CONSENT AND CAPACITY ISSUES FOR ESTATES PRACTITIONERS

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1. Introduction

The ability to make decisions about one's own wellbeing and bodily integrity is a fundamental right that is a cornerstone of our health care and substitute decision-making legislation. Respect for autonomy and independent decision-making, followed by respect for individuals' wishes and best interests are the underpinnings of capacity and consent legislation in this province. This paper will address the following: the legislative framework for capacity and substitute decision-making as it pertains to personal care, including capacity to grant and revoke powers of attorney for personal care; challenges to findings of incapacity; the role of substitute decision-makers (SDMs); challenges to decisions by SDMs; disputes between health care practitioners and SDMs; and, finally, practice management tips to avoid litigation and solicitor's negligence claims.

In Ontario, two statutes govern consent and capacity: the *Health Care Consent Act, 1996*[1] (the "HCCA") and the *Substitute Decisions Act, 1992*[2] (the "SDA"). The HCCA is engaged whenever a person requires treatment, admission to a long-term care facility ("Admission"), or personal assistance services which may be provided to individuals residing in long-term care facilities ("PAS"). Consent from a capable person is required before treatment can be provided or a person can be admitted to a facility or receive services. Recourse must be had to the provisions of the HCCA whenever there is a question as to whether the person is capable of consenting to treatment, admission or services and the consent of someone else must be obtained. Similarly, where there is

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1. S.O. 1996, c. 2, Sch. A.
2. S.O. 1992, c. 30.

question as to a person's capacity to manage personal care or property, or where someone else (a "substitute decision-maker" or "SDM") is required to make decisions respecting personal care or property, the SDA governs the required assessments and substitute decision-making. The SDA also governs the issue of powers of attorney for personal care and property.

2. Capacity to Make Personal Care Decisions (Respecting Treatment, Admission to Care Facility, Personal Assistance Services)

(1) The Legislative Framework

The SDA and HCCA both provide the means by which a person can be determined to be incapable of making decisions and by which others can be authorized to make decisions for them.

(a) The Health Care Consent Act, 1996

The HCCA applies the principles of consent and capacity, in the same manner, to all settings and to treatment, Admissions and PAS. The HCCA:

- provides rules with respect to consent;
- defines capacity to consent;
- facilitates treatment, Admission and PAS for persons lacking the capacity to make decisions about such matters;
- sets out a hierarchy of individuals who can provide consent on behalf of someone else;
- establishes the principles upon which such decisions are to be made;
- provides mechanisms by which persons who have been found incapable to consent can challenge such findings; and
- provides mechanisms by which substitute decision-makers can be required to exercise their decision-making authority in accordance with the HCCA and can be replaced as decision-makers.

(b) The Substitute Decisions Act, 1996

The SDA is broader in scope than the HCCA and provides mechanisms for long-term planning with respect to both personal care and property issues, by enabling individuals to grant powers of

attorney both for personal care and finances. As well, the SDA provides for the appointment of substitute decision-makers for persons who are found to be incapable of managing their property or personal care, including in circumstances where persons are unable or unwilling to appoint a SDM. These decision-makers include attorneys appointed pursuant to Powers of Attorney for Property or Personal Care, statutory guardians (including the Public Guardian and Trustee ("PGT"), who are permitted to act where a person's incapacity may result in serious adverse effects for an incapable person and his or her property), and court-appointed guardians. Like the HCCA, the SDA provides for presumptions of capacity and for the assessment of a person's capacity, and ensures that individuals are entitled to make those decisions they are capable to make, and that their choices, made while capable, will be respected if they become incapable of making their own decisions.

(2) Consent and Capacity With Respect to Treatment

The HCCA confirms the right of capable persons to make informed decisions about health care and treatment.

The HCCA defines "treatment" broadly, to include anything done for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purposes, excluding assessments, examinations, history taking, admission to hospital or other facility, personal assistance service, and treatment that poses little or no risk of harm to the patient.[3]

(a) Consent to Treatment

The basic principle with respect to treatment is that a health care practitioner shall not administer treatment unless informed consent to the treatment has been given by the person (if he or she is capable with respect to treatment) or by the person's authorized SDM, if the person is not capable with respect to treatment.

The principle that "[f]orced medical procedures must be one of the most egregious violations of a person's physical and psychological integrity",[4] recently acknowledged by Binnie J., has been codified in the HCCA.

For consent to treatment to be valid, the consent must: relate to the treatment; be informed; be given voluntarily; and must not be

3. HCCA, s. 2(1).
4. *Manitoba (Director of Child and Family Services) v. C. (A.)*, [2009] 2 S.C.R. 181, 309 D.L.R. (4th) 581, 66 C.C.L.T. (3d) 1 (S.C.C.), at para. 167, cited in Ontario in *Isber v. Zebrowski* (2009), 181 A.C.W.S. (3d) 1042 (Ont. S.C.J.).

attained through misrepresentation or fraud.[5] As well, the person must be capable of consenting to the treatment proposed.

It is important to note that the one exception to the rule requiring consent to treatment is with respect to emergency treatment. The HCCA provides that a health care practitioner may administer treatment to a patient without consent if:

- in the health care practitioner's opinion the person is incapable with respect to treatment;
- the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if treatment is not administered promptly; and
- the delay required to obtain consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.[6]

(b) Test for Capacity

A person is presumed to be capable with respect to treatment, Admission and PAS. Capacity means that a person is:

(1) able to understand the information that is relevant to making the decision about the treatment, admission or personal service as the case may be; and
(2) able to appreciate the reasonably foreseeable consequences of the decision or lack of decision.

