Advance Care Planning

NATIONAL ELDER LAW, HEALTH LAW, AND WILLS, ESTATES AND TRUST LAW SECTIONS
CANADIAN BAR ASSOCIATION

June 2010

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PREFACE

The Canadian Bar Association is a national association representing 37,000 jurists, including lawyers, notaries, law teachers and students across Canada. The Association's primary objectives include improvement in the law and in the administration of justice.

This submission was prepared by the National Elder Law, Health Law, and Wills, Estates and Trust Law Sections of the Canadian Bar Association, with assistance from the Legislation and Law Reform Directorate at the National Office. The submission has been reviewed by the Legislation and Law Reform Committee and approved as a public statement of the National Elder Law, Health Law, and Wills, Estates and Trust Law Sections of the Canadian Bar Association.

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Advance Care Planning

I. INTRODUCTION

The Canadian Bar Association's National Elder Law, Health Law, and Wills, Estates and Trust Law Sections (CBA Sections) are pleased to respond to the consultation of the Canadian Hospice Palliative Care Association considering a national framework for advance care planning (ACP). The CBA is a national organization of over 37,000 lawyers, notaries, law students and academics, with a mandate that includes improvement in the law and the administration of justice. The CBA Sections include specialists in their respective areas of law from every part of the country.

The CBA Sections represent lawyers intimately involved in ACP from different perspectives. Estates lawyers often draft advance directives and other similar documents to deal with wishes about future treatment.[1] Lawyers who work with the elderly are often called upon to advocate for them when they are no longer able to express their wishes. Health lawyers work with hospitals and other treatment organizations and providers, and are faced daily with questions relating to Advance Directives, treatment decisions and consent. In addition, some members of the CBA Sections have had prior careers in the health professions (e.g. nursing, social work).

ACP is not age specific. Children (and their families) facing terminal and chronic illnesses also need to engage in this process, as do all individuals who confront terminal illness or massive trauma early in their lives.

The CBA Sections commend the Canadian Hospice Palliative Care Association's National Framework Project Task Group (Task Group) for producing a framework on this critical issue. As medicine advances and people live longer, the process of ACP has become increasingly essential. Respecting autonomy in health care decisions (including ACP) is a fundamental

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[1] For ease of reference, we refer throughout this submission to any documents that set out wishes in regard to future treatment as Advance Directives (noting that such documents have different names in different provinces/territories).

cornerstone of the Canadian health care system, embedded in provincial and territorial statutes dealing with consent to treatment, recognized in case law[2] and accorded constitutional protection in particular cases.[3]

We agree with the fundamental point in the Framework, that ACP is a process. We share the Task Group's concerns about relying solely on documents that are static. We believe that the Advance Directive is not a substitute for consent; it is a vehicle to assist in the consent process. We also know that wishes may change over time. Advance Directives provide evidence of prior wishes for individuals and assist in the consent process.

Our comments are not limited to issues raised in the Task Group's on-line survey, but also address areas the CBA Sections view as specifically relevant. We have provided both general substantive and specific editorial comments on the Framework.

II. GENERAL COMMENTS

A. Consent to Treatment

Consent to treatment is a fundamental ethical and legal principle underpinning health care in Canada.[4] Consent must be given voluntarily, by a client/patient (patient) with capacity or substitute/proxy for a patient who lacks capacity (substitute), referable both to the particular treatment and to the person administering that treatment. It must be given in the context of full information about the risks and benefits of the treatment, alternate treatments and no treatment.

Health care providers must follow provincial and territorial law and any consideration of ACP should be about consent to treatment and ACP in that context. In addition, there are significant variations in provincial and territorial laws. For example, Saskatchewan legislation permits Advance Directives to function as consent in particular circumstances where the health care decision clearly anticipates and gives directions relating to treatment for specific

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2 See *Starson v.* Swayze, [2003] 1 S.C.R. 722, 2003 SCC 32; Fleming *v. Reid* (1991), 4 O.R. (3d) 74 (Ontario Court of Appeal).

3 *Fleming* v. *Reid* 82 D.L.R. (4th) 298 (Ontario Court of Appeal).

