consider when engaged in advance care planning. A list of additional resources is also provided.

What is advance care planning (ACP)?

Advance care planning is a process whereby individuals discuss and identify personal choices about how they wish to be cared for in future medical situations. Advance care planning may also include appointing someone to make decisions on behalf of the individual should they become unable to do so.

Why is ACP important?

For many people, there may come a time when they are unable to make their own decisions. The inability to make decisions for oneself may happen suddenly as with a serious stroke or gradually as with Alzheimer's disease. In these situations, a substitute decision-maker(s), as defined in the Ontario law, will be identified to make decisions on behalf of the individual.

Advance care planning helps to ensure that individuals receive the kind of care they want. Having made decisions in advance may also help to reduce the stress for family members and healthcare providers in times of crisis.

What kind of choices can be made?

Individuals can make choices about any personal care matter including healthcare, food, living arrangements, clothing, hygiene, and safety. Individuals can also choose their substitute decision-maker(s) by appointing an Attorney for Personal Care. Advance care planning for personal care does not include financial and property decisions, as these are managed through a different process.

How are choices communicated?

An individual can express their wishes verbally, in an audio or videotape, or in any written form. The wishes should be expressed to the individual's substitute decision-maker. Individuals may also choose to communicate their wishes to other family members, their doctor, close friends, or their lawyer.

If an individual wishes to name someone to be his/her Attorney for Personal Care, this must be done in writing, dated, signed, and appropriately witnessed.

Can individuals change their mind about their choices?

Yes, if individuals change their mind they should inform their substitute decision maker(s) and healthcare providers. The most recently expressed capable wish (whether verbal or written) should guide decision making.

What is the difference between an advance directive, a living will, and a Power of Attorney for Personal Care?

In an advance directive or living will, an individual documents their wishes. A Power of Attorney for Personal Care may also be used to do this, but in addition it includes the appointment of an individual(s) to be the person's substitute decision-maker.