The first element of the test requires the person to have the cognitive ability to process, retain and understand relevant information. The second element requires the person to be able to apply the information provided to their own circumstances. Common indicators of the ability to appreciate consequences are:

- whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her;
- whether the person is able to assess how proposed treatment alternatives could affect his or her quality of life; and

5. HCCA, s. 11.
6. HCCA, s. 25.

- whether the person's choice is substantially based on a delusional belief.[7]

The test is an objective one. It deals only with cognitive capacity, and not wisdom. In other words, a capable person has the right to refuse treatment that may be in their best interest – even treatment that could prevent serious bodily harm or delay death. The health care practitioner who proposes treatment determines capacity of the person for whom treatment is proposed.[8]

One of the fundamental concepts of consent and capacity law is that a person who is mentally incapable for some purposes may be capable for other purposes. Capacity is, therefore, time, fact and issue-specific.[9] A person may be capable of consenting to treatment at one time and incapable at another time, and may be capable of consenting to some treatments but not to others. That is to say, one is capable or incapable with respect to a specific treatment, and not to "treatment" generally.

Of significance in litigation, contrary to the impression of many lay people and even some health care practitioners, there is no age of consent to treatment in Ontario. The implications of this are obvious: young people may be able to refuse counselling or other treatment that is recommended to them and, in those circumstances, it is irrelevant what their parents decide or which parent has decision-making authority over other aspects of their lives.

(3) Consent and Capacity With Respect to Admission to a Care Facility and Personal Assistance Services

As noted above, the HCCA addresses consent and capacity with respect to Admission and to PAS, as well as treatment and does so in generally the same manner with respect to each decision.

The HCCA defines a "care facility" as:

(a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*,[10] or
(b) a facility prescribed by the regulations as a care facility.[11]

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7. *Starson v. Swayze*, [2003] 1 S.C.R. 722, 225 D.L.R. (4th) 385, 1 Admin. L.R. (4th) 1 (S.C.C.), cited in *Heinekamp v. Livermore* (2010), 184 A.C.W.S. (3d) 513, 2010 ONSC 358 (Ont. S.C.J.).
8. HCCA, s. 10.
9. HCCA, s. 15(1), (2).
10. S.O. 2007, c. 8.
11. HCCA, s. 2(1).

A "personal assistance service" is defined by the HCCA as "assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service".[12]

The HCCA governs Admissions and PAS in the same manner as treatment, except that the HCCA provides that an Evaluator is to determine capacity regarding consent to Admission or consent to PAS.[13] An Evaluator may be a social worker, speech pathologist, nurse, occupational therapist, physician, physiotherapist, psychologist, or anyone prescribed by regulation.[14] The provisions of Part II of the HCCA respecting the determination of capacity and decision-making by an SDM are mirrored in Parts III and IV of the HCCA which deal with Admissions and PAS, respectively.

(4) Consent and Capacity with respect to Management of Personal Care

The SDA does not apply to treatment but it does provide a presumption of capacity and a test for and mechanism for the assessment of a person's capacity to make a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety.[15]

(a) Capacity for Personal Care

A person is incapable of making personal care decisions if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[16]

(b) Presumptions of Capacity

The SDA provides presumptions of capacity. A person 18 years of age or more is capable of entering a contract,[17] and a person 16 years

12. HCCA, s. 2(1).
13. HCCA, s. 40.
14. HCCA, s. 2 and O. Reg 264/00.
15. SDA, Part II.
16. SDA, s. 45.

of age or more is capable of giving or refusing consent in connection to his or her own personal care.[18] As well, s. 3 of the SDA, which allows a court to appoint counsel for a person whose capacity is in issue in a proceeding under the SDA and who does not already have counsel, provides that such otherwise allegedly incapable person is deemed capable to retain and instruct counsel.[19]

(c) Assessments of Capacity

A thorough capacity assessment requires a clinician and/or a health care team to assemble as much information as possible about the subject of the evaluation as is available. In addition to in-depth clinical evaluation, data from which the decision is made should include information about the person's prior functioning, limitations, values, beliefs and interests. The principal component of a capacity evaluation is a detailed mental status examination that assesses the subject's cognitive functioning. The test for capacity is not whether the person understands matters relevant to his or her competence, but whether the person is able to understand the nature of his or her illness, the proposed treatment, and the effect of granting or withholding consent. This requires that the person be able to apply the relevant information to his or her circumstances and be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

In instances where a health practitioner or evaluator finds a person incapable with respect to treatment, Admission, or PAS, that health practitioner or evaluator must, in accordance with the relevant professional body's guidelines, provide the person found to be incapable "such information about the consequences of the findings as is specified in the guidelines".[20] A person who has been found incapable with respect to treatment, Admission or PAS may have the right to challenge that finding to the Consent and Capacity Board, as outlined below.

3. Challenging Findings of Incapacity

A person who has been found incapable with respect to treatment, Admission or PAS has the right to apply to the Consent and Capacity Board ("CCB" or "Board") for a review of the finding of incapacity.[21]

17. SDA, s. 2(1).
18. SDA, s. 2(2).
19. SDA, s. 3.
20. HCCA, ss. 17, 47.1, 62.1. This requirement applies equally for capacity assessments in respect of treatment, admission and PAS.
21. HCCA, ss. 32, 50, 65.

