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ADVANCE DIRECTIVES AND SUBSTITUTE DECISION-MAKING IN PERSONAL HEALTHCARE

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ALBERTA LAW REFORM INSTITUTE

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Table of Contents

PART I — SUMMARY

The final report on Advance Directives represents the last stage in a two phase project. The first phase explored the need for individuals to be able to indicate in advance what their wishes were for financial management. In essence we recommended that a Power of Attorney have an enduring aspect, being effective when the donor of the power is no longer competent to handle their affairs. The final recommendations on Enduring Powers of Attorney were enacted in the *Powers of Attorney Act*, S.A. 1991, c. P-13.5.

The second phase of this project concerns the ability to give directions for healthcare decisions which will be made when the patient is no longer able to make them. A Report for Discussion, No. 11, was issued in November of 1991 and there has been significant feedback and consultation since that time. This report represents the culmination of that process.

The present law relating to substitute healthcare decision-making is deficient in two respects. First it requires that consent be obtained but does not provide a practical mechanism for doing so, thus placing healthcare practitioners in an untenable position. Second, the law fails to provide individuals with a mechanism for planning for their own incapacity with respect to healthcare decisions.

The report suggests that legislation be introduced to give legal force to healthcare directives. A directive could appoint an agent to make the healthcare decisions in the event of the incapacity of the maker of the healthcare directive; it could identify anyone whom the individual does not wish to act as a healthcare proxy; finally, it could give specific instructions as to what is to happen in certain specified circumstances.

The second major recommendation is the creation of a back up system of substitute decision-making for those patients who have not appointed a healthcare agent. This is done by a statutory list of proxy decision-makers whose order of priority roughly corresponds to the closeness of the relationship to the individual.

Either the healthcare agent or the healthcare proxy uses three stages to determine what healthcare decision is correct. First the agent or proxy looks to the relevant and unambiguous instructions given by the individual; second, the agent or proxy looks for the decision which it is believed the patient would have

decided if competent. Finally, as a last resort, the agent or proxy will make a decision which is in the best interests of the patient.

The intention of the proposed scheme is to create advance directives which are relatively simple to create, which will provide clear and unambiguous instruction to the healthcare decision-maker and will settle issues without resort to delaying litigation.

The report contains 28 recommendations which give effect to the core of the policy decisions. In addition, the report contains draft legislation entitled *Health Care Instructions Act* which would create the advance directive, create the healthcare agent or proxy and integrate the scheme into other healthcare decisions.

PART II — REPORT

CHAPTER 1 — THE REPORT FOR DISCUSSION

A. Introduction

The Report for Discussion on *Advance Directives and Substitute Decision-Making in Personal Health Care* was published in November 1991.[1] A 90-page report containing 26 recommendations, it focused on two fundamental questions in the area of mental incapacity and healthcare[2] decision-making. First, who should make healthcare decisions on behalf of patients who lack the mental capacity to do so themselves? Second, what, if any, legal mechanisms should exist to enable individuals to exercise autonomy and self-determination in respect of healthcare decisions made after they become mentally incompetent?

Chapter 1 of our Final Report briefly summarizes the conclusions and major recommendations contained in the Report for Discussion. Chapter 2 outlines various developments which have occurred since the publication of the Report, while Chapter 3 discusses the submissions which we received in response to the Report. Chapter 4 sets out our final recommendations. Part III contains draft legislation.

B. The Need for Reform

The present law in this area, which is discussed in detail in the Report for Discussion,[3] can be summarized as follows:

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1 *Advance Directives and Substitute Decision-Making in Personal Health Care* (Report for Discussion No. 11, 1991).

2 Some people who responded to the Report for Discussion, particularly those from the health professions, suggested that we use the single word "healthcare" rather than "health care", as this more accurately portrays the intended meaning as well as reflecting the accepted usage in these professions. Accordingly, throughout our final report we have used the term "healthcare". See also *infra*, Chapter 3(C), and Recommendation 8.

3 *Supra*, note 1 at Chapter 2.

1. If an adult (other than an involuntary psychiatric patient) is mentally incapable of consenting to medical treatment, the only person who has legal authority to consent on the adult's behalf is a guardian appointed under the *Dependent Adults Act*.[4]

2. Treatment can be given to a mentally incompetent person without anyone's consent if (a) the treatment is immediately necessary to preserve the life or health of that person, or (b) the person has no guardian and two physicians issue a written certificate[5] stating that he or she is in need of the treatment and is incapable of consenting to it.

3. It is generally assumed that an advance healthcare directive (often referred to as a "living will") has no legal force in the absence of legislation, but recent case-law from Ontario[6] casts significant doubt on this assumption. The position under Alberta law remains uncertain.

4. The appointment of an attorney with authority to make healthcare decisions on behalf of the principal in the event of the latter's mental incapacity is probably ineffective under current Alberta law.[7]

In our Report for Discussion we took the view that the present law is unsatisfactory, primarily for two reasons. First, it places healthcare professionals in an untenable position. On the one hand the law requires that consent be obtained before treatment is administered, but on the other hand the law fails to provide a practicable mechanism for obtaining consent where the patient is mentally incapable of providing it. This may well interfere with patients

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4 R.S.A. 1980, c. D-32.

5 Pursuant to the *Dependent Adults Act*, s. 20.1.

6 In particular, *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.). See also the comments of Lord Donaldson in *Re T*, [1992] 3 W.L.R. 782 at 787 (C.A.), and the House of Lords decision in *Airedale NHS Trust v. Bland*, [1992] H.L.J. No. 49.

7 The word "probably" has been added so as to make the statement slightly more qualified than that which appeared in our Report for Discussion. This is in response to a few submissions which pointed out that it is at least arguable that such an appointment would be effective under the *Powers of Attorney Act*, S.A. 1991, C. P-13.5. At best the position is uncertain, and that in itself justifies clarifying the issue in the proposed legislation.

receiving timely and proper treatment. It is also unacceptable that healthcare professionals should be faced with uncertainty in the law with respect to such vital issues as the legal effect of living wills and other advance directives for healthcare.

The other deficiency in the present law is that it fails to provide individuals with a mechanism of planning for their own incapacity with respect to healthcare decisions. One of the principal aims of the law in this area should be the protection and promotion of individual autonomy, dignity and self-determination, and this can be achieved by giving people greater control over decisions affecting their own healthcare after they become mentally incompetent. There is also a need to give real meaning to the philosophy underlying the *Dependent Adults Act*—guardianship only as a last resort—by providing a viable alternative to guardianship proceedings.[8] These were central themes in our earlier reports on enduring powers of attorney with respect to financial decisions,[9] and they apply with equal force in the present context. As we concluded in the Report for Discussion:[10]

> [I]n our view there is a need to reform the law relating to health care decision-making and mental incapacity. The goal should be to design a model of substitute decision-making which will provide clarification and certainty for health care professionals, and also promote autonomy and self-determination for individuals who are no longer mentally capable of making health care decisions personally.

The Report for Discussion considered four possible models for reform. The first—the "professional judgment" model—places decision-making authority in the

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8 As we noted in our Report for Discussion, the primary motivation underlying many guardianship applications is the need to have someone with legal authority to make healthcare decisions on behalf of the dependent adult.

9 *Report for Discussion on Enduring Powers of Attorney* (Report for Discussion No. 7, 1990); *Report on Enduring Powers of Attorney* (Report No. 59, 1990). The recommendations in these reports were implemented in the *Powers of Attorney Act*, S.A. 1991, c. P-13.5.

10 *Supra*, note 1 at 18.

hands of the attending physician.[11] It allows the physician to make whatever healthcare decisions he or she considers to be in the best interests of the mentally incapable patient, subject only to the requirement that the physician act reasonably in the circumstances. We rejected this approach, on the ground that it fails to address the second reason for reform, namely, the need to promote the patient's autonomy and self-determination with respect to healthcare decisions after incapacity.

The second possible model for reform—the "nearest relative" approach—is quite common in other jurisdictions and has been adopted in Alberta's *Mental Health Act*.[12] It involves a statutory list of relatives in descending order of proximity to the patient; if the patient lacks the capacity to make a healthcare decision, the first available person on the list has legal authority to make the decision on the patient's behalf.[13]

Though we saw considerable merit in this approach, we also noted that as a sole model for reform it has a number of deficiencies. First, it provides no mechanism for patients who would prefer someone other than their nearest relative to make healthcare decisions for them. Second, it does not enable patients to exercise any control over the content of the decision, for example by leaving instructions or guidelines to be followed by the nearest relative when making healthcare decisions.

The third possible approach involves the "living will".[14] This is the term most commonly used to describe an advance directive which expresses the maker's preferences and instructions with respect to future medical treatment. For example, it might state that in the event of the writer being in a persistent vegetative state, no artificial ventilation, nutrition or hydration is to be given. The greatest drawback to this type of approach is the problem of interpretation. In preparing a living will, an individual has to anticipate what medical condition he or she may be faced with in the future, and what treatment options may be available at that time. This inevitably leads to difficulties of interpretation,

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11 See *ibid.*, at 19-20.

12 S.A. 1988, c. M-13.1, s. 28(1).

13 See Report for Discussion, *supra*, note 1 at 21-24.

14 See *ibid.*, at 24-32.

particularly if the document utilizes vague terminology such as "extraordinary care" and "heroic measures".

These and other difficulties associated with living wills have led many legislatures, particularly in the United States, to adopt a fourth approach to the problem, namely, the "attorney for health" model. This model transplants the power of attorney concept from its traditional financial context into the healthcare context. It enables an individual, while mentally competent, to appoint someone who will have authority to make healthcare decisions on the donor's behalf once the donor becomes mentally incapable of making these decisions personally.[15]

After canvassing these four options in detail, and their respective advantages and disadvantages, the Report for Discussion concluded that the best solution lay in combining various aspects of each model, in a way similar (though not identical) to that adopted by the proposed legislation in Ontario[16] and by the Manitoba Law Reform Commission.[17] This approach relies heavily on the concept of the "healthcare directive".

