

PRESS RELEASE

December 19th 1994

LIVING WILLS IN NOVA SCOTIA

The Law Reform Commission of Nova Scotia, an independent advisory agency to government supported by the Law Foundation of Nova Scotia and the Department of Justice, is pleased to announce the release of its *Discussion Paper, Living Wills in Nova Scotia*. In this *Discussion Paper* the Law Reform Commission looks at the law as it relates to advance health care directives (more commonly known as "living wills") in Nova Scotia. This *Discussion Paper* is the second part of the Commission's project on Adult Guardianship which examines the *law* regulating how decisions are made for people when they are unable to make decisions for themselves. The *Discussion Paper on Living Wills* deals only with personal and health care decision-making and does not deal with decisions which involve property or financial matters.

At present, Nova Scotia has a law, called the *Medical Consent Act*, which allows a person to appoint someone to make health care decisions in the event of incapacity (this person is called a "proxy"). This law does not specifically recognize living wills. A living will is a document which contains specific instructions about the type of health care a person would want to receive in the event of certain medical conditions happening to them. The Executive Director of the Commission comments that, "Issues of autonomy and the right to self-determination are increasingly important and the right to make decisions with respect to personal health care is a crucial one. The *Discussion Paper on Living Wills* describes the law as it presently exists in Nova Scotia and makes a number of suggestions for how this law could be changed. Generally, the issue is whether people should be able to appoint another to make decisions for them (the current law in Nova Scotia) or whether people should be able to leave explicit instructions to speak for them, or both."

The Commission suggests that both of these options should be available to Nova Scotians who wish to plan for their own decision-making incapacity. In other words, a person should be able to appoint a proxy to make health care decisions, and should be able to leave specific instructions, or do both. The *Discussion Paper* contains a number of other specific suggestions regarding the kinds of decisions that can be made as well as discussing some of the more practical issues such as what happens if a person changes their mind and whether or not directives should be registered. The Commission is seeking comments on its preliminary suggestions and invites public commentary and response. The *Discussion Paper* is available free of charge from:

**The Law Reform Commission of Nova Scotia
1526 Dresden Row
Halifax, Nova Scotia
B3J 2K2
Phone: 423-2633
Fax: 423-0222**

**Internet E-Mail: mmcconne@fox.nstn.ns.ca
and through Chebucto Freenet at
<http://www.cfn.cs.dal.ca/Law/LRC-Home.html>**

Copies of the Report or a Summary in English, French or Mi'kmaq can be made available on Word Perfect 5.1 diskette.

Copies of the Report or a Summary in English, French or Mi'kmaq can be made available on Word Perfect 5.1 diskette.

A DISCUSSION PAPER

LIVING WILLS

in

NOVA SCOTIA

**Law Reform Commission of Nova Scotia
November 1994**

The Law Reform Commission of Nova Scotia was established by the Government of Nova Scotia under the

Law Reform Commission Act in February 1991.

The Commissioners are:

William Charles, Q.C., President
Ronald Culley, Q.C.
Justice John Davison
Jennifer Foster
Dawna Ring
Dawn Russell
Dale Sylliboy

Dr. Moira McConnell is Executive Director to the Commission.

Anne Jackman, LL.B., is Legal Research Officer to the Commission.

The Commission offices are located at 8th Floor, Garrison Place, 1526 Dresden Row, Halifax, Nova Scotia, B3J 2K2. The telephone number is (902)423-2633, Fax Number is (902)423-0222 and the E-Mail Number is mmcconne@fox.nstn.ns.ca. The Commission research is also accessible through the Community Freenet at <http://www.cfn.cs.dal.ca/Law/LRC-Home.html>.

The Law Reform Commission receives its funding from the Government of Nova Scotia and the Law Foundation of Nova Scotia. The Commission gratefully acknowledges this financial support in carrying out its research projects.

Canadian Cataloguing in Publication Data:

Law Reform Commission of Nova Scotia Discussion Paper on Living Wills in Nova Scotia, November 1994.

WHAT DO YOU THINK?

The Law Reform Commission is very interested in knowing what you think about the issues raised in this Discussion Paper: *Living Wills in Nova Scotia*.

If you would like to have any of the issues in this Paper explained more fully, please call (902) 423-2633.

We have attempted, as much as possible, to describe the law and the problems with the present system in a way that can be understood by people who are not lawyers and who are not familiar with the legal system. Your criticism and comment will assist us in preparing a Final Report to the Minister of Justice on how the law dealing with Living Wills in Nova Scotia can be reformed.

This Discussion Paper is not a Final Report and it does not represent the final views of the Commission. This Discussion Paper is designed to encourage discussion and public participation in the work of the Commission.

If you would like to comment on our suggestions you may:

- Send or fax a letter to the Commission at (902)423-0222;
- Send us an e-mail at mmcconne@fox.nstn.ns.ca;
- Telephone the Commission at (902)423-2633 and ask to speak to the Legal Research Officer; or
- Telephone or write to the Commission and arrange to speak with someone about your views.

In order for us to fully consider what you think about these issues before we prepare our Final Report, please contact us before February 28th, 1995. You may write to us at the following address:

Living Wills Project
Law Reform Commission of Nova Scotia
8th Floor, Garrison Place
1526 Dresden Row
Halifax, Nova Scotia B3J 2K2

Telephone: (902)423-2633
Fax: (902)423-0222
E-mail: (902)mmcconne@fox.nstn.ns.ca

A DISCUSSION PAPER

LIVING WILLS

in

NOVA SCOTIA

Law Reform Commission of Nova Scotia
November 1994

TABLE OF CONTENTS

English Summary (i-iii)
French Summary (iv-vii)
Mi'kmaq Summary (viii-ix)

I INTRODUCTION 1

The project 1
Language 2

II THE LAW IN NOVA SCOTIA 3

The problem 3
The law of consent to treatment 3
What is an advance health care directive? 5
The law in Nova Scotia 6
The law in other places 6

III SUGGESTIONS FOR REFORM 7

1. Does the law in Nova Scotia require change? 7
2. What type of advance health care directive model is appropriate? 8
3. Who should be able to make an advance health care directive? 10
4. When would an advance health care directive come into effect? 10
5. Should a person be able to revoke a directive, if so, how? 11
6. What is a "health care" decision? 12
7. Should there be any matters that a proxy not be allowed to consent to
without specific directions from the person? 13
8. Should there be restrictions on who can be a proxy? 15
9. Should a person be allowed to name alternate or joint proxies? 16
10. What principles should be applied by a proxy who is asked to make
health care decisions? 17
11. Should notification or registration of a directive be required? 18
12. Should a proxy have the power to refuse to act? 19
13. Should a proxy be allowed to delegate decision-making authority? 20
14. Should health care information be available to proxies? 21
15. Should health care providers be protected from liability? 22
16. What other legal formalities should be required? 23

IV SUMMARY OF RECOMMENDATIONS 27

DISCUSSION PAPER

LIVING WILLS IN NOVA SCOTIA

SUMMARY

In this Discussion Paper the Law Reform Commission looks at the law as it relates to advance health care directives (more commonly known as "living wills") in Nova Scotia. This Discussion Paper is the second part of the Commission's project on Adult Guardianship which examines the law regulating how decisions are made for people when they are unable to make decisions for themselves. This Discussion Paper on Living Wills deals only with personal and health care decision-making and does not deal with decisions which involve property or financial matters.

At present, Nova Scotia has a law, called the *Medical Consent Act*, which allows a person to appoint someone to make health care decisions in the event of incapacity (this person is called a "proxy"). This law does not specifically recognize living wills. A living will is a document which contains specific instructions about the type of health care a person would want to receive in the event of certain medical conditions happening to them. For example, a person may not wish to be kept alive on life support if terminally ill. A living will would tell others how to decide when the person is no longer able to do so. Laws have been altered in several provinces in Canada and in the United States to legally recognize these kinds of documents.

Issues of autonomy and the right to self-determination are increasingly important and the right to make decisions with respect to personal health care is a crucial one. Respect for the individual and non-interference are also values which exist in the Mi'kmaq culture in Nova Scotia. This Discussion Paper describes the law as it presently exists in Nova Scotia and makes a number of suggestions for how this law could be changed. Generally, the issue is whether people should be able to appoint another to make decisions for them (the current law in Nova Scotia) or whether people should be able to leave explicit instructions to speak for them, or both.

The Commission is of the view that both of these options should be available to Nova Scotians who wish to plan for their own decision-making incapacity. In other words, a person should be able to appoint a proxy to make health care decisions, should be able to leave specific instructions, or do both. Also the Commission suggests that the law should contain a list of people who have authority to consent on behalf of the person. In that way, if a person has not appointed someone or left specific instructions, the list can be used to automatically provide decision-making authority to a stated list of people. This list will be organized in order of preference (e.g., (1) spouse or partner; (2) daughter or son; etc.) and give decision-making authority to these people for health care decisions.

The Commission suggests that the best way to make these options available is through a new law. This law should include the following ideas:

- That the advance health care directive should come into effect whenever its maker is incapable of health care decision-making.
- That a person must be competent in order to make or revoke an advance directive.
- That a health care decision should be defined to include consent to health care, refusal of health care or withdrawal of consent to health care. Health care should be defined as anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, including a course of treatment.
- A person who is specifically selected by another person to decide should have power to make personal decisions on behalf of the person and to act as a guardian of the person. However, this should not be the case if he or she becomes a proxy through the use of the statutory list.
- A proxy should use a "substituted judgement" test when deciding health care matters with the person's specific instructions, whether given orally or in writing, providing evidence of the person's intentions. If there is no evidence as to what a person might have intended, the proxy would be required to act in the best interests of the person.
- That a proxy should **not** be able to consent to the following health-related actions unless the person making the advance health care directive has specifically agreed to it:
 - Removing tissue, while living, for transplantation or for medical education or research purposes;
 - Health care, the primary purpose of which is research; and
 - Sterilization that is not medically necessary to protect the person's health.