However if a person has a guardian who is authorized to make the decisions in question, that person cannot bring such an application. If the person in question has made a Power of Attorney for Personal Care ("POAPC"), and has an attorney for personal care, and the POAPC does not contain a provision waiving the person's right to apply for the review, then such person may still bring an application to challenge the finding of incapacity.[22]

If a person brings an application to the Board in respect of treatment (*i.e.*, not Admission or PAS), the HCCA prohibits implementing the proposed treatment until the application has been disposed of and if no appeal of the Board's decision has been commenced.[23] The only exceptions to this prohibition are if there is an "emergency"[24] or if, while an appeal to the Superior Court of Justice is pending, the court grants an order authorizing treatment.[25]

The parties to a hearing challenging a finding of incapacity are the person applying for the review, the health practitioner or evaluator, and any other person the CCB specifies.[26] In the case of Admissions, the person responsible for authorizing admissions to the care facility is also a party,[27] and with PAS, the member of the service provider's staff who is responsible for the personal assistance service is also a party.[28]

Under the HCCA, the Board has the authority to confirm the health practitioner or evaluator's finding of incapacity or may find the person capable and substitute its opinion for that of the health practitioner or evaluator.[29]

The HCCA limits the frequency of applications to challenge one's capacity. If a finding of incapacity is confirmed by the Board, then the person who was found incapable is not permitted to bring another application for a further six months,[30] unless the person is granted leave by the Board on the basis that there has been a "material change in circumstances that justifies reconsideration of the person's capacity".[31]

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22. HCCA, ss. 32(2), 50(2), 65(2).
23. HCCA, s. 18.
24. HCCA, s. 18(4).
25. HCCA, s. 19.
26. HCCA, ss. 32(3), 50(3), 65(3).
27. HCCA, s. 50(3).
28. HCCA, s. 65(3).
29. HCCA, ss. 32(4), 50(4), 65(4).
30. HCCA, ss. 32(5), 50(5), 65(5).
31. HCCA, ss. 32(6), 50(6), 65(6).

(1) The Consent and Capacity Board

In Ontario, most of the litigation surrounding consent, capacity and mental health issues is dealt with at the Consent and Capacity Board. The CCB is an independent tribunal that was established by the province of Ontario to deal with a variety of issues related to the HCCA and SDA as well as other statutes, such as the *Mental Health Act*.[32]

Board members include psychiatrists, lawyers and members of the public. Each hearing panel is comprised of either a single senior lawyer member or three members who are a lawyer, psychiatrist and community member.[33]

The CCB holds hearings with respect to:

- reviews of capacity to consent to treatment, Admission or PAS;
- appointment of a representative for an incapable person;
- reviews of a SDM's compliance with rules for substitute decision-making;
- reviews of a patient's involuntary status;
- reviews of findings of incapacity to manage property; and
- reviews of a statutory guardianship for property.

CCB hearings are required to be held within seven days of receipt of the application, unless the parties agree otherwise.[34] Proceedings before the Board always include the patient or incapable person who is a party to the proceedings and has the right to counsel, often funded by Legal Aid Ontario.

The CCB has been held to be a specialized and expert tribunal to which deference is accorded on matters of consent, capacity and substitute decision-making.[35]

Appeals of Board decisions are heard by the Superior Court of Justice. Appeals must be brought within seven days of receipt of the Board's decision.[36]

32. R.S.O. 1990, c. M.7.
33. The CCB also has at least one critical care physician who would be part of a panel hearing cases involving medical (non-psychiatric) treatment.
34. HCCA, s. 75(2).
35. *M. (A.) v. Benes* (1999), 180 D.L.R. (4th) 72, 70 C.R.R. (2d) 29, 46 O.R. (3d) 271 (Ont. C.A.), at para. 46; *Rasouli (Litigation guardian of) v. Sunnybrook Health Sciences Centre* (2011) 107 O.R. (3d) 9, 281 O.A.C. 183, 2011 ONCA 482 (Ont. C.A.), at para. 61; *Starson v. Swayze*, *supra*, footnote 7.
36. HCCA, s. 80.

(2) Challenges Regarding Assessments of Capacity to Manage Property or Personal Care

In *Re Koch*, the issues of a wife's capacity to consent to placement in a care facility and to manage her property arose in the context of family law proceedings. Ms. Koch had suffered from Multiple Sclerosis for 15 years, and was confined to a wheelchair and lived alone with supports. She had separated from her husband and they were in the process of negotiating the division of their matrimonial property. After her lawyer forwarded a draft separation agreement to her husband's lawyer, the husband raised concerns about Ms. Koch's capacity. He then took steps to arrange for an assessment of Ms. Koch's ability to manage her finances pursuant to the SDA, after alleging that Mrs. Koch had demonstrated an inability to manage her finances. The husband also arranged for an assessment of her capacity to consent to admission to a care facility, pursuant to the HCCA.

The assessments were undertaken in close proximity, by an evaluator under the HCCA (a nurse) and by an assessor under the SDA (a social worker). Ms. Koch was not informed of the possible consequences of the assessments, and her lawyer was not present for either assessment. After receiving information from the husband with respect to various matters (including Ms. Koch's spending habits) and interviewing Ms. Koch for a period of 90 minutes, the evaluator found Ms. Koch incapable of consenting to placement in a care facility. Likewise, the assessor, who interviewed Ms. Koch on one occasion in a hospital, found her incapable of managing her property.