C. Healthcare Directives

The principal recommendation in our Report for Discussion was that legislation be introduced to give legal force to healthcare directives. A healthcare directive would enable individuals to exercise control over future healthcare decisions in a number of ways. First, it could be used to appoint someone as a healthcare agent, who would have legal authority to make healthcare decisions on behalf of the individual in the event of his or her becoming incapable of making these decisions personally. Second, the healthcare directive could identify anyone whom the individual does not wish to act as his or her healthcare proxy. Third, it could be used to provide instructions and information concerning future

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15 See *ibid.*, at 32-37.

16 As contained in the *Substitute Decisions Act 1991* (Bill 108) and the *Consent to Treatment Act 1991* (Bill 109). Both of these Bills received third reading on December 7, 1992, but are not expected to be proclaimed in force for at least one year. See *infra*, Chapter 2.

17 Manitoba Law Reform Commission, *Report on Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Report No. 74, 1991). These recommendations have now been implemented in legislation. See *infra*, Chapter 2.

healthcare decisions; for example, instructions as to what types of medical treatment the individual would not want in certain circumstances. If these advance instructions were unambiguous and relevant to the healthcare decision being considered, they would be legally binding and would have to be followed.

Thus, by using a healthcare directive, people will not only be able to determine who will make healthcare decisions on their behalf (by appointing a healthcare agent), they will also be able to exercise some control over the content of these decisions by including instructions in the directive. In this way, the autonomy of the individual is respected and protected to the greatest possible extent.

The Report for Discussion also contained several recommendations dealing with issues such as the formalities of execution for a healthcare directive, capacity and age, qualifications of a healthcare agent, and termination.[18]

D. Statutory List of Healthcare Proxies

Studies in the United States show that many people will not execute a healthcare directive.[19] This is due to a number of factors, not the least of which is a reluctance to contemplate one's own mental incapacity, terminal illness and death.[20] Thus, there is a need to create a system of substitute decision-making for those patients who have no guardian and who have not appointed a healthcare agent. The Report for Discussion recommended that this be done by way of a statutory list of proxy decision-makers.[21] In the event of a patient[22]

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18 See Report for Discussion, *supra*, note 1 at 49-58.

19 W.L. Leschensky, "Constitutional Protection of the Refusal-of-Treatment" (1991) 14 *Harvard Journal of Law & Public Policy* 248 at 257; J.C. Fletcher & M.L. White, "Patient Self-Determination Act to Become Law: How Should Institutions Prepare?" *BioLaw*, January 1991, S:509; P.A. Singer & M. Siegler, "Advancing the Cause of Advance Directives" (1992) 152 *Archives of Internal Medicine* 22.

20 See Report for Discussion, *supra*, note 1 at 32 and 36. See also J.A. Menikoff *et al.*, "Beyond Advance Directives—Health Care Surrogate Laws" (1992) 327 *New England Journal of Medicine* 1165.

21 See Report for Discussion, *supra*, note 1 at 58-65.

being mentally incapable of making a healthcare decision, the first available person on the statutory list would have legal authority to make the decision on the patient's behalf. We recommended that the statutory list be as follows:

(a) a guardian appointed under the *Dependent Adults Act* (or the equivalent legislation in another jurisdiction) with authority to make healthcare decisions on behalf of the patient;

(b) a healthcare agent appointed by the patient pursuant to a healthcare directive;

(c) the patient's spouse or partner;

(d) the patient's children;

(e) the patient's parents;

(f) the patient's siblings;

(g) the patient's grandchildren;

(h) the patient's grandparents;

(i) the patient's uncle and aunt;

(j) the patient's nephew and niece;

(k) any other relative of the patient;

(l) the patient's healthcare practitioner.

E. Substituted Judgment Test

One of the key recommendations of the Report for Discussion concerned the criteria for substitute decision-making.[23] As previously noted, we took the view that if the patient's healthcare directive contains instructions which are unambiguous and relevant, these should be legally binding. What if there are no such instructions? In the Report for Discussion we proposed that, where possible,

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[22](...continued)

[22] In the case of a minor, the common law is clear that the parents have legal authority to make healthcare decisions on behalf of their child if the child lacks the mental capacity to make the decision personally. Our proposed scheme codifies that common law rule.

[23] See Report for Discussion, *supra*, note 1 at 65-70.

proxies should apply a substituted judgment test; that is, they should decide according to what they believe the patient would have decided if competent, rather than according to what they consider to be in the patient's best interests. In our view this approach is essential to our goal of promoting the patient's interest in autonomy and self-determination.

These recommendations represent the policy core of the Report for Discussion: the healthcare directive, the statutory list of healthcare proxies, and the substituted judgment test. The Report, of course, contained many other recommendations, which fleshed out the details of that underlying policy. Some of these recommendations will be referred to at length in Chapter 3, when we discuss the submissions which we received in response to the Report.

CHAPTER 2 — DEVELOPMENTS SINCE THE REPORT FOR DISCUSSION

A. Legal Developments in Other Provinces

A number of legal developments have taken place in other provinces since the publication of our Report for Discussion.

(1) Manitoba

The recommendations of the Manitoba Law Reform Commission with regard to healthcare directives,[24] which in many respects are similar to our own, have now been implemented (with some minor modifications) in legislation.[25] The Act received Royal Assent in June 1992, but has not yet been proclaimed in force.

(2) Ontario

The proposed legislation in Ontario,[26] which is discussed in detail in our Report for Discussion,[27] was referred to the Ontario Legislature's Standing Committee on the Administration of Justice,[28] and received third reading on December 7, 1992. However, it is not expected to be proclaimed in force for at least one year, to allow the necessary administrative machinery to be put in place.

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24 *Supra*, note 17. The Manitoba recommendations are discussed in our Report for Discussion, *supra*, note 1 at 43-45.

25 *Health Care Directives Act*, S.M. 1992, c. 33 (also C.C.S.M., c. H27).

26 *Supra*, note 16.

27 *Supra*, note 1 at 38-43.

28 For debate on the Bills at the Committee stage see *Ontario Hansard* for the following dates in 1992: February 10-21; March 9-13, 24-25; May 25-26; and June 15-16, 22-23.

(3) Newfoundland

In January 1992 the Newfoundland Law Reform Commission published a discussion paper on advance directives and attorneys for healthcare.[29] Its recommendations on healthcare directives are very similar to our own and to those of the Manitoba Law Reform Commission. The basic position adopted by the discussion paper is that individuals should be able to use a healthcare directive to appoint a healthcare proxy, and also to provide information and instructions which would be binding on the proxy. As with the Manitoba report, the focus of the Newfoundland discussion paper is limited to healthcare directives. It does not consider the additional issue of whether there should be a statutory list of proxy decision-makers, so as to deal with the situation where the patient has not appointed a healthcare agent.

(4) Saskatchewan

In December 1991 the Law Reform Commission of Saskatchewan published a report recommending the enactment of legislation giving legal effect to advance healthcare directives.[30] However, the Saskatchewan recommendations are much narrower in scope than those of other provincial law reform agencies. In particular, the Saskatchewan Commission took the position that advance directives should be limited to cases of "last illness". Thus, the Commission recommended that an advance directive should be given recognition "if it is intended to take effect when the maker is suffering from a condition that is terminal, or will result in a significantly diminished quality of life." [31]

(5) British Columbia

As part of the Project to Review Adult Guardianship in British Columbia, a Joint Working Committee[32] published a discussion paper in May 1992,

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29 Newfoundland Law Reform Commission, *Advance Health Care Directives and Attorneys for Health Care* (Discussion Paper No. 6, 1992).

30 Law Reform Commission of Saskatchewan, *Proposals for an Advance Health Care Directives Act* (1991).

31 *Ibid.*, at 29.

32 The Joint Working Committee consisted of equal representation from government (Interministry Committee on Issues Affecting Dependent Adults) and the community (Project to Review Adult Guardianship).

containing preliminary proposals relating to substitute decision-making and adult guardianship in that province.[33] Although the terminology in the discussion paper differs from our own—the discussion paper uses the term "representation agreement"—in substance the two have much in common. In particular, the representation agreement would allow individuals to appoint an agent to make healthcare (as well as financial and personal care) decisions on their behalf after they are no longer mentally capable of making these decisions personally. The agreement could also contain information and instructions with respect to future decisions.

It should be noted, however, that the legal requirements and formalities surrounding the proposed representation agreement are much more onerous than those recommended in our Report for Discussion. For example, the representation agreement would have to be signed in the presence of two independent witnesses, each of whom would be required to sign an affidavit of execution. In addition, the agreement would have to be registered with a Representation Agreement Registry, which would be part of an on-line computer network with 24-hour access.[34]

B. Recognition of Foreign Healthcare Directives

At its meeting in Newfoundland in August 1992, the Uniform Law Conference of Canada addressed the issue of recognition of foreign healthcare directives.[35] Following initial discussions a committee was established to prepare draft legislation, which was subsequently adopted by the Conference.[36] The full text of the draft uniform legislation appears in Appendix A to this Report.

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33 Joint Working Committee, *How Can We Help?* (1992).

34 See *ibid.*, at 17-23.

35 For a detailed discussion of the problems associated with lack of uniformity and recognition legislation in this area see C.A. Roach, "Paradox and Pandora's Box: The Tragedy of Current Right-to-Die Jurisprudence" (1991) 25 *University of Michigan Journal of Law Reform* 133.

36 See *Report of the Uniform Law Conference of Canada Committee on Recognition of Foreign Health Care Directives* (Document No. 840-663/069, 1992).

The draft legislation contains a test for recognition which focuses on the formalities of execution. A foreign healthcare directive will pass that test if it complies with the formalities of execution required by any one of the following jurisdictions: (1) the implementing jurisdiction, which in our case would be Alberta; (2) the jurisdiction where the directive was made, or (3) the jurisdiction where the person who made the directive was habitually resident at the time the directive was made. According to the draft legislation, if a foreign healthcare directive meets this test, it has exactly the same effect as a validly executed local healthcare directive.

The draft legislation also addresses the question of how a person who is deciding whether or not to act on a foreign healthcare directive can determine whether it complies with the formalities required in a particular jurisdiction. This obviously could be a difficult problem in practice; for example, a doctor in Alberta might be faced with deciding whether to comply with a healthcare directive signed in Ontario. According to the draft legislation, a person may rely on a certificate from a lawyer in that jurisdiction, certifying that the directive complies with the requisite formalities.