The Commission is as yet unresolved about whether a proxy should be able to place a person in a psychiatric facility irrespective of his or her consent or direction and seeks specific commentary on this issue.

- A proxy should be aged 16 or older and should be mentally capable of health care decision-making. There should not be any other restrictions on who can act as proxy, such as ones based upon whether or not the proxy will benefit under the will of the person.
- A person should be able to name any number of alternate proxies to replace a proxy if the proxy dies, refuses to act, or loses decision-making capacity. Joint proxies should not, however, be allowed and, where more than one proxy is named in a directive, they should be presumed to act successively.

- Although there should be no formal requirement for registration or notification about the existence of an advance health care directive, a person making a directive should have responsibility for telling others of its existence. However, health care providers and health care facilities should also be required to inquire as to the existence of a directive.
- Nothing in the law should compel a person to be a proxy if he or she does not want to do so. A proxy who wishes to "resign" from this responsibility must notify the maker of the advance health care directive.
- A person who is a proxy should not be able to delegate the decision-making to another person.
- A proxy should have access to all health care information available which is relevant to the decision to be made (subject to any limitations placed on the release of information by the maker). He or she should also be required to keep the health care information confidential.
- Health care providers should be protected from liability either if they comply with a health care directive or if they fail to comply because they were not aware of the existence of the directive. The new law should not punish a health care provider who does not follow a directive. The current common law remedies are sufficient.
- An advance health care directive should not have to be in any specific form but the law should include a sample to show people the types of issues they should be considering.
- Although periodic renewal of an advance directive is desirable it should not be mandatory.

The Commission is seeking advice from the public on these suggestions and on any other issues raised in this Discussion Paper.

DOCUMENT DE REFLEXION SUR LES TESTAMENTS DE VIE EN NOUVELLE-ECOSSE

SOMMAIRE¹

Dans ce document de réflexion, la Commission de réforme du droit se penche sur l'état du droit en Nouvelle-Écosse relativement aux mandats de soins médicaux en prévision de l'incapacité (communément appelés "testaments de vie"). Le présent document de réflexion constitue la seconde partie du projet de la Commission concernant la curatelle au majeur lequel traite des lois régissant la façon dont sont prises les décisions pour les personnes qui sont incapables de prendre les décisions les concernant. Le présent document de réflexion sur les testaments de vie se limite au processus décisionnel relatif aux décisions rattachées à la personne et aux soins de santé et exclut les décisions financières et patrimoniales.

Présentement en Nouvelle-Écosse, la *Loi sur le consentement médical (Medical Consent Act)* permet à une personne de nommer une autre personne afin de prendre les décisions relatives aux soins de santé qui s'imposent en cas d'incapacité (cette personne se nomme mandataire). Cette loi ne reconnaît pas expressément les testaments de vie. Un testament de vie est un document qui contient des instructions précises relatives au type de soins médicaux qu'une personne voudrait recevoir lors de l'avènement de certaines situations. Par exemple, une personne peut désirer ne pas être maintenue en vie par des moyens artificiels lorsqu'elle se trouve en phase terminale. Un testament de vie sert aussi à indiquer aux tiers quelles décisions prendre lorsque la personne ne peut plus les prendre. Dans plusieurs provinces canadiennes et aux États-Unis, des lois ont été amendées afin de reconnaître ces types de documents.

Les concepts d'autonomie et d'autodétermination revêtent une grande importance. De même, le droit de prendre les décisions médicales nous concernant s'avère crucial. Le respect des personnes et la non-intervention constituent aussi des valeurs faisant partie de la culture Mi'kmaq en Nouvelle-Écosse. Le présent document de réflexion décrit le régime existant présentement en Nouvelle-Écosse et propose un certain nombre de changements à ce régime. De façon succincte, il importe de déterminer s'il est plus approprié de permettre à un individu de pouvoir nommer une autre personne afin que cette dernière prenne des décisions en son nom (régime existant en Nouvelle-Écosse), plutôt que de permettre à cet individu de laisser des instructions explicites. Une combinaison des deux régimes est peut-être aussi appropriée.

La Commission croit que les Néo-Écossais qui désirent planifier leur avenir en cas d'incapacité devraient pouvoir recourir à ces deux options. En d'autres termes, une personne devrait avoir le droit de nommer un mandataire afin de prendre les décisions relatives aux soins de santé, de laisser des instructions précises ou d'utiliser les deux méthodes. De plus,

¹ Traduit de l'anglais par Me Nathalie Bernard, LL.B (Université Laval), LL.M (Dalhousie University).

la Commission suggère que la loi pertinente contienne une liste de personnes pouvant consentir au nom d'autres personnes. De cette façon, lorsqu'une personne n'a ni nommé de mandataire, ni laissé d'instructions, cette liste peut servir à identifier les personnes pouvant prendre les décisions et à leur en donner le pouvoir. Cette liste sera dressée de façon à établir un ordre de priorité (ex: (1) époux ou conjoint, (2) fille ou fils, etc..) et à donner à ces personnes le pouvoir de prendre les décisions relatives aux soins de santé.

La Commission croit que la meilleure façon de permettre aux Néo-Écossais de recourir à ces options passe par une nouvelle loi. Cette loi devrait inclure les éléments suivants:

- * Ce mandat de soins médicaux en prévision de l'inaptitude devrait être mis en application dans tous les cas où le mandant est incapable de prendre ses propres décisions relatives aux soins de santé.
- * La personne qui donne des instructions ou révoque des instructions pour les soins de santé futurs doit avoir la capacité de le faire.
- * L'éventail des décisions relatives aux soins de santé devrait comprendre le droit de consentir, de refuser ou d'annuler son consentement aux soins de santé. Les soins de santé devraient comprendre tout acte posé à des fins thérapeutiques, préventives, palliatives, de diagnostic, esthétiques ou à toute autre fin, incluant un programme de traitements.
- * La personne désignée par le mandant devrait avoir le pouvoir de prendre des décisions de nature personnelle au nom du mandant et d'agir comme gardien à la personne du mandant. Cependant, cette personne ne devrait pas posséder ces droits si elle a été choisie suivant la liste des personnes pouvant consentir au nom d'une autre personne prévue par la loi.
- * Lorsqu'il prend des décisions relatives aux soins de santé, le mandataire devrait avoir l'obligation de suivre le test de la "substitution de jugement" à l'aide d'instructions orales ou écrites émanant du mandant, à condition que la preuve de telles instructions puisse être faite. Dans le cas où cette preuve n'existe pas, le mandataire doit alors agir dans le meilleur intérêt du mandant.
- * Le mandataire ne devrait pas pouvoir consentir aux décisions relatives aux soins de santé décrites ci-bas, à moins que le mandant ait consenti à l'avance à de tels actes:
 - * le prélèvement de tissus, alors que le malade est toujours en vie, dans le but de les utiliser pour une transplantation ou à des fins de recherche médicale et d'enseignement;
 - * les soins de santé dont le but premier est la recherche médicale; et
 - * la stérilisation qui d'un point de vue médical n'est pas nécessaire à la protection de la santé du malade.

La Commission ne s'est pas encore formée d'opinion sur la question du placement du mandant, par le mandataire, dans un institut prodiguant des soins psychiatriques indépendamment du consentement ou des instructions du mandant. La Commission invite le public à lui faire parvenir des commentaires à ce sujet.

- * Le mandataire devrait être âgé d'au moins 16 ans et devrait posséder la capacité de prendre des décisions relatives aux soins de santé. Aucune restriction ne devrait être établie concernant le mandataire, telle qu'une restriction basée sur le fait que cette personne sera avantagée en vertu du testament du mandant.
- * Une personne devrait pouvoir désigner un certain nombre de mandataires successifs afin de remplacer un mandataire qui décède, refuse d'agir ou perd la capacité de prendre des décisions. Une personne ne devrait pas pouvoir prévoir que des mandataires agiront conjointement. De plus, lorsque plusieurs mandataires sont désignés dans les instructions, il devrait être présumé qu'ils sont des mandataires successifs.
- * Malgré le fait qu'aucune condition de validité, telle l'enregistrement ou la publication, n'existe quant au mandat de soins médicaux en prévision de l'inaptitude, le mandant devrait avoir l'obligation d'informer son entourage de l'existence de ce mandat. Cependant, les intervenants dans le domaine des soins de santé de même que le personnel des établissements de santé devraient avoir l'obligation de s'informer quant à l'existence d'un mandat.
- * Cette loi ne devrait pas avoir pour effet de forcer une personne à agir à titre de mandataire sans son consentement. Le mandataire qui désire être relevé de ses obligations, doit en aviser le mandant.
- * Le mandataire ne devrait pas avoir le droit de déléguer son pouvoir décisionnel à un tiers.
- * Le mandataire devrait avoir accès à toute l'information médicale disponible et pertinente à la décision qui doit être faite (sous réserve des restrictions établies par le mandant quant à la divulgation d'information). Le mandataire devrait avoir l'obligation de garder l'information médicale confidentielle.
- * Les intervenants dans le domaine des soins de santé ne devraient pas être tenus responsables tant lorsqu'ils respectent les instructions relatives aux soins de santé que lorsqu'ils ne suivent pas de telles instructions parce qu'ils ignorent leur existence. La nouvelle loi ne devrait pas punir un intervenant qui n'a pas suivi les instructions données. Les recours de droit commun (common law) sont suffisants.
- * Le mandat de soins médicaux en prévision de l'inaptitude ne devrait pas devoir suivre une forme prescrite. Néanmoins, la nouvelle loi devrait proposer un modèle afin de faire réfléchir les gens sur un certain nombre de questions.

- * Même si le renouvellement périodique du mandat de soins médicaux est souhaitable, cela ne devrait pas être obligatoire.

La Commission invite le public à lui faire part de ses commentaires concernant les éléments traités ci-dessus ou toute autre question soulevée dans ce Document de réflexion.