4 *Supra* notes 2 and 3.

circumstances.[5] Those particular legislative caveats are not in place uniformly across Canada, and principles of consent vary. The CBA Sections believe that, as a rule, specific consent from the patient or patient's substitute (if there is one) should be obtained.

The primary concern of the CBA Sections is that the Framework does not clearly articulate a legal requirement for health care providers to obtain consent from the patient or substitute even when an Advance Directive is in place. Although there is some reference in the Framework to the necessity for consent, the Framework should clearly specify that Advance Directives are evidence of an individual's prior wishes, but are not themselves to function as consents.

Health care providers are not legally authorized to make decisions for a patient (other than in true emergencies) and so cannot make decisions based on the patient's Advance Directive. Such decisions still need to be made by the individual (if capable) or the substitute (if the individual is not capable). Decisions should certainly be made with regard to the Advance Directive, the current treatment context as well as on the basis of information from the health care provider regarding the person's condition, the treatment options, the risks, benefits, side effects, alternatives and what would happen if there is no treatment. The Advance Directive can be overridden by the express direction of the patient (if capable) or the substitute (if aware that the patient's prior wishes have changed or did not contemplate the particular treatment context) at the time when the treatment choice arises. Consent is given by a person, not a document.

The public's lack of education on Advance Directives supports the need for informed consent prior to acting on a patient's wishes as expressed in an Advance Directive. Members of the CBA Sections know from experience that individuals often do not realize the effect of their Advance Directive. We have also witnessed older adults being coerced or pressured to sign Advance Directives without speaking to a health care provider or having the opportunity to seek legal advice. Often Advance Directives are simply comprised of "tick boxes" and health care providers use the tick box forms as their direction. Based on examples from our own practical experiences, consider:

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5 See *Heath Care Directives and Substitute Health Care Decision Makers Act*, c. H-0.001 of the Statutes of Saskatchewan. 1997, as amended, 2000, c.A-5.3; and 2004, c.65. See, section 5(1).

- The administrator of a home for the aged advising that her facility had been criticized strongly by physicians at a local hospital because the facility had transferred residents to the hospital for acute care problems (such as wound care, broken hip, fractures) although the patients had Advance Directives that stated that they did not want transfer to the hospital or "extraordinary measures". The administrator interpreted those Directives as meaning the residents did not want transfer to the hospital at end of life (so they would die in the long-term care home) but that of course they would get treatment at the hospital for ongoing care needs. The hospital physicians thought the "directive" (a tick box form completed on admission without an explanation of the implications of signature of the form) was a directive to them to not treat. The administrator, a nurse, stopped using these forms because they are often misinterpreted and the facility is moving to a very different model that connects the consents and advance wishes in a way that complies with the province's law.
- Long-term care home staff and physicians using Advance Directives as consents to administer drugs on the basis that the generalized Advance Directives permit this, without consent from the patient or substitute.
- Patients having filled in a form indicating they do not want any "life saving measures" on a pre-printed advanced directive form but then, in their mid 40's, unexpectedly have a life threatening event during a routine and minor surgical procedure.

Advance Directives in the context of consent supports the categorization of ACP as a process. It is a process that must be robust, yet flexible enough to deal with situations not specifically contemplated at the time of signing. ACP can be seen as a process best advanced when the health care provider realizes that consent must still be sought for treatment decisions.

RECOMMENDATION

1. **The CBA Sections recommend that the Framework clearly specify that Advance Directives are evidence of an individual's prior wishes, but are not to be relied upon for consent. Consent is always required for each treatment, whether or not an Advance Directive exists.**

RECOMMENDATION

2. **The CBA Sections recommend that the Framework should specify the elements of consent generally to include:**
   a. **voluntariness (e.g. lack of coercion)**
   b. **given by the patient or if the patient lacks capacity, the legally authorized substitute**

c. reference to the particular treatment and administrator of the treatment

d. full information about the risks and benefits of the

i) particular treatment

ii) alternatives to the particular treatment, and

iii) no treatment.