In our view the draft legislation is an appropriate response to the difficult problem of recognition of foreign healthcare directives. We recommend that it be incorporated into the proposed legislation for Alberta.

C. Public Interest and Support for Advance Directives

In our Report for Discussion we noted that the topic of healthcare directives has generated considerable public interest and support. Evidence of this continues to grow. For example, a 1991 study of residents of Edmonton, conducted by Dean Janet Storch and Dr. John Dossetor,[37] indicates overwhelming public support for the concept of advance healthcare directives.

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[37] J.L. Storch & J.B. Dossetor, *Public Attitudes Towards End-of-Life Treatment Decisions: Implications for Nurses* (1991).

Likewise, a 1992 survey of 1,000 family physicians in Ontario[38] shows widespread support for advance directives.[39]

The response to our Report for Discussion is also indicative of the level of public interest in this topic. For example, the demand for copies of the Report far exceeded our supply, and the public forums held across the province to discuss the Report, organized by the Health Law Institute, were extremely well attended.[40] As we noted in the Report for Discussion:[41]

> This is an area of considerable concern to many people, who fear that they will be subjected to inappropriate and overly-aggressive medical treatment during the end stages of life. The increasing public interest in issues such as "living wills" and "death with dignity" is a reflection of this concern. Most people are extremely fearful of the prospect of losing control over decisions which affect them, and nowhere is this more pronounced than in the context of life-sustaining medical treatment.

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38 D.L. Hughes & P.A. Singer, "Family Physicians' Attitudes Toward Advance Directives" (1992) 146 *Canadian Medical Association Journal* 1937.

39 However, the study also indicates that most physicians rarely discuss advance directives with their patients. This seems to highlight the need for public and professional education in this area: see Recommendation 26 in our Report for Discussion, *supra*, note 1 (now renumbered as Recommendation 28).

40 For a transcription of the presentations at the Edmonton seminar see (1991) 1(1) *Health Law Review* 3-22.

41 *Supra*, note 1 at 16-17.

CHAPTER 3 — RESPONSE TO THE REPORT FOR DISCUSSION

A. Overall Response to the Core Policy Issues

In Chapter 1 we set out what we termed the "policy core" of the Report for Discussion: the healthcare directive, the statutory list of healthcare proxies, and the substituted judgment test. The submissions which we received in response to the Report for Discussion[42] indicated overwhelming support for that policy core. Indeed, of the many submissions, only one questioned the wisdom of a statutory list and only one rejected the use of the substituted judgment test.

While voicing strong support for the overall policy structure of the Report, many individuals and groups who responded made suggestions as to the specific details of some of our recommendations. The remainder of this Chapter will discuss these specific suggestions.

B. Healthcare Directives

(1) Formalities of Execution

In the Report for Discussion we recommended that the proposed legislation require that a healthcare directive be in writing, be signed by the person making it, and be witnessed by one person other than the healthcare agent or the spouse of that agent. A number of submissions questioned the need to disqualify the agent's spouse, and on reflection we agree. We have changed our final recommendations accordingly.

A few submissions also suggested that the witness be required to certify that the person making the healthcare directive appeared capable of understanding its nature and effect. Some submissions, on the other hand, expressly rejected this requirement. In addition to the doubts which we expressed in our Report for Discussion as to the wisdom and necessity of such a requirement,[43] we are particularly concerned about the consequences of non-compliance. We anticipate that many healthcare directives will be drawn up without legal advice. If the witness is unaware of the requirement to certify the

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[42] For a complete list of the individuals and organizations who made submissions, see Appendix B.

[43] *Supra*, note 1 at 49.

maker's apparent capacity, is the healthcare directive thereby void? In our view such a result would be unduly harsh. Conversely, if the healthcare directive is not thereby void,[44] what purpose is served by requiring the witness to certify capacity, if failure to do so has no consequences? On this issue we tend to favour our original position, that the witness not be required to certify the maker's apparent mental capacity.

(2) Filing and Registration

Some respondents favoured the introduction of a filing system which would enable healthcare directives to be registered, for example, with the Public Guardian, or the local board of health, or by using the Canadian Medic Alert Foundation. With only one exception, these submissions contemplated a voluntary rather than mandatory registration scheme. We agree. We do not believe that the proposed legislation should require healthcare directives to be registered, but we anticipate that voluntary schemes may well be developed to facilitate some type of registration system.

(3) Standard Form

Some respondents suggested that the proposed legislation include a prescribed (or at least, recommended) standard form of healthcare directive. We do not share this view. To include a recommended form in the legislation might well give the misleading impression that it is the only form (or the preferred form) of healthcare directive, and thus might be adopted regardless of the particular individual's needs and circumstances. A healthcare directive should be tailored to fit the wishes and needs of the individual, and we would not wish the legislation to imply that there is a "boilerplate" version which can be used in all cases. Moreover, to the extent that it may be useful to develop some standard forms of healthcare directive, we would anticipate that various organizations will undertake this, and indeed we are aware of several healthcare facilities which are already in the process of doing so.

(4) Ulysses Agreements

A lawyer in Edmonton kindly provided us with a copy of a "Ulysses Agreement" which had been obtained from the British Columbia Project to

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[44] As is the case with the B.C. proposal: see *supra*, note 33 at 17.

Review Adult Guardianship.[45] A "Ulysses Agreement" refers to an informal agreement used by persons with a mental illness, as a means of planning for times during which they may be incapable of making decisions about their health and personal care. One of the key features of such an agreement is the recognition by these individuals that during times of ill health they may express wishes or decisions (for example, a decision to refuse medication) which do not represent their true preferences. Thus, the Ulysses Agreement contains instructions to caregivers and friends as to how they should respond in such a situation, and may request that these instructions take precedence over any contrary statements made during a time of ill health.[46]

Our proposed healthcare directive is flexible enough to accommodate the Ulysses Agreement, and thus it does not appear that any changes to our recommendations are necessary to give effect to this type of arrangement.[47]

(5) Age and Mental Capacity

In our Report for Discussion we recommended that the minimum age for executing a healthcare directive be 18 years. A number of submissions took issue with this, and emphasized (as we ourselves pointed out in the Report for Discussion)[48] that this recommendation is inconsistent with the present law governing the age of consent to healthcare in Alberta. Some respondents were in favour of setting the age at 16; others suggested that there should be a test of capacity rather than a specified age, that is, a requirement that the person be capable of understanding the nature and effect of the healthcare directive. In our view the latter would introduce too much uncertainty. On the other hand, we are persuaded that 16 is probably more appropriate than 18 as the minimum age. We

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45 See *supra*, notes 32-34 and accompanying text.

46 The agreement takes its name after Ulysses who, wishing to experience the sounds of the Sirens, tied himself to the mast and ordered his crew not to release him and to ignore any of his instructions to the contrary.

47 One submission questioned whether our recommendation dealing with revocation (originally Recommendation 6, now Recommendation 7) would prevent a Ulysses Agreement from being used. In our view it would not, because the healthcare directive can only be revoked if the maker is mentally capable of understanding the nature and effect of the revocation.

48 *Supra*, note 1 at 52.

have amended our recommendation accordingly, along with the parallel recommendation dealing with the minimum age for healthcare proxies.

One submission emphasized the need to develop guidelines and standards for assessing mental capacity, as has been done, for example, in Ontario.[49] We agree, but view this as a much larger project which goes beyond our present mandate. We believe that until such a project is undertaken, our suggested definition of capacity (namely, capacity to understand the nature and effect of the healthcare directive) is both adequate and consistent with the common law relating to capacity.[50]

(6) Qualifications of the Healthcare Agent

In the Report for Discussion we recommended that no particular individual or group should be disqualified from being appointed as a healthcare agent.[51] Some submissions suggested that it would be inappropriate for the healthcare practitioner directly managing the patient's case, and an employee of the facility in which the patient is resident, to be appointed as agent. However, we agree with the view expressed in several other submissions, namely, that the patient should be free to choose whomever he or she feels is an appropriate person to act as healthcare agent.

Several respondents, including a lawyer who represents a number of congregations of Sisters, suggested that the proposed legislation make it clear that the holder of an office from time to time (as opposed to the specific incumbent of the office at the time the directive is signed) may be appointed as a healthcare agent; for example, the Mother Superior of a particular Order. We agree with this suggestion, and have amended our recommendation accordingly.

To remove any doubt we have also expressly provided that an individual may appoint an alternate healthcare agent, who would have authority if the first named agent were unavailable.

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49 See *Final Report of the Ontario Enquiry on Mental Competency* (1990).

50 See Report for Discussion, *supra*, note 1 at 51.

51 *Ibid.*, at 52-53.

(7) Termination

In the Report for Discussion we recommended that the appointment of a healthcare agent should terminate if it is revoked by its maker at a time when he or she is mentally capable of understanding the nature and effect of the revocation.[52] We did not recommend any restrictions on the method of revocation. A number of submissions questioned the wisdom of allowing verbal revocation. For example, the CBA Health Law Section (North) stated that verbal revocation might lead to "confusion and chaos", and suggested that revocation be in writing or by destruction, by or under the direction of the maker of the healthcare directive. On reflection we agree with this suggestion, and have amended our recommendation accordingly.

With respect to revocation by divorce, the Alberta Healthcare Association and the Council of Teaching Hospitals of Alberta, in a joint submission, suggested that the proposed legislation make it clear that the revocation does not preclude the individual from executing another healthcare directive, appointing his or her former spouse as healthcare agent. To remove any doubt on this issue, we have incorporated this suggestion into our recommendation. We have also added nullity of marriage as a ground for revocation, in line with the Manitoba legislation.

One submission recommended that the healthcare agent's appointment automatically terminate if the court issues a guardianship order under the *Dependent Adults Act* in respect of the patient. We prefer to leave this to the discretion of the court. Under our recommendation the court has the power to issue an order terminating the healthcare agent's appointment, and it can consider whether or not to do so when granting the guardianship order. The same submission also suggested that the legislation make provision for the healthcare agent to renounce the appointment, but in our view this is unnecessary. Under Recommendation 8 (now renumbered as Recommendation 9), if the healthcare agent is unwilling to act, authority passes to the next person on the statutory list of healthcare proxies.

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52 *Ibid.*, at 54-55.