Ms. Koch challenged each assessment to the CCB, which upheld each of the assessor's and the evaluator's findings. Ms. Koch then appealed to the Ontario Superior Court[37] seeking a reversal of the Board's decision. The appeal raised the concerns of what is required before a person can be deprived of his or her liberty on the grounds of mental incapacity. Justice Quinn was extremely critical of the brevity of assessments and conclusions reached by the assessors based on irrelevant factors such as Ms. Koch's allegedly poor spending habits (*i.e.*, incurring $1,200 in credit card debts and purchasing a $200 portrait when she reasonably anticipated an equalization payment) and her cluttered apartment. The court criticized the lack of information provided to Ms. Koch as well as the low level of probing and independent verification of answers by assessors. The court held that assessors and evaluators are required to probe and

37. *Koch (Re)* (1997), 33 O.R. (3d) 485, 70 A.C.W.S. (3d) 712 (Ont. Ct. (Gen. Div.)).

verify their concerns and to keep comprehensive notes and files. As well, Justice Quinn stated that an assessor should be alive to the presence of improper motives of those who seek to have another found to be without mental capacity.

Ultimately, the court set aside the findings of incapacity. Justice Quinn concluded his judgment by noting that the mechanisms of the SDA and HCCA are formidable and can result in the loss of liberty, including the loss of one's freedom to live where and how one chooses. As well, the court emphasized that there is a distinction between failing to understand and appreciate the risks and consequences and being unable to understand and appreciate the risks and consequences. It is only the latter which can lead to a finding of incapacity. Justice Quinn emphasized that it is immaterial whether the subject's words, deeds and choices appear reasonable to the assessor, as reasonableness is not the test.

It should be noted that *Re Koch* has been limited in a number of subsequent decisions from the CCB as well as the court,[38] particularly with respect to assessments under the HCCA (which do not require the same formality or level of disclosure as assessments under the SDA). However, the cases following *Koch* have made a distinction between an assessment of capacity conducted in a one-time discrete process, which was the case in *Re Koch,* and which remains problematic, and one conducted after a period of therapeutic interaction. Nonetheless, the principles set out above remain applicable to assessments conducted under the SDA and likely under the HCCA.

4. The Role of the Substitute Decision-Maker (SDM)

When a person has been deemed incapable with respect to a treatment, Admission, PAS or other personal care issues, then those decisions must be made on that person's behalf by his or her SDM. An SDM must, however make decisions in accordance with the requirements set out in the legislation.

(1) Substitute Decision-Making

Where a person is incapable with respect to treatment, his or her SDM may give or refuse consent on the person's behalf. A person may give or refuse consent on behalf of another person (*i.e.*, act as SDM) only if:

38. *Per* Spies J. in *Saunders v. Bridgepoint Hospital* (2005), 144 A.C.W.S. (3d) 555 (Ont. S.C.J.), at para. 109.

a) he or she is capable with respect to treatment;
b) he or she is at least 16 years old (unless he/she is the incapable person's parent);
c) he or she is not prevented by a court order or separation agreement from having access to the incapable person;
d) he or she is available; and
e) he or she is willing to assume the responsibility of giving or refusing consent.[39]

The HCCA sets out rules for decision-making by a SDM, as follows:

- A SDM shall give or refuse consent in accordance with a prior expressed wish that is applicable to the circumstances, expressed by the incapable person while capable and after attaining 16 years of age, and is known to the SDM.[40]
- If there is no such wish, or such wish is unknown, or impossible to comply with, the SDM shall act in the incapable person's best interests.
- When making a decision in accordance with an incapable person's best interests, the SDM is required to take into consideration:
  - the values and beliefs that the SDM knows the incapable person held when capable and believes they would still act on if capable;
  - any wishes expressed by an incapable person when he/she was not capable; and
  - the likely impact of the treatment.[41]

(2) Wishes

A person may, while capable, express wishes with respect to treatment, admission to a care facility, or personal assistance service.[42] Wishes may be expressed orally, or in any written form, including in a POAPC made pursuant to the SDA.[43] Later wishes expressed while capable prevail over earlier wishes.[44]

Additionally, the HCCA provides a mechanism by which health care practitioners can ask the Consent and Capacity Board to determine whether a SDM is making decisions on behalf of an

39. HCCA, s. 20(2).
40. HCCA, s. 21(1).
41. HCCA, s. 21(2).
42. HCCA, s. 5.
43. HCCA, s. 5(2).
44. HCCA, s. 5(3).

incapable person in accordance with the rules set out in the HCCA, and can ask that the SDM be removed for failure to comply with same. Similarly, a health care practitioner or SDM may apply to the Board for directions with respect to the applicability of a wish expressed by the incapable person with respect to the treatment[45] or for permission to depart from such a wish.[46] These applications are addressed in detail, below.

(3) Who is to Act as Substitute Decision-Maker

The SDA outlines procedures for appointing substitute decision-makers, either by way of power of attorney or guardianship. The HCCA provides a hierarchy of decision-makers and a procedure for decision-makers to be appointed by the Consent and Capacity Board.

