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CLINICAL PRACTICE GUIDELINE

HEALTH CARE PROVIDERS' GUIDE TO CONSENT TO HEALTH CARE

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Table of Contents

Introduction.....	1
Purpose of this Guide.....	1
Who is the Guide for?	2
Which health care providers are under the <i>HCCCFAA</i> ?	2
What health care is covered?.....	2
What health care is excluded?.....	3
Obtaining Consent	3
Who can provide consent?.....	3
Presumption of capacity.....	4
Consent rights.....	4
Who is responsible for obtaining consent?.....	4
Requirements of valid consent.....	4
What information would a reasonable person need?.....	5
Communicating effectively.....	5
Documenting consent.....	6
Protection from liability.....	7
The Scope of Consent.....	7
Consent to a course of treatment.....	7
Providing care beyond the scope of consent.....	7
Duration of consent.....	8
When is Consent not Required?.....	9
Preliminary examination, treatment or diagnosis.....	9
Emergency health care.....	9
Delivered by health care providers to whom the <i>HCCCFAA</i> applies.....	9
Delivered by an emergency medical assistant.....	10
Determining if Substitute Consent is Needed	11
Incapacity must be demonstrated.....	11
Document a finding of incapability.....	11
Implications of a finding of incapability.....	12
Obtaining Substitute Consent.....	12
Adults with a Personal Guardian or Representative	12
Personal Guardians (Committee of the Person).....	12
Representatives.....	13
Adults with an Advance Directive	16
What does an Advance Directive look like?	17
The scope of an Advance Directive.....	18
When should an Advance Directive not be followed?.....	19
Adults with an Advance Directive and a Personal Guardian and/or Representative	19

Adults with no Personal Guardian or Representative or Advance Directive	20
Selecting a Temporary Substitute Decision Maker	20
What is a reasonable effort?	21
How long does the appointment last?.....	21
What health care decisions can a TSDM be asked to make?	22
What are the duties of a TSDM?.....	23
Access to information.....	23
When Conflicts Arise	24
Who can apply to the court for an order?	24
What can the court order?	24
Advance Directives Made in Another Jurisdiction	25
Appendices.....	25
Appendix 1: Glossary of Terms	26
Appendix 2: Regulated Health Professions Subject to the <i>HCCCFAA</i>	30
Appendix 3: Consent Flow Charts	31
Figure 1: Non-Emergency Preliminary Examination, Treatment or Diagnosis of an Adult	31
Figure 2: Obtaining Consent from a Capable Adult for a Treatment Proposal	32
Figure 3: Determining Who Can Provide Substitute Consent for an Incapable Adult.....	33
Figure 4: Obtaining Consent from the Substitute Decision Maker of an Incapable Adult	34
Figure 5: Emergency Treatment Involving an Adult.....	35
Figure 6: Treatment involving an adult detained in or through a designated facility.....	36
Appendix 4: Scenarios.....	37

Introduction

In recent years the laws surrounding consent to health care have become more formal and more technical. This is largely due to the desire to increase self-determination in the making of health care decisions. For health care providers this means providing enough information so that adults or their substitute decision makers can make informed decisions about consenting to or refusing treatment. For adults this means finding ways to express their wishes in advance so that if they become incapable, their wishes will be respected and followed.

In 2001, the *Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA)* came into effect. It set down in statutory form the basic legal requirements for obtaining consent to health care in British Columbia.

A key aspect of the *HCCCFAA* was to formalize and regulate the role of substitute decision makers in providing consent on behalf of incapable adults. The *HCCCFAA* recognizes three types of substitute decision makers: a Committee of Person appointed by the court under the *Patients Property Act*; a Representative appointed by way of a Representation Agreement as provided for in the *Representation Agreement Act*; and a Temporary Substitute Decision Maker (TSDM) chosen by a health care provider under the *HCCCFAA*.

On September 1, 2011, amendments to the *HCCCFAA* came into effect to formalize the role of Advance Directives. As of September 1, 2011, Advance Directives are recognized as legal documents which allow an adult to provide advance consent to or refusal of treatment directly to a health care provider. For health care providers the significance of Advance Directives is that **in** most situations involving an incapable adult who does not have a Committee of Person or Representative, an Advance Directive can be acted upon without the need to appoint a TSDM.

Purpose of this Guide

This Guide is designed to help health care providers understand the basic legal requirements for securing a valid consent (or refusal) for a proposed course of health care treatment for an adult in British Columbia, as of September 1, 2011.

The Guide provides general information about the law of health care consent, but it is not a substitute for legal advice. Health care providers should seek legal advice if faced with a situation in which there is conflict or ambiguity.

A Glossary of Terms is provided in Appendix 1.

Who is the Guide for?

The Guide is for health care providers delivering health care to which the *HCCCFAA* applies.

The Guide is also for emergency medical assistants insofar as it relates to their responsibilities under the *Emergency and Health Services Act* to persons who have made an Advance Directive (see p.9).

Which health care providers are under the *HCCCFAA*?

Potential health care providers include all persons who are licensed, certified or registered to provide health care under a prescribed act in British Columbia. The prescribed acts are the *Health Professions Act* and the *Social Workers Act*. A list of the regulated health professionals covered by those acts can be found in Appendix 2.

What health care is covered?

The health care to which the *HCCCFAA* applies means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health including:

1. A series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem;
2. A plan for minor health care (see Glossary) that
 - i. is developed by one or more health care providers,
 - ii. deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
 - iii. expires no later than 12 months from the date consent for the plan was given; and
3. Participation in a medical research program approved by an ethics committee designated by regulation.¹

¹ This description of health care is set out in section 1 of the *Health Care (Consent) and Care Facility and (Admission) Act*, RSBC, c.181. (*HCCCFAA*).

What health care is excluded?

Health care provided to children does not come under the *HCCCFAA*. The *Infants Act* remains the governing statute when treating anyone up to age 19.

Other specific exclusions are:

1. The admission of a person to a designated facility under section 22, 28, 29, 30 or 42 of the *Mental Health Act*;
2. The provision of psychiatric care or treatment to a person detained in or through a designated facility under section 22, 28, 29, 30 or 42 of the *Mental Health Act* (but note that non-psychiatric care or treatment while in a designated facility is not covered by this exclusion);
3. The provision of psychiatric care or treatment under the *Mental Health Act* to a person released on leave or transferred to an approved home under section 37 or 38 of the *Mental Health Act*; or
4. The provision of professional services, care or treatment to a person for the purposes of sterilization for non-therapeutic reasons.²

There are in addition a number of health care treatments to which a substitute decision maker or an adult using an Advance Directive cannot give valid consent. These restrictions are outlined below in the sections dealing with the role and authority of the different types of substitute decision makers and Advance Directives.

Obtaining Consent

Health care consent is a process that results in a voluntary agreement to permit the delivery of health care to a person. The *HCCCFAA* is structured so that a health care provider makes a health care proposal to an adult or substitute decision maker and the proposal is either consented to or refused.

Who can provide consent?

A health care provider must not provide any health care without the consent of the adult or a substitute decision maker unless one of the exceptions in the *HCCCFAA* applies.

A health care provider must not seek a decision about whether to give or refuse substitute consent unless he or she has made every reasonable effort to obtain a decision from the adult,³ **including communicating in a way appropriate to the adult's skills and ability.**

² See *HCCCFAA* s. 2

³ See *HCCCFAA* s. 5

Presumption of capacity

A health care provider must presume an adult is capable of making a health care decision, until it is demonstrated that the adult is not capable of making the particular decision. Even if the adult has been found by the court to be incapable and has a Personal Guardian (i.e., the court has appointed a Committee of the Person),⁴ the first effort to obtain consent should still begin with the adult.

Consent rights

The rights associated with giving and refusing consent to health care include the following:

1. The right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death;
2. The right to select a particular form of medically appropriate health care on any grounds, including moral or religious grounds;
3. The right to revoke consent;
4. The right to expect that a decision to give, refuse or revoke consent will be respected; and
5. The right to be involved to the greatest degree possible in all case planning and decision making.⁵

Who is responsible for obtaining consent?

The health care provider who is providing the health care is responsible for ensuring that a valid consent has been obtained.

A single health care provider (e.g. a surgeon) may obtain the adult's consent for a procedure or course of treatment involving a team. This could include such things as an operation, a care plan, or a course of reasonably anticipated treatment by various providers throughout an episode of care.

Some specialized providers, such as anesthesiologists and others carrying out specific procedures, may find it prudent to obtain independent consent for the procedures they are going to perform themselves.

Requirements of valid consent

Valid consent is obtained if:

1. The consent is specific to the proposed health care;
2. The consent is given voluntarily;
3. The consent is not obtained through misrepresentation or by fraudulent means;
4. The adult is capable of making a decision about whether to receive or refuse the proposed health care;

⁴ HCCCFAA s. 3

⁵ See HCCCFAA s. 6

5. The health care provider informs the adult by providing the information that a reasonable person would require to understand the proposed health care and to make a decision, including information about:
 - i. the condition for which the health care is proposed,
 - ii. the nature of the proposed health care,
 - iii. the risks and benefits of the proposed health care that a reasonable person would expect to be told about,
 - iv. alternative courses of health care, (the likely consequences of no treatment should also be explained, when indicated), and
6. The adult has an opportunity to ask questions and receive answers about the proposed health care.

What information would a reasonable person need?

The scope of information that must be given varies with each situation. As a health care provider, you should make reasonable efforts to find out about the adult's concerns and personal circumstances that might be relevant to his or her information needs, and present information in the manner that is unique to the adult's circumstances (e.g. with a supportive family member or friend present). For example, removal of a facial mole may be a minor procedure for most people, but might be of great concern to a professional model or actor. A useful test is: what information would a reasonable person in the patient's position want in order to make a decision?

