

End of Life Decisions: What do Lawyers Owe Their Clients?

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Introduction

Your clients have been discussing wills and maybe some estate planning for over an hour and now you have all the information you need to prepare their Wills. They've clearly considered everything, including instructing you to direct that the family cottage must be sold because their kids have warred over it for decades.

One of the clients checks his watch and realizes how much of your time they've taken. They get up to leave, thanking you for explaining all the nuances of estate planning.

"Wait a moment," you say, "What about Powers of Attorney? Who will make your health care decisions when you no longer can?"

Husband and wife look at each other for a moment, until the light bulb goes off. "The kids, of course. Okay, see you in a week."

Your clients have just instructed you that, when incapable to make their own personal care and health care decisions, their three children who cannot agree on how to share the family cottage will have to agree on whether, when and which nursing home they go to, when to insist 'everything' be done to keep your client alive and when to consent to the discontinuation of his or her life support.

It might be a good idea to continue the conversation.

Now that your clients have figured out everything that is to happen after their death, you owe it to them to direct their minds to their waning years. Especially whatever time they might live while incapable of making their own health care decisions. Just completing a Power of Attorney for Personal Care ("POAPC") however named¹ does not cover the variables of these potentially life-ending directives. One thing your clients do not want is to have their last days embroiled in bitter family dissension or

¹ I am using Ontario terms. Other provinces may have Advance Care Directives, Representation Agreements or other names for documents that appoint decision-makers for personal care and healthcare decisions, and/or express healthcare wishes.

dissension between family and treatment team. The rest of this paper is about avoiding those conflicts.

Religion

In end of life litigation, religious beliefs are the frequent justification for families insisting that “everything be done” to continue the life [or dying process] of a loved one.²

No religion requires that the “dying process” be extended if the primary consequence is causing the patient suffering, but “suffering” is a very nuanced word even within religions.

Also nuanced are religious directives regarding discontinuing active treatments where the result will be death and even what a treatment is. Is a feeding tube a treatment? “You can’t starve a person to death” is a common assertion and not only for religious reasons. Does that mean everyone gets a feeding tube inserted into their stomach directly through an abdominal incision when necessary? Do your clients want them? What are the risks and benefits and when is it okay to remove it before death?

Some clients will want their end of life decisions made strictly according to the laws of their religion. In that case, their POAPCs should say so. But the document also needs to identify who interprets the religious strictures. Will it be a particular Imam or Rabbi, or the religious head of a particular mosque, synagogue or other house of worship, or a family member?

² *Golubchuk v. Salvation Army Grace General Hospital et al.*, 2008 MBQB 49 (CanLII); *S S (Re)*, 2011 CanLII 5000 (ON CCB); *Sweiss v. Alberta Health Services*, 2009 ABQB 691; *Scardoni v. Hawryluck*, 2004 CanLII 343 (ON SC); *FF (Re)*, 2012 CanLII 38989 (ON CCB)

In *Scardoni*, Justice Cullity noted that the ‘official’ religious beliefs were not what were important but rather the patient’s interpretation of them. Your clients might wish to examine this question for themselves—they could decide on their personal interpretations of their religious obligations and want them followed in spite of the “party” line.

Another consideration around religious beliefs is that, in some religions, once you ask the question, you are stuck with the answer. Your clients may trust their current clergyman, but what if he or she is replaced with someone more or less strident? Or, what if the substitute decision-makers have different religious beliefs—or even just a different clergyman?

I Want Everything Done

Alzheimer’s Dementia is not a good death. The common perception of Alzheimer’s is forgetfulness, even senility, without regard to the physical impact of this disease as it ravages the brain. Where along the path of decline will your client think, “Enough.”

A larger proportion of substitute decision-makers than individuals want “everything done.” In other words, some patients at end of life are having “everything done” even though they wouldn’t have wanted that—except no one ever asked and they never thought to raise it.

In a law office, deciding how much medical care is enough is unlikely to be an informed decision, so you should encourage your clients to get medical information about any particular concerns they have. Some clients, however, may better understand what having “everything done” entails by reading some of the case law, for example this quote from *Re SR*:³

³ *S.R. (Re)*, 2011 CanLII 79858 (ON CCB)

S.R. was admitted to the hospital on July 19. By July 22 he was intubated and transferred to the ICU where he had a tracheostomy hooked to a ventilator for breathing. He was fed by a tube in his stomach. The clinical summary refers to “a long complicated course in” ICU. Among other things he has had aspiration pneumonia, his fingers and toes were necrotic (blackened and dead) as a result of the high dose pressors during a period of septic shock. He had had many fevers caused by infections. He had ulcers all over his body which were treated with bandages. However over time the skin on his back and groin area had oozed so much liquid that it had torn away and could not be dressed. He required turning in his bed every two hours and his facial grimaces indicated that this caused him pain. He had frequent diarrhea which caused pain to his raw skin and presented a constant risk of further infection. Throughout the doctor’s evidence it became apparent that many of the treatments for one problem created another problem...

...(Nurse) Devane’s notes of her twelve hour shift the day before the hearing graphically set out the reality of S.R.’s painful existence in the ICU. He was completely helpless. The doctor’s orders were to withdraw pain medication in the morning so that they could assess S.R.’s capabilities. It was apparent to her from S.R.’s gestures and grimaces that he felt more pain then. His heart rate increased when she was turning him or treating his ulcers and this was also an indication that he felt pain. She had to change his bed pad every two hours as it was wet and soiled. He showed pain during his frequent bowel movements and more pain when she tried to clean him. Ms. Devane said S.R.’s eyes could open when he heard voices but he could not follow her movements. He did tear up when experiencing pain. He showed no emotion other than pain. His condition had been very similar for the entire 112 days he had been in ICU.