B. Definitions

The CBA Sections recommend adding a definition section at the beginning of the Framework to ensure that readers understand the nomenclature in the document. Provinces and territories often use different words for similar concepts, and the Framework could be confusing unless a common nomenclature is established. Given that the various terms could mean slightly different things, it is important that provincial and territorial representatives review this section for accuracy. The Framework should use one term consistently throughout the document even if there is one term used to represent all terms – e.g. Advance Directive including power of attorney for personal care, living will, health care directive, etc. In our view, definitions should at minimum be provided for: Advance Care Planning, Advance Directive (see footnote 39 of the Framework), Substitute (which needs to include the term proxy and substitute decision maker), Public Guardian and Trustee (called Public Trustee in certain jurisdictions) and Incapacity.

RECOMMENDATION

3. The CBA Sections recommend that a Definition Section be developed at the beginning of the Framework to ensure a common nomenclature for purposes of the Framework. Definitions should include, at minimum, Advance Directive, Advance Care Planning, Substitute, Public Trustee, and Incapacity.

C. Interpretation of the Advance Directive

In the case of incapacity of the patient, the substitute and not the health care provider is legally authorized to interpret that patient's advance wishes in the context of consent to a particular treatment, subject to limited exceptions including emergency situations where patient/ substitute consent cannot be obtained and medical determinations as to the efficacy of treatment.

We are aware of situations where health care providers believe that the Advance Directive functions as consent and proceed on the basis of the Advance Directive without getting patient or substitute consent if there is incapacity. The consent would need to be based on the Advance Directive, unless the substitute has evidence that prior capable wishes of the patient have changed.

There should be a clear determination of incapacity prior to accepting substitute consent and the substitute must make decisions based on the patient's wishes, when known.

RECOMMENDATION

4. **The CBA Sections recommend that the Framework state that the Advance Directive does not function as patient or substitute consent and consent must be sought from the patient if capable, or the legally authorized substitute if the patient is incapable. The Framework should articulate that health care providers cannot consent for the patient, nor rely on the Advance Directive in the absence of consent to or refusal of a particular treatment.**

RECOMMENDATION

5. **The CBA Sections recommend that the Framework state that there must be a clear determination of patient incapacity prior to obtaining consent from the substitute.**

D. Role of Law and Lawyers in Advance Directives

In our view, the Framework should clearly articulate that there is a legal framework which must be followed, including the need for consent, for Advance Directives to be voluntary and for individuals to understand what they are signing. Further, the Framework should outline the legal requirements in each Canadian jurisdiction, given that health law is a matter of provincial and territorial jurisdiction, and requirements will vary. This should be part of the training provided for health care providers and people involved in drafting and implementing Advance Directives.

The fourth paragraph of the proposed Preamble and Assumptions indicates that the Framework is to be seen through a health lens. However, legal considerations are also

significant, especially given the involvement of lawyers in drafting Advance Directives and dealing with matters of consent. Lawyers should be recognized as integral to the process and should be trained in speaking with clients about Advance Directives. The paragraph should be amended to state that the Framework is seen primarily through a health lens, "recognizing and building on the interaction with the legal and ethical frameworks across the country and profession."

Lawyers, especially those who draft wills, often recommend Advance Directives. This would be the perfect opportunity to discuss ACP and the need to view this as a process. Tools would need to be provided, so that drafting an Advance Directive involves more than naming a substitute. Many provinces and territories have departments or agencies with a mandate for education in the area of ACP or play a role in substitute decision-making and tools for substitutes (e.g. Ontario Public Guardian and Trustee, Ontario Seniors Secretariat). We recommend that these government departments and agencies be involved in developing tools and education in ACP.

RECOMMENDATION

6. **The CBA Sections recommend that the Framework clearly articulate that there is a legal framework to follow that includes the need for consent, with all its component elements (as specified in Recommendation 2).**

RECOMMENDATION

7. **The CBA Sections recommend that an additional tool that should be developed is a summary of the legal requirements for Consent, Substitutes and ADs in each province and territory.**

The CBA Sections would be pleased to assist in developing this tool, as well as a guidance document for drafting Advance Directives (incorporating the suggestions in Recommendation 13).