The amount of information a person will need about potential risk depends on two things:

1. the seriousness of the potential harm from the proposed health care; and
2. the likelihood that the harm will occur.

If the potential harm is serious (e.g., death, paralysis or deafness) this should be explained to the adult even if the chance of harm occurring is slim. If there is a significant chance of some harm occurring, this must also be explained, no matter how minor the potential harm may be.

Communicating effectively

When seeking an adult's consent, or deciding whether an adult is incapable of giving, refusing or revoking consent, a health care provider has a duty to communicate in a way that is appropriate to the adult's skills and abilities.

The *HCCCFAA* explicitly says that an adult's way of communicating is not, by itself, grounds for deciding that he or she is incapable of understanding.⁶

Often someone close to the adult can help with communication. Health care providers are encouraged to invite family members, friends or other supportive individuals to help the adult understand, or to demonstrate an understanding of, the information given.

⁶ See *HCCCFAA* s. 3 (2)

A person can communicate consent in many different ways: by speaking, by writing, by using an alternative or augmentative communication system, or by conduct that implies consent. For example, an adult might consent by:

- a nod of the head;
- offering an arm for an injection when requested; or
- complying with a treatment regimen.

It must, however, be consent to the specific treatment with an understanding of what it is and why it has been proposed. Cooperation should not be confused with consent. If an adult does not have any information about the health care being provided, consent cannot be implied by behavior. There has to be some reasonable basis for believing that the adult's cooperation is the result of informed consent.

Documenting consent

While the *HCCCFAA* does not specifically deal with the issue of documenting consent, it is important to document accurately and completely all decisions made and actions performed.

Consent to health care may be expressed orally or in writing or may be inferred from conduct. Formal documentation of the fact that consent has been obtained on a chart or a consent form is advised whenever practical.

Consent for many non-facility based or facility ancillary services will often be verbal or implied through patient cooperation with the care or procedure. Written consent to a formal written care plan or confirmation of valid consent may be requested of the adult, if appropriate to the situation.

Written consent is strongly advised from a risk management perspective for all invasive, surgical and certain specified medical and diagnostic procedures, including blood transfusion and organ/tissue removal. **Note:** This is a recommendation only. It is not required by the *HCCCFAA*.

The signing of a consent form is an administrative tool that is used to document consent. While it can be evidence of consent, it does not by itself prove the adult had all the information necessary to give a valid consent.

A person who witnesses the signing of a consent form is indicating only that the adult was seen signing the form, not that he or she was fully informed and giving valid consent. It is good practice to have someone other than a relative of the adult or the provider performing the health care act as the witness.

If you do not use a consent form, you should document how consent was obtained (for example, by a nod of the head). Careful notes of your communication with the adult can help establish what information was given and how you established the basis for valid consent should that ever be called into question.

Protection from liability

A health care provider who acts in good faith and uses reasonable care in obtaining consent is protected under the *HCCCFAA* from liability for making an error related to consent.⁷

The Scope of Consent

Consent to health care is specific to the treatment or procedure being proposed. It may also be specific to a named provider. If the consent of the adult is specific to a named provider, no one else may give the health care without first getting a new consent from the adult unless:

- the health care is already in progress when the adult's wishes become known; or
- delay is likely to put the adult's life or health at risk.⁸

[Note: The same consent rules apply in situations where substitute consent is being sought on the adult's behalf.]

Consent to a course of treatment

An adult may be asked to consent to a number of similar procedures that are part of an overall course of health care, including repetitions of certain procedures. In this situation, a health care provider should get consent for the full course of treatment at the outset (e.g., at the start of a course of chemotherapy or physiotherapy treatments). The health care can then continue until there is a change in the course of treatment or until the adult refuses the health care. An adult may also consent to a plan of minor health care which could include a variety of matters. But note that if the consent is for a plan of minor health care, the plan must not extend beyond 12 months from the date the consent for the plan was given.⁹

In addition, if there is a change to the care plan, or a new procedure not covered by the previous consent is introduced, consent for the new treatment must be obtained.

Providing care beyond the scope of consent

Not everything in health care is predictable. A health care provider may explain a procedure fully to an adult and get a valid consent. Then, part way through the treatment, something further or different may need to be done. In some situations it may not be practicable to get another consent.

⁷ See *HCCCFAA* s. 33

⁸ See *HCCCFAA* s. 9 (4)

⁹ See the definition of "health care" in the Glossary.

The *HCCCFAA* allows a health care provider to deliver additional or alternative health care to an adult if:

1. The health care that was consented to is in progress;
2. The adult is unconscious or semi-conscious; and
3. Additional or alternative health care is medically necessary to deal with conditions that were unforeseen when consent was given.¹⁰

For example, during surgery, something may be encountered that was not anticipated in advance. The surgeon can do what is medically necessary, even though the adult has not consented to the additional procedure.

Duration of consent

Consent provided for a course of health care is valid unless:

1. The adult or a substitute decision maker withdraws consent at any time.
2. If a TSDM has given consent, more than 21 days have passed before the start of treatment.
3. If, after a TSDM has given consent, a health care provider has reasonable grounds to believe that the adult may be capable of giving or refusing consent to health care, the health care provider must again determine if the adult remains incapable, and if the health care provider decides that the adult is capable the decision of the TSDM is rescinded.¹¹
4. In the period between the giving of consent and the commencement of treatment, there is a change in the adult's condition and the treatment consented to may no longer be medically appropriate.
5. The health care provider's knowledge about the condition changes in a way that affects either the original information given to the adult, or the plan for subsequent procedures.
6. The substitute decision maker for the adult changes and the new substitute decision maker withdraws consent; or, as noted above.
7. More than 12 months have passed since consent was given to a plan for minor health care.

It should be noted that the health care provider delivering the health care is responsible for ensuring, to the extent possible, that the consent remains valid throughout the ongoing delivery of care.

¹⁰ See *HCCCFAA* s. 9 (3)

¹¹ See *HCCCFAA* s. 17 (2.1, 2.2)

When is Consent not Required?

The general rule is that consent is required for all types of health care, with two exceptions:

1. Preliminary examination, treatment or diagnosis; and
2. Urgent or emergency health care.

Preliminary examination, treatment or diagnosis¹²

A health care provider may undertake triage or another kind of preliminary examination, treatment or diagnosis without complying with all the requirements to fully inform the adult as long as:

- the adult indicates that he or she wants to be provided with the health care, for example, by coming to an emergency department or nurse practitioner's office; or
- in the absence of any indication by the adult, the adult's spouse, near relative or close friend indicates that he or she wants the adult to be provided with health care.¹³

This exemption does not relieve health care providers from the ongoing professional obligation to explain to the adult what is going to be done and, to the extent possible, obtaining consent before providing treatment.

Emergency health care¹⁴

Delivered by health care providers to whom the HCCCFAA applies

The rules regarding valid consent do not apply to urgent or emergency health care situations if the following circumstances are present:

1. It is necessary to provide the health care without delay in order to preserve the person's life, to prevent serious physical or mental harm or to alleviate severe pain;
2. The adult is apparently impaired by drugs or alcohol or is unconscious or semi-conscious for any reason or is, in the health care provider's opinion, otherwise incapable of giving or refusing consent;
3. The adult does not have a Personal Guardian (Committee of the Person) or Representative who is authorized to consent to the health care, is capable of doing so and is available; and
4. Where practicable, a second health care provider confirms the first health care provider's opinion about the need for the health care and the incapability.¹⁵

¹² See Flowchart of Preliminary Examination consent process in Appendix 3, Figure 1

¹³ See *HCCCFAA* s. 13

¹⁴ See Flowchart of Emergency consent process in Appendix 3, Figure 2

¹⁵ See *HCCCFAA* s. 12 (1)

In urgent or emergency situations where these circumstances are not present, it is necessary to obtain consent, and, if possible, a health care provider should try to obtain consent even **in the above circumstances**.

If, however, a health care provider has reasonable grounds for believing that the adult when capable expressed a wish or instruction to refuse consent to the health care that is relevant to the emergency circumstances, the health care provider must **not provide the health care**.¹⁶

In addition, if the adult has an Advance Directive containing instructions that clearly apply to the presenting health need and the range of treatment choices, these instructions must be followed.

It should be noted that if treatment is started without consent and the adult subsequently refuses treatment, treatment must be withdrawn. The same is true if a substitute decision maker subsequently intervenes to refuse treatment,¹⁷ or an Advance Directive is subsequently located which refuses treatment.¹⁸ It should be noted, however, that if a Personal Guardian (Committee of the Person) or a Representative refuses consent to urgent or emergency health care, and the health care provider is of the opinion that it is necessary to provide the health care without delay in order to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain, and that the Personal Guardian or Representative has not complied with their statutory duties, the health care provider may provide the health care.¹⁹

In determining whether the adult has a Personal Guardian or Representative authorized to consent to the health care, the *HCCCFAA* requires only that the health care provider do what is reasonable in the circumstances to identify and communicate with that person.²⁰

Delivered by an emergency medical assistant

As of September 1, 2011, an emergency medical assistant must not provide a service under the *Emergency and Health Services Act* in respect of a person if the emergency medical assistant has reasonable grounds to believe that the person has made an Advance Directive that refuses consent to the service.²¹

¹⁶ See *HCCCFAA* s. 12.1

¹⁷ See *HCCCFAA* s. 12 (3)

¹⁸ See *HCCCFAA* s. 19.9

¹⁹ See *HCCCFAA* s. 12.2

²⁰ See *HCCCFAA* s. 12 (2)

²¹ See *Emergency and Health Services Act*, s. 11.1

Determining if Substitute Consent is Needed

As noted above, the *HCCCFAA* presumes an adult to be capable until the contrary is demonstrated.