**"ula wi'katkin wesku'tkl LIVING WILLS-el wjit Nopa Sko'sia: wejiaq na asite'lsulti
wjit LIVING WILLS-el Medical Consent Act-iktuk"**

SUMMARY²

Ula na, mawi-aknutmamkewey wi'katiken ankaptimi'ty Law Reform Ksmisnaq, wjit tan teli majulktmitij teplutakn, ula tan kokwel telui'tasikl, "living will", ula Nopa Sko'sia. Ta'puewey ula mawi-aknutmamkewey wi'katikn kisikwilutk kmisn wjit mimajuinu'k aqq wjit teptutaqn ten ta'n tlikisianko'tasitew elmiaq ika'q wen mukiseyasik aqq elmiaq mu kjijituk wsitqamu. Ula mawi-aknutmamkewey wi'katikn teluisik "Living Wills" pasik maliaptitew ta'n tliankwo'tasitew wen, mu wjit ta'n tla'sitew wutmo'taqn kisna wsulieweyim, kisna wi'k.

Nike Nopa Sko'sia teplutaqnm, telulisik Medical Consent Act, asistelmsk ika'lan na'tuen ta'n kisi ilsutew ta'n ki'l ilsutew ta'n ki'l tle'tsk elmiaq mu kjijitu'n wsitqamu, (ula na'tuen elt telui'tut "Proxy"). Katu ula teplutaqn etek nike mu piami wult'tmukl "Living Wills-el". Living williktuk na ewikasik ta'n wen tli maliamaten elmiaq ksnukwaqn wsua'lij togo wen mu kejituk wsitqamu. Staqa nike, eyk wen elmiaq kesi ksnukwaj mu pewatmuk mimaju'nuksin aqq nastaqu'luksin wjit pasi telimimaju'nut tlia mu wtawsik living will natek, kaqi wikasitew wen ta'n tel pewatk tla'luksin elmiaq na na'kwek ikaa'q. Teplutaqnn Kanta aqq Pastunkewa'ki ktlamite'tasital living willsel.

Pemi aji wsku'tasik nike ta'n wen telsutmawkwey aqq ta'n tel pewatk tlian ta'n nekm telsutekej, aqq ta'n tli maliamuksin ksukwaniktuk. Mi'kmaq na Nopa Sko'sia kepmite'tmitij ta'm teli Inuitasij ti'tij wen aqq mimajuinu nekm ta'n teli alsumsij. Ula mawi aknutmaqney wi'katikn napwi'tikl teplutaqnn ta'n nike eykl Nopa Sko'sia aqq kekinua'tekek ta'n me kisi aji wuli wikasitew aqq ta'n nike teli wikasik. apjhiw tan tujuw ketusku'tasik ta'n mimajuinu ketw wi'taj wenl wsutmalsewalkn (na nike teltek teplutaqn Nopa Sko'sia), kisna wen kisi nqatmn keknu'e'kl klusaqnn wjit natuenl kisi wsutmalseqwn kmisn telaptik tepias wen na kistla'teken wikij Nopa Sko'sia aqq asite'lmuksi kisi ikani isluteken aqq wi'tan wenl kisna wikasin tan wenl nekm welte'lmatl nsutmalsewkn, kisna kitk kistla'tekn. Kmisn teluek tepias ten teplutaqniktuk ta'n wenik kisi nsutmalsewa'titl ksinukewinu'l. Kulamnan elmiaq mu ika'laq wenl kisna mu nqatmuk keknu'e'kl klusuaqnn na mkutukwaiw kisna mknaten ta'n we nikanwikasit aqq eyk kisna mu nekm i'muk na ta'n wen e'tmapukwit (kutey nike, 1. wikma'jl, 2. wmijann kisna wikma) aqq wsko'tmn asite'lsuti wsutmalsewan.

Komisn teluek tepias na ula tlwikasin pile'l teplutaqnn:

- * clmiaq wen mu knijituk wsitqamu na tujiw pputlukwetal wsutmalsemkewe'l.
- * miamuj wen nstuo'qnmit misoqu kisutk wsutmalsemkewe'l, kisna kisi naqa'tun.
- * wsutmalsemkewe'l asite'l asite'lmasuti tli nsitasin wiaqi wikasin anko'taqn kisna moqoe, kisna mu asite'lmasuti anko'taqn ten. Tepias tli wikasin ta'n tela'luj wen, ta'n tijiw nutaq wen wjit weliaqm, npisunn, teli wa'qijewimk, ta'n teli wejitasik wsunukwaqnm, wjit ta'n wen teli msna'luj, kisna koqoeq piluey wjit nepisimk maw

²Mi'kmaq translation provided by Joseph B. Marshall, Eskasoni, N.S.

- teli kpijimpisij.
- * wen ta'n kisi mknuj wsutmjalsewen tepias wsko'tmn asite'lsuti kisitlsutekn ta'n nekm telnmitoq. Pasik katu, ma kisi tlasinuk ta'n tujiw wjimknuj ta'n mesqnikasi'tij aq e'tmapuk witij.
 - * proxy tepias nekm kisi kiwaska'tun wklusuaqnml ksnukewinal, ketlsik telapukuelij kisna tlwikasik, pasik nutaq mulmikjijitun ta'n telpewatnilij. Mu wen nulmikjijituaq ta'n telpewatmilij, proxy nekm kisi ilsutew ta'n nekm teli tetpaqaptik wjit ksnukewinu'l weliaqam.
 - * proxy nekm na'sik ma kisi ilutmukl eykl keskmana'q ksinukewinu kis kisi wi'tmuk, staqa:
 - * eyk kogoey wtinink kesk mimajij mna'tasin wjit se'k wen iknmuksin, kisna mampale'wijik kinamatnewmuow kisna pile'l ksinukwaqnu kwilasin.
 - * wjit napi npliaqn ta'n pasik puktaqi tlukwekl pile'l ksinukwagmn kwilasin.
 - * tepkisa'ltimk ta'n tujiw mu nuta'nuk wjit wen ulotim. Kmism mna'q kisitumuk ketloqo proxy kisi ikalan wenl elewe'wiete'woko'mk tliaq lo'q nekml kisutumlj aq kmisn kwilk skku'tasin ula nekewey.
 - * proxy na miamuj telujek newtiska'q jel asukom kisna jel me', aq miamuj tepnma j nsutuo'qn kisutum ksnuko'winu'l weliaqm. Mu nuta'nuk i'ktn kogoey ta'n naqa'tukutew wen proxyewin, kutey nike ma wji kisituk ula proxy ta'n telutmalij ksinukewinu'l.
 - * ksnukewinu tepias kisi wi'tan ta'n ketui te'siliji proxyaq ta'n ankmayiw piley proxy qamitew elmiaq amskwesewa'j npik kisna mu ktu'lsutekek kisna mu kisilsutekek. Tapwi-proxyiaq ma asite'tasi'k katu elmiaq me ajelk aq newte'jit tepias e'tmapukwit kisi klusin pasik.
 - * katu ta'n tujiw mu tami ewikasinuk living will ta'n wen kisitoq miamuj nekm kekinua'teket etek. Lukewinu'k ksinukewinuo'komk tepias pipanikesulti'tij ten living will.
 - * teplutaqnu tepias mu ktmoqja'lan wenl proxyewilin mu ktu'tla'stekek. Proxy ta'n kisi mknut tepias kisi nqatmn wtlukwaqn pasik miamuj keknu'uatl ksnuko'winu'l.
 - * proxy nekm mu wesko'tmuk asite'lsuti pilue'l mknan proxyal.
 - * proxy nekm tepias kaqi sko'tmn kekinua'taqnn ta'n ksinukewinu teli ksinukwaj keskmaq telsutasik ma kisi nmitukl. Tepias ula proxy kisi klo'tmn kinua'taqnn wkamulamunk.
 - * lukewinu'k ksinukewo'ko'mk ma kisi lsu'tmuajik klamsitmitij living will, kisna listmi'tij mita mu kejitu'tikip ten. Piley teplutaqn tepias mu punishewa'lan lukewinuk ksinukewinuo'ko'mk ta'n mu majulkatmuk living will. Ki's etekl maqtewe'l teplutaqnn.
 - * living will mu nuta'nuk keknu'ten kisna keknu'wikasin katu teplutaqn tepias ten ta'n kisi majulkwatal wen.
 - * tlia lo'q jijuaqa ika'q miamuj kiwaska'tasin kisna ilwi'kasin tepias mu miamuj pa tlten.

Kmisn alaptik apoqmasuti wjit wula klusuaqnn kisna pilue'l koqoe'l wesuk'tasikl ula mawi aknutmamkewey wi'katikn.

I INTRODUCTION

The project

In the summer of 1992 the Law Reform Commission started a project examining the law relating to adult guardianship in Nova Scotia and, more specifically, reform of the *Incompetent Persons Act*³. In its Discussion Paper *Adult Guardianship in Nova Scotia*, released in September 1993, the Commission proposed several principles which should guide reform of adult guardianship law in the province. The Commission suggested that a new law on guardianship should reflect the beliefs that:

- an adult has the right to autonomy and self-determination;
- guardianship should be used as a last resort; and
- the wishes of the adult should be taken into account in all matters of substituted decision-making.

During the consultation and research stages of the Adult Guardianship project there was a great deal of concern expressed to the Commission about the law dealing with alternatives to guardianship and the ability of a person to prepare for a time when he or she may be incapable of decision-making. There was special concern for personal and health-related issues. In particular, support was expressed for advance health care directives, or, as they are more commonly referred to "living wills" (also called instruction directives). A living will is a document which contains specific instructions about the type of health care a person would want to receive in the event of certain medical conditions. For example, where a person does not wish to be kept alive on life support if terminally ill, the directive would tell others how to decide about this issue when the person is no longer able to do so. Although Nova Scotia now has a law, called the *Medical Consent Act*⁴, which allows people to appoint others to make health care decisions in the event of incapacity, this law does not specifically allow living wills.