RECOMMENDATION

8. **The CBA Sections recommend that the fourth paragraph of the Preamble and Assumptions be revised to indicate that the Framework is seen primarily through a health lens, "recognizing and building on the**

interaction with the legal and ethical frameworks across the country and profession."

RECOMMENDATION

9. **The CBA Sections recommend that the health community work in tandem with the legal community to view ACP as a process and to each participate in the process of ACP. For example, tools and training should be provided to lawyers regarding discussions with clients about ACP and the drafting of Advance Directives.**

RECOMMENDATION

10. **The CBA Sections recommend that the appropriate government departments and agencies with responsibility for ACP be engaged to assist in developing and disseminating tools and education related to ACP.**

E. Coercion or Pressure to Sign Advance Directives

Patients are sometimes required to complete Advance Directives as a condition of admission to or continued residence in long-term care facilities. This is a stressful time for patients and their families, with life and death decisions made while a patient is hooked up to machines in the Intensive Care Unit (ICU). Under these trying circumstances, there is usually no opportunity for medical or legal advice. As a result, Advance Directives are often filled in by or with health care administrators, in the absence of discussions with other health care or legal professionals.

In such cases, Advance Directives are often merely forms with tick boxes that are then used to replace a consent requirement even if they lack the specificity of a consent. Their application to specific treatments can be very generally worded (e.g. "I only want comfort care." However, what the patient means by comfort care is unclear).

Advance Directives administered without appropriate discussions with health care and legal professionals can present very real problems. For example, in one situation, a physician removed a patient from all medications for Parkinson's disease because the patient had signed a level of care form on admission to a long-term care home indicating that he wanted no CPR and only comfort measures in the event of a failing condition.

It is appropriate to encourage patients – and all people – to engage in ACP, but where possible, this must be done in a situation that is not pressured or coercive, and with full opportunity for medical and legal advice as well as education as to how an Advance Directive can and would be used.

RECOMMENDATION

11. The CBA Sections recommend that the Framework specify that Advance Directives must be voluntary, focus primarily on principles and values rather than tick boxes, clarify that consent to treat or refuse treatment is still required, and should be signed only after consultation with a health care provider and the opportunity for legal advice.

F. Training of Front Line Staff

A process or system is only as good as its weakest link. Front line staff have an important role in providing treatment, and need to be trained as to what an Advance Directive is and where it might be located. They should know to ask if an Advance Directive exists and if so, to bring it to the attention of the treatment team.

Nova Scotia legislation requires health care providers to ask if there is an Advance Directive prior to obtaining consent from a substitute and the provider must place a copy of the Advance Directive on the patient's record.

RECOMMENDATION

12. The CBA Sections recommend that training be provided to front line staff so they routinely ascertain if an Advance Directive has been filled out and if so, bring it to the attention of the treatment team.

G. Form of Advance Directives

Although possibly beyond the scope of the Framework, we believe that providing suggestions regarding the form of Advance Directives would be useful. Advance Directive documents tend to become static and not necessarily reflect changes over time. This again highlights the need to always obtain consent and provides support for focusing Advance Directives more on a principled approach to determining end of life treatment decisions, rather than on the specifics of particular technologies.

As well, individuals who enter into Advance Directives need to be educated on what these documents are and how they can be used and interpreted.

ACP is an important process, but if done poorly – if the patient is not told about the consequences of expressing a wish, how that wish will factor into consent, how that wish will be used after the patient becomes incapable, how that wish will be interpreted and used by the health care team – then it is a problem. Advance Directives are sometimes completed with the help of volunteers, administrative staff and other non-medical personnel. The process should not take place in the absence of discussions with medical personnel and the opportunity for legal advice.

ACP also provides the ideal opportunity for individuals to make their wishes known in regard to organ donation. This allows medical practitioners to fulfill requests regarding organ donation and assists the family and next of kin, who are most often faced with this question when death is imminent.