Lastly, one submission recommended that healthcare directives terminate automatically after five or seven years. For the reasons given in our Report for Discussion,[53] we disagree with this suggestion.

C. Personal Care

One of the most difficult issues which we considered in the Report for Discussion was whether the healthcare agent's authority should be limited to matters of healthcare, or should extend to all matters affecting the individual's personal care and well-being.[54] For a number of reasons we came out in favour of the former. Many submissions, from both the legal and healthcare professions as well as from the Society for the Retired and Semi-Retired, suggested that this recommendation requires reconsideration. These submissions stressed that in practice the boundary between healthcare and personal care is often unclear, and that many important decisions affecting matters such as nutrition, personal hygiene, and admission to a healthcare facility, might be left in limbo as a result of our recommendation. On the other hand the Alberta Association of Registered Nurses agreed with our recommendation, noting that it could be reviewed at a future date if it led to problems in practice. A number of other submissions also supported our recommendation, without giving reasons.

Having had the benefit of these submissions we are persuaded that our original recommendation is unduly restrictive. On the other hand, we still foresee problems if the legislation provides for "personal care agents" and not simply healthcare agents. For example, as we have already noted, part of the policy core of our recommendations is that there be a statutory list of healthcare proxies, because in many cases the patient will not have signed a healthcare directive appointing a healthcare agent. If the agent's authority under a healthcare directive is extended to include all matters of personal care, there seems to be no principled reason why the authority of the proxies in the statutory list should not also be extended in like manner. In our view such a scheme would not simply provide individuals with a means of avoiding guardianship (by appointing an agent for personal care); it would entirely replace the concept of a court-appointed guardian, with what in essence would be a statutory guardian. We are not convinced of the wisdom of such an approach.

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53 *Ibid.*, at 55.

54 *Ibid.*, at 57-58.

In our view the appropriate resolution of this problem is to be found in a suggestion made in the joint submission from the Alberta Healthcare Association and the Council of Teaching Hospitals of Alberta, namely, that the proposed legislation define "healthcare"[55] broadly so as to include personal care matters related to health, such as nutrition and hydration, personal hygiene, and choice of residence. This would apply to all healthcare proxies, including a healthcare agent appointed under a healthcare directive. By using a broad definition, the proxy is given authority to deal with personal care matters which are ancillary to the patient's health. We are in favour of this approach, and have amended our recommendations to reflect this. To ensure consistency, we have also recommended that the definition of "health care" in the *Dependent Adults Act* be amended accordingly.

D. Healthcare Proxies

(1) The Statutory List

We received a number of suggestions with respect to the specific details of the proposed statutory list of healthcare proxies. Our original paragraph (c) comprised the patient's "spouse or partner". The term "partner" was criticized by many respondents as being too vague[56] and probably not amenable to practicable statutory definition. For example, if "partner" were to be defined in terms involving a period of cohabitation, how would the healthcare practitioner be able to determine whether the definition was met in a particular case? We have been persuaded by these arguments, and by the fact that individuals who wish to have their non-spousal "partner" act as healthcare proxy can easily achieve this by appointing the "partner" in a healthcare directive. Accordingly, we have deleted "partner" from paragraph (c).

In paragraphs (i) and (j), one respondent noted that the terms "uncle and aunt" and "nephew and niece" should be pluralized. We agree.

With respect to paragraph (l)—the "default proxy"—most submissions favoured our recommendation that this be the patient's healthcare practitioner, rather than other possibilities such as the Public Guardian. Some suggested the

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[55] See also *supra*, note 2.

[56] Several expressed surprise at the prospect of their business partner acting as their healthcare proxy.

patient's "friend", but in our view this is too vague. However, one modification to the healthcare practitioner option was suggested, namely, that this be changed to the patient's "healthcare practitioner in consultation with the healthcare team". In our view this is laudable as a goal, but impracticable as a statutory requirement. We fully expect that in practice the practitioner would likely consult with other members of the healthcare team before making a decision, and we can see the obvious benefits of such consultation. However, to make this a requirement would lead to difficult practical problems, not the least of which would be defining who forms part of the "healthcare team", and for that reason we do not favour incorporating this into the proposed legislation. To add greater clarification, however, we have changed "healthcare practitioner" to "healthcare practitioner who is responsible for performing the proposed treatment".

(2) Triggering Event

Under our proposals, the healthcare proxies assume decision-making authority in the event of the patient being incapable of making the healthcare decision in question. One submission which we received suggested that the proposed legislation place a duty on the healthcare practitioner to assess the patient's mental capacity. In our view this is unnecessary. The common law already imposes such a duty, because it requires practitioners to obtain valid consent before administering treatment, which in turn places a responsibility on practitioners to address the issue of whether the patient has capacity to give a valid consent.[57]

(3) Qualifications of the Proxy

We have already discussed our decision to change the minimum age for healthcare proxies from 18 to 16 years.[58] Another of our proposed qualifications for proxies attracted some discussion, namely, the requirement that the proxy have had personal involvement with the patient at some time during the preceding twelve months. One submission suggested that we change "personal involvement" to "personal contact", but for the reasons given in the Report for Discussion[59] we prefer the former. Although the term is unavoidably vague, we

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57 See Report for Discussion, *supra*, note 1 at 6-8.

58 See *supra*, B(5).

59 *Supra*, note 1 at 62.

still believe that there is much to be said for requiring proxies to have had some recent personal involvement with the patient before they can assume the role of decision-maker. This is particularly so in view of the substituted judgment test; healthcare decisions are taken on the basis of what the proxy believes the patient would have decided if competent. A proxy who has had no personal involvement with the patient in the last twelve months is unlikely to be in the best position to make that judgment. However, we have amended our recommendation to provide for the court to dispense with the twelve-month requirement if it considers this appropriate.

(4) Multiple Proxies

In the Report for Discussion we recommended that if more than one person is acting as healthcare proxy, the decision of the majority should prevail, and that in the absence of a majority decision, proxy authority should pass to the next person or category of persons on the list.[60] A number of respondents, including the Good Samaritan Society, the Capital Care Group, the Alberta Healthcare Association, and the Council of Teaching Hospitals of Alberta, expressed concerns about the practical problems involved in healthcare professionals and facilities having to deal with more than one proxy. In the words of one submission:

> While it is healthy for all family members to be aware of and interested in the healthcare decisions of their close relatives, it is impractical for institutions providing healthcare to respond to multiple family members and, in effect, more than one proxy.

Their suggestion was that in the event of there being more than one proxy, the relevant group should be required to select a spokesperson from within the group, who would then have the responsibility of ascertaining the decision of the group (or of the majority of its members) and conveying this decision to the healthcare practitioner. The practitioner would be required to consult only the spokesperson rather than every member of the group.

In our view this is a legitimate concern, and we agree with the suggested solution. The group should be required to nominate a spokesperson, who would have responsibility for ascertaining the decision of the group (or of a majority of its members) and for communicating that decision to the patient's healthcare

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60 *Ibid.*, at 63-64.

practitioner. The healthcare practitioner would be entitled to rely on that decision without consulting other members of the group, unless he or she had reasonable grounds to believe that the decision was not in fact one with which the group (or a majority of its members) agreed. If the group (or a majority of its members) refused or failed to nominate a spokesperson, proxy authority to make the healthcare decision would pass to the next person or group on the statutory list. We have added a new recommendation (Recommendation 13) dealing with this.

(5) Healthcare Practitioner's Duty

The Report for Discussion[61] recommended that healthcare practitioners be required to make "reasonable inquiry" to determine who has proxy authority, and so long as this is done, they would not liable for failing to find the correct proxy. Some submissions suggested that the proposed legislation define "reasonable inquiry", but in our view this would not be practicable. What is reasonable will depend on the particular circumstances of the case, and will be affected by a wide range of factors such as the nature of the patient's condition and the urgency of treatment, the geographical location of the proxy, etc. In addition, the term "reasonable inquiries" is used in the parallel provision of the *Mental Health Act*,[62] and we are not aware of its having given rise to problems in practice.

(6) Emergency Treatment

Under our proposal for a statutory list of healthcare proxies, if a proxy is "unavailable", or is unable or unwilling to make a decision, proxy authority passes to the next person or category of persons on the list. We recommended that the proposed legislation provide that a proxy is "unavailable" if it is not possible for the healthcare practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a consent or refusal of consent. Part of the intent of this recommendation was to preserve the common law rule relating to emergency treatment. In other words, the healthcare practitioner will not have to delay emergency treatment so as to obtain consent from the healthcare proxy, because the definition of whether a proxy is "available" refers to whether that proxy's consent can be obtained within a time that is reasonable in the circumstances. If no proxy is immediately available, and it would be unreasonable to delay the treatment so as to wait for one to become available,

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61 *Ibid.*, at 64-65.

62 S.A. 1988, c. M-13.1, s. 28(7).

proxy authority will pass to the last person on the statutory list, that is, the healthcare practitioner.

Despite the intent of this recommendation, some respondents felt that it was not sufficiently clear that the common law emergency doctrine is preserved. This is an extremely important point, and we believe that any element of doubt should be removed. Accordingly, we have amended our recommendation to provide explicitly that the emergency doctrine is preserved.

E. Criteria for Substitute Decision-Making

We have already noted that we received overwhelming support for our recommendation that the substituted judgment test be used whenever possible as the criterion for substitute decision-making,[63] that is, the proxy must make the decision according to what he or she believes the patient would have decided if competent. As part of that overall test, we recommended that the proxy must follow any written instructions which the patient has given while mentally competent and has not revoked, if these instructions are unambiguous and relevant to the healthcare decision in question.[64] Some of the submissions expressed concern that this might be interpreted as compelling healthcare practitioners to offer treatment options which are medically futile (such as CPR, in certain circumstances) or which contravene ethical or professional standards.

We do not believe that our recommendations need to be revised to accommodate this concern, for two reasons. First, Recommendation 16 (now renumbered as Recommendation 18) expressly provides that the proxy cannot authorize anything which the patient, if competent, could not lawfully have authorized. Second, the whole tenor of the proposed legislation makes it clear that the proxy is placed in exactly the same position as the patient would have been in if competent; the proxy "stands in the shoes" of the patient. The proxy can neither authorize nor insist on treatment if the patient, if competent, could not have done so. Thus, if it is indeed the case that a healthcare practitioner is not legally obliged to offer a competent patient treatment which in the practitioner's

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63 See *supra*, Chapter 1(E).