Incapability must be demonstrated

In deciding whether an adult is incapable of making a particular health care decision, the decision must be based on whether the adult demonstrates that he or she:

1. Understands the information being given about his or her health conditions;
2. Understands the nature of the proposed health care, including the risks, benefits and alternatives; and
3. Understands as well that the information applies to his her own situation (e.g. a patient with severe depression or anorexia that understands what is being said, but denies being depressed or anorexic, is not understanding that the information applies to his or her own situation).

The following points provide some suggestions about what should be considered when deciding whether or not an adult is incapable of making a particular health care decision:

1. The adult repeats and explains the disclosed information in his/her own words;
2. The adult gives clear, consistent and unambiguous answers to questions;
3. Through appropriate questioning, the adult demonstrates understanding of the consequences of authorizing or not authorizing treatment;
4. The adult asks pertinent questions which reflect an understanding of the proposed therapy.

Document a finding of incapability

Whatever the decision, it is important that the health care provider who is proposing the health care documents how the decision was reached, including recording the observations that form the basis of his or her opinion.

The following are best practice principles to apply when determining whether an adult is incapable of making a health care decision:

- Begin with the presumption the adult is capable of making the decision
- Deal only with the specific decision needed
- Keep the best interests of the adult at the forefront of the process
- Respect and protect the adult's well-being, self-esteem and right to privacy
- Conduct the process in consultation with the adult and those supportive of the adult

(Developed by the Incapability Steering Committee in collaboration with the Ministry of Health and Ministry Responsible for Seniors and the Public Guardian and Trustee of BC, February 15, 2000)

Implications of a finding of incapability

In the event a patient is determined to be incapable of making a specific health care decision, and the health condition is not a triage, or other preliminary examination situation, the health care provider must make reasonable efforts to determine whether the adult has a substitute decision maker or has made an Advance Directive relevant to the proposed health care.

There are two categories of substitute decision makers - formal (or pre-authorized) and temporary. Formal substitute decision makers are Personal Guardians (Committees of the Person) appointed by the court and Representatives appointed by the adult when capable in a Representation Agreement. A TSDM is chosen by a health care provider, and may include a person authorized by the Public Guardian and Trustee.

Obtaining Substitute Consent

Adults with a Personal Guardian or Representative

Personal Guardians (Committees of the Person) and Representatives are both formally appointed substitute decision makers. The potential scope of their respective decision making authority, however, can be quite different. Reviewing their documentation – court order or Representation Agreement – is the best way to find out if they have the authority to make the health care decision that is required.

Personal Guardians (Committee of the Person)

1. How is a Personal Guardian appointed?

A Personal Guardian, whose formal name is Committee of the Person (pronounced Kom-i-tee), is appointed under the *Patients' Property Act* by a judge of the Supreme Court of British Columbia. This appointment follows a hearing where the judge hears evidence and makes a finding that an adult is incapable of managing him or herself. The court issues an order naming one or more persons as committee. Where two or more people are appointed, the order will specify whether they must act jointly or whether they can act separately.

2. What is the scope of their authority?

A Personal Guardian is the highest ranking substitute decision maker and, unless restricted by the court order making the appointment, can give or refuse or withdraw consent to any health care to which the adult could give or refuse consent when capable, except non-therapeutic sterilization. In the circumstance where a Personal Guardian has been appointed for an adult who has a Representative, the Representation Agreement will have been terminated, unless the court has ordered otherwise.²² Once the Representation Agreement has been terminated, the Representative no longer has any authority to make health care decisions for the adult. A Personal Guardian may withdraw a consent given by an adult when capable or by way of an Advance Directive, or by a Representative or a TSDM.

²² *Patients Property Act* s. 19 (b)

A Personal Guardian should be asked to produce a copy of the court order appointing him or her as committee and the health care provider should review the order to ensure that it appoints the person as the adult's Committee of the Person. The reason for this is that the court may appoint a person as an adult's Committee of the Estate only, in which case the person would not have authority to make health care decisions on behalf of the adult. A Committee of the Estate is responsible for financial and legal matters. An adult may have the same person appointed as Committee of the Person and the Estate, or one person appointed as Committee of the Person and another as Committee of the Estate.

3. What are their duties?

A Personal Guardian is guided by the best interests of the adult. The *Patients Property Act* specifies that the powers of a committee be exercised for the benefit of the patient and the patient's family having regard to the circumstances and needs of the patient and the patient's family.

4. Access to information

A Personal Guardian has the same right the adult would to information necessary to make a decision about health care for the adult.²³

Representatives

1. How is a Representative appointed?

Representatives are still fairly new²⁴ and are an almost uniquely British Columbian form of substitute decision maker. A Representative is a person appointed by an adult under a Representation Agreement to make or help make decisions on behalf of the adult at a time when the adult becomes incapable of making decisions independently. A Representation Agreement is similar to what is called an Enduring Power of Attorney for Personal Care in some other jurisdictions.

There are restrictions on who can be appointed as a Representative. The *Representation Agreement Act* prohibits a paid caregiver, or an employee of a facility in which the adult resides and through which the adult receives personal and/or health care services, other than the adult's spouse, parent or child, from being named as a Representative.²⁵

Having a Representation Agreement cannot be a mandatory condition of receiving a good or service.²⁶

²³ *HCCCFAA* s. 6 (e) and (f); s. 10

²⁴ The *Representation Agreement Act* came into force on February 28, 2000.

²⁵ *RAA* s. 5 (1)(a)

²⁶ *RAA* s. 3.1

2. What is the scope of a Representative's authority?

Representatives must act within the authority given to them in the Representation Agreement.

Representation Agreements are variously referred to as “standard” or “enhanced,” or as “section 7” or “section 9” agreements. These names refer to the names and section numbers in the *Representation Agreement Act* where the various types of authority that can be given to a Representative in a Representation Agreement are spelled out.²⁷

The scope of decision making authority of a standard, or section 7, agreement is more restricted than an enhanced, or section 9, agreement. For example, a Representative with a section 7 Representation Agreement cannot consent to any of the matters prescribed under section 34(2)(f) of the *HCCCCFAA*.²⁸ In addition, a Representative with a section 7 Representation Agreement cannot be authorized to do the following:

- Help make, or make on the adult's behalf, a decision to refuse life-supporting care or treatment; or
- Despite the objection of the adult, physically restrain, move or manage the adult, or authorize another person to do these things.²⁹

A Representative with a section 9 Representation Agreement can give or refuse consent to any of these matters, but since September 1, 2011, the authority to consent to any of the matters prescribed under section 34(2)(f) of the *HCCCCFAA* must be expressly stated in the Representation Agreement.³⁰

A Representative must not consent to non-therapeutic sterilization.³¹ An adult may not authorize a Representative to refuse consent to:

- a. the adult's admission to a designated facility under section 22, 28, 29, 30 or 42 of the *Mental Health Act*,
- b. the provision of professional services, care or treatment under the *Mental Health Act* if the adult is detained in a designated facility under section 22, 28, 29, 30 or 42 of that Act, or
- c. the provision of professional services, care or treatment under the *Mental Health Act* if the adult is released on leave or transferred to an approved home under section 37 or 38 of that Act.³²

A health care provider should ask to see the Representation Agreement before obtaining substitute consent from a Representative.

²⁷ The names given to section 7 and section 9 are actually “standard provisions” and “non-standard.” In common parlance they are called standard and enhanced.

²⁸ For the list of matters prescribed under section 34 (2)(f) of the *HCCCCFAA*, see “prescribed health care list” in the Glossary, Appendix 1.

²⁹ See *Representation Agreement Act*, s. 7 (2.1)

³⁰ See *RAA*, s. 9 (2)(a)

³¹ See *RAA*, s. 11 (2)

³² See *Representation Agreement Act*, s. 11 (a), (b) & (c)

3. What does a Representation Agreement look like?

A Representation Agreement is a written document signed by an adult and witnessed by two people (or one person if the witness is a lawyer or a member in good standing of the Society of Notaries Public of British Columbia). Before it can be used by a Representative, the Representation Agreement must also be signed by the Representative. There is no prescribed form for a Representation Agreement.

A witness to the adult's signing of a Representation Agreement cannot be a person who is named as a Representative or alternate Representative, or be the spouse, child, parent, agent or employee of a person who is named as a Representative. There is an exception to the prohibition against an agent or employee being a witness if the Representative or alternate Representative is the Public Guardian and Trustee, a financial institution, a lawyer or a member in good standing of the Society of Notaries Public of British Columbia.

A Representation Agreement made before September 1, 2011 must include a Certificate signed by the Representative. After September 1, 2011, only a Representation Agreement made under section 7 needs to have a Representative's Certificate.³³ In addition, a person signing a section 7 Representation Agreement on behalf of an adult, each witness to a section 7 Representation Agreement, and a monitor appointed under a section 7 Representation Agreement, must complete a Certificate.

4. What are the duties of a Representative?

The general duties of a Representative are set out in the *Representation Agreement Act*. These require that a Representative must:

- act honestly and in good faith;
- exercise the care, diligence and skill of a reasonably prudent person; and
- act within the authority given in the Representation Agreement.

In addition, the *Representation Agreement Act* says that when helping the adult to make decisions or when making decisions on behalf of the adult, a Representative must:

- consult, to a reasonable extent, with the adult to determine his or her current wishes; and
- comply with those wishes if it is reasonable to do so. Please note, however, that in a section 9 Representation Agreement an adult may provide that the Representative need only comply with any instructions or wishes the adult expressed while capable.

³³ See *HCCCFAA*, s. 5 (4)

Where the adult's current wishes are not known, or are unreasonable, the Representative must comply with the instructions or wishes the adult expressed while capable. If these are not known, a Representative must act:

- on the basis of the adult's known beliefs and values; or
- in the adult's best interests, if his or her beliefs and values are not known.³⁴

When interpreting the best interests of the adult, a Representative must consider the factors set out in section 19(3) of the *HCCCFAA*.³⁵

5. Access to information

A Representative has a right to information related to the incapacity of the adult and to any matter within the area of authority granted to the Representative.³⁶

Adults with an Advance Directive

An adult who has made an Advance Directive, has consented to health care in advance of a decision being required about that health care. An Advance Directive provides consent or refusal to health care by the adult to a health care provider. This means that the appointment of a TSDM is not required unless any of the circumstances described in *'When should an Advance Directive not be followed?'* are present.