Carefully Expressing Wishes

In an era of near daily stunning advances in medicine, what constitutes the “heroic measures” so many people say they do not want? And, what “heroic measures” today will still be in that category in a decade?

Now some decades ago, my father had one of the first heart bypass operations ever done. I remember the cardiac surgeon explaining it to him, using phrases such as, “heroic measure” and, “it’s a Hail Mary pass.” It was experimental surgery then but

today is frequently done almost as day surgery. Had my father survived then done a POAPC stipulating “no heroic measures,” how would or should that be interpreted today?

When my instructions for a POAPC include the concept of “no heroic or artificial measures,” I use this provision to express it:

Death is as much a reality as birth, growth, maturity and old age. It is the one certainty of life. I recognize this.

Therefore, while I am incapable, should a situation arise where my attending physician determines that I will not recover from a disability and that my death, but for medical intervention, would be imminent, I DIRECT MY ATTORNEY to permit me the dignity of a peaceful passing. I do not wish to be kept alive by artificial or heroic measures that would only serve to prolong my dying process, but I rather wish to die with dignity and in comfort. In that situation, I wish for treatments that will allow me to die peacefully even though they may abbreviate the dying process, resulting in a hastening of my death.

Nice Words, But...

Words are always open to interpretation. An advance directive has little meaning to a person bound and determined that “Dad would want to live, no matter what.” At least as important as the written document is the conversation between Grantor and Attorney for Personal Care. Absent that conversation, how will the Grantor know that the Attorney will respect an advance directive and interpret it according to the Grantor’s intent?

I make clients promise they will talk to their proposed Attorneys about their end of life views, both to ensure the Attorney knows that the words and wishes are in fact those of the Grantor, as well as to “empower” the Attorney to make those hard decisions. As well intentioned as my client’s Attorney may be, I hope to avoid situations in which they simply cannot bring themselves to accept the reality of the client’s condition.

While Mr. J.S. testified with great dignity, it was clear to us that he was not ready to accept his mother's condition. Mr. J.S. could not reconcile his views of Mrs. K.M.S.'s broad life values, as he described them, with what she directed in her Power of Attorney. He conceded the obligation, as one of his mother's Attorneys, to honour her direction but searched for reasons to delay and deny: it had to be Dr. Parke (who decided her condition was terminal); He would not consider a feeding tube to be an artificial measure; he rejected the prospect that a feeding tube made Mrs. K.M.S.'s condition worse.⁴

You Might Have to Testify

When the words in a POAPC are disputed, or someone asserts the Grantor didn't have his or her mind directed to them, or asserts the Grantor did not have the requisite "capacity" to express them, one way to help resolve the issue is to have the lawyer who prepared the POAPC testify.

How good are your notes? How good will your memory of a particular interview be in a decade or two when your evidence is crucial to ensuring that your client's end of life wishes will be respected?

It is wise to make it a practice to specifically direct your clients' mind to any treatment wishes translated from their thoughts to your words and an equally good idea to chart that and have clients initial right beside those words. And, comprehensive notes of your interviews are mandatory—you owe your client that. This has just become significantly more important with the release on April 3rd 2013 of *Friedberg et al v. Korn*⁵

Friedberg was an appeal of a Consent and Capacity Board Decision holding that a wish for no "heroic or artificial measures" in a Power of Attorney was the Grantor's wish and should govern her treatment decisions. The Board relied upon the

⁴ *K.M.S. (Re)*, 2007 CanLII 29956 (ON CCB)

⁵ 2013 ONSC 960

evidence of the lawyer who prepared the POA, the essence of which was that the Grantor had time and opportunity to review the document before executing it and that although the lawyer had no recollection a decade later of this particular client, her standard practice was to bring this provision to the client's attention while reviewing the POA before execution. There was clear evidence at the Hearing that the Grantor was an Orthodox Jew whose religious beliefs would not have countenanced such a direction. The Court held that this evidence rebutted the presumption that the Grantor was aware of the provision in the POA.

Was Your Client Capable at the Time of Execution?

Most lawyers do not make specific notes about capacity unless something occurs to make it questionable. Do you attend on clients in hospital or a care facility? Has the client been diagnosed with dementia or are there signs of diminished legal capacity?

Do you know the relevant definition of "capacity?"

Ontario has two definitions of "capacity" relevant to a POAPC. One, set out in *The Substitute Decisions Act*, is the definition of capacity to execute a POAPC. The other, capacity to express a treatment wish, is set out in *The Health Care Consent Act*. As the latter is more stringent, you might face a situation in which the client is capable to execute the POAPC but incapable to express a treatment wish.

My practice includes being retained by other lawyers to attend their clients in hospital or a care facility for the execution of Wills and POAs. If there's any question about the client's capacity at all, I video record my interviews, making sure to get consent from the client to the recording while the camera is running. Then I ask all the questions needed to establish the client's capacity, as well as canvassing in detail any treatment wishes expressed. I also get instructions from the client regarding to whom and on what circumstances the video may be released. I then transfer the

video to a CD, retain a copy in my file and provide another as the client directed, where applicable. On at least one occasion, seeing the video helped a family decide not to commence litigation and on at least one other the video obviated the need for me to give evidence in a trial. If you have a computer and just about any digital camera, you have all the equipment you need!

Conclusion

In the context of end of life decisions, what do we as lawyers owe our clients?

At the minimum, I submit we are obliged to alert clients to the need to consider end of life planning and assist with selection of the correct substitute decision-maker. We also owe an assurance that their wishes are properly expressed and will be respected and enforced.