64 See Report for Discussion, *supra*, note 1 at 65-66.

opinion is medically futile (and we express no view on this),[65] the proxy of an incompetent patient is in no different a position.

The CBA Wills and Trusts Section (South) suggested that provision be made for a proxy to apply to the court to be relieved from making a particular healthcare decision, while retaining proxy authority with respect to other future healthcare decisions. Our intent in drafting Recommendation 8 (now renumbered as Recommendation 9) was to provide for this, in that if the proxy refuses to make a decision, authority to make that decision passes to the next person on the list, but the original proxy still retains authority in respect of other decisions (unless, of course, that proxy indicates an unwillingness to be involved in any decisions on behalf of the patient). To clarify this point, we have added the words "to make that decision" in the last part of the recommendation.

One submission raised the question of who decides whether the patient's instructions are unambiguous and relevant, and what if there is disagreement on this issue between the proxy and the healthcare practitioner? It is clear from the Report for Discussion[66] that in our opinion the proxy is the appropriate person, after proper consultation with the healthcare practitioner, to decide this issue. If the healthcare practitioner disagrees with the proxy's decision, and the disagreement cannot be resolved by discussion or by some other informal means (such as an ethics committee meeting), the healthcare practitioner has the option of applying to the court to have the proxy's decision reviewed.

Another submission suggested that significant developments in medical science and technology since the time the healthcare directive was signed should constitute a ground for refusing to carry out instructions contained in the directive. In our view this is already accommodated by our recommendations. Such developments would undoubtedly be an important factor to be considered by the proxy (and, ultimately, by the court) in deciding whether the patient's instructions are "unambiguous and relevant to the healthcare decision in question".

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65 For a discussion of this issue see E. Toth, "Commentary on the National Guidelines for No Resuscitation Orders" (1991) 3(3) *Bioethics Bulletin* 4; T. Tomlinson & H. Brody, "Futility and the Ethics of Resuscitation" (1990) 264 *Journal of American Medical Association* 1276; Singer & Siegler, *supra*, note 19.

66 *Supra*, note 1 at 66.

Finally, one submission took issue with our recommendation that the *Dependent Adults Act* be amended to ensure that the same criteria for substitute decision-making apply to guardians as apply to other healthcare proxies.[67] We still stand by our original position, and see no compelling reason why the decision-making criteria for guardians should be different from those for other healthcare proxies.

F. Restrictions on the Proxy's Authority

In the Report for Discussion we recommended that unless the patient provides otherwise in a healthcare directive, the healthcare proxy should not be able to authorize certain procedures, including *inter vivos* tissue donation.[68] One respondent pointed out, however, that there is no reason to prevent a healthcare agent from consenting to tissue donation after the patient's death. We agree. Although this does not actually relate to the patient's healthcare, we consider it appropriate that the healthcare agent be added to the list of next of kin contained in the *Human Tissue Gift Act*,[69] and we have recommended that the Act be amended accordingly.

It was also suggested that reproductive procedures be added to the list of restrictions on the proxy's authority. On balance we are not convinced that there is a strong case for limiting the proxy's authority in this way. Indeed, if one considers the recent German case which attracted considerable media attention,[70] in which a pregnant woman was kept on artificial life support even though she was clinically brain dead, in order that the fetus might be born alive, there may well be cases where decisions relating to "reproductive choice" should fall within the authority of the proxy rather than be left to the judgment of the healthcare team.

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67 Recommendation 14 (now renumbered as Recommendation 16).

68 *Supra*, note 1 at 70-71.

69 R.S.A. 1980, c. H-12, s. 5(1).

70 See *Edmonton Journal*, October 31, 1992, at A4. The woman subsequently suffered a miscarriage: see *Edmonton Journal*, November 17, 1992, at A5.

G. Review Procedures

In our Report for Discussion we discussed some of the safeguards which should be incorporated into the proposed legislation.[71] One of our recommendations was that if a healthcare practitioner determines that a patient lacks the capacity to make a healthcare decision, the practitioner should be required to advise the patient that this decision will be taken on the patient's behalf by his or her healthcare proxy. One submission suggested that the practitioner should be relieved of this requirement if he or she feels that it might be detrimental to the patient's health or well-being. On balance we believe that such an exemption cannot be justified, given the importance of the right which is taken away from the patient by reason of the assessment of incapacity (that is, the right to make one's own healthcare decisions). Moreover, we believe that the wording of the requirement (that the practitioner advise the patient that the decision will be taken on the patient's behalf by the healthcare proxy) should give practitioners sufficient latitude to ensure that patients are informed in such a way that is not detrimental to their health or well-being.

With respect to our proposed review procedures, some submissions indicated that there is also a need for an informal, non-judicial review mechanism. We agree that this type of procedure (such as review by a hospital ethics committee) could serve a useful role, for example, in mediating disputes between the healthcare proxy and the healthcare practitioner. Nothing in our recommendations prevents these types of informal mechanisms from being developed and used, and indeed in some facilities they are already in place.

The specific wording of our recommendation was that any interested party be able to apply to the court "to have the decision of a healthcare proxy reviewed". One submission suggested that it be made clear that this includes the power to review a proposed decision, that is, before it is implemented. We agree, and have amended our recommendation accordingly. We have also amended it to incorporate the suggestion made in another submission, that the healthcare proxy be able to apply to the court for advice and directions.

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[71] See *supra*, note 1 at 72-75.

H. Protection from Liability

In the Report for Discussion we recommended that the proposed legislation confer protection from liability on persons acting in good faith in accordance with a decision made by a healthcare proxy, and on healthcare proxies in respect of a decision made by them in good faith.[72] The CBA Wills and Trusts Section (South) suggested that the protection go beyond this, to ensure that a decision by a proxy (particularly where that decision hastens the death of the patient) does not adversely affect the proxy's entitlement under the patient's will or insurance policy. This is quite a common provision in other jurisdictions,[73] and we agree that it should form part of the proposed legislation.

I. Access to Information

We recommended that the proposed legislation provide that a healthcare proxy has the same rights of access to healthcare information, and to healthcare records, that the patient would have had if competent.[74] We agree with two submissions which were made with respect to this recommendation, and have amended it accordingly. First, the proxy's right of access should be subject to any restrictions or contrary instructions contained in the patient's healthcare directive. Second, consequential amendments will have to be made to the *Hospitals Act*[75] and the *Alberta Health Care Insurance Act*[76] to give effect to our recommendation.

One submission also suggested that the proxy's right of access should be limited to information which is relevant to the healthcare decision which the proxy is called upon to make. The problem with this limitation is that it would likely be the healthcare practitioner or facility that would decide whether or not information was "relevant". How would the proxy determine whether this assessment was correct? In our view, a healthcare proxy should have the same unrestricted right of access as a guardian appointed under the *Dependent Adults Act*.

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72 *Ibid.*, at 75-76.

73 See, for example, *Health Care Directives Act*, S.M. 1992, c. 33 (also C.C.S.M., c. H27), s. 24.

74 See Report for Discussion, *supra*, note 1 at 76.

75 R.S.A. 1980, c. H-11.

76 R.S.A. 1980, c. A-24.

J. Mental Health Act

In the Report for Discussion we recommended that the proposed legislation should not apply to formal patients as defined in the *Mental Health Act* (that is, patients who have been committed under the Act), but that the *Mental Health Act* should be reviewed to determine whether it should be amended to incorporate the principles contained in the proposed legislation.[77] Some respondents strongly disagreed with this. In the words of one:

> I see no reason to treat formal patients under the Mental Health Act differently than any other individual in society. If the Mental Health Act must be amended to provide for a unified scheme of substitute decision making, then such amendments should follow as a matter of course. I believe that the onus is on those in the mental health field to come up with even one reason why the scheme you have proposed should not apply to formal patients under the Mental Health Act. I am of the view that there is no such reason.

We do not disagree with the sentiment underlying this view. However, we still believe that a great deal of consultation will be required on this issue, much greater than we have been able to achieve in this project, and that it should be done as part of a wider review of the *Mental Health Act* in general.[78]

K. Education

Our final recommendation was that appropriate education programs be established to ensure that the general public, and healthcare professions and institutions, are made fully aware of the legislation governing healthcare directives and proxy decision-making.[79] We think it important to record that this

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77 *Supra*, note 1 at 77-78.

78 This is particularly so in light of the recent decision of the Ontario Court of Appeal in *Fleming v. Reid* (1991), 4 O.R. (3d) 74, in which certain of the treatment provisions of Ontario's *Mental Health Act* were held to be in violation of the *Canadian Charter of Rights and Freedoms.*

79 See Report for Discussion, *supra*, note 1 at 78. A similar recommendation has also been made by several other provincial law

(continued...)

recommendation was singled out for explicit endorsement by a large number of groups and individuals.

In their joint submission the Alberta Healthcare Association and the Council of Teaching Hospitals of Alberta suggested that healthcare providers be required to ask patients, on being admitted to a healthcare facility, whether they have a healthcare directive. We are not convinced that this should be a statutory requirement, but we hope that with the proper professional education program it will become standard practice.

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[79](...continued)
reform agencies: see Manitoba Law Reform Commission, *supra*, note 17 at 24; Newfoundland Law Reform Commission, *supra*, note 29 at 97-98; B.C. Joint Working Committee, *supra*, note 33 at 15.

CHAPTER 4 — FINAL RECOMMENDATIONS

In light of the foregoing discussion, we have made the following changes and additions to our original recommendations:

1. We have amended Recommendation 1 so as to make it clear that an individual may appoint an alternate healthcare agent.[80]

2. We have amended Recommendation 2 so that the spouse of a healthcare agent is not disqualified from acting as a witness to the signing of the healthcare directive.[81] We have made similar changes to Recommendation 3, which deals with a healthcare directive which is signed at the request and under the direction of a person who is physically incapable of signing it personally.