In response to this concern, the Commission decided that rather than providing the government with recommendations on adult guardianship it would be more useful to provide comprehensive advice on the whole area including advance health care directives. This Discussion Paper examines Nova Scotia's *Medical Consent Act* and seeks to determine whether the current form of advance health care directive in Nova Scotia should be expanded to include other models, such as a "living will" model. The Commission's Final Report will combine the issues in this Discussion Paper with those raised in the Discussion Paper on Adult Guardianship.

Language

This Discussion Paper attempts to present legal information in as clear a way as possible so that people who do not have legal training can understand and provide comments on the Commission's suggestions for change. In this Paper the following legal terms are used:

³ R.S.N.S. 1989, c.218.

⁴ R.S.N.S. 1989, c.279.

- adult guardianship** - will be used to describe the law relating to the way someone is appointed to make another person's decisions;
- advance health care directive** - is a legal document which appoints someone to make health care decisions in the event of incapacity or that gives specific instructions about health care matters, or both;
- guardian of the estate** - is a person who is a legal decision-maker for another person's financial matters;
- guardian of the person** - is a person appointed as legal decision-maker for another person's personal matters (often health related).

As well, the following non-legal terms are used throughout the Paper:

- artificial nutrition and hydration** - is a medical procedure used when a person is no longer able to eat or drink and normally involves feeding through a tube into the stomach or through the injection of fluid into a vein;
- life support** - machines used to keep a person alive by maintaining circulation and breathing (ventilation);
- terminally ill** - is an irreversible condition that cannot be cured and that will eventually result in death;
- persistent vegetative state** - a coma which results from the loss of all higher brain functions including consciousness and feelings.

II THE LAW IN NOVA SCOTIA

The problem

It is well known that medical technology has progressed to a stage where people who develop medical problems can be kept alive longer than ever before. Unfortunately, one of the problems with this technology is that it may be used to keep us alive artificially longer than we would want. As a result, difficult decisions often have to be made by family and friends, with respect to withdrawing life support for a loved one when there is no possible hope of recovery.

Some people would like to be able to give instructions in the event that they are in such a situation and want to ensure that they will not be kept alive artificially. This is of special concern in light of an aging population because a large degree of unwanted medical intervention often occurs during the last weeks of a

person's life. This happens because both families and health care professionals feel obliged, ethically and legally, to do everything possible to preserve life, even if the person would not have agreed to the intervention.

The law has not always responded quickly enough to these difficult ethical issues and this Discussion Paper attempts to address this problem. Personal autonomy and the right to self-determination are important values in our society and the right to make decisions with respect to our health care is a crucial one. Respect for the individual and non-interference are also values which exist in the Mi'kmaq culture in Nova Scotia. This Discussion Paper describes the law as it presently exists in Nova Scotia and sets out a number of suggestions the Commission is considering regarding ways the law could be changed to better meet the needs of society.

The law of consent to treatment

It is a fundamental principle in Canadian law that every adult who is capable of decision-making has the right to consent to or refuse medical treatment. This is so even if the outcome of the decision is life-threatening, which may be the case with the refusal of antibiotics or a blood transfusion.⁵ This general right to "self-determination" is not absolute, and in cases of a medical emergency, treatment is often provided on the basis of a legal principle called implied consent or necessity. But, even in an emergency situation, a physician may be obliged to follow a person's prior instructions with respect to the refusal of medical treatment. For example, in a case called *Malette v. Shulman*⁶ the Ontario Court of Appeal upheld the refusal of a life-saving blood transfusion by a woman who was unconscious (and therefore unable to consent to treatment) who had previously signed a "no blood products" card because of her religious objection to blood transfusions. Although the court upheld her views as expressed in the card, it said that her situation was different from cases where a person is terminally ill, or in a persistent vegetative state. Many people believe that this case recognized "living wills" and that it supports the right to self-determination including the right to refuse medical treatment. This view is also supported by another recent Ontario case *Fleming v. Reid and Gallagher*⁷ where the court agreed with the importance of the right to self-determination in a case involving the refusal of psychiatric health care.

These cases are examples of the increasing importance of the idea that people have the right to make decisions about their own bodies in a medical care context. The importance of respect for the body is also reflected in the fact that a health care provider (most often a physician) who administers medical treatment without a person's "informed consent"⁸ may be liable both under the common law and the criminal law. For example, under the common law a physician may be found to have committed a "battery" and

⁵ *Mulloy v. Hop Sang*, [1935] 1 W.W.R. 714 (Alta. Ct.); *Hopp v. Lepp* (1977), 77 D.L.R. (3d) 321 ; revd [1979] 98 D.L.R. (3d) 464; revd [1980] 2 S.C.R. 192; *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

⁶ (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

⁷ (1992), 48 O.A.C. 46.

⁸ *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 33 N.R. 361. 14 C.C.L.T. 1.

compensation may be granted even though the consequences are unintentional or unforeseeable.⁹

Treatment without consent may also be considered to be the criminal act of assault under the *Criminal Code of Canada*¹⁰. At the same time, there is also a general duty to continue an act, once undertaken, if stopping the act may be dangerous to life. In 1982 the Law Reform Commission of Canada¹¹ recommended that the *Criminal Code* be changed so that a physician would not be required to continue to give medical treatment against the clearly expressed wishes of the person or to continue to treat when it is medically useless. It also recommended that nothing should prevent a physician from undertaking measures intended to eliminate or to relieve the suffering of a person for the sole reason that such care or measures are likely to shorten the life expectancy of the person. To date, these changes have not been made to the *Criminal Code* but there appears to have been no cases convicting a health care provider for failing to continue treatment once undertaken.

The legal documents created to remove some of this uncertainty and to allow people to give legally binding instructions in advance about their health care treatment (or non-treatment) are called "advance health care directives". In Canada, although some provinces have introduced advance health care directives laws, Parliament has yet to change the *Criminal Code* so that criminal liability for following these instructions is still technically an issue. There is a possible argument that the provincial governments may be constitutionally unable to guarantee legal protection from criminal liability to health care providers.¹²

What is an advance health care directive?

Although most people call them "living wills", advance health care directives can take a number of different forms including a living will. The technical name for all of these documents is advance health care directives. Advance health care directives are generally understood to be documents which, in the event that the person is no longer able to make decisions, allow him or her to:

- (1) give specific instructions about health care decisions (called either a "living will" or an "instruction directive");
- (2) appoint another person to make the decisions (called either a "proxy directive" or a

⁹ A.M. Linden, *Canadian Tort Law*, 4th ed., (Toronto: Butterworths, 1988) 40-43 and 64-65; additionally, if a physician does not act in a reasonable manner she or he may also be liable in negligence. In the *Malette* case, although there was no physical harm to the woman since her life was saved, the action of the physician giving her a transfusion despite her refusal still amounted to a battery and the physician was liable for \$20,000 in damages.

¹⁰ R.S.C. 1970, c. C-34 [hereinafter referred to as the *Criminal Code*].

¹¹ Law Reform Commission of Canada, Working Paper 28, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Law Reform Commission of Canada, 1988)

¹² But it has also been argued that the *Charter of Rights and Freedoms* (Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.) 1982, c. 11 [hereinafter *Charter*]) gives the right to a person to control future health care decisions. This may then overrule the provisions of the *Criminal Code* if there is an established "government nexus" to allow the *Charter* to apply; see Manitoba Law Reform Commission *Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care* (Winnipeg, Manitoba: Manitoba Law Reform Commission, 1990) at 9 (citing F. Carnerie, "Euthanasia and Self-Determinism: Is There a *Charter* Right to Die in Canada?" (1987) 32 *McGill Law Journal* 299 at 303-305).

"durable medical power of attorney"); or

- (3) combine both methods (i.e., appoint a proxy and give specific instructions).

These documents are based on a belief that is important to legally recognize an individual's right to autonomy and self-determination. Perhaps more significantly, however, they also reflect a societal attitude that withholding or withdrawing medical treatment in some circumstances is morally acceptable.

It is important to note that a legally recognized advance health care directive is a document made by a person who is "mentally competent" at the time the directive is given. For those who were never capable of making decisions these directives are of no assistance since some other form of substituted decision-making, usually using adult guardianship law, is required. Advance health care directives are only available for people who are capable of making them and they do not, therefore, address the equally serious question of the rights of "never-capable" individuals.

The law in Nova Scotia

Nova Scotia was the first province in Canada to pass a law providing for some form of advance health care directive. This law is the *Medical Consent Act*. This *Act* allows a capable adult to authorize another adult to provide substitute consent for, or give other directions in relation to, medical treatment. The person who is chosen is called "proxy" in this Paper. The proxy's power to make decisions is used only in the event of incapacity on the part of the other person.

The *Medical Consent Act* requires that the appointment of a proxy must be in writing, signed by the maker and independently witnessed. The appointment of the proxy is cancelled either when the person making it revokes it or when a court appoints a guardian, or when it is revoked by a judge. The court also has the ability to revoke the authority of a proxy who is deemed "incapable" and another person may then be substituted.

This Nova Scotia law only allows advance health care directives in the form of a "proxy directive". There is no provision allowing a person to give directions which are legally binding. The Commission has learned, however, that some lawyers in the province who draft proxy appointments under the *Act* also include directions as to specific treatment choices. Although the *Medical Consent Act* has been in place since 1988, research suggests that not many legal and medical professionals are familiar with it. A study conducted by the Dalhousie Health Law Institute concluded that only one-third of physicians and two-thirds of lawyers who responded to a mailed questionnaire were aware of the *Medical Consent Act*.¹³

As will be seen in the next section, other provinces and many American states have taken various approaches to the issue of how best to ensure that a person's wishes are respected in the event of decision-making incapacity through the use of advance health care directives.

The law in other places

¹³R.E. Elgie, A.M. MacIntosh & M.C. Rideout, "'Miles to Go': An Examination of the Responses of Physicians and Lawyers to Advance Health Care Directive Legislation" (Health Law Institute, Dalhousie University) [unpublished].