If the Advance Directive is valid and relevant to the decision required, a health care provider:

- may provide health care to an adult if the adult has given consent to that health care in the adult's Advance Directive;
- must not provide health care to an adult if the adult has refused consent to that health care in the adult's Advance Directive;³⁷ and
- must stop and withdraw health care to an adult if after having provided the health care the health care provider becomes aware of an Advance Directive which refuses consent to the health care.³⁸

A health care provider is not required to make more than a reasonable effort to determine if an adult has an Advance Directive, a Personal Guardian (Committee of the Person) or Representative.³⁹

It should be noted that having an Advance Directive cannot be a condition of receiving a good or service. For example, an adult cannot be required to sign an Advance Directive before being admitted to a care facility.⁴⁰

³⁴ See *Representation Agreement Act*, s. 16

³⁵ See the meaning of "best interests" in the Glossary.

³⁶ See *Representation Agreement Act*, s. 18

³⁷ See *HCCCFAA*, s. 19.7 (2)(b)

³⁸ See *HCCCFAA*, s. 19.9

³⁹ See *HCCCFAA*, s. 19.7 (3)

⁴⁰ See *HCCCFAA*, s. 19.91

What does an Advance Directive look like?

The Ministry of Health has developed an Advance Directive form for individuals to use when doing Advance Care Planning with their health care provider. Use of the form is optional.

The legal requirements of an Advance Directive are that it be in writing (i.e., not oral), be signed by the adult at a time when the adult was capable, and be witnessed by two people (or one person if the witness is a lawyer or a member in good standing of the Society of Notaries Public of British Columbia). The Advance Directive should also be dated, but, it does not matter if the date is before or after September 1, 2011 as documents purporting to be Advance Directives made before September 1, 2011 are deemed to be Advance Directives if they were made in accordance with the other requirements for Advance Directives set out in the *HCCCFAA*.

The *HCCCFAA*, s. 19.5(5), prohibits the following people from acting as witnesses:

1. A person who provides personal care, health care or financial services to the adult for compensation, other than a lawyer or a member in good standing of the Society of Notaries Public of British Columbia;
2. A spouse, child, parent, employee or agent of a person described in paragraph (a);
3. A person who is not an adult; or
4. A person who does not understand the type of communication used by the adult, unless the person receives interpretive assistance to understand that type of communication.

The same people are also prohibited from signing an Advance Directive on behalf of an adult who is physically incapable of signing it him or herself.

A person who signs an Advance Directive on behalf of an adult who is physically incapable of signing it him or herself, cannot also be a witness.

If a health care provider has a reasonable doubt that an individual, who is prohibited from acting as a witness, or from signing on behalf of the adult, has done either, the health care provider should seek legal advice on how to proceed. Despite this, if in an emergency or urgent circumstance, a health care provider has reasonable grounds to believe that an Advance Directive reflects an instruction or wish applicable to the circumstances and expressed while the adult was capable, the health care provider must not provide emergency or urgent health care to which the adult has refused consent.

In addition to these formal execution requirements, the *HCCCFAA* requires that an adult who makes an Advance Directive must indicate in the Advance Directive that the adult knows that:

1. a health care provider may not provide to the adult any health care for which the adult refuses consent in the Advance Directive; and
2. a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consent in the Advance Directive.⁴¹

The scope of an Advance Directive

Through an Advance Directive, an adult can give or refuse consent to health care described in the *HCCCFAA*, except for the prescribed types of health care to which a TSDM cannot give consent.⁴² An adult may not give consent for non-therapeutic sterilization in an Advance Directive.

A health care provider who becomes aware of an Advance Directive that refuses consent to a specific health care after having provided that health care to an incapable adult is required to stop and withdraw the health care.⁴³

An instruction in an Advance Directive to do anything that is prohibited by law, or to omit to do anything that is required by law, is not valid, and must be severed from the Advance Directive.⁴⁴

An adult may also provide in a Representation Agreement that a health care provider may act in accordance with instructions in the adult's Advance Directive without the consent of the adult's Representative.⁴⁵

⁴¹ See *HCCCFAA* s. 19.4 (1). As of September 1, 2011, there are no prescribed matters that must be included or addressed in an Advance Directive.

⁴² See *HCCCFAA* s. 9 (1.1). For the list of matters to which a TSDM cannot give consent, see "prescribed health care list" in the Glossary, Appendix 1.

⁴³ See *HCCCFAA*, s. 19.9

⁴⁴ See *HCCCFAA* s.19.2 (2)

⁴⁵ See *HCCCFAA* s. 19.3 (2)

When should an Advance Directive not be followed?

An Advance Directive does not apply to a decision to give or refuse consent to health care when a health care provider reasonably believes that the Advance Directive:

1. Does not deal with the health care decision at issue;
2. Is so unclear that it cannot be determined if the adult has given or refused consent to the health care;
3. Is in conflict with the patient's known wishes, values or beliefs;
4. Was made prior to changes in medical knowledge, practice or technology that might substantially benefit the adult, unless the Advance Directive expressly states that it applies regardless of changes in medical knowledge, practice or technology;⁴⁶
5. Was not made voluntarily;
6. Was obtained by fraud or misrepresentation; or
7. The adult was not capable of making a decision about whether to give or refuse consent to the health care which the Advance Directive addresses.⁴⁷

If any of the above conditions apply, and the adult does not have a Representative with authority to make a decision about the health care at issue, a health care provider should seek the appointment of a TSDM, in accordance with the provisions of the *HCCCFAA*. This procedure should be followed even if there is any instruction or wish expressed in the Advance Directive about who may give substitute consent in the event that any of the circumstances described above are present. The reason for this is that an adult may only appoint someone to make health care decisions on the adult's behalf in a Representation Agreement.

Adults with an Advance Directive and a Personal Guardian and/or Representative

An adult may have an Advance Directive, and either or both a Personal Guardian (Committee of the Person) and Representative.

Personal Guardians are always the highest ranking substitute and their authority cannot be overridden except by the court. A Personal Guardian can use any instructions or wishes expressed by the adult in an Advance Directive, Representation Agreement, or other document to inform their decision making; however, none of these documents can bind the decisions of a Personal Guardian.

If an adult has an Advance Directive and a Representative, and any instructions in the Advance Directive relate to a matter over which the adult's Representative has authority, the Representative must treat the instructions of the adult in the Advance Directive as the adult's wishes expressed while capable. A health care provider may act in accordance with a health care instruction in an Advance Directive which relates to a matter over which the adult's Representative does not have authority.

⁴⁶ See *HCCCFAA* s. 19.8

⁴⁷ See *HCCCFAA* s. 6 (b), (c) and (d)

If an adult's current wishes are not known, or an adult, in a section 9 Representation Agreement, has provided that the Representative need only comply with any instructions or wishes the adult expressed while capable, a Representative has a duty to comply with any instructions or wishes expressed by the adult when capable, which would include those contained in an Advance Directive.⁴⁸

Adults with no Personal Guardian or Representative or Advance Directive

If the adult has not done any advance care planning and no one has been appointed Personal Guardian (Committee of the Person) by the court, health care providers will continue the practice of appointing a TSDM from the list of eligible persons in the *HCCCFAA*.

Selecting a Temporary Substitute Decision Maker

As of September 1, 2011, the list of people eligible to be appointed as a TSDM has been expanded to include a broader range of family members, as well as close friends of the adult.

To obtain substitute consent to provide major or minor health care to an adult, a health care provider must **choose the first**, in listed order, of the following who is available and qualifies:

1. The adult's spouse;
2. The adult's child;
3. The adult's parent;
4. The adult's brother or sister;
5. The adult's grandparent;
6. The adult's grandchild;
7. Anyone else related by birth or adoption to the adult;
8. A close friend of the adult (see the Glossary for a definition);
9. A person immediately related to the adult by marriage.

To qualify a person must:

1. Be at least 19 years of age;
2. Have been in contact with the adult during the preceding 12 months;
3. Have no dispute with the adult;
4. Be capable of giving, refusing or revoking substitute consent; and
5. Be willing to comply with the duties of a TSDM.⁴⁹

Health care providers are not required to do more than make a reasonable effort in the circumstances to find out if there is someone who is available and qualifies to be a TSDM.

⁴⁸ See *Representation Agreement Act* s. 16 (1)(2.1) and *HCCCFAA* s. 19.3 (1)

⁴⁹ See, *HCCCFAA*, s. 16

What is a reasonable effort?

The effort required to find a TSDM will depend upon the specific situation. Available time, resources and the urgency of the situation must all be considered.

If a qualified person does not accompany the adult, it may be necessary to look through the adult's personal effects, make telephone calls, confer with whoever brought the adult for treatment, or use other means to gather information as appropriate.

If a person on the list refuses to be a TSDM, the health care provider must choose the next person on the list who is available and qualifies.

In some cases, family members and friends of the adult may meet and decide among themselves who would be the most appropriate TSDM. A person higher on the list can then, by informal agreement within the group, decline to act in favour of a person lower on the list who is a better or more appropriate TSDM.

[Note: A health care provider must not work down the list to find someone who will give consent because the others higher on the list have refused the proposed treatment.]

If two or more equally ranked and qualified potential TSDMs disagree about who should be chosen, the health care provider should make a reasonable effort to obtain agreement about who will act. If an agreement is not possible, the Health Care Decisions Team at Public Guardian and Trustee should be contacted. The Health Care Decisions Team of the Public Guardian and Trustee has the authority to authorize an individual, including a member of the Team, to be chosen by a health care provider as a TSDM.