In summary, we suggest:

- Advance Directives focus on principles and values held by the individual, rather than tick boxes
- Advance Directives specify an individual's wishes regarding organ donation
- Advance Directives only be made and signed after discussions with a health care provider and the opportunity to seek legal advice or a waiver of that opportunity
- Advance Directives and ACP take place in a non-stressful environment whenever possible
- Naming a substitute (similar to an executor in a will) to make treatment decisions if the person becomes incapable and authorizing the substitute to have access to the full medical record solely for purposes of making those decisions
- Requiring that the substitute sign the Advance Directive, attesting to having read and understood the document and having discussed it with the person making the Advance Directive
- Requiring a witness to signatures on an Advance Directive and a statement that consent will still be required for treatment
- Regular review to ensure that Advance Directives continue to represent the patient's wishes.

The Framework indicates that the Advance Directive should be in the medical record (page 3). However, it is unclear which medical record is intended – that of the family physician, the specialist or the hospital. There are advantages and disadvantages of standardizing where the Advance Directive should be kept. Ideally, this could be considered in a manner that respects privacy, and appropriately deals with considerations including updating, revocation and responsibility for maintenance of the storage facility. How this might be adapted in jurisdictions using electronic health records should be considered, for example, the movement to self-management care portals already in effect in some institutions and jurisdictions.

RECOMMENDATION

13. The CBA Sections recommend that the Framework include specific suggestions for making Advance Directives more robust and reliable documents, including:

- **a. focusing on principles and values**
- **b. specifying wishes regarding organ donation**
- **c. requiring discussions with health care provider(s) and obtaining legal advice or a waiver of that advice**
- **d. Advance Directives and Advance Care Planning occurring in a non stressful environment, where possible**
- **e. strongly recommending that a substitute be named and that substitute sign the Advance Directive and attest to having read, understood and discussed the document with the patient making the Advance Directive**
- **f. requiring signatures to be witnessed**
- **g. stating that consent is still required for individual treatment decisions, and**
- **h. regular review to ensure that Advance Directives continue to accurately reflect the patient's wishes.**

RECOMMENDATION

14. The CBA Sections recommend that consideration be given to standardizing where the Advance Directive should be stored (and the attendant concerns such as privacy, updating, revocation, responsibility for the process), so that the Advance Directive is not overlooked in a treatment situation.

H. Discussions about ACP and Death

There are good recommendations in the Framework about the need to educate students, health care providers and lawyers. In addition to education, there needs to be ongoing assistance and

support to providers, patients and their family members to facilitate talking about illness and death. A reluctance to contemplate and speak about these issues often stands in the way of effective ACP.

RECOMMENDATION

15. The CBA Sections recommend that training in ACP be provided and include how to facilitate discussions of illness and death in an open manner, and that support for staff, patients and their families be offered.

I. Fee Codes for ACP

We support governments setting fee codes for physicians and other health care providers for the service of engaging in ACP with a patient. This recognizes ACP as a medically necessary service. The fee to engage in ACP with a patient should reflect that the process is similar to counseling, and could require a fair amount of time. As well, there should be provision for the service to be repeated to maintain the currency of the Advance Directive.

RECOMMENDATION

16. The CBA Sections recommend that governments set fee codes for physicians and other health care providers to engage in ACP, bearing in mind the need to take appropriate time to do this, and the need to repeat the process periodically to ensure that the Advance Directive remains up to date.

J. Role of Accreditation Canada and Funding and Regulatory Bodies

Accreditation Canada, (formerly, the Canadian Council on Health Services Accreditation) has a strong role in "directing behaviour" of health care organizations seeking accreditation. Accreditation Canada could require as a part of accreditation that each health care organization have a policy on ACP. Accreditation Canada could review the practices of the organization to determine if the policy is being consistently implemented.

The funding and regulatory agencies for health care organizations (e.g. provincial Ministries of health, Regional Health Authorities) can alter behaviour with respect to ACP by requiring that organizations develop and implement ACP policies. This could be in Guidelines issued by the regulatory authorities or in the deliverables specified in the funding agreements.

RECOMMENDATION

17. The CBA Sections recommend that Accreditation Canada and relevant funding and regulatory authorities in the provinces and territories be engaged to set requirements for policies and practices regarding ACP.