3. We have added a new recommendation (Recommendation 4) that the proposed legislation incorporate the Uniform Law Conference of Canada text of draft legislation on recognition of foreign healthcare directives (1992).[82]

4. In the original Recommendation 4 (now renumbered as Recommendation 5), we have changed the minimum age for executing a healthcare directive from 18 years to 16 years. We have made a similar amendment to Recommendation 10 (now renumbered as Recommendation 11) with respect to the minimum age for healthcare proxies.[83]

5. We have changed Recommendation 5 (now renumbered as Recommendation 6) to make it clear that an office, as opposed to the specific incumbent of the office at the time the directive is signed, may be appointed as a healthcare agent.[84]

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80 See *supra*, Chapter 3(B)(6).

81 See *supra*, Chapter 3(B)(1).

82 See *supra*, Chapter 2(B).

83 See *supra*, Chapter 3(B)(5).

84 See *supra*, Chapter 3(B)(6).

6. Recommendation 6 (now renumbered as Recommendation 7), dealing with termination of a healthcare directive, has been amended so as to (1) require that revocation be in writing or by destruction, by or under the direction of the maker of the healthcare directive, (2) include nullity of marriage as a ground for revocation, as in the case of divorce, and (3) provide that revocation by divorce or nullity of marriage does not preclude the individual from executing another healthcare directive, appointing his or her former spouse as healthcare agent.[85]

7. We have deleted our original Recommendation 7, which recommended that the proposed legislation should not make provision for advance directives for personal care. In its place we have added a new recommendation (now renumbered as Recommendation 8), proposing that the legislation define "healthcare" broadly so as to include personal care matters related to health, such as nutrition and hydration, personal hygiene, and choice of residence.[86] We have also recommended a consequential amendment to the definition of "health care" contained in the *Dependent Adults Act*.

8. The statutory list of healthcare proxies (originally Recommendation 8, now renumbered as Recommendation 9) has been changed as follows:[87]

(1) in paragraph (c), the words "or partner" have been deleted;

(2) in paragraphs (i) and (j), the terms "uncle and aunt" and "nephew and niece" have been pluralized;

(3) in paragraph (l) the words "healthcare practitioner" have been changed to "healthcare practitioner who is responsible for performing the proposed treatment"; and

(4) the words "to make that decision" have been added before the word "passes" in the last part of the recommendation.

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85 See *supra*, Chapter 3(B)(7).

86 See *supra*, Chapter 3(C).

87 See *supra*, Chapter 3(D)(1) and 3(E).

9. In our original Recommendation 10 (now renumbered as Recommendation 11), we have provided that the court may dispense with the requirement that in order to act as a healthcare proxy a person must have had personal involvement with the patient at some time during the preceding twelve months.[88]

10. We have added a new recommendation (Recommendation 13) requiring the appointment of a spokesperson in the situation where more than one person is acting as healthcare proxy.[89]

11. We have amended our original Recommendation 12 (now renumbered as Recommendation 14) to make it clear that the proposed legislation preserves the common law doctrine relating to emergency treatment.[90]

12. We have changed our original Recommendation 15 (now renumbered as Recommendation 17) to provide that the *Human Tissue Gift Act* be amended to enable a healthcare agent to consent to tissue donation after the patient's death.[91]

13. We have amended our original Recommendation 19 (now renumbered as Recommendation 21) to make it clear that a court can review a proposed decision of a healthcare proxy, prior to the decision being implemented, and also to provide that a healthcare proxy may apply to the court for advice and directions.[92]

14. We have extended the protection conferred on healthcare proxies by our original Recommendation 21 (now renumbered as Recommendation 23), by providing that a decision made by a proxy in good faith shall not affect the proxy's entitlement to benefit under a testamentary disposition by the patient, or under a policy of insurance on the life of the patient, or under family relief legislation, or under the laws of intestate succession.[93]

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88 See *supra*, Chapter 3(D)(3).

89 See *supra*, Chapter 3(D)(4).

90 See *supra*, Chapter 3(D)(6).

91 See *supra*, Chapter 3(F).

92 See *supra*, Chapter 3(G).

93 See *supra*, Chapter 3(H).

15. In the original Recommendation 22 (now renumbered as Recommendation 24), dealing with the proxy's right of access to healthcare records and information, we have made this right subject to any restrictions or contrary instructions contained in the patient's healthcare directive, and we have recommended that consequential amendments be made to the *Hospitals Act* and the *Alberta Health Care Insurance Act*.[94]

Accordingly, our final recommendations are as follows:

RECOMMENDATION 1

We recommend that legislation be introduced to enable individuals to execute a healthcare directive, in which they can

(1) appoint someone (including, if they wish, an alternate) as their healthcare agent, who will have authority to make healthcare decisions on their behalf in the event of their becoming incapable of making these decisions personally;

(2) identify anyone whom they do not wish to act as their healthcare proxy, as provided in Recommendation 9; and

(3) provide instructions and information concerning future healthcare decisions.

RECOMMENDATION 2

We recommend that the proposed legislation require that, subject to Recommendation 3, a healthcare directive be in writing, be signed by the person making it, and be witnessed by one person other than the healthcare agent.

RECOMMENDATION 3

We recommend that the proposed legislation provide that a healthcare directive may be signed on the maker's behalf, in the presence and under the direction of the maker, by a person other than the healthcare agent or a witness, if the maker is physically incapable of signing it.

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[94] See *supra*, Chapter 3(I).

RECOMMENDATION 4

We recommend that the proposed legislation incorporate the Uniform Law Conference of Canada text of draft legislation on recognition of foreign healthcare directives (see Appendix A).

RECOMMENDATION 5

We recommend that the proposed legislation provide that in order to execute a healthcare directive, a person must be at least sixteen years of age and must be capable of understanding the nature and effect of the directive.

RECOMMENDATION 6

We recommend that the proposed legislation

(1) should not disqualify any particular individual or group from being appointed as a healthcare agent; and

(2) should make it clear that the holder of an office from time to time, as opposed to the specific incumbent of the office at the time the directive is signed, may be appointed as a healthcare agent.

RECOMMENDATION 7

We recommend that the proposed legislation provide that the appointment of a healthcare agent terminates

(1) if it is revoked in writing or by destruction, by or under the direction of its maker, at a time when he or she is mentally capable of understanding the nature and effect of the revocation;

(2) in the case where the healthcare agent is the spouse of the maker of the of the healthcare directive, on the marriage terminating by divorce or being declared to be a nullity, but the revocation does not preclude that individual from executing another healthcare directive, appointing his or her former spouse as healthcare agent; and

(3) if a court issues an order terminating the appointment.

RECOMMENDATION 8

We recommend that

(1) the proposed legislation define "healthcare" broadly so as to include personal care matters related to health, such as nutrition and hydration, personal hygiene, and choice of residence; and

(2) this definition be incorporated into the *Dependent Adults Act*.

RECOMMENDATION 9

We recommend that the proposed legislation provide that if a person (the "patient") lacks the capacity to make a healthcare decision, that decision may be made on the patient's behalf by his or her healthcare proxy, defined as the first named person or group of persons on the following list:

(a) a guardian appointed under the *Dependent Adults Act* with authority to make healthcare decisions on behalf of the patient;

(b) a healthcare agent appointed by the patient pursuant to a healthcare directive;

(c) the patient's spouse;

(d) the patient's children;

(e) the patient's parents;

(f) the patient's siblings;

(g) the patient's grandchildren;

(h) the patient's grandparents;

(i) the patient's uncles and aunts;

(j) the patient's nephews and nieces;

(k) any other relative of the patient;

(l) the patient's healthcare practitioner who is responsible for performing the proposed treatment,

and that if a healthcare proxy (or in the case of a group of proxies, the entire group) is unavailable, or is unable or unwilling to make a decision, proxy authority to make that decision passes to the next person or category of persons on the list.

RECOMMENDATION 10

We recommend that the proposed legislation provide that a person has capacity to make a healthcare decision if that person is capable of understanding the information that is relevant to making the decision and is capable of appreciating the reasonably foreseeable consequences of a decision or lack of decision.

RECOMMENDATION 11

We recommend that the proposed legislation provide that an individual cannot act as a healthcare proxy

(1) unless that individual

(a) is at least sixteen years of age and apparently has capacity to make the healthcare decision in question, and

(b) with the exception of a proxy mentioned in paragraphs (a), (b), and (l) of Recommendation 9, has had personal involvement with the patient at some time during the preceding twelve months, unless the court directs otherwise; or

(2) if the patient has indicated in a healthcare directive that he or she does not wish that individual to act as healthcare proxy.

RECOMMENDATION 12

We recommend that the proposed legislation provide that if more than one person is acting as healthcare proxy ("the group"), the decision of a majority of available members of the group prevails, and that in the absence of a majority decision, proxy authority passes to the next person or category of persons on the list.

RECOMMENDATION 13

We recommend that the proposed legislation provide that if more than one person is acting as healthcare proxy ("the group")

(1) the group (or a majority of its available members) must nominate a spokesperson from within the group, who shall have responsibility for ascertaining the decision of the group (or of a majority of its available members) and for communicating that decision to the patient's healthcare practitioner;

(2) the healthcare practitioner is entitled to rely on that decision without consulting other members of the group, unless he or she has reasonable grounds to believe that the decision is not in fact one with which the group (or a majority of its available members) agrees; and

(3) if the group (or a majority of its available members) refuses or fails to nominate a spokesperson, proxy authority to make the healthcare decision passes to the next person or group on the list.

RECOMMENDATION 14

We recommend that for the purposes of Recommendation 9, the proposed legislation provide that

(1) a healthcare proxy is "unavailable" if it is not possible for the healthcare practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a consent or refusal of consent;

(2) the healthcare practitioner is required to make reasonable inquiry to determine who has proxy authority, and so long as this is done, the practitioner is not liable for failing to find the correct proxy; and

(3) nothing in the legislation requires a healthcare practitioner to obtain the consent of a proxy listed in paragraphs (a) to (k) of Recommendation 9 in respect of emergency treatment, where the treatment is immediately necessary to preserve the life or health of the patient and where the delay involved in obtaining consent from the proxy would likely pose a significant risk to the patient.

RECOMMENDATION 15

We recommend that the proposed legislation provide that when making a healthcare decision on behalf of a patient, a healthcare proxy

(1) shall follow any instructions contained in any existing healthcare directive executed by the patient, if these instructions are unambiguous and relevant to the healthcare decision in question, and in the absence of unambiguous and relevant instructions

(2) shall make the decision according to what he or she believes the patient would have decided if competent, and if this is not possible

(3) shall make the decision according to what he or she believes to be in the patient's best interests.