Similarly, if, after a reasonable effort, there is **no one** able to make a health care decision for an incapable adult, health care providers should contact the Health Care Decisions Team. The Health Care Decisions Team can either authorize someone to be chosen as the TSDM (i.e., someone who is available and willing, but is not otherwise qualified), or **authorize one of the Team to be chosen**. Contact information for the Public Guardian and Trustee is available at: www.trustee.bc.ca

How long does the appointment last?

A TSDM is chosen for the purpose of giving or refusing consent to a particular health care decision, or course of treatment, rather than being chosen for a period of time. Each time consent is required a TSDM must be chosen.

It should be noted that the *HCCCFAA* also requires that if there is a delay of more than 21 days between a TSDM providing consent and treatment beginning, the health care provider must confirm in writing that the adult is still incapable and the TSDM still consents to the health care.⁵⁰ This can occur in elective surgery situations where consent is provided at the time the adult is placed on a waiting list, and then confirmed when the adult is called and admitted for surgery.

⁵⁰ See *HCCCFAA* s. 17 (2)

What health care decisions can a TSDM be asked to make?

A TSDM chosen by a health care provider can be asked to give or refuse consent to any type of health care covered by the *HCCCFAA*, except for the prescribed health care listed in the Health Care Consent Regulation (see “prescribed health care list” in the Glossary).

There are different procedures to follow, however, depending on whether the health care is defined as major health care or minor health care (see “major health care” and “minor health care” in the Glossary), or whether the health care is considered necessary to preserve life.

A TSDM authorized by the Public Guardian and Trustee can be restricted to making minor health care decisions.

1. Major health care

Before providing major health care to an incapable adult, a health care provider must make a reasonable effort to consult with any available spouse, near relative or close friend and with any other person who has relevant information.

After the consultation, and if the health care provider decides the adult needs the major health care, the health care provider must choose a TSDM, obtain substitute consent and then inform the adult and any spouse, near relative or close friend of the adult, who accompanies the adult by way of a notice provided for in section 6 of the Health Care Consent Regulation, of the following:

- the determination that the adult is incapable;
- the name of the person chosen as TSDM; and
- the decision to give or refuse substitute consent.⁵¹

The *HCCCFAA* does not specify any timeframe for this process, but all the steps must be completed before the major health care is provided.

2. Minor health care

Minor health care can proceed with substitute consent only. There is no requirement for prior consultation or subsequent reporting to the adult or anyone else.⁵²

3. End of life decisions

A TSDM may make a decision to refuse consent to health care necessary to preserve life but only if there is substantial agreement among the health care providers caring for the adult that the decision to refuse consent is medically appropriate.⁵³

⁵¹ See *HCCCFAA* s. 14

⁵² See *HCCCFAA* s. 15

⁵³ See *HCCCFAA* s. 18 (2)

What are the duties of a TSDM?

Substitute decisions about health care are often fraught with complex personal and moral dilemmas for family, friends and anyone else involved. The prescribed duties of a TSDM, as outlined in the *HCCCFAA*, are designed to help guide a TSDM in making a good decision on behalf of the adult.

The first duty of a TSDM is to consult with the adult to the greatest extent possible. If the TSDM is appointed by the Public Guardian and Trustee, the consultation must also include any near relative or close friend who asks to assist.

The second duty of a TSDM is to comply with any instructions or wishes the adult expressed when capable. If the instructions or wishes are not known, the TSDM must decide to give or refuse consent on the basis of the adult's best interests.

When deciding whether it is in the adult's best interests to give, refuse or revoke consent, a TSDM must consider:

- the adult's current wishes, and known beliefs and values;
- whether the adult's condition or well-being is likely to be improved by the proposed health care;
- whether the adult's condition or well-being is likely to improve without the proposed health care;
- whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm; and
- whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.⁵⁴

Accordingly, a health care provider must provide the information which a TSDM requires in order to make a decision based upon these considerations.⁵⁵

Access to information

A TSDM has a right to all information and documents that would be given to the adult in order to make an informed decision about whether to give or refuse consent. This would include information about the condition for which the health care is proposed, the associated risks and benefits and information about the alternatives. It would not include information about the adult that is not relevant to the proposed health care.⁵⁶

⁵⁴ See *HCCCFAA* s. 19

⁵⁵ See *HCCCFAA* s. 17 (6)

⁵⁶ See *HCCCFAA* s. 17 (7)

When Conflicts Arise

Most conflicts can be resolved through discussion and other informal means. Some will require a formal resolution process. Since September 1, 2011, the *HCCCFAA* has provided for an application to court and has specified who can bring the application and what the court has jurisdiction to order.⁵⁷

Who can apply to the court for an order?

Any person may apply to the court for an order voiding an Advance Directive on the basis that fraud, undue pressure or some other form of abuse or neglect was used to induce an adult to make the Advance Directive, or to change or revoke a previous Advance Directive.

A health care provider who is of the opinion that a decision of a Committee, Representative or TSDM is medically inappropriate may apply to the court for an order. If a health care provider is of the opinion that a TSDM authorized by the PGT is not complying with his or her duties, the health care provider may request the PGT to revoke the authorization.

What can the court order?

The court has specific authority to make the following orders:

1. Order the adult to attend at the time and place the court directs and submit to one or more assessments of incapability;
2. Give directions respecting:
 - i. the interpretation of a provision of an Advance Directive, or any other health care instruction or wish, made or expressed by an adult when capable; or
 - ii. who should be chosen to provide substitute consent under the *HCCCFAA* for an incapable adult;
3. Confirm, reverse or vary a decision by:
 - i. an adult's Representative or Personal Guardian (Committee of the Person); or
 - ii. a TSDM, to give or refuse consent to health care or admission to a care facility;
4. Make any decision that a person chosen to provide substitute consent under the *HCCCFAA* could make.⁵⁸

The Supreme Court also retains its very broad discretion to make decisions that protect the interests of people who are incapable of making their own decisions.

⁵⁷ See *HCCCFAA* s. 33.4

⁵⁸ See *HCCCFAA* s. 33.4 (2)

Advance Directives Made in Another Jurisdiction

Currently, there is no vehicle for recognizing a document made in another jurisdiction as an Advance Directive under the law in British Columbia unless the document meets the requirements for an Advance Directive as set out by the *HCCCFAA*. As it is very unlikely that this will occur unless someone specifically sets out to write an Advance Directive that meets BC's requirements, Advance Directives (or similar documents) from elsewhere will largely perform the function of informing a substitute decision maker about the adult's wishes, or if they express an instruction or wish to refuse consent to health care, can apply to an emergency situation. As noted above, in an emergency situation a health care provider must not provide health care if there are reasonable grounds to believe the adult while capable, expressed an instruction or wish applicable to the circumstances to refuse consent to the health care.

In the rare instance where an Advance Directive from somewhere else appears to meet the *HCCCFAA* requirements, health care providers would be prudent to obtain a legal opinion before relying on the document.

Appendix 1: Glossary of Terms

Advance Care Planning

Advance care planning is the process by which a capable adult considers and communicates their beliefs and wishes for their future health care, including end-of-life care, for use when the adult is no longer capable of communicating these wishes on their own behalf. A person may also appoint a Representative under the *Representation Agreement Act* and/or develop an Advance Directive as part of the advance care planning process.

Advance Directive

Advance Directive is a written legal document made by a capable adult that:

- a. gives or refuses consent to health care for the adult in the event that the adult is not capable of giving the instruction at the time the health care is required, and
- b. complies with the requirements of Part 2.1 of the *HCCCFAA*.

A document made before September 1, 2011, which complies with the legislative requirements prescribed on September 1, 2011, is deemed to be an Advance Directive.

Best Interests

Section 19(3) of the *HCCCFAA* states:

When deciding whether it is in the adult's best interests to give, refuse or revoke substitute consent, the person chosen under section 16 [a TSDM] must consider

- a. the adult's current wishes, and known beliefs and values,
- b. whether the adult's condition or well-being is likely to be improved by the proposed health care,
- c. whether the adult's condition or well-being is likely to improve without the proposed health care,
- d. whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm, and
- e. whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.

Close friend

A close friend under the *HCCCFAA* means another adult who has a long-term, close personal relationship involving frequent personal contact with the adult, but does not include a person who receives compensation for providing personal care or health care to that adult.

Committee of the Person

A Committee (pronounced Kom-i-tee) of the Person is appointed by the court under the *Patients Property Act* to be the Personal Guardian of an adult. The powers of a Committee, though extensive, can be limited by restrictions imposed in the order issued by the court appointing the Committee.

Health Care

Health care means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes:

- a. a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,
- b. a plan for minor health care that
 - i. is developed by one or more health care providers,
 - ii. deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
 - iii. expires no later than 12 months from the date consent for the plan was given, and
- c. participation in a medical research program approved by an ethics committee designated by regulation;⁵⁹

For the purposes of the *HCCCFAA*, health care is categorized as either major or minor health care.

Health Care Provider

Health care providers are defined as persons who are licensed, certified or registered under the *Health Professions Act (1996)*, and/or other prescribed Acts (Appendix 1) to provide health care in the province.⁶⁰

Major Health Care

Major health care means

- a. major surgery,
- b. any treatment involving a general anesthetic,
- c. major diagnostic or investigative procedures, or
- d. any health care designated by regulation as major health care.

The following have been designated as major health care by regulation:

- a. radiation therapy;
- b. intravenous chemotherapy;
- c. kidney dialysis;
- d. electroconvulsive therapy; and
- e. laser surgery.

⁵⁹ See *HCCCFAA* Health Care Consent Regulation s. 2

⁶⁰ See *HCCCFAA* Health Care Consent Regulation s. 3

Minor Health Care

Minor health care means any health care that is not major health care, and includes

- a. routine tests to determine if health care is necessary, and
- b. routine dental treatment that prevents or treats a condition or injury caused by disease or trauma, for example,
 - i. cavity fillings and extractions done with or without a local anesthetic, and
 - ii. oral hygiene inspections.