(4) Hierarchy of Substitute Decision-Makers

The HCCA sets out a hierarchy of decision-makers (in descending order) for an incapable person, as follows:

1) the person's Guardian of the Person (if a guardian has been appointed and has the authority to refuse/give consent);
2) the person's Attorney for Personal Care (if the person has executed a POAPC, and the POAPC confers that authority);
3) the person's representative appointed by the CCB (if a representative has been appointed and the representative has authority to give or refuse consent to the treatment);
4) the incapable person's spouse or partner;[47]

45. HCCA, s. 35.
46. HCCA, s. 36.
47. It is noteworthy that the definitions of "spouse" and partner are broad, including two people who:
    (a) are married to each other
    (b) are living in a conjugal relationship outside marriage and,
        (i) have cohabited for at least one year,
        (ii) are together the parents of a child, or
        (iii) have together entered into a cohabitation agreement under section 53 of the *Family Law Act*, or
    (c) have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

    However, the HCCA provides that two persons are *not* spouses for the purpose of this section if they are living separate and apart as a result of a breakdown of their relationship. Accordingly, once a spouse has moved out, he or she is no longer a potential SDM for his or her former/estranged

5) a child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent;
6) a parent of the incapable person who has only a right of access;
7) a brother or sister of the incapable person;
8) any other relative of the incapable person.[48]

The PGT is a decision-maker of last resort, that is, only acts if there is no other person listed above who can act as decision-maker.[49]

(5) Guardian of the Person

A guardian of the person ranks first in the hierarchy of personal care decision-makers under the HCCA.

The SDA provides for the appointment of a guardian for personal care in circumstances where a person has not named an attorney for personal care, or in other circumstances that make the appointment of a guardian of the person necessary.

Guardianship of the person is a very powerful tool. The SDA allows the Superior Court of Justice to appoint a guardian of the person who may have control over many aspects of a person's life. This process should be considered only if the applicant is willing to assume the onerous responsibilities inherent in the appointment and if there is no alternative or less restrictive means of caring for the incapable person. It is important to note that the guardian has only the authority granted by the court which may vary from case to case.[50] Additionally, as a guardianship order requires a finding that the person is incapable with respect to treatment or personal care, and requires an assessment of capacity in that regard, courts are reluctant to make such an order if there is insufficient evidence that an assessment is necessary and if a less restrictive approach is available.

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spouse, unless a power of attorney document, which has not been revoked, names the spouse as attorney. In these circumstances, recourse could be had to the CCB to appoint another person as representative for the incapable person.

48. HCCA, s. 20(1).
49. HCCA, s. 20(5).
50. SDA, s. 55.

Indeed the court is proscribed from appointing a guardian of property if there is a less intrusive means of ensuring the incapable person's interests are protected. Specifically, the court "shall not appoint a guardian if it is satisfied that the need for decisions to be made will be met by an alternative course of action that does not require the court to find the person to be incapable of managing property, and is less restrictive of the person's decision-making rights than the appointment of a guardian".[51]

Courts must also have regard to the wishes of incapable persons that are expressed by way of power of attorney, and are loath to replace individuals named in power of attorney documents with court-appointed guardians. On the analogous issue of property decision-making, courts have ruled that where a valid power of attorney exists, an attorney should not be replaced with a Guardian of Property unless "it can be demonstrated that the attorney has misbehaved or not acted appropriately in exercising the power of attorney".[52]

(6) Powers of Attorney for Personal Care

The SDA provides for the granting (and revocation) of POAPCs.[53] By means of a POAPC, a person, while capable of granting one, can appoint someone to act as his or her SDM for personal care matters. A POAPC authorizes the attorney named in the document to make personal care decisions, including treatment, admission or PAS decisions under the HCCA, as well as about other personal care in the event the grantor becomes incapable of such decisions. A POAPC may contain procedures that must be followed to confirm incapacity before an attorney may act, or may be silent, in which case the attorney may make decisions pursuant to the POAPC without further steps being taken. A POAPC may contain wishes or other instructions, thereby enabling the grantor to have control over his or her personal care even after becoming incapable to make personal care decisions.[54]

A person is capable of granting a POAPC if the person:

(a) is able to understand whether the proposed attorney has a genuine concern for the person's welfare; and

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51. SDA, s. 22(1) and 22(3).
52. *Nguyen-Crawford v. Nguyen* (2010), 195 A.C.W.S. (3d) 837, 2010 CarswellOnt 9492, 2010 ONSC 6836 (Ont. S.C.J.); *Teffer v. Schaefers* (2008), 93 O.R. (3d) 447, 169 A.C.W.S. (3d) 658, [2008] O.J. No. 3618 (Ont. S.C.J.).
53. SDA, s. 46.
54. SDA, s. 46(7).

(b) appreciates that the person may need to have the proposed attorney make decisions for the person.[55]

A person is capable of revoking a POAPC if he or she is capable of granting one: the capacity test is the same for both granting and revoking a POAPC.[56]

One can be capable of granting or revoking a POAPC even if he or she is not capable of making personal care decisions.[57]

(7) Representative Appointed by the Consent and Capacity Board: "Form C Application"

The hierarchy at s. 20(1) of the HCCA provides that after a guardian of the person, and attorney for property, a "representative appointed by the Board" has authority to give or refuse consent to a treatment for an incapable person.

A person who has been found incapable with respect to treatment, admission or PAS pursuant to the HCCA, and does not have a guardian for personal care, or attorney for personal care, may apply to the Board for the appointment of a representative to be his or her substitute decision-maker.[58] Likewise, another individual (or individuals) may bring an application to the Board to be appointed representative(s) for an incapable person.[59] The application is termed a "Form C" application, in reference to the form employed in the application.[60] The application is heard by the Board.

