Helpful Legal Information for MAHCP Members

Health Care Directives and End of Life Treatment

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Because of the positions as highly trained, intelligent professionals working in the medical field, members of the Manitoba Association of Health Care Professionals are often asked by friends and family members to act as representatives during periods of incapacity or vulnerability. As discussed in a previous article in this newsletter, there are three distinct offices that one may undertake on behalf of another. They are: (1) executors or trustees under a will; (2) agents under a power of attorney document; and (3) proxies under a health care directive. The topic of this article is to describe the usefulness of the Health Care Directive.

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A Health Care Directive, is an inexpensive and effective estate planning tool that can save money and unnecessary inconvenience during periods of incapacity. A health care directive is a legal document by which the donor grants authority to another person (proxy) to make health care related decisions on the donor's behalf when the donor is incapacitated. A health care directive is only effective during the donor's life, terminating upon death. A health care directive is limited to making health care related decisions and is only effective when the donor is incapacitated and unable to provide instruction themselves.

A health care directive must be in writing, dated and signed by the maker. Health care directive becomes effective when maker is unable to communicate his or her own wishes. The decision maker can then make a health care decision on behalf of the donor.

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There are some significant limitations to what type of decisions a proxy is able to make on the basis of a health care directive. Does the decision maker have a right to demand end of life (EOL) life sustaining medical treatment? The Act doesn't say. Section 25 provides "Nothing in this Act abrogates or derogates from any rights or responsibilities conferred by statute or common law."

The Health Care Directives Act provides in preamble that Manitobans have right to "consent or refuse to consent to medical treatment". That means that a proxy making a "health care decision" is limited in their decision making to "a consent, refusal to consent or withdrawal" of consent to EOL treatment. Many people don't realize this.

The College of Physicians and Surgeons issued a statement on February 1, 2008 identifying the following principles and guidelines regarding EOL treatment:

1. Death takes place when there is irreversible cessation of brain function (Vital Statistics Act)

2. No legislation or the common law provides a right to demand life-sustaining treatment

3. No-one, other than proxy under health care directive or committee appointed by the court, has the right to consent or refuse consent to medical treatment

4. The courts have recognized that physicians have the authority to withhold or withdraw EOL medical treatment without the consent of a decision maker

Where the withdrawal of EOL treatment is being considered, The College of Physicians and Surgeons requires the attending physician to go through a 4 step assessment process:

1. Clinical Assessment - Must assess the patient based on minimum goal of life-sustaining treatment (minimum goal means, "maintenance of cerebral function that allows patient awareness of self, environment and experience existence"). If the minimum goal is not achievable, life-sustaining treatment may be withdrawn

2. Communication - Physician must identify the person to whom they must communicate their decision to withdraw treatment. All relevant information should be shared and decision makers should be allowed to express their position. The discussion should include the patient's relevant personal, cultural, religious and family issues

3. Implementation - Treatment may be withheld where the physician and the decision maker agree. The physician's decision to withhold treatment may be implemented so long as s/he has complied with requirements of the statement. The grieving process should be respected

4. Documentation - There should be accurate and complete documentation

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of the assessment and ommunication with the decision maker and the implementation plan. There should also be sufficient identification of the basis for conclusion to withdraw treatment

Where a decision maker declines treatment offered by a physician, the health care directive is effective and the physician must withhold treatment. This is essentially the limit of what the health care directive can speak to when the issue of life sustaining treatment is being considered.

Where the physician determines that a minimum goal is not realistically achievable, and decides to withdraw life sustaining treatment and the decision maker disagrees, the physician must, "if possible" consult with another physician. Where the consulted physician agrees with first physician, treatment can be withdrawn. The decision maker must be informed of the context of the second opinion, including location, date and time.

Where the minimum goal is achievable but the physician decides to withdraw EOL treatment and the decision maker does not agree the physician must consult with another physician. Where the second physician does not support the decision of the first physician, treatment must be provided. Where the second physician supports the decision, the decision maker should be informed of second opinion and allowed time to transfer care of the patient to another facility. Where care is not transferred and there is no consensus, even though the minimum goal is achievable, a physician can withdraw treatment with 96 hours written or verbal notice of:

- Name of patient, location, name address and phone number of physician, diagnosis;
- Date, time and location and description of treatment to be withdrawn;
- Date, time and name of person to whom notice made.

In emergency situations the physician has discretion, after assessment of the patient's status, whether to withhold life-sustaining treatment

In February of 2008 there was a legal battle regarding the issue of withdrawal of life sustaining treatment. The patient in that case had ventilation and feeding tubes. The patient could not speak or walk. There was no conclusive proof of brain function. The physician made a decision to disconnect life support, ventilator and feeding tube. The family brought an application to court for an injunction to stop the hospital from withdrawing treatment. The court had to decide whether "just or convenient" to continue injunction prohibiting withdrawal of treatment until trial.

The family argued that removal of treatment required consent and that it was a battery on the patient to possibly hasten his death. The family also raised the issue of a Charter violation. The court stated its role as a finder of fact and to provide advice as to the legality of a course of conduct prior to the death of the patient. Court discussed the issues for trial: The removal of the ventilator involves interaction with the patient. Might this constitute battery or require consent? Can the plaintiff successfully argue a Charter violation of security of the person or religious freedom? It may be that the College statement is not accurate in its assertion that the physician has the final say? The court in that case granted the injunction and set the matter down for trial in fall of 2008.

The patient died before the case went to trial so the law as it stands now in Manitoba is that the physician can make the determination to withdraw support where he follows the steps outlined above.

Where does that leave the validity of health care directives in light of the College's statement above? Does a physician have the ultimate authority to provide or withdraw EOL treatment? The Act provides that it does not "abrogate or derogate from any rights or responsibilities by the common law". The College statement is intended to comply with common law principles. Where the health care directive speaks to issues of withdrawal of consent, it will be effective. Where the health care directive attempts to enforce a positive requirement to administer EOL medical treatment, it is likely not effective.

Regardless of the limitation of a health card directive, it is a useful legal document that can smooth a lot of the emotional harm suffered by families left to make personal decisions when their loved one is no longer able to make treatment decisions on their own.

Choosing the Attorney

As you know, Inkster Christie Hughes LLP offers a legal assistance program to the members of MAHCP. Under this plan you receive reduced rates on a number of specific legal matters such as the purchase or sale of a home, Wills, Powers of Attorney, Health Care Directives, separation agreements, divorces as well as a reduction on general legal rates.

This paper is intended as an introduction to the topic and not as legal advice. If you require specific advice with respect to your situation, you should contact a lawyer.

This series of articles will continue in future editions of the MAHCP News. If there is a topic that you would be interested in, please contact Wendy at 772-0425.

MAHCP LEGAL ASSISTANCE PLAN

Membership does have its privileges

MAHCP members receive reduced legal fees on house purchases, sales and mortgages as well as Wills, Powers of Attorney and Health Care Directives under the MAHCP Legal Assistance Plan.

Discounts also apply to family law matters and members benefit from a 20% reduction in other legal fees.

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