Near Relative

A near relative under the *HCCCFAA* means an adult child, a parent, a grandparent, an adult brother or sister, any other adult relation by birth or adoption, or a spouse of any of these.

Personal Guardian

A Personal Guardian is the name used in the *HCCCFAA* to describe a Committee of the Person for an adult who is declared under the *Patients Property Act* to be:

- a. incapable of managing himself or herself, or
- b. incapable of managing himself or herself and his or her affairs.

Prescribed Health Care List

The Health Care Consent Regulation, BC Reg. 20/2000, s. 5, lists the following as health care to which a Temporary Substitute Decision Maker cannot consent:

- a. abortion unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult for whom it is proposed;
- b. electroconvulsive therapy unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult for whom it is proposed;
- c. psychosurgery;
- d. removal of tissue from a living human body for implantation in another human body or for medical education or research;
- e. experimental health care involving a foreseeable risk to the adult for whom the health care is proposed that is not outweighed by the expected therapeutic benefit;
- f. participation in a health care or medical research program that has not been approved by a committee referred to in section 2 (of the *HCCCFAA*);
- g. any treatment, procedure or therapy that involves using aversive stimuli to induce a change in behaviour.

The same list of health care cannot be consented to by an adult using an Advance Directive or by a Representative acting under section 7 of the *Representation Agreement Act*.⁶¹

⁶¹ See *HCCCFAA* s. 9(1.1)

Representation Agreement

A Representation Agreement is an agreement made under the *Representation Agreement Act*. There are two types of Representation Agreements. There are those which contain only the standard provisions as provided for in section 7 of the *Representation Agreement Act*, and those which include other provisions as provided for in section 9 of the *Representation Agreement Act*.

A Representation Agreement must be read over in order to determine the scope of decision making given to the Representative by the adult.

Representative

A Representative is someone appointed in a Representation Agreement to make or help in making decisions on behalf of another and includes an alternate Representative.

Spouse

Spouse means a person who:

- a. is married to another person, and is not living separate and apart, within the meaning of the *Divorce Act* (Canada), from the other person; or
- b. is living and cohabiting with another person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender.

Substitute Decision Makers

Substitute decision makers are:

- Personal Guardians, also called Committees of the Person, appointed by the court under the *Patients' Property Act*,
- Representatives appointed under the *Representation Agreement Act*, and
- Temporary Substitute Decision Makers appointed under the *HCCCFAA*.

Depending on the kind of appointment and any limitations set out in statute, court order or Representation Agreement, substitute decision makers have differing legal authority to make health care decisions on behalf of an incapable adult.

Temporary Substitute Decision Maker

A Temporary Substitute Decision Maker (TSDM) is appointed when an adult is incapable of making a specific major or minor health care consent decision and there is no Personal Guardian (Committee of the Person) or Representative appointed nor an Advance Directive dealing with the situation.

A TSDM is chosen by a health care provider in accordance with a list set out in the *HCCCFAA*. If there are no near relations or close friends available for the health care provider to choose, the health care provider must ask the Public Guardian and Trustee to authorize a person to be appointed as a TSDM.

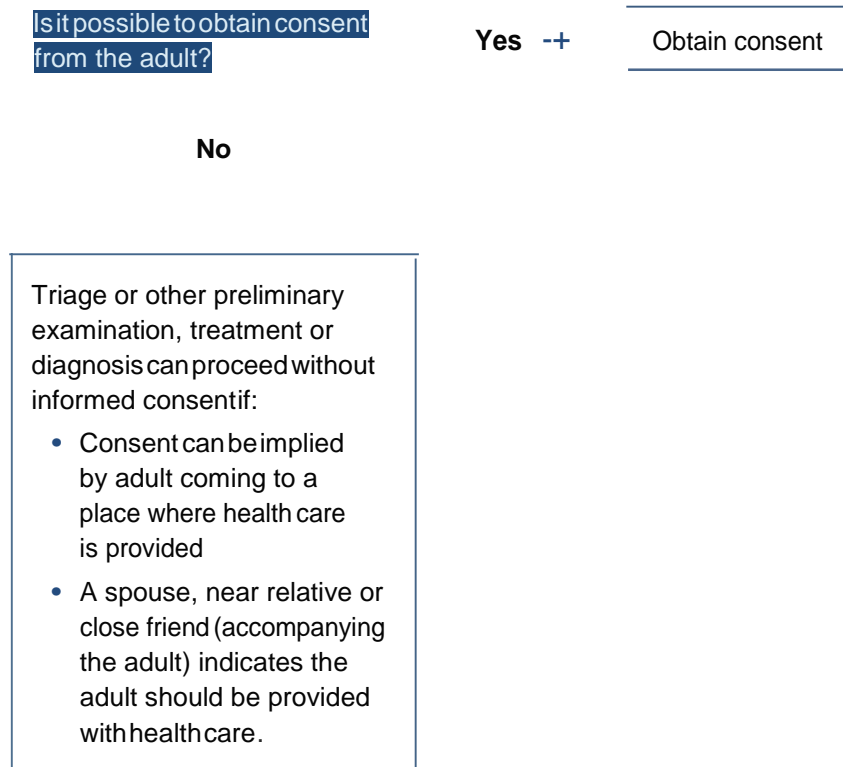
Appendix 2: Regulated Health Professions Subject to the *HCCCFAA*

Acupuncturists
Audiologists
Chiropractors
Dental Hygienists
Dental Technicians
Dentists
Dental Assistants
Denturists
Dietitians
Hearing Instrument Practitioner
Licensed Practical Nurses
Massage Therapists
Midwives
Naturopathic Physicians
Nurse Practitioners
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physical Therapists
Physicians
Podiatrists
Psychologists
Osteopathic Physicians
Registered Nurses
Speech-Language Pathologists
Registered Social Workers
Surgeons
Traditional Chinese Medicine herbalists
Traditional Chinese Medicine practitioners

Appendix 3: Consent Flow Charts

Figure 1: Non-Emergency Preliminary Examination, Treatment or Diagnosis Involving an Adult 19 years of age or older

Triage and other types of preliminary examination, treatment or diagnosis is an exception to the requirement to obtain informed consent. It deals with the type of situation where, for example, someone comes or is brought to a treatment centre for either emergency or non-emergency health care. Consent for preliminary examination, treatment and diagnosis is generally assumed. If treatment is required beyond this phase, however, either the emergency treatment consent rules, or the regular treatment consent rules must be followed depending on the circumstances.



Note: Health care providers must stop or withdraw treatment if consent is subsequently withdrawn or refused.

Figure 2: **Obtaining Consent from a Capable Adult for a Treatment Proposal**

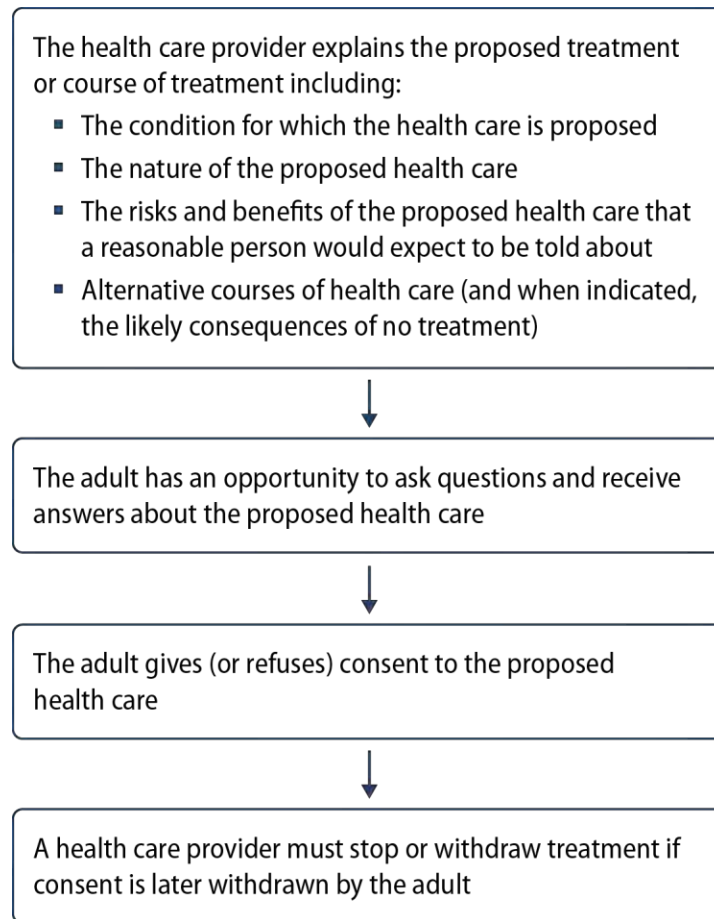
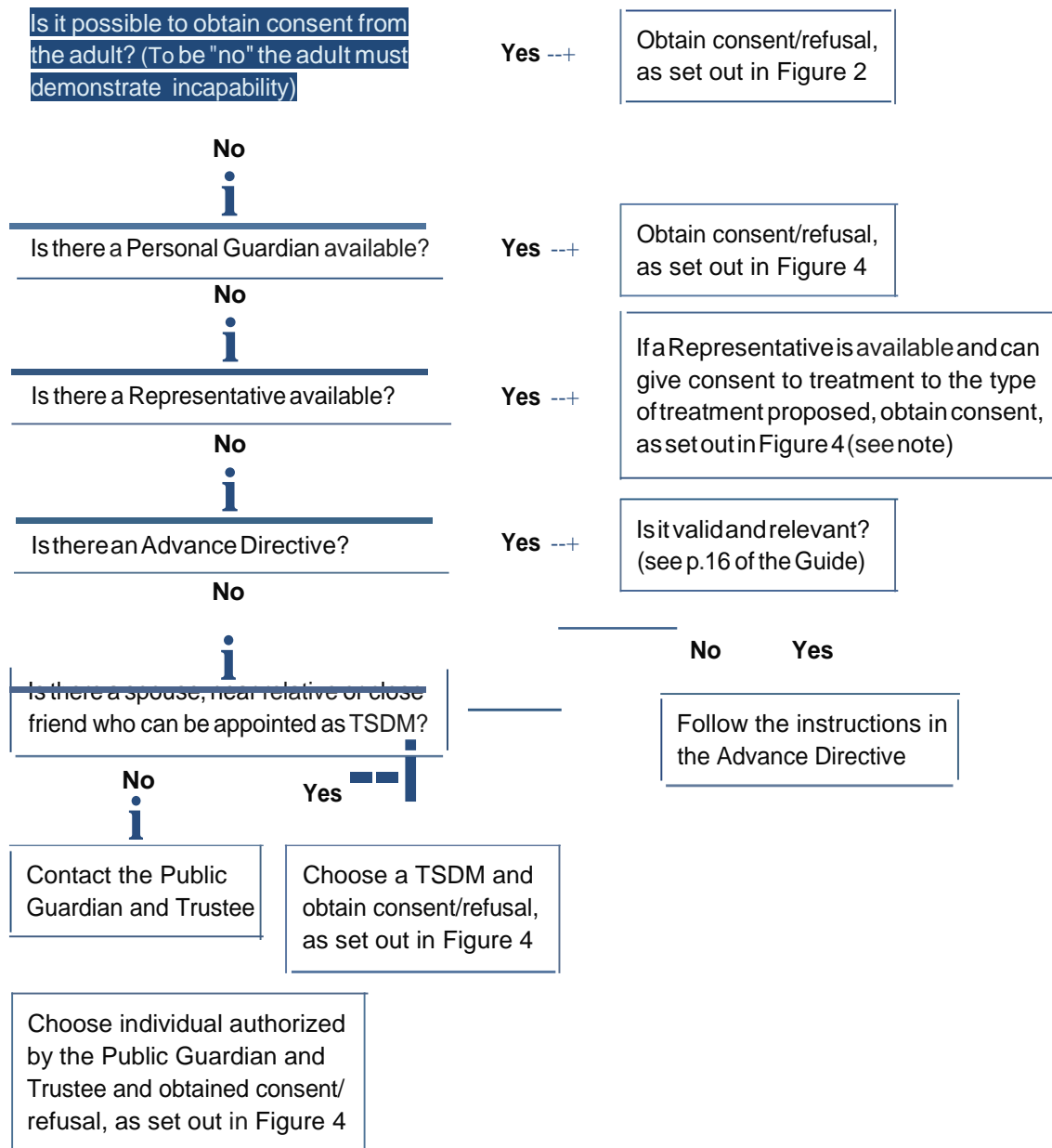