The parties to a Form C application are the incapable person, the proposed representative in the application, the incapable person's spouse or partner, child(ren) or parent(s), and siblings.[61] In the case of a treatment decision, the health practitioner who proposed the treatment is also a party.[62] Where the issue is one of admission, the person responsible for authorizing admissions to the care facility is also a party,[63] and if the matter is one in respect of PAS, then the

55. SDA, s. 47(1).
56. SDA, s. 47(3).
57. SDA, s. 47(2).
58. HCCA, ss. 33(1), 51(1), 66(1), and ss. 33(3), 51(3), 66(3). The legislation requires that the incapable person be 16 years of age or older.
59. HCCA, ss. 33(2), 51(2), 66(2).
60. See <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&ENV=WWE&NO=014-2976-04>.
61. HCCA, ss. 33(4), 51(4), 66(4).
62. HCCA, s. 33(4).
63. HCCA, s. 51(4).

member of the service provider's staff who is responsible for the PAS is a party as well.[64]

On the issue of *treatment* specifically, if a Form C application is brought relating to treatment, the HCCA proscribes commencing the proposed treatment until the application has been disposed of, and no appeal is brought within the required time.[65]

In order to make a determination about a proposed representative, the Board must also make a finding about the incapable person's capacity. A Form C application is deemed to include an application to the Board in respect of the person's capacity, unless the Board has made such a determination within the previous six months.[66] If the Board does not find the person incapable with respect to the proposed treatment, admission or PAS, the Form C application is dismissed.

In considering whether to appoint the proposed representative as the decision-maker, the Board is to consider the following criteria:

a. that the incapable person does not object to the appointment;
b. that the representative consents to the appointment, is at least 16 years of age and is capable with respect to the treatments or the kinds of treatments for which the appointment is made; and
c. that the appointment is in the incapable person's best interests.[67]

"Best interests" are addressed at s. 21(1) of the HCCA and include consideration of the values and beliefs of the incapable person, wishes of the person, the potential impact of the proposed treatment, the expected benefit and harm of the proposed treatment, and whether a less restrictive or intrusive treatment could similarly benefit the incapable person.[68]

In a Form C application, the Board may appoint a different representative from the person named in the application, limit the duration of the appointment, impose conditions on the appointment, or remove, vary or suspend conditions.[69]

A Form C application can also be brought where a person seeks the termination of the appointment of a Board-appointed representative, the representative is no longer capable with respect

64. HCCA, s. 66(4).
65. HCCA, s. 18.
66. HCCA, ss. 37.1, 54.1, 69.1.
67. HCCA, ss. 33(6), 51(6), 66(6).
68. HCCA, s. 21(2).
69. HCCA, ss. 33(7), 51(6), 66(6).

to the treatment, admission or PAS, the appointment is no longer in the incapable person's best interests or the incapable person has a guardian of the person or attorney for personal care who is authorized to make the decision in question.[70]

5. Challenges in Decision-Making by Attorneys and Other Substitute Decision-Makers

While s. 21 of the HCCA outlines the considerations that substitute decision-makers (including guardians, attorneys, Board-appointed representatives and family members) are to take into account when making personal care decisions, there is often difficulty in applying those criteria.

Section 21 outlines the "Principles for giving or refusing consent" and provides that the first basis on which a decision maker is to act is further to capable wishes expressed by the person. Those wishes may be written or oral, as outlined above. To be applied by the SDM, however, the wish must have been made when the person was capable and 16 or order, and must be "applicable in the circumstances".

An attorney for personal care may have the benefit of an advance "directive" in the POAPC. Such directive can assist the SDM as it can constitute a "wish applicable in the circumstances" as defined by s. 21(1) of the HCCA. However, as s. 5 of the HCCA provides that "[l]ater wishes expressed while capable prevail over earlier wishes", if the incapable person expressed a different wish, even orally, after executing the POAPC, that later wish could effectively revoke the directive in the POAPC. The HCCA does not value written wishes over oral wishes: the emphasis is on capacity at the time the wish is expressed and the timing of the wish.

If there are no prior capable wishes, then the decision-maker is to make decisions based on the person's "best interests" which comprise a range of considerations, including the values and beliefs held by the person while capable, the wishes of the person (even if not capable), and the likelihood of benefit or harm from the proposed treatment, admission or PAS. Section 21(2) which outlines "best interests" provides no hierarchy of considerations such that an SDM is required to consider all the factors in concert.

The HCCA provides that an SDM can apply to the Consent and Capacity Board for directions respecting an incapable person's wish, or for permission to depart from wishes. These applications are addressed in more detail, below.

70. HCCA, ss. 33(8), 51(6), 66(6).

6. Drafting Powers of Attorney for Personal Care to Meet These Challenges

The SDA creates mechanisms that allow people to plan in advance for substitute decision-making. It provides for the appointment of an SDM where an individual lacks the capacity or will to appoint his or her own decision-maker.

A drafting solicitor must ensure that his or her client has the requisite capacity to grant or revoke the power of attorney in question.

It is also important for a solicitor to determine whether the client is capable of making personal care decisions. The issue of capacity to make personal care decisions is important if the POAPC will contain directives about personal care.

A grantor should put careful thought into the proposed attorney(s) for personal care. An attorney for personal care may be called upon on short notice to make personal care, treatment, Admission or PAS decisions and should therefore be reasonably available and easy to contact. A grantor should also consider that the proposed attorney must be capable with respect to any proposed treatment or care. Clearly the person selected should be someone the grantor trusts.