Only three Canadian provinces have laws which legalize advance health care directives: Nova Scotia and Quebec¹⁴ have "proxy" models while Manitoba¹⁵ allows a combination of proxy and instruction directives. Two other provinces (Ontario¹⁶ and British Columbia¹⁷) have passed laws (called Bills) which also allow proxy and instruction directives but these are not yet in force as law in these provinces.

A recent joint report of the Alberta Law Reform Institute and the Alberta Health Law Institute¹⁸ supports the introduction of legislation recognizing advance health directives by both proxy and instruction directive. The Law Reform Commission of Saskatchewan also recommended legalizing advance health care directives but it would allow advance health care directives only in the event of "final illness".¹⁹ Like its counterparts in Manitoba and Saskatchewan, the Newfoundland Law Reform Commission also examined the issue of advance health care directives in a Discussion Paper in 1992.²⁰ It too recommended legally recognizing directives by the appointment of proxy, by instruction, or both.

III SUGGESTIONS FOR REFORM

1. *Does the law in Nova Scotia require change?*

This is the most important question which the Commission faces. As discussed earlier, Nova Scotia's *Medical Consent Act* only allows advance health care directives by "proxy directive". Many people are of the view that while this is useful, there should be more choices available and, in particular, the law should also allow an "instruction directive" or a living will. Some of the reasons why appointing a proxy may not be enough include: (1) some people may not have anyone close to them who will agree to act as a proxy and, as a result, would not be able to have an advance directive; (2) some people may appoint a proxy and never discuss health care issues and therefore the proxy may not be deciding matters as the person would have desired; and (3) a proxy may be under pressure from other family members to decide a certain way and without specific instructions from the person may do something the person would not have wanted.

At the same time, however, there are concerns about living wills, especially ones which may be considered

¹⁴ *Civil Code of Lower Canada (C.C.L.C.)*, as amended by the *Public Curator Act*, S.Q. 1989, c. 54, s. 111.

¹⁵ *Health Care Directives and Consequential Amendments Act*, S.M. 1992, c. 33.

¹⁶ The *Substitute Decisions Act 1992*, S.O. 1992, c.30 and the *Consent to Treatment Act, 1992*, S.O. 1992, c.31.

¹⁷ Bill 48, *Representation Agreement Act*, 2d Sess., 35th Leg. B.C., 1993.

¹⁸ *Advance Directives and Substitute Decision Making in Personal Health Care* (Edmonton: Alberta Law Reform Institute, Report No. 64, March 1993).

¹⁹ *Proposals for an Advance Health Care Directive Act* (Saskatoon: Law Reform Commission of Saskatchewan, 1991).

²⁰ *Discussion Paper on Advance Health Care Directives and Attorneys for Health Care* (St. John's, Newfoundland: Newfoundland Law Reform Commission, January 1992).

inappropriate by family and health care providers. Most significant is the concern that the living will may not be updated by the person when it needs to be used and may not reflect changes in medical technology which might have affected the person's instructions. Similarly, some people in writing their living will use vague language such as "extraordinary means" or "reasonable quality of life". This means that someone still has to decide what the person meant and how it would apply in the particular situation. The terms used may mean different things to different people.

While these are important concerns, the Commission believes that the principles of autonomy and the right to self-determination suggest that the law in Nova Scotia should be reformed. This reform should allow people to make decisions while they are capable of doing so and should allow a more flexible approach to advance health care directives.

The Commission suggests:

That the law in Nova Scotia should be changed to allow various types of advance health care directives.

2. What type of advance health care directive model is appropriate?

As highlighted in the earlier discussions, there are a variety of forms or models for advance health care directives including:

- (i) *proxy or agency model* - this enables people to appoint someone to make health care decisions on their behalf in the event of their incapacity;
- (ii) *instruction directive or living will model* - this enables people to make a directive, indicating their wishes as to future medical treatment in the event of their incapacity; and
- (iii) *statutory list model* - this provides a list of persons who, in order of priority, have authority to consent on behalf of the person.²¹

The current law in Nova Scotia's *Medical Consent Act* operates on the *proxy model*. This approach is beneficial, especially for people who want to appoint someone they trust to make health care decisions without having to give specific instructions. Some people may prefer not to think about the types of decisions that may have to be made and for them this model may be the best form of advance health directive. In light of this, the Commission believes that this should continue to be an option for Nova Scotians.

The *instruction directive or living will model* also has benefits which have been outlined above. By providing specific instructions about the refusal of treatment or other health care issues people can assist

²¹ See Alberta Law Reform Institute Discussion Paper, note 16 above.

families and health care providers by making their decisions in advance. People frequently receive an excessive amount of medical intervention in the last weeks of their lives and if they do not want this, instructions will make this clear to health care providers. More importantly, though, it must be recognized that not everyone has someone who is willing to act as a health care proxy to make decisions for them. The Commission is of the view that this type of model should also be available to meet the needs of people who wish to provide instructions for their decision-making incapacity and do not have a proxy. The Commission is of the view that it should also be possible to combine an instruction directive with the appointment of a proxy if this is what a person wants.

The *statutory list model* is one which was proposed by the Alberta Law Reform Institute in its draft law. If a person does not have any type of advance directive, the list is used to automatically provide health care decision-making authority to people who are listed in the law in order of priority. In Nova Scotia, this is similar to the provision under the *Hospitals Act*²² which allows next-of-kin to consent to treatment if the person is in hospital and is unable to make health care decisions. Unlike the *Hospitals Act*, however, a statutory list model would apply to all health care decisions and not just ones which require hospitalization. Currently, the practice is to approach the family of a person believed to be incapable of decision-making, although this practice is not strictly speaking "legal". Only a guardian appointed under the *Incompetent Persons Act* can make substituted decisions on behalf of a person. Such an appointment process is expensive and time-consuming, however, and most physicians consult with a person's family instead. The statutory list model would, in effect, legalize what is already common practice but could also specify that "spouse" would include a same-sex partner to ensure that the appropriate person is contacted. This list would only be resorted to for health related matters only and could not be used in place of a "guardian of the person" unless the person specifically authorized it in advance. As suggested by the Alberta Institute, a person should also be able to specify who they do not wish to act as a proxy in the event that health care providers have to resort to the statutory list.

The Commission suggests:

That three models of advance health care directives should be included in the law to allow for the appointment of a proxy or the execution of a living will or both. A statutory list model which allows for substituted health care decision-making should also be included in the law for people who have not made an advance health care directive.

3. *who should be able to make an advance health care directive?*

Under Nova Scotia's *Medical Consent Act* a person must be an adult, that is, 19 years of age in order to legally create a document appointing a proxy to make health care decisions. The laws in Quebec and British Columbia also require the person to be an "adult". This is contrary to the common law, however, where a mature minor may consent to or refuse medical treatment. The test for capacity to make health

²²R.S.N.S. 1989, c.208.

care decisions is the same for minors as it is for adults at common law, that is, the ability to understand the nature and consequences of the treatment or the impact of non-treatment. For example, a recent New Brunswick case decided that a boy of 13 was capable of health care decision-making and was legally allowed to refuse blood products for the treatment of cancer.²³

Some provinces, such as Manitoba and Ontario, have chosen in their laws to say that once a person is 16 years of age, there is a presumption that he or she is capable of executing an advance directive. This is not a codification of the common law, however, since minors as young as 10 or 11 may be capable of consenting to treatment but rather it is a compromise position.

The Commission is of the view that, as much as possible, a new law should reflect the common position law and a person should not have to be an adult in order to make an advance directive. The Commission considered a number of ages and suggests, for the purposes of discussion, that the age of 16 (as is the case in some other provinces) is most appropriate. This uniformity will also assist the law in cases where people make directives and move from one province to another. Additionally, as with any legal document, there should be a requirement that the person be mentally capable in order to make an advance directive.

The Commission suggests:

That in order to make an advance health care directive a person should be 16 years of age and be mentally capable of creating a legal document.

4. when would an advance health care directive come into effect?

In Canadian provinces which have advance health care directive laws a directive comes into effect when the person who made the directive is no longer capable of making health care decisions for themselves. This is the case with Nova Scotia's *Medical Consent Act*. "Incapacity" or "incompetency" is decided by using the provincial adult guardianship law standards. This approach to when a directive comes into effect is unlike some American States where the directive comes into effect only when a person is terminally ill. The majority of Commissioners are of the view that advance health care directives should be effective whenever a person is no longer capable of making decisions for themselves and should not, unless specifically stated by the person, be restricted to cases of terminal illness. This issue is particularly important for individuals who may have lengthy periods where they are not capable of decision-making or for those who have fluctuating capabilities depending upon illness or medications. In addition, there was some concern about how to determine when an illness is "terminal". There was, however, also a view in the Commission that they should be limited to situations where a person is terminally ill. This view reflected a concern that advance health care directives might be used to prevent otherwise appropriate medical treatment of non-terminal illness.

²³*Region 2 Hospital Corp. et al. v. J.W. et al.* (1994), N.B.R. (2d) Advance Sheets, October 27, 1994, page 35.

The majority of the Commission suggests:

That an advance health care directive should come into effect whenever the maker is incapable of health care decision-making.

5. *should a person be able to revoke a directive, if so, how?*

It is important that in a matter involving personal autonomy and self-determination that a person be able to change his or her mind about a directive and revoke it when desired. This is important if one recognizes that the goal is to allow the person to maintain autonomy. There is, however, some concern about whether or not an "incompetent" person can revoke a directive which was made while he or she was "competent". Some argue that once a person is deemed or declared incompetent that the directive is in effect and it cannot be revoked.

Some people are concerned with the dangers inherent in ignoring the instructions of a person, even if mentally "incompetent", especially when the person is requesting life-sustaining treatment. One of the responses is to allow a person to revoke a directive at any time without question of competency while another approach has been to regard the person's last wishes, however expressed, to be the determining factor.

The Commission is of the view that a person must be competent in order to revoke an advance directive. It was felt that if an "incompetent" person was allowed to revoke the directive then the person would no longer be in a position to execute another because he or she lacked competency.