Figure 3: Determining Who Can Provide Substitute Consent for an Incapable Adult 19 years of age or older for a Treatment Proposal



Note: Health care providers must stop or withdraw treatment if consent is subsequently withdrawn or refused.

Note: If the adult has an Advance Directive as well as a Representative, the Advance Directive may override the need for consent from the Representative if the Representation Agreement expressly states that the consent of the Representative is not required. In addition, if an adult has provided instructions in an Advance Directive with respect to any matter over which the Representative does not have decision-making authority, a health care provider should follow the instructions in the Advance Directive.

Figure 4: Obtaining Consent from the Substitute Decision Maker of an Incapable Adult for a Treatment Proposal

The health care provider explains the proposed treatment or course of treatment including:

- The condition for which the health care is proposed
- The nature of the proposed health care
- The risks and benefits of the proposed health care that a reasonable person would expect to be told about
- Alternative courses of health care (and when indicated, the likely consequences of no treatment)

The substitute decision maker has an opportunity to ask questions and receive answers about the proposed health care

The substitute decision maker (depending on the type) consults with the adult, considers the known wishes of the adult expressed when capable, or if not known, the known values and beliefs of the adult, or if not known, the best interests of the adult

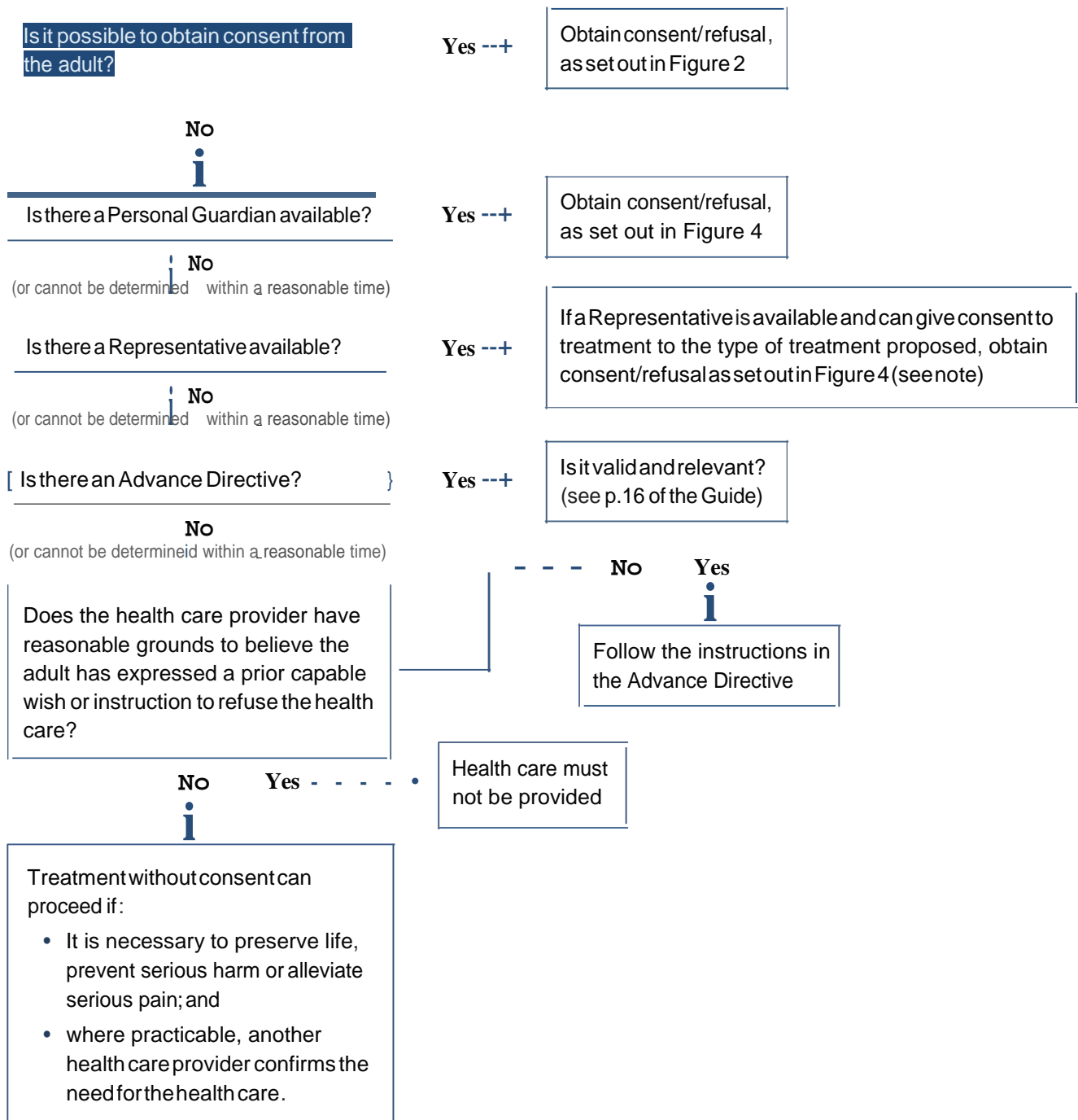
The substitute decision maker gives (or refuses) consent to the proposed health care

A health care provider must stop or withdraw treatment if consent is withdrawn by the substitute decision maker

Consent must be renewed if:

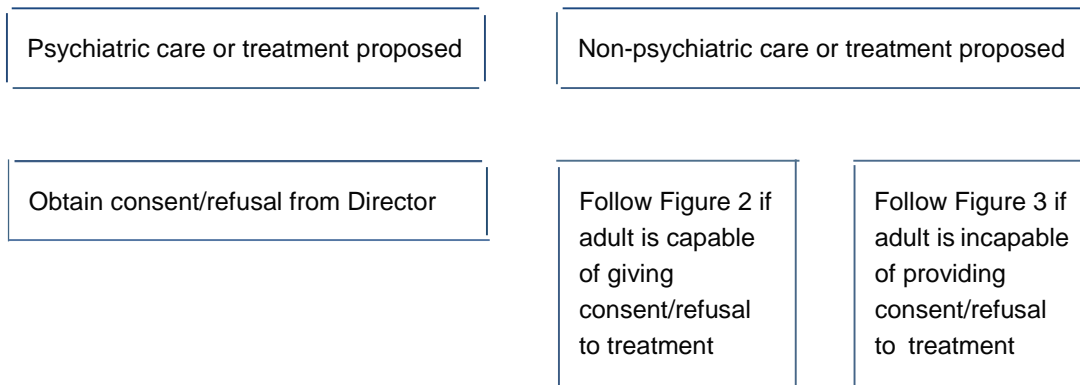
- More than 21 days pass between the consent of a TSDM and the start of treatment
- A TSDM has given consent and the adult's level of capacity changes
- There is a change in the adult's health status and the treatment consented to is no longer appropriate

Figure 5: Emergency Treatment Involving an Adult 19 years of age or older



Note: Health care providers must stop or withdraw treatment if consent is subsequently withdrawn or refused.