RECOMMENDATION 16

We recommend that consequential amendments be made to the *Dependent Adults Act* to give effect to Recommendation 15 in respect of a guardian acting as a healthcare proxy.

RECOMMENDATION 17

We recommend that

(1) the proposed legislation provide that unless the patient provides otherwise in a healthcare directive, a healthcare proxy does not have authority to consent to non-therapeutic sterilization, psychosurgery, non-therapeutic research, or *inter vivos* tissue donation; and

(2) the *Human Tissue Gift Act*, section 5(1) be amended by adding the healthcare agent (as the first paragraph) to the list of those who may consent to tissue donation after the death of an individual.

RECOMMENDATION 18

We recommend that the proposed legislation provide that a healthcare proxy cannot authorize anything which the patient, if competent, could not lawfully have authorized.

RECOMMENDATION 19

We recommend that the proposed legislation provide that if a healthcare practitioner determines that a patient lacks the capacity to make a healthcare decision, the practitioner shall advise the patient that this decision will be taken on the patient's behalf by his or her healthcare proxy.

RECOMMENDATION 20

We recommend that the proposed legislation provide that if a healthcare practitioner determines that a patient lacks the capacity to make a healthcare decision, but the patient objects to the proposed treatment, that treatment shall not be performed on the basis of consent obtained from the patient's healthcare proxy unless a second healthcare practitioner confirms that the patient lacks the capacity to make the healthcare decision.

RECOMMENDATION 21

We recommend that the proposed legislation provide that

(1) any interested person may apply to the court to have the decision or proposed decision of a healthcare proxy reviewed;

(2) if the court considers that the proxy's decision is unreasonable having regard to the criteria set out in Recommendation 15, it may rescind the proxy's decision and substitute its own decision based on the criteria set out in Recommendation 15;

(3) the court may issue an order terminating the authority of a healthcare proxy if it considers that the proxy is likely to continue to make unreasonable decisions or is otherwise unsuitable to act as healthcare proxy; and

(4) a healthcare proxy may apply to the court for advice and directions.

RECOMMENDATION 22

We recommend that consequential amendments be made to the *Dependent Adults Act* to give effect to Recommendation 21 in respect of a guardian acting as a healthcare proxy.

RECOMMENDATION 23

We recommend that the proposed legislation

(1) confer protection from liability on persons acting in good faith in accordance with a decision made by a healthcare proxy, and on healthcare proxies in respect of a decision made by them in good faith; and

(2) provide that a decision made by a healthcare proxy in good faith shall not affect the proxy's entitlement to benefit under a testamentary disposition by the patient, or under a policy of insurance on the life of the patient, or under family relief legislation, or under the laws of intestate succession.

RECOMMENDATION 24

We recommend that

(1) the proposed legislation provide that subject to any restrictions or contrary instructions contained in the patient's healthcare directive, a healthcare proxy has the same rights of access to healthcare information, and to healthcare records, that the patient would have had if competent; and

(2) consequential amendments be made to the *Hospitals Act* and the *Alberta Health Care Insurance Act* to give effect to this recommendation.

RECOMMENDATION 25

We recommend that the proposed legislation provide that no presumption as to a person's healthcare wishes arises from the fact that the person has not executed a healthcare directive.

RECOMMENDATION 26

We recommend that section 20.1 of the *Dependent Adults Act* be repealed.

RECOMMENDATION 27

We recommend that

(1) the proposed legislation provide that it does not apply to a formal patient as defined in the *Mental Health Act*; and

(2) the *Mental Health Act* be reviewed to determine whether it should be amended to incorporate the principles contained in the proposed legislation.

RECOMMENDATION 28

We recommend that appropriate education programs be established to ensure that the general public, and healthcare professions and institutions, are made fully aware of the legislation governing healthcare directives and proxy decision-making.

C.W. DALTON
A. FRUMAN
W.H. HURLBURT
D.P. JONES
J.C. LEVY
B.L. RAWLINS

J.L. FOSTER
A.D. HUNTER
H.J.L. IRWIN
F.A. LAUX
P.J.M. LOWN
A.C.L. SIMS

CHAIRMAN

DIRECTOR

March 1993

PART III — DRAFT LEGISLATION

HEALTH CARE INSTRUCTIONS ACT

Table of Contents

Interpretation **1(1)** In this Act,

(a) "directive" means a health care directive under this Act;

(b) "health care" means anything that is done for a therapeutic, preventive, palliative, diagnostic or other health-related purpose, and includes nutrition, hydration, personal hygiene and choice of residence;

(c) "health care agent" means a person appointed in a directive as a health care agent;

(d) "health care decision" means a consent, refusal to consent or withdrawal of consent to health care;

(e) "health care practitioner" means a person responsible for providing health care;

(f) "health care proxy" means a person who is a health care proxy under this Act.

(2) For the purposes of this Act, a health care proxy is "not available" if it is not possible for a health care practitioner, within a time that is reasonable in the circumstances, to communicate with that person to obtain a health care decision.

(3) For the purposes of this Act, a person has capacity to make a health care decision if the person is able to understand the information that is relevant to making the decision and is able to appreciate the reasonably foreseeable consequences of the decision or lack of decision.

Mental Health Act prevails **2** In the case of a "formal patient", as defined in the *Mental Health Act*, this Act does not apply and the *Mental Health Act* prevails.

PART 1

HEALTH CARE DIRECTIVE

Qualifications to make a directive **3** A person who is at least 16 years of age and understands the nature and effect of a health care directive may make a health care directive.

Directive's contents

4(1) In a directive a person may

(a) provide instructions and information about future health care decisions to be made on his behalf;

(b) appoint individuals as his health care agent for all or for specified health care matters and may appoint alternates in case the first appointed individuals are unavailable or unwilling to act as health care proxies;

(c) appoint the occupant of an office as his health care agent;

(d) state who is not to act as his health care proxy.

(2) A person may appoint a former spouse to be his health care agent.

Signing a directive

5 To be valid a directive must be written and the person who makes the directive must

(a) sign it in the presence of a witness who is not appointed in the directive as a health care agent, or

(b) direct another person to sign it when he and another witness are present, in which case the person signing and the witness may not be a health care agent appointed in the directive.

Revoking, terminating a directive

6(1) A directive may be revoked by the person who made it if he understands the effect of revoking it.

(2) A directive may only be revoked

(a) by a later directive,

(b) by a written declaration that expresses an intention to revoke all or part of the directive,

(c) by destroying, with the intent to revoke, all original signed copies of the directive, or

(d) directing another person to destroy, with the intention to revoke, all original signed copies of the directive in the presence of the person who made the directive.

(3) If a person has made a directive in which his spouse is appointed as a health care agent and subsequently the marriage is terminated by divorce or is found to be void or declared a nullity by a court, the appointment is terminated.

PART 2

INCAPACITATED PERSONS HEALTH CARE

Division 1
Health Care Proxy

Incapacitated patient

7(1) If a health care practitioner has a patient who requires the administration of health care but lacks the capacity to make a health care decision or is unable to communicate a health care decision,

(a) the health care practitioner must make a reasonable attempt to determine whether the patient has a health care proxy who is available, and

(b) the health care decision may be made on the patient's behalf by the health care proxy.

(2) A health care practitioner is not required to obtain a health care proxy's consent in the case of emergency health care, if the health care is necessary to preserve the patient's life or health and the delay involved in obtaining consent from a health care proxy probably poses a significant risk to the patient.

Health care proxy

8(1) A health care proxy must be at least 16 years of age and be the first named person or a member of the category of persons on the following list:

(a) a guardian appointed under the *Dependent Adults Act* with authority to make health care decisions on behalf of the incapacitated person;

(b) a health care agent appointed by the incapacitated person in his directive under this Act or in a directive that meets the requirements of section 10;

(c) the incapacitated person's spouse;

(d) the incapacitated person's children;

(e) the incapacitated person's parents;

(f) the incapacitated person's siblings;

(g) the incapacitated person's grandchildren;

(h) the incapacitated person's grandparents;

(i) the incapacitated person's uncles and aunts;

(j) the incapacitated person's nephews or nieces;

(k) any other relative of the incapacitated person;

(l) the incapacitated person's health care practitioner who is responsible for the proposed health care.

(3) Notwithstanding subsection (1), if a health care proxy is not available, or is unable or unwilling to make the health care decision, the health care proxy for that decision becomes the next available person or category of persons listed in subsection (1).

(4) Notwithstanding subsection (1), if a person has indicated in a directive that he does not wish an individual to act as his health care agent the individual may only act as the health care proxy if he is the person's guardian appointed under the *Dependent Adults Act*.

(5) Notwithstanding subsection (1), a health care proxy other than a guardian under the *Dependent Adults Act*, health care agent and health care practitioner may not act as a health care proxy unless they have had personal involvement with the incapacitated person at some time during the preceding 12 months.

(6) A health care proxy other than a guardian under the *Dependent Adults Act*, health care agent or health care practitioner may apply to the Court of Queen's Bench to shorten or waive the 12-month requirement under subsection (5).

More than one proxy

9(1) If more than one person in a category is qualified to act as a health care proxy, the decision of the majority prevails, and in the absence of a majority decision, the health care proxy becomes the next available person or category of persons listed in section 8(1).

(2) If more than one person is qualified to act as a health care proxy, the persons must designate one person from among themselves to communicate their health care decisions to the health care practitioner and the practitioner may assume that the person is communicating the health care decision of the majority of the proxies unless the practitioner has reasonable grounds to believe that it is not so.

(3) If the proxies fail to designate a person under subsection (2), the health care proxy becomes the next available person or category of persons in section 8(1).

Out-of-province directives

10(1) For the purposes of section 8(1)(b) a directive that is not made in Alberta has the same effect as though it were made in accordance with this Act if

(a) it meets the requirements of section 5 and has not been revoked in accordance with section 6, or

(b) it was made under and meets the requirements for making a directive established by the legislation of

(i) the jurisdiction where the directive was made, or

(ii) the jurisdiction where the person who made the directive was habitually resident at the time the directive was made or revoked.

