

Baycrest

Advance Care Planning

Making your Health Wishes Known



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"Making your Health Wishes Known"

Ask yourself:

"Does my family know what medical treatments I would want if I could no longer make my own healthcare decisions?"

"Have I thought about who would make my healthcare decisions if I could no longer make my own decisions."

If you answered no to either of these questions, it's time to start thinking about Advance Care Planning.

How do I start Advance Care Planning?

You will need to think about your values, learn about your medical conditions, choose who will speak for you when you cannot speak for yourself, and communicate your future care wishes to those who matter most to you. Planning your future care starts by discussing your wishes today with the people closest to you – your family, trusted friends, your health care team, and the person or persons you would want to decide for you if you cannot make your own decisions. This person is called your substitute decision-maker(s), referred to as SDM.

Once I have engaged in Advance Care Planning, do I need to write down my wishes?

An Advance Care Plan does not need to be written, however when an Advance Care Plan is written it is called an Advance Directive. An Advance Directive (sometimes referred to as a Living Will) is used to document your future care wishes so that the person you have chosen to speak for you can refer to it when making future care decisions on your behalf.

If you have an Advance Directive please give a copy to the healthcare team as it will become part of your medical record. Be sure to discuss your wishes with your doctor and social worker, and with your spiritual leader or chaplain, if that would be helpful.

Why Baycrest Wants to Know this Information

As a Baycrest client, understanding what your future care wishes are, is an important part of your overall healthcare plan. In the event that you are not able to communicate your wishes, the healthcare team will turn to your SDM for guidance in understanding your wishes, values, and beliefs. Knowing your care wishes ahead of time has been shown to decrease stress for your family and SDM.

You and your family will be invited at a later date to attend a care conference to discuss your future care wishes.

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1. THINK - about your beliefs, values and concerns. What brings quality to your life? What do you value, or what is important in your life that gives it meaning? For example, being able to live independently, being able to recognize important people in your life, being able to communicate, being able to eat and taste food, spending time with friends and family, and being treated with dignity, taking care of your family and so on.

You may wish to talk with the people who matter most to you to help clarify your thoughts and feelings.

Notes:

2. LEARN - about your existing medical conditions, talk to your doctor and other health care providers. Ask about your prognosis - what you might expect to experience in the future as a result of these conditions. Learn about possible treatments for existing or future health conditions and about the type of care decisions you may be asked to make in the future. Learning about your medical condition and what to expect can help you to decide what is most important to you.

What information about your illness that you don't know would be helpful or important for you know?

Questions to Ask:

3. DECIDE - on your Substitute Decision Maker (SDM) - the person or persons who will make healthcare decisions for you if you are unable to make your own decisions. You may have more than one SDM.

In Ontario, everyone is presumed mentally capable. Mentally capable means that you are able to understand and appreciate the foreseeable consequences of accepting or refusing a particular treatment. If for any reason you are not able to understand and appreciate the information about the treatment being proposed by the doctor or other healthcare provider, you will be deemed mentally incapable. In this situation your doctor or healthcare provider must contact your SDM(s) to obtain consent for any treatment or procedure.

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However, in an emergency situation, where the delay to obtain consent from your substitute decision maker would prolong suffering or you could experience serious harm, the health-care provider may provide treatment without consent. Please note that the treatment may be continued only for as long as it seems reasonable to locate and obtain consent from your SDM.

When deciding who will be your SDM, it is important to ask yourself if the person or persons is/are:

- Willing to accept this role and make future healthcare decisions for you?
- Willing to talk to you to understand your life goals, values and beliefs?
- Willing to be present and understand your care needs and what it is like to live with your condition?
- Willing to interpret, honour and follow your wishes as much as possible when they apply?
- Able to ask questions and talk to your doctors/healthcare team?
- Able to make hard decisions?
- Is 16 years of age or older?

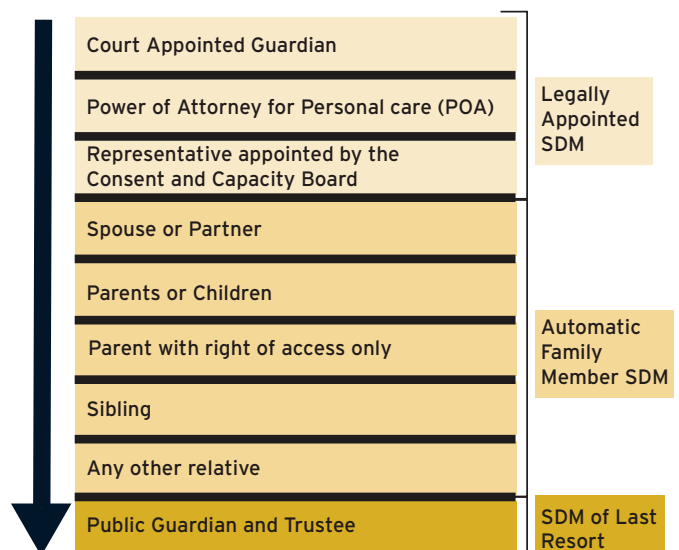
You should understand that everyone in Ontario has an automatic SDM. By default, this will be your closest living family member. If the highest ranking family member on the list is not the person you want to make decisions for you, there is a formal process where you may appoint a Power of Attorney for Personal Care (POA).

Refer to list 1. This is the list that the Doctor and Health Care providers will turn to in the event that you become mentally incapable and cannot make your own healthcare decisions.