Further, the Commission suggests that a law should state that revocation would be deemed to have occurred if the person made a later directive; if another document states that the earlier directive has been revoked; or if the person destroys the directive or tells someone else to destroy it. This is similar to the current law in Nova Scotia governing wills.

The Commission also feels that there should be no legal requirement that the person give formal or legal notice to anyone upon revocation (as is the case in Ontario and British Columbia). This is in keeping with the Commission's desire to have as few legal formalities as necessary.

There is also some debate about the provisions seen in Alberta and Manitoba whereby a divorce (or nullity of marriage) automatically revokes the appointment of the former spouse as proxy. While some people may believe that a divorce automatically invalidates a directive, the Commission feels that ultimately, advance directives require initiative on the part of the maker and he or she should be responsible for updating them if they are no longer appropriate. The Commission in taking this view was concerned about having a law which automatically terminates an appointment.

The Commission suggests:

A person must be competent in order to revoke an advance directive. A directive will be considered revoked if the person makes a later directive; if another document states that the earlier directive has been revoked; or if the person destroys the directive or tells someone else to destroy it.

6. *what is a "health care" decision?*

A health care decision can be defined in many ways ranging from broad refusals of treatment to consent only for limited treatment. The Commission suggests that a health care decision should be understood to include a consent to health care, a refusal of health care or, in some cases, a withdrawal of consent to health care. Although many places use the language of consent to "treatment", the Commission believes that the term "health care" is a better choice since it encompasses other types of medical and diagnostic care as well as interventions which require a person's consent. For example, it is clear that consent is needed prior to taking a blood test, but this is not normally what we think of as "treatment".

The issue then becomes how to define "health care". Most of the provinces which have defined "treatment" or "health care" include anything done for a "therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment" (this is the case in Manitoba and Ontario). A course of treatment would include, for example, a course of chemotherapy. The Commission believes that this definition of health care is also appropriate for Nova Scotia law.

With respect to what types of health care decisions a person appointed as proxy can make without specific instructions, the Commission is of the view that the decisions should include decisions of a personal nature such as would be made by a "guardian of the person" under adult guardianship law. This would have the effect of allowing people not only to appoint someone to make health care decisions on their behalf but also to appoint a guardian of the person as well. This approach is akin to an enduring power of attorney for property which allows an individual to appoint someone to make all of the decisions which a "guardian of the estate" would make. This would not apply, however, to a person who becomes proxy on the basis of the "statutory list" provisions since this person has not been selected to act as a "guardian of the person". The determination of who would be an appropriate guardian in those circumstances should still be made by a court.

The Commission suggests that while a person may wish to give instructions about personal decisions which are not "health care" decisions, these instructions should not be binding on a proxy since they may not be feasible. For example, someone may indicate in a directive that she or he does not want to move to a nursing home. Since this decision would not be a "health-care decision" as defined above but would be a decision relating to the care of the person, this instruction would not be legally binding. While the proxy may do everything to accommodate this, it may reach a point where the individual needs 24-hour care and his or her instructions on this matter would have to be disregarded.

The Commission suggests:

That a health care decision should include a consent to health care, a refusal of health care or, in some cases, a withdrawal of consent to health care. Health care should be defined as anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, including a course of treatment.

A proxy who is specifically selected by a person making an advance health care directive should have power to make personal decisions on behalf of the person and to act as a guardian of the person. These powers would only be given if the proxy is appointed by the person and not if he or she is made a proxy under the statutory list of health care decision-makers.

7. *should there be any matters that a proxy not be allowed to consent to without specific directions from the person?*

In the Law Reform Commission's Discussion Paper *Adult Guardianship in Nova Scotia* it was recommended that there be some limits on what a personal guardian can consent to on behalf of another person without the court's approval. In that Paper the Commission suggested, for example, that a personal guardian should not be able to consent to procedures the sole purpose of which is sterilization.

Most provinces which have considered the issue have placed restrictions on what a proxy may be asked to consent to and also prohibited consent by the proxy to certain types of health care **unless** the person has given specific instructions that the procedure is to be used or not used. The rationale for these restrictions is to protect people from potentially abusive situations. Some of the procedures that have been prohibited in other places without specific authorization by the person in an advance health care directive include:

- (i) *Removing tissue from the maker of the directive, while he or she is living, for transplantation or for medical education or research purposes.***

Most provinces which have advance health care laws state that transplantation, from a living donor, is not allowed unless it was specifically agreed to by the person making the health care directive. For example, a person may specify in an advance health care directive that she or he wishes to donate a kidney to a sibling. If, at the time a donation is needed, the person is incapable of consenting, the wishes he or she expressed in the directive would be followed. This would require a significant change to the law in Nova Scotia because currently a proxy does not have authority to authorize an *inter vivos* (between living people) gift transplant under the Nova Scotia *Human Tissue Gift Act*²⁴. Amendments would be needed to the *Human Tissue Gift Act* to allow this in an advance health care directive.

- (ii) *Health care, the primary purpose of which is research.***

²⁴R.S.N.S. 1989, c.215.

This is a controversial matter especially with respect to experimental drug trials. Some people feel that since prior to testing on humans the drugs are tested in laboratory situations and are therefore usually without severe side effects, there is not a great risk to the person. Additionally, there is also the chance that the medication will increase the person's quality of life. Others, however, feel that some experimental medications, especially psychiatric drugs, have significant side effects and a proxy should not be allowed to consent to their use.

(iii) *Sterilization that is not medically necessary to protect the person's health.*

The Commission is of the view that sterilization is a fundamentally personal decision which should not be made on behalf of another person unless it is medically necessary or unless the person has given specific instructions agreeing to it in a directive. This is consistent with the Commission's suggestion in its Discussion Paper *Adult Guardianship in Nova Scotia* that a guardian of the person should not be able to make a decision that a person be sterilized if the procedure is not medically necessary.

(iv) *Placement in a psychiatric facility.*

The issue of placement of the person in a psychiatric facility is one of the more difficult questions. In its Discussion Paper *Adult Guardianship in Nova Scotia* the Commission proposed that a guardian should not have authority to place a person in a psychiatric facility without his or her consent. Although many people agree that a proxy should not be able to circumvent the committal criteria under the *Hospitals Act*, there is concern about specialized dementia units, for example, for Alzheimers patients. Quite frequently people refuse to go to these units and it was felt that the proxy should be able to consent in these cases. There are other types of dementia which may require psychiatric care such as AIDS-related dementia which could conceivably also be a problem.

While on the one hand the Commission does not want to tie the hands of the proxy unnecessarily, there needs to be safeguards to prevent mentally ill individuals from being placed in a psychiatric facility against their will when they do not meet the criteria for committal under the *Hospitals Act*. The Commission is unresolved at this time on this question and seeks specific public commentary on this matter.

The Commission suggests:

That a proxy should not be able to consent to the following health care procedures unless there is specific authorization from the maker of the advance health care directive:

- **Removing tissue from the maker of the advance health care directive while he or she is living, for transplantation or for medical education or research purposes;**
- **Health care, the primary purpose of which is research; and**
- **Sterilization that is not medically necessary to protect the person's health.**

The Commission is unresolved at this time with respect to placement in a psychiatric facility and seeks specific public commentary on this issue.

8. *should there be restrictions on who can be a proxy?*

There are often restrictions placed upon who can act as proxies either because of age or, more obviously, because the proxy is required to be capable of health care decision-making. For example, as noted earlier, Nova Scotia's *Medical Consent Act*, requires that the person appointed as proxy be of the age of majority. Although there is no explicit requirement that the proxy be mentally "competent", there is authority in the Supreme Court of Nova Scotia to overturn the appointment if it determines that the proxy is "incapable of giving consent".

For the same reasons discussed above about the appropriate age for presuming that a person is capable of making a directive, the Commission believes that there should not be a restriction which requires a proxy to be an adult and favours, instead, a presumption that a person who has reached the age of 16 is capable of acting as a proxy. A proxy should also be required to be mentally capable of health care decision-making.

Some places do have restrictions on who cannot be a proxy for another person. Such restrictions include persons who may be entitled to an inheritance upon the death of the person. Nova Scotia's *Medical Consent Act* contains no such restrictions, however, and the recommendations of the Law Reform Commission's *Adult Guardianship Discussion Paper* do not preclude the appointment of a guardian for the sole reason that he or she may be a beneficiary. The Commission does not agree with any other restrictions such as ones based upon whether or not the proxy will benefit under a will of the person. It is most likely, in fact, that the person selected as a proxy will be a beneficiary.

The Commission suggests:

That a person who has reached the age of 16 should be presumed capable of acting as a proxy. A proxy should also be required to be mentally capable of health care decision-making.

There should not be any other restrictions on who can act as proxy, such as ones based upon whether or not the proxy will benefit under a will of the person.

9. *should a person be allowed to name alternate or joint proxies?*

If one of the primary purposes of advance health care directive legislation is to ensure that a person's right to autonomy and self-determination are respected, it is important that everything be done to ensure that this can be accomplished. In other provinces, the appointment of alternate proxies or, in some places, multiple proxies attempts to solve problem of situations where the proxy may not be available to make a decision.

Nova Scotia's *Medical Consent Act* does not appear to consider the possibility of alternate or joint proxies in that it does not explicitly state that more than one proxy may be named and the singular is used to refer to the designate.²⁵

Most other provinces which have recognized the need for more flexibility in the appointment of proxies allow multiple proxies to act either one at a time or together with specific rules to resolve difficulties when the group is not in agreement. If multiple proxies are named in an advance health care directive, it allows for the possibility of the proxy pre-deceasing the

person who gave the directive. It also means, however, that the law must be clear about what will happen if there is a conflict between proxies.

Naming alternate proxies is another useful way to ensure that there is always someone to act for another person. The alternate person could be approached for health care decision-making if the first proxy dies, is no longer competent to make decisions, refuses to act as a proxy or is unavailable to act. With the use of alternate proxies a health care provider would normally be obliged to make reasonable efforts to contact the first named proxy.