Figure 6: Treatment involving an adult 19 years of age or older who has been detained in or through a designated facility under section 22, 28, 29, 30 or 42 of the *Mental Health Act* released on leave or transferred to an approved home under section 37 or 38 of the *Mental Health Act*



Appendix 4: Scenarios

The following scenarios have been developed for the use of the Ministry of Health as an Appendix in the Health Care Provider's Guide to Health Care Consent. They may only be used with written permission from the Ministry of Health. The scenarios are for educational purposes only and do not constitute legal advice. Health care providers should seek legal advice in any situation in which they are uncertain about how to proceed.

Scenario One:

Mrs. G., 79, has advanced Alzheimer's disease with increasing bouts of agitation and striking out when the care aides attempt to bathe, toilet or dress her. She frequently paces the hallways and yells at, and pushes, the other residents when they walk by her. When her 83 year old husband visits, her behaviour subsides and she is calm, but he visits only once a week. The nurses ask you, the doctor, to prescribe antipsychotic medication to manage her behaviour. Mrs. G. has no Advance Directive or Representative appointed but her husband has signed a No Cardiopulmonary Resuscitation (No CPR) form.

Issues to think about:

- With advanced Alzheimer's Mrs. G., would be demonstrably incapable of making a decision about her own health care;
- Nothing she does, such as opening her mouth to accept medication, could be reasonably interpreted as informed consent;
- Unless an emergency situation arises, substitute consent must be obtained before Mrs. G's condition can be treated;
- Even with an emergency, substitute consent would be needed for on-going treatment;
- Mrs. G.'s husband is a reasonably available substitute decision maker and the first choice as Temporary Substitute Decision maker (TSDM). What information would Mrs. G's husband need to be able to make an informed decision about whether or not to consent to antipsychotic medication being prescribed for her? The husband must consult with Mrs. G, and comply with any instructions or wishes she expressed while capable. It is only if the last are not known that he may decide in Mrs. G's best interests (see section 19 of the *HCCCFAA*).

Scenario Two:

Mr. S., 81, is a widower in the last six months of life with terminal bone cancer with metastases, and has four adult children living in the same city who take turns visiting him on a rotating, daily basis, but rarely together. Two children are licensed health care providers, one is a non-practicing lawyer and the fourth child who is closest to Mr. S. is a school teacher. The children all have different expectations for their father's care, and Mr. S. has not prepared an advance care plan, Advance Directive, or appointed a Representative. He has said he wants his children to decide together what is best when the time comes, but so far he remains able to make his own decisions. The children who are licensed health care providers are asking you, the physician to give their father stronger pain medication, while the child who is the teacher wants Mr. S. to have less so he can stay awake longer when he visits. Mr. S' condition is declining daily.

Issues to think about:

- As an adult with a fairly predictable prognosis, Mr. S. is a good candidate for advance care planning;
- Involving his children in the planning process may assist in resolving issues that could be a source of future conflict;
- As he does not appear to want to choose between his children to appoint a substitute decision maker (i.e., make a Representation Agreement) and all four rank equally as TSDMs, an Advance Directive setting out his own advance consent or refusal, or a clear statement of wishes meant to inform the decision making of his children could provide a means of avoiding potential conflict;
- Should he not make a plan and a TSDM is needed, the Public Guardian and Trustee can assist if there is no agreement among the equally ranked TSDMs about who should be appointed;
- Meanwhile, Mr. S. must be presumed capable until assessed to be incapable, and any decision about his treatment, including pain medication, must be made by him.

Scenario Three:

Ms. C., 54, is a normally healthy, married female with two children. She arrives in the Emergency Room in an unconscious state after being involved in a car accident that has left her with a major spinal cord injury and extreme shock due to undiagnosed internal hemorrhaging. She is wearing a medic alert bracelet that says she is diabetic and also that she has an Advance Directive in her purse. The Advance Directive states she does not want CPR in the event she has a “catastrophic” health emergency. Her spouse and children arrive in the ER and her spouse pleads with the medical team to do everything to save her life. Shortly afterwards she goes into cardiac arrest.

Issues to think about:

- If the Advance Directive is valid and relevant, it provides advance consent (or refusal) for Ms. C. and must be followed. The views of others about the decision are not legally relevant unless:
 - a. The health care provider reasonably believes that the instructions contained in the Advance Directive do not address the presenting health care need and the range of treatment choices, or it is not clear whether Ms. C. has consented to or refused the treatment at issue, and substitute consent is required, or
 - b. Since the Advance Directive was made and while the adult was capable, the adult's wishes, values or beliefs in relation to a health care decision significantly changed, and the change is not reflected in the Advance Directive, and substitute consent is required.
- For example, to know if the instructions are relevant to the situation, Ms. C.'s husband could be asked for information about what his wife meant by a catastrophic health emergency, e.g., did she only ever speak of it in relation to severe brain injury;
- Additionally, if the Advance Directive is not recent, Ms. C.'s husband might know if her views have changed;
- Note that an Advance Directive made before September 1, 2011, or made outside BC is unlikely to have all the required elements to be valid and binding under the *HCCCFAA*
- In an emergency, though the normal consent rules do not apply, a valid and relevant Advance Directive refusing consent must be complied with;
- The *HCCCFAA* section 33 protects a person from liability if acting in good faith and using reasonable care;
- Deliberately ignoring a valid and relevant Advance Directive could expose a health care provider to liability.

Scenario Four:

Mr. W., 69, lives in a group home and has had a Personal Guardian (his brother) since he was involved in a serious car accident at the age of 47 that resulted in him having an acquired brain injury. He is pre-morbidly obese and has been suffering from diabetes and congestive heart failure for years with each successive episode being worse than the one before. His brother wants everything medically possible to be done to ensure Mr. W. lives for as long as possible, but his cardiac status has become increasingly unstable and poor in recent months, and you would not be surprised if he died in the next year. As his physician you are trying to support the brother to do advance care planning on Mr. W's behalf but he is refusing to discuss it.

Issues to think about:

- Does Mr. W. have other family members, friends or supporters (e.g., from the group home) that the brother might listen to and who can help him plan for what is medically appropriate and in Mr. W's best interests?
- Is there someone who could replace the brother as Personal Guardian through a court process if he fails to make decisions that are in Mr. W's best interests?
- Is this a situation in which an application to the court under section 33.4 of the *HCCCFAA* might be considered?

The *HCCCFAA* is designed to ensure that valid consent is obtained before health care is delivered; there is nothing in the Act that requires a health care provider to propose or provide health care that is not medically appropriate.

Scenario Five:

Mrs. B., 89, lives alone in her own home, which is filthy, dark and piled with boxes. She has a niece living nearby but refuses visits from home support workers, although she has a community nurse who visits weekly. Mrs. B. has a medical history of osteoporosis, COPD, and CHF. She has frequent falls at home and suffers skin tears that periodically become infected and may cause cellulitis that require intravenous antibiotics. After being diagnosed 4 months ago with advanced metastatic lung cancer, Mrs. B created an Advance Directive through her lawyer. In it she refuses transportation and/or admission to hospital or residential care for any reason. It also notes she does not wish to have further investigations or curative treatments for her existing health problems or any unanticipated major health care issues. It allows for status quo health care measures, such as administration of routine medications and for comfort care measures. Mrs. B.'s neighbour has visited and found that she fell four days ago and has possibly broken her arm, tore her skin open 10 cm in length, and has a weeping infection. Mrs. B. is confused and having visual hallucinations, speaking to people who are not there. The neighbour calls 911 and the attending paramedic subsequently read Mrs. B.'s Advance Directive.

Issues to think about:

- If the Advance Directive is valid and relevant, it provides advance refusal by Mrs. B. and must be followed. Mrs. B's Advance Directive indicates refusal for investigations or curative treatments but allows supportive comfort care measures, which could include symptom management for pain and delirium.
 - a. A health care provider who becomes aware of an Advance Directive that refuses consent to a specific health care after having provided that health care to an incapable adult is required to stop and withdraw the health care
 - b. If the Advance Directive does not deal with the health care decision at issue, a health care provider should choose a TSDM in accordance with the provisions of the *HCCCFAA*
- After reading Mrs. B's Advance Directive, the EMAs are unsure about how to proceed and they don't know whether or not a TSDM could make decisions for Mrs. B.
- As her only support person, the neighbour is the highest ranking candidate to be appointed as TSDM. However, he does not want to act as TSDM. In accordance with the *HCCCFAA*, the Public Guardian and Trustee can authorize someone to be chosen as a TSDM.
- Unsure about the situation and noting that her Advance Directive states that Mrs. B does not wish to go to hospital for treatment, the paramedics provide emergency minor supportive care on scene (e.g. placing an occlusive dressing over her wound and stabilizing her arm), assess Mrs. B.'s condition, and contact their regional health authority for direction.
- The health authority, in its capacity as a designated agency under the *Adult Guardianship Act*, assesses the situation and takes action under Part 3 of the *Adult Guardianship Act*. Part 3 makes provisions for situations in which an adult endangers her or his health as a result of self neglect. Under these circumstances, the health authority determines that Mrs. B's injury has affected her ability to make decisions about her care. The health authority directs the EMA's to transport Mrs. B to hospital for further assessment and for supportive, non-curative care measures that are in agreement with her Advance Directive.
- In addition, an application could be made to the court for the appointment of a Committee of the Person, under the *Patients Property Act*. A Committee of the Person is not bound to apply the provisions of an Advance Directive. The Public Guardian and Trustee may be appointed Committee.
- Finally, in a situation where a person is living under conditions that are a health hazard, and continuing to reside in a place may be a danger to the person's health, section 50 of the *Public Health Act* authorizes a Medical Health Officer to apply to the court for an order to have a person removed to a place where the person will be cared for, such as a residential care facility.