It is helpful to explain to clients that a POAPC can include details of the grantor's wishes. A POAPC can be as detailed as the grantor wishes it to be as long as the grantor is capable of giving those personal care instructions. Providing details in the POAPC will assist the attorney if he or she is called upon to make decisions on behalf of the grantor. It can also provide comfort to the grantor who may find him or herself in a position where decisions are being made by someone else. It is helpful if wishes are detailed, so as to provide as much direction to the substitute decision-maker as possible and to increase the likelihood that they can be applied in any later circumstances, without resort to the Board applications referred to above.

It is important, however, to explain to the grantor that not all wishes are absolute, and that an SDM may find that in often-unpredictable circumstances, the wishes cannot be applied. The more detail provided, however, the more likely that those directives or wishes can be referred to later. Additionally, where wishes reflect a person's values or beliefs in a broader way, they can more easily be extrapolated to address unforeseen circumstances.

While the solicitor's duty is to the grantor of the POAPC, he or she would be well advised to assist the attorney (whether through the grantor or directly) in recognizing the obligations that may one day be placed on him or her. Additionally, the solicitor can provide

significant assistance to the attorney who may one day have to make significant decisions about treatment Admissions, PAS and personal care by supporting or facilitating the communication of values, beliefs and wishes by the grantor to the attorney, so that the attorney will have a basis for any decisions he or she is required to make. The website <www.advancecareplanning.ca/making-a-plan.aspx> contains resources on Advance Care Planning including "conversation starters" and workbooks and guides, which can assist counsel and clients alike.

It is also helpful for the grantor and the attorney to meet and discuss the terms of the POAPC. While the attorney may have the guidance of the document in the event of incapacity, it is highly advisable for the grantor to discuss his or her wishes with the proposed attorney. It is important that the attorney not only know the grantor's express "wishes" but also understand the person's value system as the attorney may be called upon to make difficult and serious choices on behalf of the grantor and must, to the best of his or ability, do so based on applicable prior capable wishes, or the person's values and beliefs. It is important for the grantor to clearly express his or her wishes and priorities in respect of personal care, and to be sure to address the issue of end-of-life care.

When drafting a new POAPC to replace a prior POAPC, the solicitor should turn his or her mind to the prior POAPC. If there are directives in the earlier POAPC, the solicitor should enquire with the client as to whether he or she wishes to include those directives in the new POAPC. This is important because if that is not dealt with, an SDM could later be faced with a POAPC appointing him or her, as well as an earlier document expressing a "prior capable wish" without clarification as to whether that wish was revoked by the later POAPC. This issue is complicated if the grantor is capable to grant and revoke a POAPC at the time he or she is dealing with the updated POAPC, but is not capable with respect to personal care. A solicitor will need to turn his or her mind to this issue.

7. Resolution of Disputes Between Health Care Practitioners and Substitute Decision-Makers

The HCCA provides various mechanisms to address conflicts between health care practitioners and SDMs, as well as to generally assist health practitioners and SDMs on the issue of substitute decision-making.

(1) "Form D Application": Application for Directions

A Form D application[71] may be brought by an SDM, or as the case may be, the health practitioner, person responsible for authorizing admission to a care facility or a member of the service provider's staff responsible for providing PAS. In a Form D application the applicant seeks direction from the Board to determine the applicability of the incapable person's previously expressed wish, on the basis that the wish is not clear, it is not clear whether the wish is applicable in the circumstances, it is not clear that the person was capable when making the wish, and/or it is not clear the person was 16 or older at the time the wish was expressed.[72]

If the Form D application is to be brought by the health practitioner, or care facility or service provider staff, then the SDM must be notified of such in advance of the application.[73] The parties to the application are the SDM, the incapable person, and the health practitioner or care facility staff or service provider staff, as the case may be.[74]

A Form D application is deemed to include an application respecting the person's capacity, unless such a determination has been made by the Board in the previous six months.[75]

The Board is authorized to give directions in respect of the wish in question and to do so in light of the considerations under s. 21 of the HCCA.[76]

(2) "Form E Application": Application to the Board to Depart from Wishes

As with the Form D application, a Form E application[77] may be brought by an SDM, or the health practitioner, person responsible for authorizing admission to a care facility or a member of the service provider's staff responsible for providing PAS.[78] It also comprises a deemed application in respect of the person's capacity unless such matter has been determined by the Board within the previous six months.[79]

71. See <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-2977-04~3/$File/2977-04_.pdf>.
72. HCCA, ss. 35(1), 52(1), 67(1).
73. HCCA, s. 35(1.1).
74. HCCA, ss. 35(2), 52(2), 67(2).
75. HCCA, s. 37.1, 54.1, 69.1.
76. HCCA, s. 35(3).
77. See <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-2978-04~4/$File/2978-04_.pdf>.
78. HCCA ss. 36(1), 53(1), 68(1).