Although the Commission supports the use of alternate proxies it does not support "joint proxies" (consisting of two or more proxies acting together) this is because there may be unnecessary difficulties created when there is disagreement among the group members. The Commission suggests that if a person names more than one proxy in a directive then the proxies should be presumed to have authority to act successively, that is, each will have authority in turn based on the order in which they are named in the document. There should not be any limitations on the number of people which the person may designate as

²⁵ Technically, it can be argued than one since the *Interpretation Act*, R.S.N.S. 1989, c. 235, s. 19(i) says that in Nova Scotia laws, words written in the singular include the plural, more than one could be appointed.

alternate proxies.

The Commission suggests:

That a person should be able to name any number of alternate proxies to replace a proxy if the proxy dies, refuses or is unavailable to act, or loses decision-making capacity. Joint proxies should not, however, be allowed and, where more than one proxy is named in a directive, they should be presumed to act successively.

10. *what principles should be applied by a proxy who is asked to make health care decisions?*

A proxy may, in some situations, be required to consent to or refuse a treatment where the person has not given specific instructions. In these circumstances, it makes sense to require that the proxy "stand in the shoes" of the person and decide as he or she would have decided given the facts and information available. This "substituted judgement" approach to decision-making is generally recognized as appropriate in the literature and legislation in the field of adult guardianship as well as in the area of advance health care directives. The provinces which have laws dealing with this issue consistently favour this approach.

The approach to decision-making that has been adopted in these provinces²⁶ can be summarized as follows:

- (1) the proxy is required to follow the instructions given in the directive if the instructions are clear and unambiguous;
- (2) if there are no specific instructions relating to the health care decision, the proxy is to decide as he or she believes the person would have decided (given what the proxy knows of the person's values, desires, etc.), known as "substituted judgement"; and
- (3) if the wishes are not known, the proxy is to act in what he or she considers to be the person's "best interests".

The Commission is concerned with this type of approach since it may mean that a proxy is required to follow specific instructions even if, given what the proxy knows of the person or in light of recent conversations, he or she is of the opinion that the person would have decided differently than as set out in the instructions. For example, a person may have executed a directive and subsequently, medical technology changes such that the person would have chosen a different course of treatment if she or he had known of it.

The Commission suggests that for a proxy who has been selected by the person, a "substituted judgement" test be used first, with the person's specific instructions providing evidence of his or her intention. If there is nothing the proxy is aware of to contradict the person's instructions, they should be followed. This

²⁶ For example, Manitoba and Ontario. This was recommended by the law reform agencies in Alberta and Newfoundland.

would give some leeway with respect to ambiguous or confusing directions as well as accommodating the possibility that a person may express a contrary desire orally without revising an advance health care directive. If there is no evidence as to intention either orally or through written instructions and the proxy does not know what the person would have wanted, it would then be up to the proxy to decide based on the best interests of the person.

The Commission suggests:

A proxy selected by a person to make health care decisions should use a substituted judgment test with the person's specific instructions, either oral or in writing, providing evidence of the person's intentions. If there is no evidence of intention, the proxy will be required to act in the best interests of the person.

11. *should notification or registration of a directive be required?*

One of the practical difficulties with ensuring that a person's advance directive is respected is the possibility that a health care provider, especially in an emergency situation, will not be aware that an advance health care directive exists. This is obviously of great concern to the person who has taken the time and effort to make a valid directive and it is also a concern to health care providers who may be treating the individual. There have been a number of responses to this concern throughout North America including the requirement that a person keep a "wallet copy" similar to a organ donor card, or make use of a 24 hour on-line computer registration for the directives.

The Commission has examined the issue of whether or not the law should require any formal notification of the existence of a directive and it does not agree with laws which require registration (as in B.C.) or validation by the Official Guardian/Trustee (as in Ontario). This is largely due to concerns about the cost of computerized registration systems but also about confidentiality with respect to computer data banks. Additionally, because some people may simply never get around to registering a directive there was concern raised about any type of mandatory system which could invalidate a directive. The Commission is of the view that the person who makes an advance health care directive should have the responsibility to let people know about its existence.

Although the Commission believes that the onus should generally be on the person making an advance health care directive to inform others, it is suggested that health care providers and health care facilities (including nursing homes) should also be required to ask an individual about the existence of a directive. If the person is incapable of informing the facility there should be a requirement to inquire about the existence of a directive with the person's next of kin. It is also suggested that it be recommended to people making directives that they should provide copies to physicians and families.

The Commission suggests:

That there should not be a formal requirement for registration or notification with respect to the existence of an advance health care directive. The person making the advance health care directive should have responsibility for telling others of its existence. However, health care providers and health care facilities should also be required to ask about the existence of a directive.

12. *should a proxy have the power to refuse to act?*

Problems may arise in cases where a proxy is selected and then later refuses to act or changes his or her mind at a later date. Obviously, the person chosen as proxy should be someone who will follow instructions, but if that person later decides that he or she cannot make the types of decisions required then problems arise with respect to how the person's wishes will be respected. In the area of enduring powers of attorney for property, most places treat the relationship as a fiduciary one. This means that there is a positive duty to act placed on the appointed person on the grounds that without it, the appointment would be futile. When it comes to health care matters however, a positive duty, together with legal sanctions for failure to act seems inappropriate.

Most places which have considered this have resolved the matter in favour of allowing a proxy to refuse to act. If there were no possibility of changing one's mind then it may be more difficult to convince someone to assume the role of a proxy in the first place. It goes without saying that in the area of proxy renunciation the use of alternate proxies will facilitate the transition if it becomes necessary.

The Commission agrees that a proxy should have the authority to resign at any time. It does not agree with the approach seen in Ontario where a resignation is not valid until notification has been given to a number of individuals. The Commission feels that a verbal refusal is also sufficient. If the proxy is still capable, however, it was decided that the proxy must notify the person who named the proxy in order to be replaced.

The Commission is also of the view that it is important to define "refusing to act" to include a person who does not expressly resign but stalls and cannot make a decision.

The Commission suggests:

Nothing in the law should compel a proxy to act as one if he or she refuses to do so. A proxy who wishes to resign as proxy must notify the maker of the advance health care directive.

13. *should a proxy be allowed to delegate decision-making authority?*

The Canadian provinces which have considered this issue have all agreed that proxies may not delegate their authority to make health care decisions to any one else. This is consistent with the general recognition of the maker's right to autonomy and self-determination. Again it is useful for an alternate to be appointed originally but if this is not done there should be no delegation of power to another. In this respect, a statutory list model is useful in that if a proxy is unwilling or unable to consent to the treatment then the health care professional can look to the next person on the list for consent and the person in need of decision-making assistance is never, in effect, without a proxy unless the list is totally used up.

There are various points of view on this matter. Some people believe that where there is no alternate proxy to act in the first proxy's absence, the proxy should be able to delegate decision-making authority for short periods of time. If the proxy is chosen because he or she is trusted, then that judgement should also be respected in allowing the proxy to choose an appropriate delegate. An example is with respect to a proxy for a person with a long-term incompetency who wants to delegate authority while on vacation.

Others, however, feel that there may be reasons why the person given the delegated authority was not chosen in the first place. The choice of a proxy is seen as a very intimate decision and that the person would give a proxy express authority to delegate if so desired and otherwise it should not be transferable. On balance, the Commission agrees that a proxy should not be able to delegate his or her authority.

The Commission suggests:

A proxy should not be able to delegate decision-making authority to another person.

14. *should health care information be available to proxies?*

Under the common law a person's health care record is confidential and in most circumstances its contents cannot be released or disclosed to anyone else without the person's consent. There are some exceptions to this, for example, under fatal injuries laws or child protection laws, but the general rule applies in most situations.

Obviously, if a person is no longer capable of making health care decisions and has appointed a proxy to act on his or her behalf it is crucial that the person have authority to see the otherwise confidential information in order to make the appropriate informed decision. Most Canadian provinces which have recently introduced laws dealing with advance health care directives have included provisions allowing for the release of medical information to the health care proxy. This is usually subject to any express limits set out by the maker of the advance health care directive.

The Commission believes that if a person specifies that certain limits are to be placed on what information can be released to a proxy then this information should not be released.

Additionally, the law should state that the proxy has a duty to keep the information confidential once it has been released, although the Commission recognizes the difficulty in not allowing family members to discuss issues together. With respect to how much medical information is to be released to a proxy, the Commission believes that only health care information which is "relevant" to the health care decision

should be released to the proxy, with the issue of what is "relevant" to be left to the treating physician.

The Commission suggests:

That a proxy should have all health care information available which is relevant to the decision to be made, subject to any limitations placed on the release of information by the maker. Also, a proxy should be required to keep the health care information confidential.

15. *should health care providers be protected from liability?*

Family and friends of an individual who has made a directive may not always agree with the instructions provided by the person. Often family members will disagree on life and death decisions - such as the removal of life-support systems or the removal of artificial hydration and nutrition. It is important, therefore, that health care providers who will be following the instructions of the proxy or an instruction directive not fear law suits from family members or others who may disagree with the decision. As a result, most places have provided protection in one form or another from liability for health care providers.

Similarly, if a health care provider is unaware of the terms of a directive it is common sense to provide protection against liability for not following the instructions. The Commission believes that health care providers should be protected from liability if they comply with a directive or if they fail to comply because they were not aware of the directive. With respect to this issue, however, there should, as noted earlier, be an onus on the provider to ask about the existence of an advance health care directive.

Many places have taken the view that there should be no penalty available under advance health care legislation against a provider who does not follow a directive. It may be against a physician's conscience or professional judgement, for example, to remove artificial hydration. As a means of protecting the autonomy of individuals who may encounter this problem, a number of States in the United States require the physician or health care provider to refer the person elsewhere if the cessation of treatment is a problem.²⁷

Other places provide penalties for a health care provider who does not abide by a directive while some leave the matter to the common law which would provide some recourse through the tort of battery. The Commission suggests that the law should not contain specific penalties or sanctions against health care providers who ignore a directive and that the person continue to have available the current common law remedies, such as battery.