K. Determining whether an Advance Directive Exists

Some patients are treated against their will, notwithstanding their Advance Directives to the contrary. The Framework should contemplate a uniform and reliable process for determining whether an Advance Directive exists and whether ACP has taken place. This might be part of admission to a health care facility or hospital.

RECOMMENDATION

18. The CBA Sections recommend that the Framework include a suggested process to ensure that ACP for patients is addressed and that Advance Directives are sought out.

L. Broader Consultation

We understand that consultation regarding the Framework has to date been limited and that the Framework and Executive Summary are not publicly available. In our view, the Framework would benefit from broader consultation, including physicians and nurses who specialize in intensive care and emergency medicine, members of the public including those who work with children and the elderly and those who have experience with ACP, and government departments and agencies with a role in ACP or in providing education and other tools in ACP. Many, if not most discussions between health care providers and patients regarding end-of-life discussions are likely to occur in the ICU. Many patients have not had discussions on ACP with their families and are required to have those discussions in the crisis situation in an ICU.

ICU is where knowledge of a person's prior wishes or ACP is key. Ideally those discussions will have occurred before the patient gets to ICU, not only to avoid unnecessary and invasive treatment, but also because ICU personnel must not appear to be acting in any conflict of interest or in a coercive manner. Further, decision making in a crisis does not allow ample time for reflection. Perhaps most important, if ACP discussions occur before patients are admitted to an ICU, those patients are far more likely to be competent and can express their own wishes, instead of through a substitute.

RECOMMENDATION

19. The CBA Sections recommend that the Task Group conduct further consultations with professionals who work in the field of intensive care and emergency medicine, members of the public including those who work with children and the elderly, and government departments and agencies with a role in ACP or in providing education and other tools in ACP.

III. SPECIFIC COMMENTS

Executive Summary

1. The Executive Summary describes ACP as a process where people are making decisions about future health treatment. However, in many cases the ACP is not a decision but rather a statement of wishes, because it is speculative and based on hypothetical situations. Actual consent should still be required.

Framework

2. **Page 2 –** "Exploring Values" could include another bullet – "Considering how one wants to live during the final stage of life (e.g. at home, pain free, etc.)."
3. **Page 2 –**The Framework should specify what is meant by "conferences" in the second full paragraph.
4. **Page 7 –** The last sentence of first paragraph should include lawyers who prepare wills and powers of attorney.
5. **Page 15 –** Section 1.2 "Key Considerations", bullet 2 should specify that proxy and instructional advance directives are not mutually exclusive planning documents.
6. **Page 17,-** The Framework highlights the *Code of Ethics* of the Canadian Medical Association (CMA) but does not point out that this statement does not mean that the physician takes direction from the Advance Directive, but must still get an informed consent. Physicians may rely on the *Code of Ethics* as authority for following Advance Directives in the absence of specific consent. While we realize that the page states that the law must be followed, this section would be improved by clarifying that specific consent is still required.
7. **Page 21** - The list of core competencies (number 1) includes defining ACP and its importance, including an understanding of consent and capacity and the legal framework in the jurisdiction. However, the next point emphasizes documenting an ACP and omits the necessity to get consent. The need to get consent should be explicit in this list, as should clarification that the Advance Directive is not itself the consent.

8. **Page 24 -**The last sentence of the last paragraph includes a quote from the Ontario *Long Term Care Guidelines and Oncology Guidelines*. Stating: "When clients are incapable of giving informed consent, the team refers to the client's advance directives if available or obtains consent using a substitute decision maker**."** Under Ontario law, the team must instead turn to the substitute to interpret the Advance Directive.
9. **Page 25 -** Various tools are cited at the bottom of the page and following. We suggest that the Task Group review those materials to ensure they are legally accurate represent "best practices", either as worded or applied in practice.