You can see from the list that the Power of Attorney for Personal Care (POA) is above family members/relatives.

If the highest ranking person or persons listed is/are not the person or persons you want to make your healthcare decisions for you, than you may appoint a Power of Attorney for Personal Care (POA).

List 1. SDM Hierarchy



Ontario Health Care Consent Act (1996)

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Here’s an example:

Karen is 88 years old. Her husband died 7 years ago. She has three grown children. Looking at the SDM hierarchy, who would be Karen’s automatic SDM?

If you said her children, you would be right. Karen’s children would be asked to make all medical decisions for Karen should she become unable to make her own decisions.

Karen knows this would be tough because two of her children don’t get along and can’t agree on anything. Karen decides to appoint her middle child to make future medical decisions should she need an SDM. Her middle child would be her POA and would be asked to make all healthcare treatment decisions for Karen if she was found “not mentally capable” of making her own healthcare decisions.

For more information about selecting a POA visit:

<https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf>

Who is your SDM?

Substitute Decision Maker(s): _____

Contact Information: _____

Now that you have thought about what’s important to you and who you would like to be your SDM if you ever become mentally incapable, it’s time to talk about your wishes.

4. TALK ABOUT YOUR WISHES - your substitute decision maker will need to understand your wishes and why you have chosen one course of action rather than another. Let your substitute decision maker, those closest to you and the healthcare team know about your care wishes. You may communicate these wishes verbally, in writing, by video, braille and/or any other manner you like.

Your substitute decision maker’s role is to make decisions about any proposed treatments that reflect your wishes about your health circumstances. Your wishes may change over time as your health and/or views change, so be sure to keep the conversation open with your substitute decision maker and healthcare team and to communicate any changes in your wishes.

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This is what I would like my SDM and family to know about my wishes:

5. RECORD - your future care wishes - you can choose to record your advance care wishes in writing, on video or in any manner you choose. Whatever method you choose to record your wishes, it will be available to guide your substitute decision maker in consenting or not consenting to a treatment being proposed for you should you be unable to make your own decision. In Ontario, if you choose to write down your future care wishes, the document is called an Advance Directive. If you choose to complete an Advance Directive, be sure to complete the form as required and inform your substitute decision maker(s), those closest to you and the health care team.

Examples of Goals of Treatment

Now that you have reviewed the information, consider how you have made health related decisions in the past and what beliefs or values may have guided you.

Generally speaking, people fall into five groups when thinking about being seriously ill and what trade-offs they might be willing to make. People often have more than one goal.

For Example:

- Cure my underlying disease
- Prolong my life as long as possible
- Provide care aimed at my comfort as opposed to cure
- Improve and/or maintain my ability to function and my quality of life
- Achieve my life goals (e.g. attend granddaughter's wedding)

Which group or groups do you identify with? Be sure to share your thoughts, feelings and wishes with your SDM, family and healthcare team.

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Advance Care Planning Checklist (Person is mentally capable to make own healthcare decisions)

- I have thought about my life, what's important to me, what I value about being alive, and what medical care I might accept or would refuse in the future if I am unable to make my own healthcare decisions.
- I have spoken to my healthcare provider(s) about my current health and what future healthcare decisions I might need to make.
- I have chosen my decision-maker (or know who my default decision-maker is) who understands and can support my wishes in the future if I am unable to make my own healthcare decisions.
- I have discussed my healthcare wishes with my decision-maker, family, healthcare providers and trusted friends.

I have completed an Advance Care Plan and it can be found:

- As part of my Power of Attorney for Personal Care
- As part of my Medical Record
- With my family
- With my SDM
- I have not completed an Advance Directive
- Other _____

Thank you for doing this important work about your future care wishes. When you meet with the doctor and other members of the health care team, you may be asked some of these questions again as the team, your doctor and family work with you to develop your Plan for Life Sustaining Treatment. You can always change your mind at any time you wish about any decision you have made while mentally capable.

Remember: Your advance care plan does not go into effect until you become mentally incapable. Even then, the doctor or healthcare team member proposing the treatment will obtain consent from your Substitute Decision Maker.

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Glossary of Terms:

Mentally Capable: Used in the Health Care Consent Act to describe a person who is able to make their own health care decisions because they are able to understand, retain and appreciate the information regarding the benefits and risks of accepting or refusing a treatment or procedure.

Mentally Incapable: Used in the Health Care Consent Act to describe a person who is unable to make their own health care decisions because they are unable to understand, retain and appreciate the information regarding the benefits and risks of accepting or refusing a treatment or procedure.

Substitute Decision Maker: The person who will make health care decisions on behalf of the mentally incapable person.

References

Health Care Consent Act (1996): <https://www.ontario.ca/laws/statute/96h02>

The Office of the Public Guardian and Trustee: <https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/>

Power of Attorney for Personal Care (POA): <https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/>

Substitute Decision makers Act (1992) <http://www.canlii.org/en/on/laws/stat/so-1992-c-30/latest/>

Acknowledgements:

“Advance Care Planning”, (2014), Alberta Health Services, Calgary Zone.

Baycrest Centre “ Your Wishes Matter” Creating Your Advance care Plan (2015)

East Toronto Health Link: My Health, My Wishes,

My Plan: Advance Care Planning Workbook (2015)

Speak Up: <http://www.advancecareplanning.ca/>