The Commission disagrees with an approach which would require a physician to transfer the person to another facility. This is largely due to logistical problems involved in such a transfer, particularly in rural

²⁷ This is seen in many of the statutes in the United States while others require that the physician take reasonable steps to transfer the patient to another facility.

areas of the province.

The Commission suggests:

That health care providers should be protected from liability if they comply with a directive or if they fail to comply because they were not aware of the existence of the directive. The law should not contain additional sanctions against a health care provider who does not follow a directive and that the available common law remedies are sufficient.

16. what other legal formalities should be required?

(i) should there be a mandatory form of directive?

At present there are numerous forms of "living wills" being circulated across the country. In Nova Scotia, a group called Canadian Pensioners Concerned Ltd. have been meeting with seniors throughout the province and circulating a book entitled *Let Me Decide* by Dr. William Molloy which contains a living will form. Additionally, the Bioethics Centre in Toronto has also begun circulating a one page living will by Dr. Peter Singer.

When it comes to the particular approach of various provinces the consensus is that a simple form should be available for people to use but that the form should not be mandatory or invalidate an otherwise valid directive. The Commission agrees with this approach and suggests that there should not be a mandatory form but that a form should be included in the law. A sample form, or a number of samples, would help a person turn his or her mind to the particular issues to be addressed and would encourage people to discuss various treatment options as well as the cessation of treatment, such as artificial feeding and the use of life support machines, with a physician.

The Commission suggests:

A mandatory advance health care directive form should not be required but the law should include a sample document to show people the types of issues they should be considering.

(ii) should it be required that a directive be in writing?

Under Nova Scotia's *Medical Consent Act*, there is a requirement that the document be in writing. This does not mean that a person is required to write out the document in his or her own handwriting, but that it must be in a documented form and not oral. Most provinces do not allow directives which are given orally because of a fear of undue influence or fraud.

The Commission agrees that a directive should be in writing. Any oral instructions, however, would have

to be taken into consideration by the proxy as part of the "substituted judgement" issue discussed above.

The Commission suggests:

That an advance health care directive must be in writing.

(iii) should it be required that a directive be signed and should it be witnessed?

Most jurisdictions require that a directive be signed by the maker and witnessed by at least one, and in the case of Ontario and British Columbia, two witnesses. Most laws do not allow the proxy to witness the directive but allows a witness to sign on the maker's behalf if the maker is physically incapable of signing it.

The Commission is of the view that the directive should be signed by the person making it and if he or she is physically unable to sign he or she must direct that someone else sign on his or her behalf, but the person signing must not be the proxy or an alternate proxy. There is often some disagreement about whether or not a directive should be witnessed. Most people feel that witnessing is a good idea but there is a concern that there may be older people, living alone, who may have signed a directive without telling anyone and it may later be found by a family member when the person is no longer "competent". One of the concerns raised about this type of situation, however, is that if no-one witnesses the document no-one can attest to whether or not the person making the directive was "competent" at the time. Additionally, it was felt that having a neutral person witness the signature may assist when there is a family dispute later and adds solemnity to the making of a directive.

It was suggested, however, that there was no need for two witnesses and that one was sufficient.

The Commission suggests:

That the directive should be signed by the maker and if the person is physically unable to sign he or she must direct that someone else sign on his or her behalf, but the person signing must not be the proxy or an alternate proxy. There should also be at least one witness to the signing by the maker.

(iv) should there be restrictions on who can witness an advance directive?

Most places placed some restrictions on who can witness a directive. For example, it is a uniform rule that a proxy or alternate proxy may not witness a directive. Some also disqualify the spouse of the proxy or alternate proxy. The concern here is to avoid the potential for influencing a person to make a decision which he or she would not otherwise make. Ontario, for example, does not allow the following people to

be witnesses: the proxy or the proxy's spouse or partner; the grantor's (maker's) spouse or partner; a child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as his or her child; a person whose property is under guardianship or who has a guardian of the person; or a person who is less than 18 years old.

Similarly, British Columbia does not allow the following people to be witnesses: anyone named in the agreement as a representative (proxy) or alternate representative; a spouse, child or parent of anyone named in the agreement as a representative or alternate representative; an employee or agent of a person named in the agreement as a representative or alternate representative; anyone under 19 years of age; or anyone who does not understand the type of communication used by the adult who wants to be represented.

The Commission is of the view that a proxy or an alternate proxy should not witness an advance health care directive. The limitation that a proxy's spouse not act as a witness (as seen in other jurisdictions) is not considered necessary by the Commission. Similarly, the Commission does not feel it necessary to place any other restrictions on who can witness the document since the Commission believes that reforms should make it easier for people to make directives not more difficult with too many formalities. In keeping with earlier decisions, it is suggested that there is no reason why a witness has to be an adult and that the presumption of capacity at 16 years of age is appropriate.

The Commission suggests:

That a person who has reached the age of 16 is presumed to be capable of witnessing an advance directive. The witness to an advance health care directive should not be the proxy or an alternate proxy named in the directive.

(v) should periodic renewal of a directive be required?

Another concern with respect to advance health care directives is whether or not a directive should remain valid after a long period of time has passed and if so, whether it can be said to reflect the person's current wishes. One of the ways in which some places have attempted to safeguard against this potential problem is by requiring a periodic renewal of a directive after a certain period of time has passed. One of the difficulties with this approach, however, is that a person may simply forget to renew a directive without wanting to make any changes in instructions or proxy selection. Additionally, there will be added costs associated with a renewal of the directive which will be burdensome to many people. As a result, most provinces do not have a mandatory renewal of a directive to keep it valid.

The Commission agrees that periodic renewal of a directive is desirable to keep up to date with medical developments. This should be encouraged but it should not be mandatory, as many people will still not regularly renew a directive for the same reasons that they do not update their wills.

The Commission suggests:

That although periodic renewal of an advance directive is desirable, it should not be mandatory.

The Commission also invites comments from the public on how the issue of living wills in Nova Scotia can best be brought to the attention of Nova Scotians. In order for people to exercise their options and plan for their future health care decision-making, they need to be aware of the law and how it affects them. The Commission would welcome any suggestions about a public education campaign on these important issues.

IV SUMMARY OF RECOMMENDATIONS

1. That the law in Nova Scotia should be changed to allow various types of advance health care directives.
2. That three models of advance health care directives should be included in the law to allow for the appointment of a proxy or the execution of a living will or both. A statutory list model which allows for substituted health care decision-making should also be included in the law for people who have not made an advance health care directive.
3. That in order to make an advance health care directive a person should be 16 years of age and be mentally capable of creating a legal document.
4. That an advance health care directive should come into effect whenever the maker is incapable of health care decision-making.
5. A person must be competent in order to revoke an advance directive. A directive will be considered revoked if the person makes a later directive; if another document states that the earlier directive has been revoked; or if the person destroys the directive or tells someone else to destroy it.
6. That a health care decision should include a consent to health care, a refusal of health care or, in some cases, a withdrawal of consent to health care. Health care should be defined as anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, including a course of treatment.
7. A proxy who is specifically selected by a person making an advance health care directive should have power to make personal decisions on behalf of the person and to act as a guardian of the person. These powers would only be given if the proxy is appointed by the person and not if he or she is made a proxy under the statutory list of health care decision-makers.
8. That a proxy should not be able to consent to the following health care procedures unless there is specific authorization from the maker of the advance health care directive:
 - Removing tissue from the maker of the advance health care directive while he or she is living, for transplantation or for medical education or research purposes;
 - Health care, the primary purpose of which is research; and
 - Sterilization that is not medically necessary to protect the person's health.
 - The Commission is unresolved at this time with respect to placement in a psychiatric facility and seeks specific public commentary on this issue.
9. That a person who has reached the age of 16 should be presumed capable of acting as a proxy. A proxy should also be required to be mentally capable of health care decision-making. There should

not be any other restrictions on who can act as proxy, such as ones based upon whether or not the proxy will benefit under a will of the person.

10. That a person should be able to name any number of alternate proxies to replace a proxy if the proxy dies, refuses or is unavailable to act, or loses decision-making capacity. Joint proxies should not, however, be allowed and, where more than one proxy is named in a directive, they should be presumed to act successively.
11. A proxy selected by a person to make health care decisions should use a substituted judgment test with the person's specific instructions, either oral or in writing, providing evidence of the person's intentions. If there is no evidence of intention, the proxy will be required to act in the best interests of the person.
12. That there should not be a formal requirement for registration or notification with respect to the existence of an advance health care directive. The person making the advance health care directive should have responsibility for telling others of its existence. However, health care providers and health care facilities should also be required to ask about the existence of a directive.
13. Nothing in the law should compel a proxy to act as one if he or she refuses to do so. A proxy who wishes to resign as proxy must notify the maker of the advance health care directive.
14. A proxy should not be able to delegate decision-making authority to another person.
15. That a proxy should have all health care information available which is relevant to the decision to be made, subject to any limitations placed on the release of information by the maker. Also, a proxy should be required to keep the health care information confidential.
16. That health care providers should be protected from liability if they comply with a directive or if they fail to comply because they were not aware of the existence of the directive. The law should not contain additional sanctions against a health care provider who does not follow a directive and that the available common law remedies are sufficient.
17. A mandatory advance health care directive form should not be required but the law should include a sample document to show people the types of issues they should be considering.
18. That an advance health care directive must be in writing.
19. That the directive should be signed by the maker and if the person is physically unable to sign he or she must direct that someone else sign on his or her behalf, but the person signing must not be the proxy or an alternate proxy. There should also be at least one witness to the signing by the maker.
20. That a person who has reached the age of 16 is presumed to be capable of witnessing an advance directive. The witness to an advance health care directive should not be the proxy or an alternate proxy named in the directive.

21. That although periodic renewal of an advance directive is desirable it should not be mandatory.