A Form E application is brought in circumstances where a prior capable wish expressed by the incapable person requires the SDM to refuse to consent to proposed treatment (or Admission or PAS). If a health practitioner or care facility or service provider staff member brings the application, he or she must inform the SDM prior to doing so.[80] If the application is brought by the health practitioner or care or service staff, it is to seek permission from the Board for the SDM to depart from the incapable person's prior capable wish.[81]

The Board may grant the SDM permission to depart from the prior capable wish "if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed".[82]

(3) "Form G Application": Application to the Board to Determine Compliance under ss. 37(1), 54(1) or 69(1) of the Act

A Form G application[83] is brought by a health practitioner, person responsible for authorizing admissions to the care facility, or staff person responsible for the PAS to challenge a decision (or lack of decision) by an SDM on the basis that it is not compliant with the criteria for decision-making set out in s. 21 of the HCCA.[84] The Board is charged with determining whether the SDM has complied with the requirements of the legislation. If the Board finds that the SDM did not so comply, the Board may substitute its own opinion for that of the SDM and give directions to act.[85] If the SDM fails to comply with the Board's directions in the time set out by the Board, then the SDM is deemed not to have met the requirements of a decision-maker under s. 20(2) and the subsequent SDM in the hierarchy at s. 20(1) is then charged with the same directions.[86]

As with Form C, D and E applications, a Form G application also comprises a deemed application in respect of the person's capacity.[87]

79. HCCA, ss. 37.1, 54.1, 69.1.
80. HCCA, s. 36(1.1).
81. HCCA, s. 36(1)(b).
82. HCCA, s. 36(3).
83. See <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-2981-04~3/$File/2981-04_.pdf>.
84. HCCA, ss. 37(1), 54(1), 69(1).
85. HCCA, ss. 37(3), 54(3), 69(3).
86. HCCA, ss. 37(6.1), 54(6.1), 69(6.1).
87. HCCA, ss. 37.1, 54.1, 69.1.

8. Practice Management Tips to Avoid Litigation or Solicitor's Negligence Claims

It is essential that a drafting solicitor turn his or her mind to the capacity of the client grantor. As stated above, capacity is time, fact and situation-specific.

For granting or revoking a POAPC, the capacity standard is straight-forward: the grantor must have the ability to understand whether the proposed attorney for personal care has a genuine concern for the person's welfare; and appreciate that the person may need to have the proposed attorney make decisions on his or her behalf.[88]

If the proposed POAPC is to contain directives on personal care, then the solicitor should also be satisfied that the client has capacity to make personal care decisions. The test for capacity to make personal care decisions is whether the person understands the relevant information to making a personal care decision and is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[89]

The best way to determine the issue of capacity at the outset is to meet and have a candid discussion alone with the client, and to do so on more than one occasion. Since capacity can fluctuate, it is helpful to assess the client's capacity on more than one occasion. Detailed notes should be taken confirming the solicitor's conversation with the client and exploration of the issues relating to the test for capacity. The notes should also confirm the basis on which the solicitor concluded that the client was capable of granting or revoking an attorney for personal care.

In borderline cases, where the solicitor is not confident of the client's capacity, or is cognizant of potential challenges in the future, the solicitor is well-advised to send the client to a capacity assessor to confirm whether the person is (or is not) capable of granting a POAPC. That assessment should become part of the solicitor's file.

The fact that a person is incapable with respect to personal care does not necessarily mean that he or she is incapable of granting or revoking a POAPC. However, those circumstances may lead to a conclusion that an external capacity assessment is wise.

Only once the solicitor is satisfied that the grantor is capable of granting or revoking a POAPC (or making personal care decisions if relevant) should the solicitor act pursuant to the client's instructions.

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88. SDA, s. 47.
89. SDA, s. 45. Also see, re treatment/admission/PAS: HCCA, s. 4(1).

A solicitor is well-advised to be cognizant of the circumstances that bring the client to his or her office. If the client is brought by a family member who seeks to be appointed attorney for personal care, and perhaps replace another individual who is named in a prior POAPC, the solicitor should satisfy him or herself that he or she is receiving independent instructions from the client. The solicitor should be sure to meet with the client alone and clarify that person's clear instructions. The solicitor should also have more than one meeting with the client to attempt to discern the client's instructions.

The solicitor should always carefully note his or her observations and protect the file so that if, in the future, any dispute should arise respecting the document, he or she can easily refer to the notes and observations. The solicitor's evidence could be relevant in the event of a dispute about decision-making which can include guardianship applications, power of attorney litigation and/or applications to the Consent and Capacity Board. It is also extremely important in the event the solicitor is required to defend a negligence claim.

9. Conclusion

The Ontario legislation places a priority on autonomy by providing for presumptions of capacity, and allowing those who have been deemed incapable to challenge such findings before a specialized tribunal. The SDA provides mechanisms by which individuals may appoint attorneys for personal care so that they may decide in advance who, in the event of incapacity, can make decisions on their behalf. The SDA also allows individuals to set out instructions and directives to a named attorney. The HCCA, which is the companion legislation of the SDA, also upholds prior capable wishes as the prime consideration in substitute decision-making such that those applicable wishes expressed while capable take priority in the event of incapacity. The legislation has built in, however, mechanisms to address disputes relating to substitute decision-making which attempt to balance the autonomy of capable individuals, with their best interests.

From a lawyer's perspective, it is important to inform clients of the importance of well-crafted power of attorney documents that name appropriate individuals and provide sufficient information for the proposed attorney to make appropriate decisions. It is key that grantors and attorneys have candid and open discussions about the wishes of the grantor, so that those wishes can, to the extent possible, be respected in the future.

Drafting solicitors in this area should always be alive to the issue of capacity, both of personal care and for granting and revoking powers of attorney for personal care, as the two are interconnected. And, as always, lawyers should listen carefully, take detailed and careful notes and preserve their files as that is key to protecting themselves as well as their clients.