(2) A person who determines who is a health care proxy may rely on a certificate from an individual purporting to be a lawyer in the jurisdiction where the directive was made that certifies that a directive meets the requirements of the jurisdiction for making or revoking a directive.

Division 2
Health Care Decisions

Proxy's guide for decisions

11(1) A health care proxy shall

(a) follow any relevant and unambiguous instructions in the incapacitated person's directive;

(b) in the absence of relevant and unambiguous instructions, act in accordance with what the proxy believes would be the incapacitated person's wishes, if competent;

(c) if the proxy does not know the person's wishes, make the health care decision that the proxy believes to be the incapacitated person's best interests.

(2) A health care proxy may only consent, on behalf of an incapacitated person, to the following if the incapacitated person's directive contains clear instructions to do so:

(a) health care if its primary purpose is for research;

(b) psychosurgery;

(c) sterilization that is not medically necessary to protect the person's health;

(d) removing tissue from the person's body, while living,

(i) for transplantation to another person, or

(ii) for medical education or research purposes.

(3) A health care proxy may apply to the Court of Queen's Bench for advice and directions.

Patient notified about proxy

12 If a health care practitioner has a patient described in section 7(1), the practitioner shall advise the person that health care decisions will be taken on the person's behalf by the person's health care proxy and that any existing health care directive of the person comes into force and remains in force while the person does not have the capacity to make or communicate a health care decision.

Incapacitated patient objects to decision

13 If a health care practitioner determines that a person lacks the capacity to make a health care decision and the person objects to the proposed health care treatment, the health care treatment may not be administered on the basis of consent obtained from the person's health care proxy unless a 2nd health care practitioner confirms that the person lacks the capacity to make the health care decision.

Court reviews decisions, terminates appointments

14(1) Any interested person may apply to the Court of Queen's Bench to have

(a) the determination of who is the health care proxy reviewed, and

(b) the health care proxy's proposed health care decision or health care decision reviewed.

(2) If the Court considers that the health care proxy's health care decision is unreasonable having regard to the criteria set out in section 11, it may rescind the proxy's decision and substitute its own health care decision based on the criteria set out in section 11.

(3) The Court may issue an order stating that the person may no longer act as a health care proxy if the Court considers that the person is likely to continue to make unreasonable health care decisions or that the person is unsuitable to act as a health care proxy.

Health information

15 Notwithstanding any other enactment respecting the disclosure of confidential health information, but subject to any limitation set out in a health care directive, a health care proxy has the right to be provided with all the health care information and records that the person for whom he acts as proxy would have if the person had the capacity to make a health care decision but the health care proxy may only use the contents of the health care information and records to carry out the duties of a health care proxy.

PART 3

MISCELLANEOUS

Liability protection

16(1) No action lies against a health care proxy by reason only of having acted in good faith in accordance with this Act.

(2) If a health care practitioner makes a reasonable attempt under section 7(1), the practitioner is not liable for failing to find the correct health care proxy.

(3) No action lies against a health care practitioner who administers or refrains from administering health care to another person by reason only that the health care practitioner has acted in good faith in accordance with a health care decision made by a health care proxy.

No disentitlement

17 If a health care proxy has acted in good faith, a health care decision made by the proxy does not affect the proxy's or his spouse's entitlement to the following:

(a) a disposition under the will of the person who made the directive;

(b) the proceeds of an insurance policy on the life of a person who made a directive;

(c) a share under the *Intestate Succession Act* of the estate of a person who made a directive.

No presumptions

18 No inference or presumption arises because a person does not have a directive.

Offence

19 Any person who, without the consent of the person who made or revoked a directive, wilfully conceals, or alters the directive or the revocation of the directive is guilty of an offence and liable to a fine of not more than $2000.

Consequential

20 *Section 13(4)(e.1) of the Alberta Health Care Insurance Act is amended by adding* "health care proxy, as defined in the *Health Care Instructions Act,*" *after* "personal representative".

Consequential

21 *The Dependent Adults Act is amended*

(a) in section 1

(i) in clause (h) by striking out "and" *at the end of subclause (iv), adding* "and" *at the end of subclause (v) and by adding the following after subclause (v):*

(vi) health care, as defined in the *Health Care Instructions Act;*

(ii) by adding the following after clause (h):

(h.01) "health care directive" means a health care directive as defined in the *Health Care Instructions Act;*

(h.02) "health care agent" means a health care agent as defined in the *Health Care Instructions Act;*

(h.03) "health care proxy" means a health care proxy as defined in the *Health Care Instructions Act;*

(b) *in section 3(2) by adding the following after clause (e.1):*

(e.2) a health care agent under a health care directive made by the person in respect of whom the application is made if the agent is not the applicant or a person served pursuant to this subsection,

(c) *in section 11(a) by adding* "subject to the *Health Care Instructions Act,*" *before* "in the best";

(d) *in section 15(2) by adding the following after clause (e.1):*

(e.2) a health care agent under a health care directive made by the person in respect of whom the application is made if the agent is not the applicant or a person served pursuant to this subsection,

(e) *by repealing section 20.1;*

(f) *in section 22(2) by adding the following after clause (e.1):*

(e.2) a health care proxy if the proxy is not the applicant or a person served pursuant to this subsection,

(g) *section 68(2) is amended by adding the following after clause (a.1):*

(a.2) any health care proxy,

Consequential **22** *Section 40(5)(a) of the Hospitals Act is amended by adding* "or his health care proxy, as defined in the *Health Care Instructions Act*" *after* "legal representative".

Consequential **23** *The Human Tissue Gift Act is amended*

(a) *in section 3*

(i) *by adding the following after subsection (1):*

(1.1) A health care proxy, as defined in the *Health Care Instructions Act,* may consent to the removal forthwith of tissue from a person's body and consent to its implantation in another body if the person's health care directive directs that it be done.

(ii) *in subsection (2) by striking out* "subsection (1)" *and substituting* "subsections (1) and (2)";

(b) *in section 5(1)*

(i) *by renumbering clause (a) as clause (a.1);*

(ii) *by adding the following before clause (a.1):*

(a) his health care proxy, as defined in the *Health Care Instructions Act*, or

(iii) *in clause (a.1) by adding* "if none or if none is readily available" *before* "his spouse".

APPENDIX A

Uniform Law Conference of Canada

DRAFT TEXT

Part ___
Recognition of foreign health care directives

Definition of health care directive

1. In this Part, "health care directive" means a document that contains,

(a) a direction that relates to the health care of the person making the document and is to take effect when that person is unable to make decisions about his or her own health care; or

(b) an appointment of a person to make decisions relating to the health care of the person making the document when that person is unable to make decisions about his or her own health care.

Effect of foreign directives

2. (1) A health care directive, whether it is made in [enacting jurisdiction] or not, has the same effect as though it were made in accordance with this Act if,

(a) it meets the formal requirements of this Act; or

(b) it was made under and meets the formal requirements established by the legislation of,

(i) the jurisdiction where the directive was made; or

(ii) the jurisdiction where the person who made the directive was habitually resident at the time the direct was made.

Formal requirements

(2) For the purposes of subsection (1), the formal requirements are the requirements relating to the formalities of execution of health care directives.

Certification by lawyer

(3) A person implementing a health care directive may rely on a certification by a person purporting to be a lawyer [or notary - notaire] in a jurisdiction certifying that the directive meets the formal requirements of the jurisdiction.

Formal requirements not met

3. A health care directive that does not meet the formal requirements described in subsection 2(1) has the same effect as a health care directive made in [enacting jurisdiction] but that does not meet the formal requirements of the Act.

Where impractical to determine if requirements met

4. In circumstances in which it is impractical to determine whether or not a health care directive meets the formal requirements described in subsection 2(1), the directive has the same effect as a health care directive that was made in [enacting jurisdiction] but that did not meet the formal requirements of the Act.

APPENDIX B

LIST OF INDIVIDUALS AND ORGANIZATIONS WHO MADE SUBMISSIONS

Alberta Association of Registered Nurses	Edmonton, Alberta
Alberta Healthcare Association	Edmonton, Alberta
Dr. J. Arboleda-Florez, Director, Department of Psychiatry, Calgary General Hospital	Calgary, Edmonton
Ray Baril, Q.C., Barrister and Solicitor	Edmonton, Alberta
Canadian Bar Association, Health Law Section (Northern Alberta)	Edmonton, Alberta
Canadian Bar Association, Wills and Trusts Section (Southern Alberta)	Calgary, Alberta
Capital Care Group	Edmonton, Alberta
Gerald Chipeur, Barrister and Solicitor	Edmonton, Alberta
City-Wide Bioethics Committee (Edmonton hospitals)	Edmonton, Alberta
City-Wide Medical Directors (Edmonton hospitals)	Edmonton, Alberta
Council of Teaching Hospitals of Alberta	Edmonton, Alberta
Dr. Gordon Cuff, Acting Public Guardian	Edmonton, Alberta
Rev. Thomas Dailey, Director, St. Joseph's College Catholic Bioethics Centre	Edmonton, Alberta
Glyn Davies	Edmonton, Alberta
Mark Dolgoy, Barrister and Solicitor	Edmonton, Alberta
Dr. Peter Geggie, Tom Baker Cancer Centre	Calgary, Alberta
Good Samaritan Society	Edmonton, Alberta
Elizabeth Hall-Petry, St. Therese Hospital	St. Paul, Alberta
Martin Hattersley, Q.C., Barrister and Solicitor	Edmonton, Alberta

Health Unit Association of Alberta	Edmonton, Alberta
Dr. M.W. Hislop, Mental Health Patient Advocate	Edmonton, Alberta
Dr. E.G. King, Chairman, Department of Medicine, University of Alberta	Edmonton, Alberta
Fred McHenry	Calgary, Alberta
Margaret Ramsay, Barrister and Solicitor	Calgary, Alberta
Alexander Romanchuk, Barrister and Solicitor	St. Albert, Alberta
Alex K.H. Rose, Barrister and Solicitor	Lacombe, Alberta
Dr. Peter Singer, Centre for Bioethics, University of Toronto	Toronto, Ontario
Society for the Retired and Semi-Retired	Edmonton, Alberta
Lorne J. Ternes, Barrister and Solicitor	Edmonton, Alberta
Rick Volpel, Cross Cancer Institute	Edmonton, Alberta