IV. SUMMARY OF RECOMMENDATIONS

- The CBA Sections recommend that the Framework clearly specify that Advance Directives are evidence of an individual's prior wishes, but are not to be relied upon for consent. Consent is always required for each treatment, whether or not an Advance Directive exists.
- The CBA Sections recommend that the Framework should specify the elements of consent generally to include:
    a. voluntariness (e.g. lack of coercion)
    b. given by the patient or if the patient lacks capacity, the legally authorized substitute
    c. reference to the particular treatment and administrator of the treatment
    d. full information about the risks and benefits of the
        i) particular treatment
        ii) alternatives to the particular treatment, and
        iii) no treatment.
- The CBA Sections recommend that a Definition Section be developed at the beginning of the Framework to ensure a common nomenclature for purposes of the Framework. Definitions should include, at minimum, Advance Directive, Advance Care Planning, Substitute, Public Trustee, and Incapacity.
- The CBA Sections recommend that the Framework state that the Advance Directive does not function as patient or substitute consent and consent must be sought from the patient if capable, or the legally authorized substitute if the patient is incapable. The Framework should articulate that health care providers cannot consent for the patient, nor rely on the Advance Directive in the absence of consent to or refusal of a particular treatment.
- The CBA Sections recommend that the Framework state that there must be a clear determination of patient incapacity prior to obtaining consent from the substitute.
- The CBA Sections recommend that the Framework clearly articulate that there is a legal framework to follow that includes the need for consent, with all its component elements (as specified in Recommendation 2).

- The CBA Sections recommend that an additional tool that should be developed is a summary of the legal requirements for Consent, Substitutes and ADs in each province and territory.
- The CBA Sections recommend that the fourth paragraph of the Preamble and Assumptions be revised to indicate that the Framework is seen primarily through a health lens, "recognizing and building on the interaction with the legal and ethical frameworks across the country and profession."
- The CBA Sections recommend that the health community work in tandem with the legal community to view ACP as a process and to each participate in the process of ACP. For example, tools and training should be provided to lawyers regarding discussions with clients about ACP and the drafting of Advance Directives.
- The CBA Sections recommend that the appropriate government departments and agencies with responsibility for ACP be engaged to assist in developing and disseminating tools and education related to ACP.
- The CBA Sections recommend that the Framework specify that Advance Directives must be voluntary, focus primarily on principles and values rather than tick boxes, clarify that consent to treat or refuse treatment is still required, and should be signed only after consultation with a health care provider and the opportunity for legal advice.
- The CBA Sections recommend that training be provided to front line staff so they routinely ascertain if an Advance Directive has been filled out and if so, bring it to the attention of the treatment team.
- The CBA Sections recommend that the Framework include specific suggestions for making Advance Directives more robust and reliable documents, including:
    a. focusing on principles and values
    b. specifying wishes regarding organ donation
    c. requiring discussions with health care provider(s) and obtaining legal advice or a waiver of that advice
    d. Advance Directives and Advance Care Planning occurring in a non stressful environment, where possible
    e. strongly recommending that a substitute be named and that substitute sign the Advance Directive and attest to having read, understood and discussed the document with the patient making the Advance Directive
    f. requiring signatures to be witnessed
    g. stating that consent is still required for individual treatment decisions, and
    h. regular review to ensure that Advance Directives continue to accurately reflect the patient's wishes.
- The CBA Sections recommend that consideration be given to standardizing where the Advance Directive should be stored (and the attendant concerns such as privacy, updating, revocation, responsibility for the process), so that the Advance Directive is not overlooked in a treatment situation.

- The CBA Sections recommend that training in ACP be provided and include how to facilitate discussions of illness and death in an open manner, and that support for staff, patients and their families be offered.
- The CBA Sections recommend that governments set fee codes for physicians and other health care providers to engage in ACP, bearing in mind the need to take appropriate time to do this, and the need to repeat the process periodically to ensure that the Advance Directive remains up to date.
- The CBA Sections recommend that Accreditation Canada and relevant funding and regulatory authorities in the provinces and territories be engaged to set requirements for policies and practices regarding ACP.
- The CBA Sections recommend that the Framework include a suggested process to ensure that ACP for patients is addressed and that Advance Directives are sought out.
- The CBA Sections recommend that the Task Group conduct further consultations with professionals who work in the field of intensive care and emergency medicine, members of the public including those who work with children and the elderly, and government departments and agencies with a role in ACP or in providing education and other tools in ACP.